Why doesn't the California Medical Association work with the physician members of the legislature to introduce legislation that would require the Medical Board and the Department of Consumer Affairs to sample expert professional opinion on issues at the growing edge of medicine. It would be the further responsibility of the Medical Board or the Department of Consumer Affairs to publish these opinions in the public interest.

A vital piece of the new legislation would be that the Department of Consumer Affairs or the Medical Board be empowered to contract with long-established, viable, and representative professional organizations to provide the technical and clinical bases for opinions.

This is, of course, the germ of an idea only, but at least it is an attempt to reactivate the Medical Practice Opinion Program and at the same time protect it from capricious or venal suits.

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REFERENCE

1. Williams HE, Ramsey LL: The perils of providing medical opinion—A state medical association's experience. West J Med 1991 Aug; 155:183-185

Mistreatment of Gay Medical Students

TO THE EDITOR: I read with great interest the report by Dr Baldwin and colleagues concerning medical students' perceptions of mistreatment during their training.[1] Several areas of abuse were discussed, including humiliation, threats of physical harm, actual physical violence, and sexual, as well as racial, harassment.

There exists another form of sexual abuse, however, that was not specifically mentioned in this very well-written and thoroughly researched paper—the abuse perpetrated on gay and lesbian medical students by some members of faculty, medical staff, nursing staff, resident physicians, and peer student groups.

One type of abuse is the general and practically universal blindness of the medical profession toward the existence of gay physicians and medical students. Although many would deny their existence, gay health professionals clearly exist.[2,3] The conspiracy of silence and the unwillingness to acknowledge the presence of gays in medicine make it virtually impossible for a gay medical student to have access to gay role models. Many gay faculty and staff physicians do not feel comfortable about revealing their gayness because of potential reproach or hostility from peers or authority figures. I know this because of my own gayness.

Physicians and other health professionals have been shown to harbor very negative attitudes towards gay medical students and gay physicians.[4,5] These negative and prejudicial feelings are occasionally openly demonstrated, often in the form of a "joke," at which the gay or lesbian medical student may feel compelled to smile. Gay health professionals may be exposed to homophobic snide remarks, snickers, and derogatory comments and gestures. These I have personally encountered, a result of which I have felt hurt, anger, resentment, fear, humiliation, and embarrassment; in short, I was abused.

Most people assume the heterosexuality of physicians, and some feel compelled to force heterosexual behavior upon them. One of my teachers made a vigorous attempt to persuade me to date a certain woman physician, to my utter humiliation and confusion. I do not date women and trying to make me do so is a form of sexual abuse.

Being a gay physician, I know how much it can hurt to hear people unjustly comment on a sexuality about which they actually know little. This bigotry is clearly a form of sexual abuse. Gay and lesbian medical students need not be subjected to these painful, ignorant, and biased forms of behavior from teachers, peers, or co-workers.

I am happy and proud of my gayness. I have revealed the fact that I am a gay pediatrician through my published work.[6] I will not be silent about the pervasive sexual abuse being done to gay and lesbian members of the medical profession, including our medical students, who are particularly vulnerable to this outrage.

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REFERENCES

1. Baldwin DC Jr, Daugherty SR, Eckenfels EJ: Student perceptions of mistreatment and harassment during medical school—A survey of ten United States schools. West J Med 1991; 155:140-145

2. Wolcott DL, Sullivan G, Klein D: Longitudinal change in HIV transmission risk behavior by gay male physicians. Psychosomatics 1990; 31:159-167

3. Sharkey L: Nurses in the closet: Is nursing open and receptive to gay and lesbian nurses? Imprint 1987; 34:38-39

4. Matthews WC, Booth MW, Turner JD, Kesler L: Physicians' attitudes toward homosexuality—Survey of a California county medical society. West J Med 1986; 144:106-110

5. Wallack JJ: AIDS anxiety among health care professionals. Hosp Community Psychiatry 1989; 40:507-510

6. Fikar CR, Koslap-Petraco M: What about gay teenagers? (Correspondence). Am J Dis Child 1991; 145:252

HIV Incidence in Nevada?

TO THE EDITOR: In their recent article summarizing the epidemiology of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) in Nevada, Jarvis and Semiatin state there were 737 new HIV "seroconversions" during the first 12-month period (beginning July 1988) in which laboratories were required to report positive HIV test results, with an additional 100 "seroconversions" reported each year from anonymous test sites.[1] The authors conclude that "Taken together, these statistics seem to indicate that Nevada is experiencing nearly a thousand new HIV infections each year."[1(p40)] We think the data presented are not sufficient to estimate HIV incidence.

The authors present HIV testing and seroprevalence data from laboratories, anonymous test sites, civilian applicants for military service, unlinked anonymous newborn testing, and mandatory screening of newly incarcerated prisoners. These data measure the number of HIV-infected people in each population at the time testing was done but do not indicate when HIV exposure or seroconversion occurred. Prevalent HIV infection estimates represent the sum of new infections occurring in past years minus the number of deaths and migrations out of the state. Thus, incident HIV infections in the most recent year may represent a relatively small proportion of the infections cited by the authors. In addition, seroprevalence estimates may be artificially biased upward because many unlinked seroprevalence studies and anonymous testing strategies cannot differentiate the number of unique seropositives versus the number of positive antibody tests. Finally, persons at increased risk for HIV infection may be more likely than persons at lower risk to seek publicly funded services where antibody testing may be available.

Estimating the number of new HIV infections during a