which would vary according to the arbitrary definition of their cut point. We are encouraged by their agreement that pleural fluid antibody levels do not offer any advantage over serodiagnosis. Areas of the world with a higher prevalence of tuberculosis (such as Spain) will have inherently greater diagnostic reliability because of the relative lack of confounding atypical mycobacterial infection.

Van Vooren and co-workers adjusted Ig levels to IgG (0.5 g/L) or IgA (1 g/L) concentration before assaying specific antimycobacterial activities. We adjusted levels for total protein content. This difference in method may explain their finding of higher levels in pleural fluid than in serum in some of their patients. Their study is also compromised by having only five patients in the series, which may have led to sampling error.

We remain convinced that there is no local IgG production and that the level of antimycobacterial antibodies in pleural fluid is due to passive diffusion.

Howard Levy, M.D., F.C.C.P.
University of New Mexico Hospital, Albuquerque

REFERENCES

"Advocate's Disease": An Etiologic Approach

To the Editor:

The article entitled "Advocate's Disease" by Dr Spodick and the accompanying response by Dr Baffes, which appeared in the May 1990 issue of Chest, were both thought provoking and enlightening. However, I believe that both Drs Spodick and Baffes are, at least in part, incorrect, and the article and accompanying response deserve further comment. There would seem to be no "malpractice crisis" as described by Drs Spodick and Baffes, but rather a litigation crisis. Medicine is but one of the multitude of professions and businesses with increasing numbers of suits and increasing amounts of awards to plaintiffs. Medical malpractice has been prominent in litigation for the reason so aptly stated by Dr Baffes: "There is too much money involved."

There can be little doubt that medical litigation represents a financial and professional loss to the medical profession. Furthermore, the problem also represents an increasing liability to the patient, who eventually bears, at least in part, the financial burden of medical malpractice litigation. In this age when increasing demands are being placed on the medical profession to reduce the costs of health care, the additional burden of malpractice litigation is neither desirable nor affordable. Therefore, discussions regarding strategies to reduce malpractice litigation are both timely and appropriate.

The time has come for the medical profession to reexamine its passive role in medical malpractice litigation. Physicians must accept several premises in order to actively participate in medical malpractice litigation:

1. Physicians have the right to be protected from frivolous and inappropriate suits.
2. Such suits harm the reputation of the individual physicians and the profession.
3. Frivolous suits are a financial burden to the individual physician and to the profession as a whole (through higher medical malpractice premiums).
4. Unwarranted suits increase the cost of medical care by both direct and indirect means (practicing "defensive" medicine).
5. Physicians are probably best able to judge the appropriateness of medical care, which is increasingly technical and complex.
6. Minimal help will be obtained from the business community, which is struggling with its own litigation crisis.
7. Help is unlikely to come from the legal community.

In this context, there are several actions that the medical profession could take through organizations such as the American College of Chest Physicians to decrease unwarranted medical malpractice litigation:

1. The College could make available expert physicians to review the appropriateness of medical care who are willing to testify in court. These witnesses should be volunteers and should be willing to serve for a fee commensurate with their loss of time from professional activities.
2. The College could provide lists of expert legal counsel to physicians.
3. The College could encourage physicians to seek damages from members of the legal community who file inappropriate and frivolous lawsuits.
4. The College and its members could provide education to the public regarding medical malpractice litigation not only through individual contacts but also through the lay press.
5. The College could explore alternatives to medical malpractice litigation, such as binding arbitration.
6. Last, and most important, physicians are a community of professionals dedicated to "reaching out to their fellow human beings." Physicians must not only be willing to reach out to their patients but also must reach out to each other. Only through such cooperation will the principles on which the medical profession was built continue, and only thus will medicine survive in a form that is professionally satisfying to its practitioners and beneficial to its patients.

Richard A. Robbins, M.D., F.C.C.P.
Department of Internal Medicine, University of Nebraska Medical Center, Omaha

REFERENCES

Hemoptysis: The Third-World Perspective

To the Editor:

I read with great interest the recent article by Drs Haponik and Chin, which outlined the practicing physicians' perspectives on diagnosis and management of patients with hemoptysis.

Hemoptysis is a frightening and serious presentation of pulmonary and cardiac diseases. The source of the hemorrhage in pulmonary diseases is mostly from bronchial blood vessels, which are often tortuous, hypertrophic, and dilated. In some cases the hemorrhage is from the pulmonary arterial system, from Rasmussen's aneurysms, and or even from intercostal arteries and other vessels supplying the lungs.

Although chronic bronchitis and lung cancer are the most common causes of minor, major, and massive hemoptysis in the developing countries, pulmonary tuberculosis (PTB), with its chronic sequelae, such as bronchiectasis, broncholithiasis, and recurrent secondary pulmonary infections, is the most common cause of pulmonary diseases.