UNDER MY SKIN

The Doctor Will See You Later

I gave my name at the front desk of my new eye doctor. "Check in around the corner," said the clerk.

Two front desks, apparently. The secretary at the second one handed me some pages of demographics and medical history to fill out. In the meantime, she chatted with her associates as she scanned my insurance card.

BY ALAN M. ROCKOFF, M.D.

I sat in the waiting room as instructed. After a short while, a young man called my name. Since the ophthalmologist is a middle-aged woman, I realized at once that he was someone else.

"Hi, I'm Jeff," he said cheerily, ushering me into an exam room where he started to test my vision. ("What's the lowest line you can read? What's clearer—1 or 2? 3 or 4?")

After a few minutes, I softened my voice and said, "Please don't be offended. But who are you?"

"I'm Jeff," he explained.

"Yes, but what is your role here, exactly, Jeff?"

"I'm an ophthalmic technician," he said. "The doctor will see you when I'm done examining you and dilating your pupils."

He proceeded. In our time together, I learned a few things about Jeff. (I'm nosy that way.) Being an ophthalmic tech was his second career. His first was building custom furniture, "until I blew out my shoulder helping a buddy on a weekend." Jeff's first eye job was in the cornea department of a teaching hospital, until slow business there limited his advancement options. So far he liked private practice. He tapped clinical data onto the computer screen to his left.

I returned to the waiting room. Shortly after, I heard my name again and through a dilated blur recognized the doctor herself. Her examination was businesslike, punctuated by more taps of data onto the screen. "You have early cataracts," she said. "Not clinically significant yet, but they are there." She said I didn't need new glasses unless I wanted a different style. "See you in a year," she said, exiting. I made that appointment at the first front desk.

There are many aspects that go into a good or service. There are codes for diagnosis and procedure; these generate a fee. There are measures of efficiency and outcome aiming to streamline medical services, make them uniform, and lately, rate those who provide them. Much power and money are at stake, not to mention quality, now being energetically defined.

It's therefore understandable that for these and other reasons, many doctors delegate history taking to medical assistants, then counseling to other personnel. The doctor just comes in for the core service, the part that counts.

This seems a shame, for reasons I think go beyond sentiment, though maybe I'm fooling myself. (Without knowing the patient's background, level of motivation, and attitude toward the recommended regimen, how do you know he or she will follow it?) But larger forces at play outweigh objections like these.

Anyhow, in my own small clinical domain, I can still learn some personal things about my patients, and act as though it matters. After all, I've known many of them for a long time, some for decades.

My own internist of 25 years limited his panel and joined a national concierge firm. A colleague upstairs agreed to take me on despite a closed practice. Stan, in practice since the mid-1970's, is one of only three physicians who's been in my building longer than I have. He is quite a throwback. He has a small office, one secretary, and takes the medical history himself (no sheets). He even does his own EKG's, if you can believe it. But he does use e-mail and responds promptly.

You get the feeling that Stan actually knows who his patients are.

Stan is a vigorous guy, and he looks to practice another 5 years. Once he hangs 'em up, I figure I'll find a concierge of my own. Sometimes when you want intimacy, or its illusion, you just have to pay for it. ■

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POINT/COUNTERPOINT

Is universal vaccination of boys the next step in fighting HPV?

Boys and girls should be vaccinated.

Widespread immunization of girls and boys against human papillomavirus could fully eradicate types 16 and 18. If we miss half the equation by leaving the boys out of our vaccination strategy, that type of public health success will not be possible.

The benefits of human papillomavirus (HPV) vaccination in boys are numerous. While protecting women from HPV and the morbidity and mortality associated with cervical cancer is a significant motivation for male vaccination, males would also accrue their own health benefits through vaccination. For example, approximately 12% of oral pharyngeal cancers are caused by HPV types 16 and 18. Also, 90% of genital warts are caused by HPV types 6 and 11, which can occur in boys as well as in girls; while not life-threatening, genital warts are certainly anxiety provoking. In addition, one out of four girls and one out of six boys is the victim of sexual abuse by age 20. That's a high number of young people for whom prevention would be relevant.

ELLEN ROME, M.D.

With respect to public health, if we want to achieve herd immunity with HPV, we really need to vaccinate both sexes. There's also a larger message from society in how we choose to formulate our vaccination strategy. If we don't vaccinate boys, we are saying as a society that women and girls alone have the responsibility for society's sexual health.

Men also have a stake in the health of their future sexual partners. While boys may be only 11 or 12 years old when their parents consent to HPV vaccination, these boys and their parents will not want their future partners or offspring to be exposed to life-threatening HPV.

Cost-effectiveness estimates for vaccinating boys are not compelling at this point, but the public health benefit is clear and the medical risks associated with vaccination are extremely low. In fact, the experience with girls in the United States has been excellent, with fewer adverse events reported for the HPV vaccine than for most other common immunizations.

Making sure that all girls and women worldwide get the vaccine is the first priority, but vaccinating boys and young men would also help us more broadly prevent disease. In a perfect world, boys and girls would receive this vaccine at a young age and both would be able to reap its preventive benefits. ■

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The evidence needs time to mature.

The issue of immunizing males against HPV often comes down to whether they should receive the vaccine to protect females. Doing so is honorable and even reasonable, but at this point there is little evidence suggesting that this is cost effective.

Early cost-benefit analyses of this idea showed that a large number of males would need to be immunized to achieve even a minimal increase in protection for females. At the same time, adding males to the equation would significantly increase costs. So, until there are more compelling data to show that immunizing males will protect large numbers of females, the right thing to do is to immunize the people we are trying to protect—girls and women themselves.

KENNETH ALEXANDER, M.D.

This said, there are other reasons to consider vaccinating males. Newer data are beginning to show that HPV does more in men than might have been appreciated just a decade ago. A significant portion of head and neck cancers, anal cancers, and cancer of the larynx are caused by HPV. When you start adding up the number of cases of cancers in males attributable to HPV, you end up with roughly the same number as the amount of cervical cancer cases in the United States.

The catch is that studies showing HPV vaccines prevent these cancers in men do not yet merit changing our vaccination strategy. When the data are available, I expect we will have sound reasons to immunize males against HPV. But it will be perhaps 3-5 years before we see strong evidence related to cancer prevention benefits.

Although we are not yet in a position to offer routine HPV immunization to males, physicians still have a few tasks to consider. First, we need to ensure that all women eligible for this vaccine have the opportunity to receive it. Second, depending on the maturity of the patient, physicians can begin to discuss issues of sexuality and sexually transmitted diseases at the 11- to 12-year-old visit. This means talking to the parent and child together, then with the parent alone, and finally with the child alone. Third, we must give children honest, accurate information before they become sexually active so they can make good decisions. Even if we don't yet give young males a vaccine, we must give them the facts. ■

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