journals have increased in size over the years. After a decade of subscriptions there is little space left and they have now begun to pile up in my cellar. It is no accident that a year's printing is called a "volume."

It is merely a natural consequence of the information explosion, I assumed. Then one day, as I paged through the advertisements while searching for an article listed in the table of contents, I realized that it is the advertisements that are eating up my shelf space. I counted the number of ads for 6 consecutive months in JAMA for 1978 and again for 1988. I repeated this for a 6-month period in the New England Journal of Medicine for 1978 and 1988. Classified ads and American Medical Association informational ads were excluded. Ads were counted as one third, two thirds, or a full page. The results are listed in the Table.

I understand the necessity for advertisements, which supply needed funds and keep subscription rates low. Actually, I enjoy the ads. They are pleasant distractions from the heavy statistical content of the text. In a strange way, I admire journals that have a lot of ads. They bring in much income, and that is the American way. Admiration aside, I have come up with a practical solution to my storage problem. I think I will do what some libraries have been doing for years, and remove all of the ads. That way I should be able to keep both journals on my bookshelves for another 10 years.

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Moonlighting: Making a Buck, Compassion, and Quality Control

To the Editor—I simply must respond to the letter about moonlighting by Dr Cohen.1 He and his ever-compassionate faculty seem to have calculated a method to make money off the moonlighting activity of the house staff. Apparently, the "faculty supervisor" is available by beeper or telephone while the house officer stays up all night and does the work. The faculty physician is then paid a commensurate amount for sitting at home and "being available."

We are constantly hearing pleas for better physician role models for residents and medical students. Is it any wonder that house staff are so cynical when they are so blatantly ripped-off, as in the above scenario? These house officers have a permanent license and in the eyes of the state are permitted to practice medicine on their own. Assuming job performance is not compromised, it is none of the university's business how a resident spends his free time. But no, the faculty at the University of Pittsburgh have figured out another way to make a buck off a tired, very poor house officer. Come on fiasa, if you want extra income get it the old-fashioned way: go out and work for it!


In Reply.—I appreciate the opportunity to respond to Dr Piening since it permits me to clarify some points that could not be incorporated into my original, rather brief letter to the editor. I will take up each matter in the order in which he raises it:

"Compassion" was not the motivating force that led the faculty to agree to this arrangement. It was something called quality control, an issue that is of increasing concern in postgraduate medical education in Pennsylvania (and I assume in South Carolina, also).

The plan was not conceived by the faculty but by the hospital administration, which believed that some house officers were not exercising good judgment in the amount of moonlighting they were doing or in the degree of responsibility they were assuming in view of their level of training. At first, the faculty resisted the program, not wanting the added responsibility themselves.

The faculty member does not sit home on call. He or she is not responsible for dealing with immediate emergencies. That falls to the staff of the moonlighting institution. The faculty member meets weekly at first and then less frequently as the resident progresses to review clinical decisions and patient status and, most importantly, to do some quality, hands-on, one-on-one clinical teaching, often involving a patient population not seen much in university hospitals. This is not a cushy "being available" job.

In the more than 15 years that this plan has been in existence, I have heard nothing but praise for it. The house staff likes it, the faculty has come to appreciate it, and the moonlighting facilities are very much in favor of it. There have been no house staff comments that approach the cynicism of Dr Piening's letter.

Although the house staff are licensed physicians, they are not practicing general medicine (with rare exceptions) while moonlighting. They are, in fact, hiring themselves out as specialists, often during their postgraduate year 2. Under these circumstances, the hospital, their program director, and their faculty have a responsibility to their patients to provide some measure of oversight and quality control. In our opinion, this is the best role modeling of all.

Our faculty is about as tired and hard working as the house staff. They assume a great deal of unwanted moral and legal responsibility for doing this kind of work for a very few dollars.

Richard L. Cohen, MD University of Pittsburgh (Pa)

Confusion From Pyridostigmine Bromide: Was There Bromide Intoxication?

To the Editor.—In the February 23 issue of JAMA, Rothenberg et al described a case of presumed bromism secondary to administration of repeated doses of pyridostigmine bromide. Their conclusion about the relationship between serum bromide and the altered mental status in this case may have other explanations. The following points deserve to be mentioned.

First, the rapid resolution of symptoms is inconsistent with the half-life of the bromide ion. The half-life of bromide in serum is 12 days after oral administration. Toxicokinetic calculations, to estimate the bromide concentration 1 day before the actual serum sample was drawn, give a level of no more than 5.5 mmol/L. The single bromide level documented (5 mmol/L) is, as the authors noted, below what might be considered toxic. The therapeutic range for bromide as an antiepileptic drug is 12.5 to 18.8 mmol/L.6 Levels below 7.5 mmol/L are usually not associated with symptoms.4,6-8

Second, Rothenberg et al have not ruled out the drug levorphanol tartrate as contributory to the confusional state. Paradoxical agitation reaction with dysphoria, disorientation, and hallucinations has been reported with opiates.6 Levorphanol is a powerful synthetic narcotic agent whose effect, when given orally, is similar to that of morphine administered intravenously.6 A trial dose of naloxone hydrochloride at the