


Editor’s Note

Directing Resources to Where They Are the Most Needed

Old habits die hard. Since the 1980s, when we first came to understand that CD4 cell depletion is one of the hallmarks of immune deficiency in persons with AIDS, we clinicians have checked the CD4 counts of our stable patients every 3 months (more often for those who were sick or starting new therapy). Our patients (and we) worried from visit to visit whether their CD4 counts (we called them T-cells then) rose or dropped (mostly they dropped), and our spirits rose and fell with their counts.

That was then. Today we have highly effective antiretroviral treatment for human immunodeficiency virus (HIV) and a much better marker of how our patients are doing: the HIV viral load. Patients with undetectable virus in their blood are likely to do well as long as they keep taking their medication. The first sign of trouble is an elevated viral load. If perchance a patient of mine had a major drop in the CD4 count despite having an undetectable viral load, my first thought would be that the CD4 count was in error.

So, if CD4 counts are no longer driving treatment decisions in stable patients who are virally suppressed while receiving antiretroviral treatment, why do we still order these tests? Because it is our habit, and our patients expect it. Although ordering the test likely causes little harm to our patients (unnecessary anxiety if there is a false-negative drop in the count), the tests are expensive. As demonstrated by Hyle et al, if we would order them at most yearly for our stable virally suppressed patients (instead of every 6 months), we would save $10 million a year in the United States. We could use that money in ways that would likely have a much greater impact on the population of HIV-infected persons, including early HIV detection and linkage to medical care, medication adherence counseling (so that CD4 counts do not drop owing to missed doses), substance abuse treatment, and supportive housing.

Resources are finite. We should always seek to spend them in ways that bring the greatest good. Eliminating unnecessary CD4 counts and providing treatment with more impact is a good way to start.

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Trends in the Earnings of Male and Female Health Care Professionals in the United States, 1987 to 2010

Nearly 40 years after the adoption of the Title IX Amendments of the US Civil Rights Act, women account for almost 50% of US medical students and more than one-third of all physicians. Historically, female physicians have earned considerably less than male physicians, though in the 1990s much of this was attributable to gender differences in specialty choice and hours worked. However, more recent data suggest that female physicians currently earn less than male physicians even after adjustment for specialty, practice type, and hours worked. Salary differences between men and women currently exist among physician researchers as well. This raises questions about whether the gender gap in earnings among US physicians has closed over time, particularly compared with the earnings gap for other health care professionals and workers overall. Comparing earnings of male and female physicians over time is important in assessing the impact of policies to promote gender equality among physicians.

Methods | Using nationally representative data from the March Current Population Survey (CPS) from 1987 to 2010, we estimated trends in the male-female earnings gap among physicians, other health care workers, and workers overall. The CPS has been used to study trends in physician work hours and earnings. The CPS data are collected monthly and are based on personal and telephone interviews of approximately 60,000 households. The data are deidentified and made publicly available, and thus this study was exempt from institutional board review.

We used self-reported data from the CPS on occupation, hours worked, annual earnings, age, sex, and race. Response rates exceeded 90% across years. Physicians were identified based on a self-reported occupation of physician or surgeon. Other health care professionals were identified based on a self-reported occupation of dentist, pharmacist, nurse, physician assistant, or health care and insurance executive. Because the values of earnings reported were capped by the US census to protect identities (eg, the cap was $250,000 in 2010), we analyzed trends in median annual earnings. We analyzed 3 periods (1987-1990, 1996-2000, and 2006-2010) to smooth annual fluctuations in the data. We excluded individuals younger than 35 years to focus on physicians completing residency. The CPS does not collect data on physician specialty. Additional limitations of the CPS for studying physician earnings have been noted elsewhere.

We used median regression analysis to study trends in earnings across occupations, adjusting for age, sex, race, hours worked, and state. We adjusted for hours worked to avoid overstating gender differences in earnings if female physicians work fewer hours. For each occupation, we estimated a pooled regression model of both women and men, with interaction terms between sex and year to estimate sex-specific trends. We predicted earnings holding covariates other than sex and year fixed at their mean values. Dollar values were normalized to 2010 dollars.