Letters to the Editor

The Journal welcomes letters to the editor. If found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with Journal style. All letters that reference a recently published Journal article are sent to the original authors for their reply. If no reply is published, the authors have not responded by date of publication. Send letters to Paul M. Fischer, Editor, The Journal of Family Practice, Department of Family Medicine, Medical College of Georgia, Augusta, GA 30912, or Fax (706) 855-1107.

VASECTOMY PROCEDURE

To the Editor:

In a recent letter published in this column (*Blue B. Vasectomy procedure [letter]. J Fam Pract 1992; 35:254*), Dr Blue told of his practice of saving a portion of the vas after performing a vasectomy so that if the sperm count failed to drop as expected, the vas specimen could be sent to the laboratory to prove that the proper tissue was excised and ligated.

I submit that a malpractice attorney would almost certainly try to establish to a jury that such a move was self-serving for the physician and that he would have ample opportunity to substitute someone else's specimen for the one in question. In the current medicolegal climate, I think the physician would have difficulty proving beyond doubt that a specimen saved for several months was, in fact, the one submitted to the laboratory after the fact. This is a pity. I do not doubt that Dr Blue is scrupulously honest, but I have seen the credibility of physicians I knew to be perfectly honest cut to pieces by unscrupulous plaintiffs' attorneys operating within the rules of a court.

Craig B. Leman, MD
The Corvallis Clinic
Corvallis, Oregon

The preceding letter was referred to Dr Blue, who responds as follows:

There is nothing that is out of the realm of possibility when it comes to professional liability claims. As Dr Leman points out, specimens submitted from a private office could indeed be subject to tampering, given an unscrupulous physician. However, this tampering could also occur by specimens submitted on the spot from a previous patient who was known to have a successful vasectomy procedure.

Although we must all practice medicine with a shadow of professional liability over us, practicing good medicine is probably the best way to avoid incursions into the legal system. If indeed a patient's sperm count does not drop, he is offered a repeat procedure at no charge regardless of the pathologic findings of the specimen submitted. We inform the patient multiple times, and document it in the medical record, that he is not sterile until proven sterile by a postvasectomy sperm count and is informed so by this office.

We are all subject to being sued regardless of the quality of medicine we practice. Our only defense, both legal and psychological, is to practice the best medicine we can.

Brent A. Blue, MD
Jackson Hole, Wyoming

HUMAN GENOME PROJECT

To the Editor:

The editorial on the Human Genome Project[1] was well taken.

I am not really worried about how thoughtful, well-meaning parents and physicians will use this information.

The problem is the societal and intellectual trends that assume that marketplace values such as profit and wealth, success, and individual pleasures and desires are *the* ultimate values.

Indeed, we read continually how we need to consider a person's economic worth and ability (aka "quality of life") in "life and death" decisions—nearly always to the detriment of the chronically ill or handicapped person.[2–4] To paraphrase Elie Wiesel: we, as a profession, are getting quite used to the idea that certain people are "the other": strangers, or merely bodies that are better off dead, rather than our brothers to whom we owe compassion and love.

A society that judges human worth by IQ and success may not limit the use of the biological engineering to merely eliminate lethal genes and treat genetic illnesses. The danger is that some will use the project to fulfill "scientifically" the vision of the superman: a society of smart, successful, perfect "self-actualizing" people.

But, as history shows, combining the idea that "real" humans are perfect with the idea that some humans are better off dead is a lethal combination, both for those labeled "inferior" and for the ideas of compassion and justice.

The book *The Good Society* by Bellah et al[5] discusses how we need to revive our traditional democratic and religious values to counteract marketplace thinking in the sociological and economic sphere. In the recent presidential election, discussions of "family values" and "the new covenant" were merely different ways of pointing out the need to counteract the greed and hedonistic trends tearing apart society.

In the same way, we need a similar infusion of values to counteract the increasingly amoral trends in our own professional "ethics."

N. K. O'Connor, MD
Nanty Glo, Pennsylvania

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4. Callahan D. Setting limits: medical goals in an aging society. New York: Simon & Schuster, 1987:133–53.
5. Bellah RN, Madsen R, et al. The good society. New York: Alfred A Knopf, 1991: 3–51.

The preceding letter was referred to Dr Stein, who responds as follows:

A heartfelt and grateful amen to Dr O'Connor's moving letter. I could not, alas, situate the Human Genome Project more widely in a single, brief essay.

The Human Genome Project is but one expression of our conflicting values as a nation. Social darwinism may take us only where we wish to be taken, though with the blessing of "science" as our alibi so that we feel no anxiety, guilt, or shame. Managed genes are but an extension of a society that thinks of "managing" care, managing workplaces, managing all relationships, as though humans are motoric creatures, good only for production and then for disposal when we can no longer "produce." Disposable genes and disposable categories of less-

than-perfect people are part of the same view of human nature and of social "healing." Our society has accumulated a large collection of internal scapegoats, virtual enemies, of people condemned to be strangers in our midst, though a strangership of our own complicity.[1] In refusing to face them, in making them expendable, we refuse to own our disavowed sexuality, aggressiveness, dependency wishes, and the like.

These embody what the "normal" mainstream cannot bear to think or feel of themselves—ourselves, in most cases. Who are these? The poor, the homeless, the uninsured, the aged, the infirm, those with STDs and HIV, the unemployed, the widowed, the racial and ethnic and gender minorities. Dr O'Connor sees clearly that those whom we are quick to discount and condemn as worthless are the opposite side of our chrome-plated and polished values of smart, successful, perfect people. It is a pity that Abraham Maslow's[2,3] concept of "self-actualization," one in which inner growth and relatedness to others are part of the same synergistic process, has come popularly to connote voracious, encapsulated greed.

The social world in which the Human Genome Project takes place is, among others, also the world of the 1991 American war with Iraq, the 1992 Los Angeles riots, and the proliferation of pariah groups within the United States as the Soviet Union—the former "evil empire" of Cold War ideology—succumbs to its own nationalisms. Disturbing as it is to say, neglecting and killing are part of the social atmosphere in which the proposed large-scale genetic curing takes place. As an ideological system, the biological fantasy of perfect and flawed human beings continues to fuel and inflame racism, social classism, ethnic hatreds, and nationalism—our own included. The nationalistic fantasy of the perfect, immune body politic, the obsession with ethnic purity and eradication of those deemed defective, reached its most sinister in the National Socialist experiment in the Germany of 1933 to 1945. It was one in which a nation's physicians, psychiatrists, even many psychoanalysts, subscribed and succumbed to the "Great Treatment" in which hate was medicalized and thoroughly rationalized so as to appear as euphemism and harmless protocol.[4–7] While ours is not the direct heir of Bismarckian social hygiene, in our compulsive extremes of the fitness and wellness movements since the late 1970s,[8,9] we share other nationalists' dread of impurity, weakness, dependency, and death. We magically try to purchase time, immortality, by living off those whom we sacrifice. Ironically, in our hearts we do not wholeheartedly believe in our hard-driven marketplace productivity; if we did, we would not need to keep our society so well stocked in categories of "defectives." With Pogo, we would see that the enemy is us.

My only reservation about Dr O'Connor's analysis and proposal concerns his wish to "revive our traditional democratic and religious values." I worry about invoking and exulting traditional values as a counterweight to the oppressive individualism and entrepreneurism of the present. In its time, each social system has waged its own tyranny—whether religious, economic, family, or political[10]—against which people eventually revolted. Tradition can be as coercive as its repudiation. Moreover, we constantly reinvent "tradition" ("the way we were") through the needy eyes, the yearnings, of the present. It is all too easy to sentimentalize a past we did not have to endure.

What is now needed, I believe, is less a return to some imagined past, as a learning to have compassion for our own less-than-perfect selves, for our own mortality, for our own multitude of out-of-control characteristics, and for those people whom we are all too quick to brand and bureaucratically eliminate as sick or defective. I am indebted to Dr O'Connor for his thoughtful and aptly disturbing reply to my paper.

Howard F. Stein, PhD
Oklahoma City, Oklahoma

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LOVASTATIN vs PIB

To the Editor:

The review article (*Buchwald H, Fitch L, Campos C. Partial ileal bypass in the treatment of hypercholesterolemia. J Fam Pract 1992; 35:69–76*) of partial ileal bypass (PIB) compares the efficacy of PIB with pharmacological interventions in terms of net reduction of serum cholesterol. The authors conclude that the surgical intervention compares favorably. The authors also compare the cumulative costs of a single pharmacological agent at two doses, lovastatin 40 mg daily, and lovastatin 80 mg daily, with the cumulative cost of PIB. It is worth quibbling over these cost estimates. On initial inspection, it appears from the authors' estimation that PIB is dramatically more cost-effective in terms of cumulative dollars spent over a period of up to 20 years. The authors choose to compare the costs of PIB with one of the most costly pharmacologi-cal interventions, Lovastatin, on the grounds that it is the most effective hypocholesterolemic drug available today. The analysis fails to provide a comparison of PIB with other less expensive hypocholesterolemic agents, but this is only a minor point. When comparing cumulative costs, one ought to keep in mind the principles of compounded interest. Anyone who has purchased a house knows that the purchase price is much less than the cumulative incurred price over the 30-year mortgage period. The same rationale applies to the cumulative cost of medication or surgery.

Using the same purchase prices as given by Buchwald et al, the following table indicates the cumulative dollar cost of lovastatin, 40 mg daily; lovastatin, 80 mg daily; and PIB at various time intervals, assuming an annually compounded interest rate of 8%.

Treatment	Year 1 ($)	Year 5 ($)	Year 10 ($)	Year 20 ($)
Lovastatin 40 mg daily	1,275	7,480	18,470	58,348
Lovastatin 80 mg daily	2,550	14,959	36,939	116,690
Partial Ileal Bypass	11,393	15,499	22,773	49,166

One can compare this table with Table 3 in the article by Buchwald et al in which the 20-year cost for lovastatin, 40 mg daily, is $25,500; for lovastatin, 80 mg daily, is $51,000; and for PIB is $11,393.

Buchwald et al consider the $11,393 cost of surgery to be a fixed expense, worth the same $11,393 after 20 years. In fact, one could have invested the money (or, perhaps more accurately, the insurer could have invested the money). If the investment earned 8% compounded annually, then the cumulative value of that $11,393 investment after 20 years would be $49,166, more than four times what Buchwald et al calculate. Likewise, if one had invested the $1275 spent annually on lovastatin 40 mg daily, and if that investment earned 8% interest compounded annually, then after 20 years one would have earned $58,348, a figure more than twice the $25,500 estimated by Buchwald et al.

The above analysis assumes a constant annual growth of an investment at 8%. This is unlikely to happen in real life. In addition, there is no guarantee that the cost of a medication such as lovastatin would remain constant.

Estimating the cumulative expense of any therapy over time is a tricky business. The sooner a given sum of money is spent, the more potential income is lost.

Robert P. Blankfield
Cleveland, OH

The preceding letter was referred to Dr Buchwald, who responds as follows:

I was amused by Dr Blankfield's whimsical appraisal of our relative cost calculations for lovastatin vs partial ileal bypass. He is, of course, quite correct in what he says. Our accounting was oversimplified, at best, and based only on today's prices. Using his investment hypothesis, hypercholesterolemic patients would be financially best advised to set aside the money they would spend on any therapy and invest it for 20 years. At that time, they would have a substantial sum available to them—if they lived that long.

Using Dr Blankfield's table, partial ileal bypass is still a financial winner over time. Also, in constructing our table, we only considered drug and surgery costs, not the costs of follow-up physician visits and laboratory assessments. The routine annual follow-up care required with drug therapy may well require more time and be more costly than that required after the operative procedure.

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