CASE STUDY 5.2

Chapter End Case: The Battle Over the Cervical Cancer Vaccine

Cervical cancer, the second most common cancer among women, claims the lives of 250,000 people worldwide every year. The disease is spread through sexually transmitted human papillomaviruses (HPVs). Up to 80% of younger women in the United States are infected 5 years after they become sexually active, although most of those who come in contact with the virus successfully fight it off. Men are also infected, though only a few develop genital warts and other symptoms. The only way to completely avoid HPV is to abstain from sex before marriage and then stay monogamous for life.

The Food and Drug Administration approved the sale of a vaccine that prevents cervical cancer in 2006. Gardasil (developed by Merck) was the first cancer vaccine ever. In clinical trials the vaccine prevented infection of the two types of HPV that account for 70% of cervical cancer and the two strains that cause 90% of genital warts. Very few negative side effects were discovered. Approximately a year later Glaxo released a similar vaccine, Cervarix. Although Gardasil and Cervarix prevent the most common types of cervical cancer, they don't eliminate the need for routine cancer screening examinations. The vaccine is most effective if it is given to girls before they become sexually active.

Public health officials hailed the release of the vaccine. "This is a huge breakthrough for public health, for prevention and for cancer prevention," proclaimed the director of the Centers for Disease Control and Prevention's National Center for Immunization and Respiratory Diseases.[1] Shortly after the vaccine was approved, Texas governor Rick Perry ordered mandatory vaccination for girls in his state. He compared vaccinating for cervical cancer to requiring vaccinations for polio. South Dakota and New Hampshire began to offer the vaccine for free. The District of Columbia, New York, Maryland, California, Minnesota, and other states considered proposals to encourage or to require cervical vaccinations for fifth and sixth graders. Provinces in Canada also started to make the vaccine available to schoolgirls.

Efforts to promote mandatory cervical vaccine programs soon ran into stiff resistance. Opponents, and even some supporters of the vaccine, raised a variety of concerns, including the following:

High cost. When first released, the three-shot Gardasil treatment cost $360–400. Public health funds devoted to vaccinations could go toward more urgent health needs such as curing breast cancer. In addition, Gardasil and Cervarix don't prevent all types of cervical cancer or eliminate the need for regular checkups.

Limited benefits. Although cervical cancer may be the second leading cause of cancer deaths among women, only 3,900 U.S. residents die from the disease annually. Current health programs, which promote regular cancer screenings, have already dramatically reduced cervical cancer rates.

Limited access. Cervical cancer is a much greater problem in the developing world, where women don't have access to cancer screening. The Gates Foundation and other groups are working to make the cancer vaccines available in poorer nations. However, it is likely that only a small portion of those who would benefit from the vaccines will have access to them.

Rush to judgment. States rushed to require vaccinations instead of first educating the public about the benefits of the treatment. Other vaccines, such as the one for chicken pox, were used on a limited basis for years before being mandated. Gardasil and Cervarix may yet be found to produce serious side effects.

Suspicions about motives. Merck, which stands to make billions from Gardasil, lobbied hard at first for mandatory vaccine programs. It contributed money to pro-vaccine candidates and campaigns and funded Women in Government, the association of female state legislators that spearheaded the vaccine effort nationally. The company later suspended its lobbying efforts in response to public criticism.

Conservative values. Religious conservatives argue that vaccinating girls sends "the wrong message" by encouraging premarital sex, not abstinence. They fear that the government would overrule the rights of parents who didn't want their daughters to be treated, although many proposed vaccine programs would allow families to opt out.

Distaste. Many parents are squeamish about vaccinating their daughters against a sexually transmitted disease when they are as young as 10 years old. Few fathers and mothers want to believe that their children will become sexually active when they enter puberty.

Equity issues. Men carry HPV and also respond to the vaccine. So far girls, not boys, have been singled out for treatment.

Based on these concerns, momentum for mandatory cervical vaccine programs has slowed. However, the battle is far from over. The next months and years will determine whether cervical cancer vaccinations become as common as those for measles and tetanus.

DISCUSSION PROBES

1. Was it ethical for Merck executives to lobby for vaccination programs?
2. Do the benefits of the vaccine outweigh its costs?
3. Should boys also be vaccinated?
4. Does vaccinating girls encourage sex outside marriage?
5. What values are in conflict in this case? Is there any way that they can be reconciled? If not, how will you determine which ones should take priority?
6. If you were a state legislator or governor, would you support a mandatory cervical vaccine program for girls in your state? A voluntary program? What ethical theory would you base your decision on?
7. What leadership ethics lessons do you take from this case?

NOTE

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CASE STUDY 5.3

Chapter End Case: Curing One Patient at a Time

When asked to name someone who exemplifies service to others, most people think immediately of Mother Teresa. Yet Mother Teresa is only one example of altruism in action. There are many other leaders who help the less fortunate at great cost to themselves. Pulitzer Prize–winning journalist Tracy Kidder profiled the life of one such modern hero, Dr. Paul Farmer, in a book titled *Mountains Beyond Mountains*. The publication of the book has inspired college students from around the United States to enter careers in international health.

Paul Farmer is both a medical doctor and an anthropologist who teaches at Harvard medical school. He is a past recipient of a MacArthur Foundation "genius" grant and an international authority on infectious diseases. With credentials like these, Farmer could enjoy the lifestyle of a wealthy doctor. Farmer runs a clinic in the impoverished highlands of Haiti instead. He splits his time between Boston and his work among the desperately poor peasants who flock to his Zanmi Lasante medical complex to be treated for everything from malnutrition and gangrene to meningitis and cancer. The organization he co-founded to support his work in Haiti, Partners in Health (PIH), also oversees efforts to eradicate drug-resistant tuberculosis in the prisons and slums of Peru and Russia; projects in Boston, Mexico, and Guatemala; and clinics in the African countries of Rwanda and Lesotho.

Farmer is consumed with bringing health care to the poor, one patient at a time. Dokte Paul, as the Haitians call him, never turns away a sick person. He and his staff go to extraordinary lengths to make sure their clients follow through on treatment plans. (Failure to ensure that patients take their medications often undermines medical projects in developing nations.) According to Farmer, "The only noncompliant people are physicians. If the patient doesn't get better, it's your own fault. Fix it."[1] Farmer walks for hours over mountain paths to visit his patients in their huts to make sure that they are taking their medicines. Along the way, he stops frequently to talk with former patients and recruits new clients for the clinic. On his frequent trips back to the United States, he shops on behalf of his patients, returning with watches, Bibles, radios, and nail clippers.

Not satisfied just to treat disease, Dokte Paul established a public health system to root out the causes of illness. Zanmi Lasante administers a variety of educational and health programs, including schools, sanitation systems, vaccination and feeding programs, and literacy campaigns. These efforts have paid off. Malnutrition and infant mortality rates in the clinic's service area have dropped dramatically. The mother-to-baby HIV transmission rate is half that of the United States; deaths from tuberculosis are rare.

Farmer's medical successes have come at significant personal cost. He works constantly, sleeping only a few hours a night in a small house on clinic grounds. His teaching salary and book royalties go largely toward supporting the clinic. When Farmer does have personal funds, he may give the money to a needy patient. Expansion of PIH has increased his already demanding travel schedule. He can spend weeks on the road, traveling between project sites, speaking at international conferences, and stopping in at PIH headquarters in Boston. He rarely sees his wife and daughter.

Some would like to call Dokte Paul a saint for his self-sacrifice, but he resists this designation. Farmer believes that sacrifice for the poor should be the norm rather than the exception. He is convinced that God has special concern for the less fortunate. They are in misery because the wealthy have refused to share: "God gives us humans everything we need to flourish, but he's not the one who's supposed to divvy up the loot. That charge was laid upon us."[2]

Although most admire his efforts, Farmer does have his critics. The majority of international health decisions are made on a cost–benefit basis, with money going where it can help the most people. Farmer ignores utilitarian considerations by spending what it takes to meet the needs of a particular patient. As a result, a few could benefit at the expense of the many. Many donors focus their contributions on one narrowly defined cause, hoping to have a major impact on one disease, such as malaria or tuberculosis. Farmer rejects this "vertical funding" approach. He believes that treating a disease such as AIDS can be the gateway to solving poverty-related problems such as women's health, high unemployment (PIH hires many local workers), and deforestation (higher employment means that fewer people need to cut trees to earn a living). Some medical experts argue that distributing free vaccines as Farmer does creates dependency and can't be sustained in the long term. Dokte Paul feels that curing the patient at hand comes first.

Even sympathetic observers argue that Farmer is wasting his time by making rural house calls when he should be addressing global health issues. Not many others will follow his example, they say. Even if they do, only a handful of the sick will be cured. However, these "journeys to the sick" keep Farmer going by helping him connect as a doctor to his patients. Failing to hike to isolated families would mean that their lives matter less than the lives of others. Farmer refuses to make this distinction. Such treks also reflect his philosophy, which is taken from the Haitian proverb that serves as the inspiration for the title of Kidder's biography of Farmer. Haitians say, "Beyond mountains there are mountains." When you cross one mountain range (solve one problem), another mountain or problem will appear. So you travel on to solve that problem as well.

DISCUSSION PROBES

1. What are the advantages and disadvantages of Farmer's methods?
2. Is Farmer wasting his time by investing so much in individual patients?

3. Do leaders have an obligation to give special consideration to the poor, as Farmer believes? Why or why not?
4. Do you think that Dokte Paul will experience burnout from sacrificing so much for others? Should he expect that others would follow his example?
5. Should altruism or utilitarianism be the basis for making medical decisions in poor regions?
6. If you could sit down and talk to Dr. Farmer, what would you ask him or say to him?
7. What leadership ethics lessons do you draw from this case?

NOTES

1. Kidder, T. (2003). *Mountains beyond mountains*. New York: Random House, p. 36.
2. Kidder, p. 79.

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1. See the following:
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