sensus is to invoke the “conscience clause,” as I did in my article. I stated the following:

An additional concern is that some geneticists would conscientiously object to performing prenatal testing for disease susceptibilities, late-onset diseases, and relatively minor conditions, and some primary care physicians would conscientiously object to referring patients for such tests. Such conscientious objections might be based on the degree of risk to the fetus in performing such tests. Even if this concern is removed by the development of noninvasive testing, conscientious objections might still be based on the degree of respect the physician believes should be given to fetal life. In reply, the view in question would honor conscientious objections by physicians.

Moreover, religious traditions are a main source of influence in the formation of private conscience. Thus, it is inaccurate to suggest, as O’Connor does, that my approach excludes religious views. I invite O’Connor to take a step back and ask herself, “What approaches to the professional ethics of prenatal genetic testing would be acceptable, given the wide range of personal views among physicians?” This question poses the framework, I suggest, from which my article should be evaluated.

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Factors Affecting Access to Medical Care

I enjoyed the article by Cykert and Layson, published in the November 1993 issue of the ARCHIVES. I do agree with the authors’ hypothesis that universal health insurance will not assure universal access. However, I disagree with the “Materials and Methods” section of the article. First, the authors chose a small southern town that may not be representative of the general population. The reader was not given any demographic information, such as the mean age of the population, minority status, or percentage of the population that received Medicaid or Medicare vs private insurance. I believe this information is important because if the majority of the population had private insurance, physicians would be less inclined to accept Medicaid or Medicare.

Second, because such large differences were found between rural and urban physicians, perhaps rural physicians should not have been used in the study. To determine why rural practices were different from urban practices, it might have been interesting to find out if rural areas had recruited young physicians to the area by subsidizing their medical education or helping them start a practice.

The authors postulate that physicians cannot afford to accept Medicaid or Medicare because of “high overhead costs, and personal, practice-, and medical school-related debt.” This statement seems to put money over patient care. Most physicians I know did not go into medicine “for the money.” I can understand, however, that the large debt that one accrues during medical education may be a significant factor. Current efforts to expand national health service corporations may provide some relief in this regard.

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Moore-Waters appropriately points out that many factors influence physicians’ willingness to accept publicly insured patients. Regarding his specific comments, our survey was centered in Greensboro, NC, and its surrounding counties. The city itself has a population of 185,000, and when the surrounding communities are added, the overall population of the survey area is roughly 600,000. Approximately 12% of patients are insured by Medicaid, 13% by Medicare, and 60% by private insurance. Fifteen percent are currently uninsured. These data are not significantly different from data pertaining to cities of similar size and surroundings. This study was indeed local and in a sense does lack generalizability; however, there is no reason to think that these patient acceptance trends based on insurance status do not exist elsewhere.

We disagree with Moore-Waters’ assertion that because of the greater willingness of rural physicians to accept publicly insured patients that these data should have been excluded from our report. The reasons given for this difference are plausible and it would be extremely important to ascertain physician and environmental characteristics that contribute to these more generous acceptance policies. Our data do not support the idea that recruitment of young physicians is the driving force behind enhanced patient acceptance in rural areas since there was no significant difference in duration of practice between the rural and nonrural groups.

Finally, we believe, as Moore-Waters does, that physicians in general do not go into medicine “for the money.” However, given that the mean debt of medical students is now estimated at $55,000 and that students endure a minimum of 7 years of intense training with minimal pay, it is
likely that young physicians feel somewhat entitled to a nice home and other perks generally associated with being a well-trained professional.

Therefore, whether conveyed through the practice's business manager/consultant or through the physician's own sense that he or she ought to earn what other physicians earn, the reality is that there is pressure on primary care physicians to prefer privately insured patients. Universal health insurance that includes provisions for standardized reimbursement would significantly relieve this moral dilemma.

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Will Education Prevent Human Immunodeficiency Virus Infection?

Here was great irony in the June 1993 issue of the ARCHIVES. On the one hand, the article by Parra et al. claimed that "even though most of the females understood how HIV [human immunodeficiency virus] was transmitted and recognized themselves as at risk for AIDS [acquired immunodeficiency syndrome], they continued to share needles unsafely and place themselves at risk for acquiring HIV infection through sex." On the other hand, another article in the same issue states that "education programs on HIV that target this vulnerable group [adolescents] effectively prevent infection." How is it that HIV education is insufficient to cause significant attitudinal or behavioral change among all populations of adults studied and yet is effective among adolescents?

Ryan et al. make a fundamental mistake by assuming that school-based education makes a difference in the incidence of HIV infection. This assumption is not supported by the few references given in the article or by the adolescent literature in general. Furthermore, in other sources, knowledge about HIV has not been shown to lead to a sufficient risk reduction among homosexuals or college students.

Not only has HIV education never been shown to significantly affect attitudes or behavior, but the widespread acceptance of the idea that condoms will protect those teenagers who use them is equally unsupported and disturbing. The Centers for Disease Control and Prevention, Atlanta, Ga, has recently declared that the condom carries a failure rate of up to 30% in preventing HIV infection among adults. It is generally accepted that condoms are less likely to be effective among teenagers.

Given the lack of supporting data, it is unrealistic to consider condom education an effective component of the prevention of HIV infection among teenagers.

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In reply

Wetzel's question about the apparent irony presented by the two HIV articles in the June 1993 issue of the ARCHIVES is not an insignificant one. This is an issue around which the medical, health education, and psychology communities are increasingly coalescing to expand their understanding of the differences in outcomes of health education among diverse populations.

The only protection we have against AIDS at this time is education about the means of preventing exposure to HIV. To whom and by what methods this prevention education should be disseminated is the crux of Wetzel's question.

Wetzel draws a comparison between our study and the research presented by Parra et al. to ask about the effectiveness and practicality of HIV prevention education, yet each of these articles focuses...