FROM THE EDITOR'S DESK

Farewell, and Thank You

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Editor in Chief

This will be my last issue as Editor-in-Chief of JLGH.

As I recounted in my editorial for our 10th anniversary issue,[1] a few years after I retired from my previous role as Founder and Director of Cardiothoracic Surgery, CEO Tom Beeman suggested that I develop and become the Editor of this journal. We published the first issue in April 2006, and now, more than 15 years later, I am retiring for a second time.

The next Editor-in-Chief, Corey Fogleman, M.D., is currently a Deputy Director of the Lancaster General Hospital Family Medicine Residency Program. He is an assistant editor and frequent contributor to *American Family Physician*, and his poems – which have won national awards – have been published in *JAMA*, *CHEST*, *Family Medicine*, and the *Annals of Internal Medicine*. He has some fresh ideas for the Journal, and I am confident it will rise to greater heights under his leadership. I will be available to assist him in any way he chooses, and I may submit some Perspectives from time to time.

The Journal is the result of many people's efforts. While I have personally selected and edited the articles we publish, production of the journal has been the responsibility of three successive Managing Editors to whom I am immensely grateful. The 10th Anniversary Editor's Desk column described the talents of the first two Managing Editors, Gina Bissett and Alrica Goldstein.[1]

In this issue I would like to pay special tribute to Jean Korten, our indefatigable and indispensable current Managing Editor.

Jean will also be retiring after this issue. During her 6-year tenure, she has greatly expanded the Managing Editor's role, and become a true partner in the Journal's production. Aside from her managerial skills, her attention to detail, and her commitment to excellence, all of which have prevented countless errors, she has been proactive in helping to develop and perfect the content of the Journal. (Because of the need to hire and train Jean's replacement, it's likely that the next issue of the Journal will not be published in December, but will be a combined Winter-Spring issue for 2022.)

I am indebted to all the members of the Editorial Board who have served at various times. They have been indispensable in suggesting articles and potential authors, and have written many articles themselves. Dr. Alan Peterson heads the list with 69 articles, followed by Dr. Roy Small with 17, Dr. Joseph Kontra with 14, and Dr. Lee Shuman with 14.

I am profoundly grateful to the successive administrations of Lancaster General for not only funding the Journal, but granting it complete editorial independence, which has continued unchanged since the merger of LGH into the Penn Medicine system.

I particularly thank Christine Stabler, M.D., Vice President, Academic Affairs, to whom I report, for her enthusiastic support and unfailing assistance, and particularly her creativity when the health system's bureaucratic routines proved a bit too inflexible for our sometimes unique needs.

Lastly, I am supremely grateful to all the authors who have contributed articles to the Journal. Unlike academic physicians, practicing community physicians are not motivated to publish by a desire to advance their careers. For our authors, the often unfamiliar act of writing an article is generally prompted simply by a desire to educate and inform others.

As this is the last issue for which Jean and I are responsible, the content is special. We did not solicit new articles for this issue so that – aside from a few articles that were already in the pipeline – we could recapitulate some of our "greatest hits" – articles that I feel have enduring importance. We only have space to reprint a few such articles in their entirety; for others, depending on how they have aged, we are publishing either updates or synopses. The original articles are referenced, and remain available online.

In this valedictory column, I will also mention some features of the Journal that I consider distinctive, and focus your attention on the topics that I feel remain surpassingly important for our times.

Some of the innovations we've developed over the years include publishing entire issues devoted to a single topic, e.g. obesity;[2,3] creating new sections such as Perspectives, Spotlight on Clinical Research, and Photo Quizzes; and convening virtual round tables to discuss controversial topics such as screening for prostate cancer with PSAs.

Many readers still seem unaware that our pages are perforated near the spine so that single articles can easily be removed for reading whenever convenient.

The Editor's Desk is, of course, my most salient opportunity to put my personal stamp on this Journal. To the delight of some and the dismay of others, I have freely expressed my views on medical issues that interest me, provoke me, give me hope, or lead me to despair.

Among the topics that I've dealt with are:

- Physician-Assisted Dying (PAD).[4,5] This choice should be seen as a matter of personal autonomy, just like refusing vaccination. But though PAD doesn't affect others, conservative politicians oppose one and favor the other. As a physician, I see the matter in simple terms: since we go to elaborate extremes to alleviate suffering among the living, why should we not do the same for the dying when they ask for our help?
- The centrality of evolution to understanding human biology. In a column on diet and the heart,[6] I said: "… as biologist Theodosius Dobzhansky famously observed, 'Nothing in biology makes sense except in the light of evolution.' "

This statement need not conflict with one's faith. Dobzhansky was a Russian Orthodox Christian, and he argued that Christianity and evolutionary biology are compatible. He said "Evolution is God's, or Nature's method of creation. Creation is not an event that happened in 4004 BC; it is a process that began some 10 billion years ago and is still under way." The Jesuit priest Teilhard de Chardin said: [Evolution is a] "general condition to which all theories, all hypotheses, all systems must bow… if they are to be thinkable and true. Evolution is a light which illuminates all facts…"

- Randomized trials are not always the best way to compare therapies. Unlike trials that compare one drug regimen with another (or with a placebo), trials that compare new procedures with established ones or with medical therapy have inherent biases that occur before, during, and after randomization.[7]
- The potential problems of Big Data.[8] Electronic Medical Records now provide an irresistible treasure trove of data that will be computer-mined by aspiring academicians. They will identify many previously unsuspected associations, but association does not mean causation, so we will conduct many studies to determine which associations are meaningful. Even if the statisticians can save us from the most egregious errors, we are likely to waste much time and resources going down many blind alleys.
- The quality of medical writing. Anyone who has written for JLGH knows that I personally edit every article. In my column for the Fall 2012 issue I wrote: "It is an editor's job to help authors with phrasing, grammar, and syntax … I want to ensure that the reader doesn't have to stop repeatedly to figure out what the writer is trying to say – a problem that is sadly common in medical writing." [9]

Those are some of the topics of my previous columns. As I look ahead at problems that should concern us as physicians, three issues rise above the others:

1. Disparities in health care and the lack of universal access;
2. Growing distrust of science;
3. Global warming.

1. Our continued failure to develop a system of health care that offers universal access and basic care for all, makes us unique among developed nations. For those who oppose anything that increases the role of government, opposition to universal health care is deep-rooted, regardless of the benefits. Ironically, single payer health care would provide such large savings that it would likely enable a tax cut.

Inequality in health care threatens the health of us all. If that wasn't apparent before, the COVID-19 epidemic has demonstrated that a communicable disease will lethally exploit a system that lacks equal access.

It is notable that a disproportionate share of minorities remain unvaccinated for various reasons, but rarely because they are ideologically opposed to it as a threat to individual freedom.

An NAACP survey [10] in November 2020 found that only 14% of Black respondents trusted the COVID vaccines' safety, and only 18% would definitely get vaccinated. Though the conventional explanation for this racial gap is the mistrust engendered by three historical atrocities — Sims, Lacks, and Tuskegee [11] — that isn't the whole story. The authors concluded that a

more powerful reason is "the everyday racism that Black communities face."

In JLGH we drew attention to racial disparities in health care by publishing several articles on this topic by minority authors.[12,13,14] I particularly draw your attention to the personal narrative by Dr. Cherise Hamblin of our medical staff, which is reprinted in this special issue

The more that I contemplate the problem of systemic racism in America, the more certain I am that a white person – even one acutely aware of these problems and anxious to help rectify them – cannot ever truly understand what it is like to live in America with skin that is not white.

2. The Republican war on science is a particularly dismal development, because it hamstrings efforts to deal with problems that require unanimity of purpose. Sadly, starting with the Trump administration, many leaders of the Republican party have promoted a spurious choice between freedom and science, which harms us all in our need to deal with global issues like COVID-19 and global warming. I have dealt with this problem with growing alarm in previous columns. [15,16,17]

The American public is inadequately educated about science and the scientific method, but they used to trust scientists, especially about public health. The Salk vaccine for polio was embraced despite an early maufacturing error that made some batches of the inactivated live virus fatally infectious. Similarly, everyone of a certain age has a scar on their shoulder from a smallpox vaccination.

One of this country's founding principles was individual rights, but many seem to have forgotten that with rights come responsibilities. They fail to understand that a society with an overemphasis on individual freedom and a deficiency of communal responsibility is a society in chaos. Their insistence on freedom to fight public health measures like vaccination and masking gives freedom a bad name.

Today, the Internet and social media make everyone their own expert. People are easily misled into believing bizarre and outlandish misinformation like "vaccination makes your arm magnetic." For the gullible, it is no longer clear what is true.

3. Lastly, global warming is the overriding concern of our times. It is astonishing that Trump called climate change "a hoax," and did his best to actively counter efforts to mitigate it.

In this issue we reprint a seminal article by Dr. Joseph Kontra on infections that arose from melting permafrost in Siberia. We also invited an article by Dr. Alan Peterson on climate change and health. If the predictions of oceanographers are correct and the Atlantic Meridional Overturning Circulation slows down or – perish the thought – stops,[18] it won't be our health we need to worry about, it will be our survival.

As I bid you farewell and thank you, my gravest concern is about the growth of irrationality and superstition in America; they are hostile to the influence of science and to the survival of civilization.

Withal, it has been an honor and privilege to edit the *Journal of Lancaster General Hospital.*

> *Superstition is, always has been, and forever will be the foe of progress, the enemy of education, and the assassin of freedom.*
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> —Robert Green Ingersoll (1907)

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