Correspondence

The Editors will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words and must be typewritten, double-spaced, and submitted in duplicate (the original typescript and one copy). Authors will be given the opportunity to review the editing of their correspondence before publication.

Public Interest in Human Growth Hormone Therapy

To THE EDITOR: Before the availability of synthetic human growth hormone (hGH), the limited supply of pituitary hGH dictated its use. Now that this issue and the risk of infectious contamination have been resolved, hGH is being used in conditions other than classic growth hormone deficiency, such as Turner's syndrome. The decision to treat is no longer based only on hormonal levels but involves such factors as growth velocity, predicted ultimate height, and the concerns of the patient and parents. The largest potential use of growth hormone probably is for short, otherwise normal children who do not have classic growth hormone deficiency.[1] An extension of this process would be to consider the use of human growth hormone to augment the height of children of "normal" stature, an issue of obvious ethical importance.[2]

To determine the nature and effect of public interest in hGH, questionnaires were mailed to 1,291 (17%) of the 7,494 licensed family physicians, general practitioners, and pediatricians in Texas. Six rural and six urban counties were arbitrarily selected as target areas. Of the 517 respondents (40% return rate), 226 (44%) reported an estimated 1,042 inquiries over a five-year period. Parents made 833 (80%) of the inquiries; 92% of these were considered appropriate (short stature) and only 8% inappropriate ("normal" height, athletic enhancement). Although only 209 (20%) of the inquiries were initiated by the patients themselves, nearly half of these (42%) were considered by the physician to be for inappropriate reasons. Only 8 inquiries were for females and 5 for nonwhites.

The data derived from this study should be viewed with caution since the information obtained depended by necessity entirely upon physician recall as well as his or her own interpretation of an "appropriate" inquiry. We think, however, that the scope of the survey was of sufficient magnitude to provide a reasonable estimate of the frequency with which primary care physicians (excluding internists) are approached with questions about human growth hormone.

The results indicate that young white males and their parents are the largest group interested in hGH and the most common reason for inquiry is for short stature. There is a relatively small but definite interest in hGH for athletic enhancement by both parents and patients. Although 44% of respondents reported having at least one inquiry about hGH, the fact that, overall, only 156 (15%) of the 1,042 inquiries were considered "inappropriate" suggests that public interest in hGH (in the region surveyed) is largely for legitimate reasons.

While there is still potential for the misuse of hGH, which could escalate in the future, current interest in the inappropriate administration of this hormone appears to be less than that for anabolic steroids.[3] This may be related to the relatively high cost of hGH, the necessity for parenteral injection, and limited public awareness of the greater availability of the synthetic preparation.

PAUL S. SALVA, MD, PhD
Department of Pediatrics
Indiana University Medical Center
Indianapolis, IN 46223

GEORGE E. BACON, MD
Department of Medical Education & Research
Butterworth Hospital
Grand Rapids, MI 49503

REFERENCES

1. Gertner JM, Genel M, Gianfredi SP, et al: Prospective clinical trial of human growth hormone in short children without growth hormone deficiency. J Pediatr 1984; 104:172-176

2. Lantos J, Siegler M, Cuttler L: Ethical issues in growth hormone therapy. JAMA 1989; 261:1020-1024

3. Salva PS, Bacon GE: Anabolic steroids: Interest among parents and nonathletes. South Med J 1991; 84:552-556

Tort Reform Works

To THE EDITOR: I read with great interest the article about tort reform in the WAMI states (Washington, Alaska, Montana, and Idaho) by Rosenblatt and colleagues in the June issue[1] and their discussion of the relationship of such reform to access to obstetric care. Although the authors correctly state that it is too early to judge the effectiveness of these reforms, I am concerned that the article might plant in the minds of readers some doubt as to the effectiveness of tort reform in general.

In California our experience under the Medical Injury Compensation Reform Act (MICRA), enacted in 1975, has been so favorable that MICRA is now being used as a model for proposed national legislation and is the centerpiece of changes recently advocated by the President.

Our ability to draw firm conclusions in California rests on two major premises. First, the cap on noneconomic damages and periodic payment of future damages are superior to those in the WAMI states. Our $250,000 cap on noneconomic damages contrasts with Washington, where there is no cap. (A variable cap enacted in 1986 was struck down by the Washington Supreme Court in 1989.) In Alaska the cap is $500,000 with exceptions for physical impairment and disfigurement; in Montana there is no cap; in Idaho the cap is $400,000.

California's provision for periodic payments of both economic and noneconomic future damages applies at the request of either party at a threshold of $50,000. In Washington noneconomic damages must be paid up front. This is an especially adverse feature in view of the striking down of the cap in 1989. In Alaska there is no threshold, but the court is allowed to require periodic payments. In Montana there is no provision for periodic payments; in Idaho the threshold is $400,000.

Among the WAMI states, Montana is worthy of special mention. With the exception of pretrial screening, no major tort reforms exist. Moreover, the effects of the screening panels are further weakened because their findings are not admissible at subsequent trial. We insure most of Montana's doctors and find its tort climate and legal culture to be highly

adverse to medical defendants. Montana—without notable tort reform—should not have been included with the other three states by the authors.

We can draw conclusions regarding the effectiveness of the California reforms because they have been in place for over 15 years, whereas in the WAMI states they are much more recent. There are two reasons for the very long lag between the enactment of tort reforms and the manifestations of their effectiveness. First, the reforms must survive the perception that they are unconstitutional. This required four constitutional challenges and ten years in California. Newly enacted reforms apply only prospectively to cases filed *after* their enactment. Thus, cases that find their way to trial over the next four to five years do not reflect their effect. Additional years need to pass before there are enough cases affected by the reforms to allow any conclusions about their effectiveness. Depending on the speed with which cases come to trial in a given state, this interval is never less than five or six years, and in a state with much litigation and crowded court calendars, the delay can be as long as 10 to 12 years.

Even when reforms have been enacted, until their survival is reasonably certain, insurers must continue to reserve funds on a worst-case basis—that some or all of the reforms could be nullified by subsequent legislation or could be struck down by the courts. Insurers simply cannot chance the possibility of being caught short in their reserves. This explains why insurance premiums do not go down immediately following the enactment of tort reform.

While the debate on tort reform revolves around the small minority (5%) of cases that go to trial, the ultimate effect of reforms must be gauged by those cases that are settled short of trial and on which the trial reforms have an "umbrella" effect. Thus the negotiated cases, where the bulk of the transactions take place, suffer from the same "tort reform lag."

In California, medical malpractice premiums in 1975 were among the highest in the nation. They now stand at 35th, well below the national average. In our company, the average premium (all specialties) has declined 31% in constant 1976 dollars, not counting large policyholder dividends that have been returned which further lower the effective premium. The premium and policyholder dividend history of the other three doctor-owned companies in California is similar. In addition, all four California companies have completely repaid many millions of dollars of the original surplus contributions made by their early members to capitalize the companies. The American College of Obstetrics and Gynecology has stated that premiums for obstetricians and gynecologists in District IX, California, are the lowest in the nation, a point that pertains directly to Rosenblatt and colleagues' article.

Yes, tort reform does work. Our task now in California is to prevent the legislature from overturning all or parts of MICRA. This continues to be a major threat to stable cost and availability of insurance for doctors and, more important, for the protection of their patients.

JOSEPH D. SABELLA, MD
Chairman of the Board
Chief Executive Director
The Doctors' Company
PO Box 2900
Napa, CA 94558-0900

REFERENCE

1. Rosenblatt RA, Bovbjerg RR, Whelan A, Baldwin LM, Hart LG, Long C: Tort reform and the obstetric access crisis—The case of the WAMI states. West J Med 1991; 154:693-699

Medical Tourists

To THE EDITOR: I was intrigued by the conclusions of Fred Wurlitzer's commentary, "Volunteering in West Africa." I admire the spirit that draws Dr Wurlitzer and thousands like him to volunteer their services to those in dire need. Dr Wurlitzer concludes that the interventions of visiting physicians will fail to make a difference to the overall medical conditions in Third World countries unless these visiting physicians address public health measures such as vaccinations and sanitation and the improvement of the indigenous health system.

Despite his conclusion, Dr Wurlitzer seems to encourage physicians to volunteer in the Third World even if they are not in a position to contribute to the aforementioned endeavors. He even underscores the importance of surgical training. I would agree with Dr Wurlitzer that while the rule of rescue calls on physicians to do something to ameliorate the horrible suffering and dying that goes on daily in the Third World, in the long run the visiting clinician probably takes more from the visit in terms of adventure and experience than does the needy community.

What Dr Wurlitzer fails to mention is the potential for the visiting clinician actually to do harm by further highlighting the glamour of Western physicians, detracting from the community's willingness to interact with their own village health worker. This undermines the ability of these "barefoot doctors" to deliver their essential services long after the Western physicians have departed.

The appropriate conclusion from Dr Wurlitzer's experience is that physicians who are intent on truly being of service abroad will focus their efforts on the public health measures so aptly described in the article. Ideally those who volunteer abroad would be able to make a long-term commitment to strengthening and improving the health services in the community they choose to serve. Younger physicians may even wish to acquire training in public health before serving abroad. Perhaps if the full wisdom of Dr Wurlitzer's observations were implemented, then the current press of Third World interlopers would amount to something more than medical tourism.

DAVID BISHAI, MD, MPH
Resident Physician
UCLA Preventive Medicine Dept.
1558 Brockton Ave. #8
Los Angeles, CA 90025

REFERENCE

1. Wurlitzer F: Volunteering in West Africa. West J Med 1991; 154:730-732

* * *

Dr Wurlitzer Responds

To THE EDITOR: Commitments by medical personnel to work in public health for one or more years in Africa are needed. Concerns about the role of the village health worker are valid, but allow me some observations.

Most African national medical professionals are not "barefoot doctors." At the hospitals I attended in Sierra Leone and Zaire, the permanent expatriate staff taught public health, nursing, and surgery. One national, who had no MD degree, did several hundred hernia repairs yearly very well after such practical training. Even if expatriate staffs were to depart, I am confident many nationals would continue medical care and that many communities would continue to react positively to them. In fact, many hospitals exist today in Africa that are run well and entirely by nationals following