be helpful to offer an improvement or refinement for the fourth guideline presented, which deals with appropriate expert witness compensation. The guideline states, “The witness should receive compensation that is appropriate to his or her expertise and qualifications. Acceptance of a fee that is disproportionate to those customary for such professional endeavors is improper and unethical.” Unfortunately, since many lawyers and legal firms have difficulty obtaining physicians, they often tempt physicians by their willingness to pay a fee whatever the market will bear. Because of that, over the last few years customary fees for medical expert witness testimony may have already become inappropriately high for the time and effort spent on such activities. I feel that a good guideline to keep professional expert witness remunerative fees in perspective would be to equate the time and effort expert witnesses spend with the appropriate fees charged by most physicians for what they do best, ie, giving medical care. For example, if the pulmonary specialist charges $150.00 for an hour of time and effort expended for patient care or diagnostic consultation, this fee seems to be one that such a medical expert witness should charge and accept for an hour of expert medical witness testimony. To accept a higher hourly fee for expert medical witness testimony than one charges for the equivalent time expended in the care of a sick patient would seem inappropriate and potentially unethical.

I have heard many medical expert witnesses state that they do not like to testify in the medicolegal process but when “pushed” for whatever appropriate reasons, they show their displeasure by charging a very high fee. This obviously very faulty and unethical reasoning and behavior cannot be condoned.

In summary, I would suggest to the American College of Chest Physicians and to the Ethics Committee that they consider refinement of their fourth guideline on expert witness compensation, which relates the appropriateness of the fee to the physician’s charge for what they do the majority of their time in practice, which is giving patient care and service.

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Table 1—Cardiopulmonary Exercise Testing Results

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pre-FMV</th>
<th>Post-FMV</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>VO_{2max}</td>
<td>5.9±1.5</td>
<td>6.8±1.6</td>
<td>8.9±2.2</td>
</tr>
<tr>
<td>VO_{2peak}</td>
<td>36.8±9.9</td>
<td>41.5±8.5</td>
<td>49.9±9.2</td>
</tr>
<tr>
<td>VO_{2AT}</td>
<td>14.3±1.6</td>
<td>16.4±4.9</td>
<td>19.5±5.8</td>
</tr>
</tbody>
</table>

*Values are expressed as mean ± SD. PMV denotes percutaneous mitral valvuloplasty; AT, anaerobic threshold.

fp<0.05.

fp<0.001.

the fourth sentence in that paragraph should read: “Since the effect of lowering left atrial pressure alone would be to decrease [not increase] pulmonary vascular resistance . . . .”

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REFERENCES

Pulmonary Nocardiosis in AIDS

To the Editor:

We read with interest the data on 21 patients with pulmonary nocardiosis and the acquired immunodeficiency syndrome (AIDS), which Kramer and Urtamchandani* reported in the August 1990 issue of Chest. Here we describe an AIDS patient who presented with pulmonary nocardiosis as the first manifestation of his illness and discuss the controversies in the management of nocardiosis in patients with AIDS.

The patient was a 37-year-old black man with a history of intravenous drug abuse who had been well until two months prior to admission, when fever, chills, and a productive cough developed. He saw a physician, who noted right upper and possibly right middle lobe infiltrates on chest radiograph. Despite therapy with amoxicillin and clavulinate followed by erythromycin, the patient’s condition worsened, and he was admitted for evaluation. On examination the patient was found to be thin but in no acute distress. His temperature was 39.1°C; pulse, 120 beats per minute; respiratory rate, 20 per minute; and blood pressure, 120/60 mm Hg. Significant physical examination findings were oral thrush, numerous dental caries, bilateral posterior cervical lymphadenopathy, and a palpable left axillary lymph node. The lungs were resonant to percussion with mildly decreased breath sounds. Pain bilateral cricrakes, greater on the left, were present on inspiration. A chest radiograph showed bilateral upper lobe infiltrates, which extended to the pleura. A small area of cavitation was observed within the left upper lobe density. Initial sputum smears for Pneumocystis carinii and acid-fast organisms were negative, but a