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, 519 Pleasant Home Rd, Suite A-3, Augusta, GA 30907-3500, or Fax (706) 855-1107.

BUILDING YOUR PRACTICE YOUNG

To the Editor:

From the perspectives of a family practice educator of 13 years (W.C.) and a recent residency graduate (T.L.), we would like to share some successful methods for building a broad-based community practice. Many publications have shown that the provision of maternity care usually ensures a practice population inclusive of children and young families.[1] The advantages and outstanding outcomes of obstetrical care provided by family physicians have also been well characterized.[2–4] For the recently trained residency graduate who chooses not to provide maternity care, the "premature graying" of the practice is a common cause of dissatisfaction. W.C. can recall hearing from at least half of the 150 residents he has trained that "if I'd wanted to be an internist, I'd have trained as one. Where are all the kids in my community going for care?"

Having recently established a practice in a town of 5000 in northeastern Alabama, T.L. relearned some lessons and employed some techniques that may be of interest to others beginning a practice that does not include maternity care. His goal was to have a practice made up predominantly of young families; the result 2 years later is that his population is about 60% female, and 50% are under age 18. The lessons learned were:

1. *Research practice locations carefully.* A community where maternity care is provided only by obstetricians, especially if the OBs are 30 to 40 minutes distant, may be ideal.
2. *Open your doors to Medicaid pediatric care.* Learn to do EPSDT (early and periodic screening diagnosis and treatment) examinations efficiently. Current payment for Medicaid office visits in Alabama is within $2 of that for Blue Cross, and these patients adapt well when continuity is provided.
3. *Share call with at least two, and ideally three, family physicians who enjoy pediatrics.*
4. *Early on, visit the local Medicaid management services and demonstrate your knowledge of and special interest in pediatrics.* Later include visits to Headstart and children's church activities.
5. *Arrange and decorate your office with children's comfort in mind.* Your practice environment speaks volumes to young parents.
6. *Select a few nurses at the local hospital who are interested in pediatrics and arrange advanced training for them at your regional referral center.* This should include PALS (Pediatric Advanced Life Support) and NALS (Neonatal Advanced Life Support) courses, as well as practical training and periodic updates in venous access, respiratory therapy, and pediatric medications.
7. *Attend CME (continuing medical education) at your referral center regularly, and visit your favorite consultants while you're there.* This will maintain your personal connection with them. A few kind words about you from them to your families will go a long way toward building your reputation, especially when you refer very sick patients, which is inevitable if you see enough children.

We offer these techniques to those preparing to build a broad-based practice. If you can, provide maternity care yourself.[5] If you can't, try some of the above. We welcome other comments and ideas. With apologies to our pediatric colleagues and to paraphrase the recently coined phrase about maternity care, "The care of children is too important to be left [only] to the pediatricians."

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LESBIAN HEALTH CARE ISSUES

To the Editor:

I am writing this letter regarding Elizabeth J. Rankow's article on lesbian health care (*Rankow EJ. Lesbian health care issues for the primary care provider. J Fam Pract 1995; 40:486-92).*

From my experience, lesbian patients have no greater health care issues than heterosexual patients. The usual degree of medical insightfulness, sensitivity, and awareness of sexually transmitted diseases and routine women's health care issues are well addressed and documented in her article.

Of concern, from a social conservative standpoint, is the behavior modification and political correctness conveyed in her article. Her use of the word "homophobia" is typical of the homosexual political and education agenda to change cultural norms and acceptance of homosexuality. Homophobia is an incorrect term that is used by her in this article. Homophobia is a term that denotes persistent abnormal dread or fear of homosexuality. In this term, phobia designates abnormal or morbid fear of or aversion to the subject indicated by the subject matter of homosexuality. A more proper term would be *heterosexism*, which denotes the recognition that heterosexuality is a healthier lifestyle and superior to homosexuality.

I believe that once we use the proper terms, we will begin to better debate the issue of homosexuality vs heterosexuality.

Kenneth L. Williams, Jr, DO
Santa Ana, California

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To the Editor:

We are well past weary of the term "homophobic." This politically correct neologism appeared prominently in "Lesbian Health Issues for the Primary Care Provider" in a recent issue of *The Journal of Family Practice (Rankow EJ. Lesbian health care issues for the primary care provider. J Fam Pract 1995; 40:486-92)*. Etymologically speaking, homophobic as a term is actually bogus, since the Greek roots would imply fearing that which is like oneself. Heterosexuals, as a rule, do not fear those who are like themselves; in fact, fear has nothing to do with the subject. Practically speaking, homophobic is a pejorative spat at anyone who dares to disagree with homosexual activists. Such smearing is commonplace in today's media.

Despite such attempts at intimidation by homosexual activists; despite the efforts of American psychological organizations, numerous sympathetic academic persons and publications, and the current administration in Washington; and despite the publication of specious prevalence data and research into the so-called biochemical/anatomic etiology of homosexual practice, we remain unconvinced and politically incorrect. We stand firmly in the mainstream of honest public opinion in our nation that homosexual practice is behavioral pathology.

Homosexual individuals may disagree with us, as some have vehemently done in the past. They may even seek out another physician who agrees with them, if they care to do so. But as yet, they may not force us to accept their delusion that homosexual practice is but another fraction of the spectrum of normal human behavior or that homosexual individuals should be an officially sanctioned victim group warranting special civil rights considerations.

We reiterate, then, that we are not homophobic. We do not fear homosexual individuals. Rather, if damage must be done to Greek and we must be labeled, let us be classified as "homomorbid." Homosexual practice causes us a sensation of illness. No quantity of "education," even from the *Journal*, will suffice to change us. So please, no more "homophobia."

James L. Fletcher, Jr, MD
Cape Girardeau, Missouri

F. Edward Payne, MD
Medical College of Georgia
Augusta, Georgia

The preceding letters were referred to Ms. Rankow, who responds as follows:

The letters from Dr Williams and Drs Fletcher and Payne provide poignant illustration of precisely the attitudes my article was written to address. These doctors attempt to reduce the issue to one of semantics. The problem is not one of semantics, but of attitudes and consciousness and how these affect access to respectful and competent medical care.

If my colleagues object to my use of the term "homophobia," I am quite willing to replace it with the terms they supply. Dr Williams suggests "heterosexism." As do the similarly derived terms "sexism" and "racism," heterosexism implies not only an attitude of superiority, but the institutionalized exclusion and marginalization of one group by another. In essence, Dr Williams has said he would rather be called an oppressor than afraid. Drs Fletcher and Payne request the replacement of "homophobic" with the classification "homomorbid." They prefer to confess to "a sensation of illness" at the thought of homosexuality, rather than claim a fear of homosexual individuals.

It takes no imagination to see how such responses on the part of clinicians might have a negative impact on patient care. Would not any reasonable person hesitate to place her health in the hands of someone who admits to feeling morally superior or repulsed by her? Such attitudes limit the willingness of a patient to share confidential or sensitive information relevant to her diagnosis or treatment. Such attitudes cause her to avoid risking the vulnerability of procedures such as pelvic or breast examination. Fear of the repercussions of *exactly these provider attitudes* keeps many lesbian women from seeking medical care at all. Research on populations of lesbians has consistently demonstrated this avoidance of care until problems have become advanced or severe.

As professionals, we work diligently to encourage preventive care and early intervention to both decrease medical costs and maximize patient outcomes. Most of us have entered the field of medicine out of a desire and a commitment to promote health and ease suffering. I would appeal to us all to make the effort to evaluate the biases and assumptions that interfere with that commitment and limit our ability to offer our patients the respect, sensitivity, and compassion we would expect in our own care, or the care provided to someone dear to us.

Your being asked to consider the health needs of an underserved and at-risk population does not make you the victim of a political agenda. The only victims here are the people who die from a lack of accessible and appropriate health care. Is there anyone who is not deserving of care? Is there any life not worth saving?

Elizabeth J. Rankow, PA-C, MHS
Durham, North Carolina

LOVASTATIN-INDUCED MYOPATHY IN A HYPOTHYROID PATIENT

To the Editor:

A 58-year-old woman with hypertension and coronary artery disease had been treated with nitrates, enalapril, and nifedipine for 2 years. Recently, she was found to have hypercholesterolemia. Lovastatin was added to her medical regimen to treat the lipid disorder. Over the ensuing 2 weeks, she had an acute onset of pain in the lower part of both legs, which was so severe that it impeded her ability to walk. She also complained of pain in both upper extremities, accompanied by generalized weakness. The only remarkable physical finding was muscle tenderness to palpation. Myopathy was diagnosed.

The patient denied any history of cold intolerance, sluggishness, mental apathy, constipation, or edema. Laboratory tests revealed a creatine-phosphokinase (CPK) level of 4000 U/L. Fractionation of CPK revealed 100% of CPK-MM and normal MB and BB fractions. Lovastatin is known to be myotoxic (*Ahmad S. Lovastatin-induced lupus erythematosus. Arch Intern Med 1991; 151:1667–8*). In this case, it interacted with hypothyroidism.

Results of a workup for a connective tissue disorder were negative, and liver enzymes were within a normal range. Although the patient's thyroid-stimulating hormone (TSH) level was 50 μU/mL (50 mU/L) (normal = 0.36 to 5.5 mU/L), she was in a subclinical hypothyroid state. A daily replacement dosage of 150 μg of levothyroxine sodium was started. Two weeks after the initiation of thyroxine replacement therapy, the myopathy improved dramatically, and although she had resumed taking lovastatin, her CPK levels were normal. With the patient's consent, thyroxine replacement was withheld for 2 weeks, and again, myopathy and very high CPK levels developed. When levothyroxine was reinstituted, the patient's symptoms cleared rapidly, and her elevated CPK levels returned to nor-

mal over the ensuing 7 days while she remained on lovastatin therapy.

This patient's lipid disorder was evidently caused by hypothyroidism. When lovastatin was instituted to treat the lipid disorder, myopathy resulted. Before initiating therapy with lovastatin, secondary causes of hypercholesterolemia, such as nephrotic syndrome, uncontrolled diabetes mellitus, dysproteinemia, obstructive liver disease, diuretics, beta-blocker therapy, and in this case, hypothyroidism, should be excluded. The risk of myopathy during treatment with HMG-CoA reductase inhibitor is increased in the context of conditions such as sepsis, hypotension, major surgery, trauma, subclinical hypothyroidism, epilepsy, and severe metabolic or electrolyte disorders.

Based on this clinical observation, I suggest that an estimation of TSH levels should be an integral part of the assessment of lipid disorder before lovastatin therapy is instituted.

Saeed Ahmad, MD
Fairmont, West Virginia

MORE MALAPROPISMS

To the Editor:

The following goofs and blunders are presented courtesy of the transcription staff at St Josephs Hospital and myself. They remind us that medical language is a cart that is easily unsettled.

- The patient fell off a horse with altered mental status.
- The patient has had a persistent right lower extremity since childhood.
- The patella was easily reduced and sent to x-ray.
- The patient denies any family history of mental health.
- The patient had no vision in the right eye, and his only good eye was on the left side.
- The patient did not know the President but states that she did vote for him.
- The patient was disoriented to time and place, though very pleasantly so.
- The patient was discharged with his finger.
- He will not answer questions as to whether he has committed suicide in the past.
- I discussed the risks and benefits of sudden cardiac death with the patient.
- She is still married and lives with her retired husbands.
- The patient was kicked on the side of his knee by a cow with his foot planted.
- The patient denies abdominal pain in the rest of her body.

Adam Kartman, MD
Bellingham, Washington

CIRCUMCISION ISSUE

To the Editor:

Having read through the February issue, I am writing to correct a small but important misstatement in the letter from Drs Saab and Hamadeh on circumcision devices.[1] They mention that the American Academy of Pediatrics recommended against circumcision; that is not the case, and their uneditorialized comment may further murky the waters of discussion on the issue of circumcision. Of note is their citation of the journals *American Family Physician*[2] and *Canadian Medical Association Journal*[3] rather than an official American Academy of Pediatrics (AAP) report[4] or other complete copy of the report, missing the opportunity to facilitate deeper study by readers. The cited journals do not print the AAP report, but only allude to it, and not in a balanced way.

The pediatricians have published a number or policy statements, additions, and clarifications on the issue of circumcision, and have concluded that they do not recommend circumcision as a medically necessary procedure, despite the protection it affords from cancer of the penis and UTI in young males. They rightly point out that it is not without risk, and, since it is invasive, they shied away from putting it in the category of medically necessary. They did not recommend against it, only stated that the cost-risk-benefit analysis, though it showed benefits from circumcision (decreased incidence of UTI and penile cancer later in life), did not show a strong enough benefit-risk or benefit-cost ratio for them to recommend it as a routine procedure for all male newborns. Ironically, a 1975 review of the 1971 AAP report on circumcision included a paragraph that discussed the dramatic statistical effect circumcision had on the incidence of cancer of the penis. Unfortunately, the paragraph was mislabeled "Care of the Penis." From consequent mentions of that report in articles and conversations, it appears that many people did not read that paragraph, thinking it referred only to hygiene issues.

The point of Saab and Hamadeh's letter was quite different, of course, and I appreciate their sharing the results of their evaluation.

Roger O. Littge, MD
Folsom, California

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4. American Academy of Pediatrics, Task Force on Circumcision. Report of the Task Force on Circumcision. Pediatrics 1989; 84:388–91.
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The preceding letter was referred to Drs Saab and Hamadeh, who respond as follows:

We find the comments of Dr Littge very precise and enlightening, and would like to emphasize that the purpose of our letter was not to discuss the value nor the indications of circumcision but to describe another way of doing it.

As far as the recommendations of the American Academy of Pediatrics (AAP), we refer Dr Littge to the Report of the Task Force on Circumcision,[1] which summarizes the changes in the AAP position from 1971 until 1989. In brief, the AAP changed its position from "No valid medical indications for circumcision in the neonatal period" to "No absolute medical indication for routine circumcision of the newborn," and finally to "Newborn circumcision has potential medical benefits and advantages as well as disadvantages and risks." The statistics we report from Rockney[2] antedate the rather tolerant view of circumcision published by the Task Force in 1989. These statistics strengthen our point even more: despite the recommendations against circumcision (prior to 1989), the frequency of circumcision remained high (prior to 1989).

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