Articulating a Social Ethnic for Health Care

To the Editor.— Dr Reinhardt’s1 recent attack on my book Mortal Peril2 presents this challenge: “to the extent a nation’s health system can make it possible, should the child of a poor American family have the same chance of avoiding preventable illness or of being cured from a given illness as does a child of a rich American family?” The correct answer is no.

The health of youngsters is intimately tied to their parental care and attention; nutrition, location, and even the family car determine in part who will become injured or ill. Reinhardt tolerates these inequalities because they lie outside the health care system. But a consistent egalitarian should redress all sources of inequality, including child care, education, and crime prevention. Yet, Reinhardt neither justifies his priorities nor explains how to fund a full-scale initiative without destroying the social wealth it needs for support. Self-interest is not a universal and omnipresent human impulse, but it is a powerful one. To open the doors to forced redistribution induces the rich to spend more defending their wealth, and the poor to spend more to take it away. Both sides cannot win, and a smaller pie leads to worse health for the very persons Reinhardt cares most about.

Even within health care, his proposal for equal medical treatment perversely requires more care to children of poor parents than to children of rich ones, precisely because the rich families can more easily avoid injury and illness and can better pick up any slack in health care delivery. Worse, programmatic success depends not just on offering carrots but on wielding sticks by overriding parental judgments on children’s food, lifestyle, and education. Yet, Reinhardt never explains how any ambitious program can curb political excesses, control administrative costs, prevent overutilization of resources, or ensure that equality in treatment comes from raising care for the poor instead of lowering it for the rich. Political interventions to date have created a 2-tier system that funds enormous Medicare subsidies in part by payroll taxes on the poor. Why expect the next generation of social programs to do better?

There is an alternative strategy. Do not increase taxes by ramping up subsidies and regulation. Reverse field and in- reverse access by lowering costs, dismantling entry barriers, cutting subsidies, and increasing disposable income. Then, repair our tattered tradition of charitable service now crowded out by state-run programs. We can improve the situation for people at the bottom without lurching to Reinhardt’s egalitarian ideal, which promises the same disastrous consequences in health care at home as it has wreaked in the world at large. How sad that at this late date Reinhardt has to search for a clearly articulated social ethic having none of his own to offer. After 30 years of trying, he should recognize that his conceptual cabinet is empty.

Richard A. Epstein, LLB
University of Chicago
Chicago, Ill


Guidelines for Letters

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To the Editor.—Dr Reinhardt 1 paints a bleak portrait of America as a Dickensian society that woefully and conclusively neglects its young. Few would admit to being a member of that society and few can argue with him since he has adroitly positioned himself so securely on the moral high ground that the rest of us, particularly those who may carp with some of his arguments, wallow in the swamps of social callousness and indifference. While other Western nations have said “yea” to his model for a nation’s health care system, Reinhardt likely sees the United States as a primitive, socially backward society on the road to moral bankruptcy.

Why the contrast in attitudes about health care systems and social programs among these nations? Is it a fierce sense of rugged individualism, independence, and self-reliance that has been and still are the hallmarks of the American ethos? Is it because Americans have said “nay” not to a system that denies care but “yea” to the historical right of a democratic society to make its choices uninhibited by the steely hand of pernicious governmental influence and free of the specter of social systems that are bleeding the economies of Western Europe?

Reinhardt’s bogeymen are the nation’s “policymaking elite.” He portrays them as a covert enemy, a cabal, ready to formulate policy that would deny social justice to the downtrodden and the dispossessed. Who are the members of this all-powerful elite? Where do they meet? Do they have an Internet address? I’m sure he realizes that it is not physicians who control the political process and the focus of health care. In Reinhardt’s home state of New Jersey, physicians have become so politically impotent that they are attempting the unthinkable for professionals—joining a labor union. Reinhardt does tell us that a majority of the members of Congress are part of the nation’s policymaking elite. If so, his argument is with the American people as their leaders and representatives mirror the ideas and sentiments of their constituency. If this elite that controls the direction of the nation’s health care is special interest and lobbying groups, then Reinhardt’s distress is with the current American political process. Reinhardt may be uncomfortable with this, but as we approach the fin de siècle, it is this same American political process that has triumphed in this century. It has been said that “nearly every great domestic policy debate has revolved around the poles of elitism and egalitarianism.” In keeping with that theme and with all the guile of a polished politician, Reinhardt could not resist the temptation to frame his thesis in terms of class struggle and a redistribution of wealth. Reinhardt has much to contribute to the national debate about health care system reform; unfortunately, he dilutes his fine rhetorical skills by resorting to the effete and trite. His is a romantic egalitarianism for which cost presumably is to be borne by the individual physician rather than by society as a whole. How could this work in practice? In the end, his approach would ration health care by ability to pay simply through the locational choices of physicians.

Lally writes of “a fierce sense of rugged individualism, independence, and self-reliance that have been and still are the hallmarks of the American ethos.” Where are these rugged individualists? Are they among the rugged farmers, who cannot make it through the day without huge government subsidies? Are they among any of the Americans who plead for federal funds and for the Federal Emergency Management Agency whenever disaster strikes, or, perchance, among the investment bankers whose investments in Hampton Beach properties are protected by the US Army Corps of Engineers and by federal flood insurance? Would I find them in the medical profession, whose members rely so heavily on public subsidies for their education and the science they apply, who now seek a federal tax preference for medical savings accounts, who plead with government to punish managed care organizations that are late in paying bills, to impose on managed care organizations any-willing-provider laws, and to regulate managed care organizations with countless other strictures, and who have never balked at using archaic licensure laws to protect their own economic turf? Are there really any rugged individualists at all in this society of imagined victims who run to the courts for succor at their slightest discomfort?

As all of these self-styled, rugged individualists enlist their government’s coercive power to protect their own fiscal health, they might more gracefully countenance the use of that power and also protect the physical health of poor children and, indeed, of all poor people. After all, serious illness is a natural disaster too.

Uwe E. Reinhardt, PhD
Princeton University
Princeton, NJ

Antihypertensive Therapy: Recommendations and Realities

To the Editor.—Experienced physicians may be enthusiastic about the Fifth Joint National Committee on the Detection, Evaluation, and Treatment of High Blood Pressure (JNC V) recommendations for treatment of hypertension for reasons not addressed by Drs Siegel and Lopez. β-Blockers significantly impair quality of life for many patients. For instance, if a patient neglects to mention his drug-related impotence to a physician, his wife might do so. Lethargy, constipation, and bronchospasm are common enough adverse effects to engender reluctance among physicians to burden patients with β-

Donald G. Lindsay, MD
Ventura, Calif

In Reply.—Only Mr Epstein answers my pointed question forthrightly; Dr Lindsay and Dr Lally beg the question with sermons.


Antihypertensive Therapy: Recommendations and Realities

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blockers. Except for dry cough in some patients, angiotensin-converting enzyme inhibitors are remarkably free of adverse effects and, in addition to their antihypertensive actions, may improve left ventricular function and may reduce the risk and severity of diabetic nephropathy.

The use of combined hydrochlorothiazide with triamterene preparations reduces the need for potassium supplementation and for frequent electrolyte measurements. Costs of laboratory tests and potassium supplements are not considered in the authors’ calculations.

The recommendations for JNC V are well known to the practice community. The federal government’s focus on cost control, perhaps at the expense of reduced quality of life for patients, has caused these recommendations to be regarded with some degree of skepticism. Compassionate physicians attempt to promote the best achievable quality of life for patients encumbered by the need for daily medication.

Carol W. Garvey, MD, MPH
Thomas Q. Garvey III, MD
Ponemah, MD


In Reply.—Drs Garvey and Garvey raise extremely important issues: the prevalence of adverse effects and quality of life associated with various classes of antihypertensives, and the need to individualize therapy. In terms of adverse effects and quality of life, 2 prospective placebo-controlled, blinded studies provide direct comparisons of different antihypertensive drugs. In 1 study, in which 902 men and women were studied for an average of 52 months, the differences in lipid levels and drugs. In 1 study, in which 902 men and women were studied for an average of 52 months,1 the differences in lipid levels and ventricular arrhythmias in hypertensive men. JAMA. 1992;267:1085-1089.


Long-term Care in Japan and the United States: A Medical or Social Issue?

To the Editor.—Japanese social reformers clearly have the same problem as their US counterparts. Both are unable to separate social problems from medical system problems, and both want to put the onus for visible support of social problems on the nation’s physicians (and the invisible support on the nation’s other taxpayers). This tendency to burden the backs of its physicians with the nation’s social problems is clearly stated in the last sentence of the article by Dr Ikogami, ‘‘To what degree the public in general, and physicians in particular, is willing to deal with these issues is a challenge for the 21st century.”

On occasion, a partial solution to social problems may require the purchase of medical services, but physicians are not and never will be primary players in legislative decisions to fund long-term care (LTC) whether in the United States or Japan. The LTC legislation is unequivocally a social problem related to family support or its absence and only incidentally is connected to medical problems. Of course, since everyone believes that the medical system is too expensive, increasing medical system costs by engraving the expenses of social problems on it generally goes undetected and is accepted as “normal.” Few people understand that significant portions of the health care system budget, at least in the United States, actually fund solutions to social issues. Ikogami appears to be promoting doing the same thing in Japan.

George C. Manning, MD
Fort Wayne, Ind


In Reply.—I agree with Dr Manning that social problems have been frequently, and inappropriately, thrust onto the medical care system. However, this is precisely the reason new public LTC insurance was established in Japan as a separate system distinct from the existing health insurance system. Where Dr Manning and I disagree is that he thinks LTC legislation is “unequivocally a social problem related to family support or its absence.” I believe that while the social aspects are important because it is difficult to draw a line between LTC and ordinary life, a good LTC system should also integrate medical and social care. Therefore, although physicians will be playing a less dominant role in LTC in comparison with acute medical care, medical supervision will continue to be an important component. Without it, a chronic medical condition, such as diabetes or arthritis, that could be improved with medical attention or rehabilitation will be seen as an untreatable functional impairment that re-

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quires only care and support. I hope other physicians will agree and take an active interest in LTC as it will play a growing role in the aging society. In Japan, public LTC insurance legislation has passed the Diet on December 9, 1997, so that it will be implemented as planned in the year 2000.

Naoki Iegami, MD, MA
Keio University
Tokyo, Japan

The Pendulum of Business and Professionalism in Medicine

To the Editor.—While it must have been painful to have to write your Editorial on professionalism, it was courageous to reprint it from January 5, 1990,2 which emphasized the need to correct the growing expressions of greed by our profession. I do not believe that physician greed is anything new but have become convinced that greed, cynicism, and hypocrisy are growing among the leadership of organized medicine. How else to explain that the outrageous agreement with Sunbeam Products Inc was announced less than 2 months after the adoption of the American Medical Association’s Vision by its Board of Trustees? The question in the minds of many of the members of the American Medical Association must surely be how many of the individuals who drafted and, subsequently, adopted this admirable Vision were party to the decision to endorse the Sunbeam agreement?

The fallout from the Sunbeam debacle was that staff’s heads rolled. It is time that the medical leaders involved accept responsibility for their disservice to our profession and the public and make way for physicians of integrity.

Max M. Cohen, MD
Grace Hospital
Wayne State University
Detroit, Mich


To the Editor.—The Editorial “The Business and Professionalism of Medicine” should be required reading in many quarters. I only wish I could have put things as well.

If organized medicine makes its decisions and sets its policies by first determining what is right to the best of its considerable ability, the best interests of physicians will be served in all respects. The results may not be immediate, but the public outcry when the Sunbeam deal was revealed indicates that the American Medical Association’s image has improved in the last 20 years, and its views are more trusted and respected because of much hard work by many devoted colleagues.

But the critics are out there. A recent lecture I attended included the opinion that professions raise educational standards and licensing requirements mainly to improve and protect the incomes of their members though usually cloaking their true motives with pieties about quality and the public good. It was depressing to hear. Yet, some of our colleagues have done just this and are prevailing reasons for cynics to so believe.

I believe, as you do, that most physicians try to heal, to serve, and to do something good. Of course, we also hope we will live well, too, but greed is not a motive for most of us.

Like you, I can make the diagnosis, but, tell us, where do we go from here? We need clarion voices from the ranks of our branches. And I do not hear them.

Jerome K. Freedman, MD
Princeton, NJ


Antibiotic Therapy for Premature Rupture of Membranes to Prevent Respiratory Distress Syndrome

To the Editor.—Dr Mercer and colleagues of the National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network have recently recommended that women with expectantly managed preterm premature rupture of membranes (PPROM) remote from term (<32 weeks) should receive a specific regimen of antimicrobials to reduce infant morbidity. Whereas we applaud their efforts, we cannot agree that the conclusion should necessarily follow from their results given contemporary perinatal practice.

Prominent among their positive outcomes was a reduction in respiratory distress, and impressions of overall sepsis and neonatal pneumonia and the occurrence of necrotizing enterocolitis could conceivably all be a function of respiratory compromise. Hence, the overall outcome could be heavily influenced by the respiratory illness alone. In this regard, the study exclusion criteria not permitting corticosteroid and tocolytic therapy should be highlighted. Indeed, the study’s data monitoring committee concluded after interim analyses that patient enrollment be discontinued because of the subsequent recommendations regarding early-onset group B streptococcal perinatal prophylaxis and the consensus that corticosteroids be administered to those pregnancies with preterm rupture of membranes.2 Given the potential impact of corticosteroids in this context, it is possible that these pharmacological agents would decrease the severity of respiratory distress such that a benefit of antibiotics on the aforementioned outcomes might be significantly reduced or even abolished.

In addition to the use of antibiotics for the prophylaxis of early-onset group B streptococcal sepsis, antibiotic use might be recommended in the perinatal period to reduce the frequency of preterm birth with either Escherichia coli colonization3 or microscopically defined bacterial vaginosis4 as predictive risk factors. Given the potential high frequency of antimicrobial chemotherapy use for these indications, the longer-term impact on bacterial resistance must be considered. We have recently illustrated a temporal association of perinatal prophylaxis with increasing antibiotic resistance for E coli that has been isolated from mothers and newborns.5

It would be logical to conclude from the data of Mercer et al that the particular antibiotic regimen could reduce infant morbidity in those pregnancies with PPROM (<32 weeks gestation) and in mothers to whom corticosteroids and tocolytics have not been given, but it would not necessarily follow that the same antibiotic use would be of value among those administered corticosteroids. The question now is whether antibiotics are of significant benefit as an adjunct to corticosteroids. The hypothesis testing begs consideration for a greater spectrum of outcomes (eg, antimicrobial resistance and its impact on neonatal intensive care) beyond early neonatal morbidity.

Nevio Cimolai, MD, FRCPC
Children’s and Women’s Health Centre of British Columbia
Vancouver

In Reply.—Dr Cimolai raises several important issues, including the possibility that antibiotics will be ineffective in reducing infant morbidity if corticosteroids are administered and that antibiotic treatment may lead to bacterial resistance.

Respiratory distress syndrome (RDS) is the most common serious morbidity affecting preterm infants. Maternally administered corticosteroids have been shown to reduce the frequency of RDS by a factor of 0.41 in unselected patients and 0.45 in the setting of PPROM. However, the beneficial impact of corticosteroids after PPROM has been questioned, and their use after PPROM has not been fully endorsed by the American College of Obstetricians and Gynecologists. Even if corticosteroids are useful after PPROM, they are not universally effective. The RDS will remain the most common serious morbidity affecting this population.

While developing this trial, we considered requiring corticosteroid administration to all participants. We believed that antibiotic treatment could enhance corticosteroid effect by increasing latency long enough to achieve the benefit of corticosteroid action. Because corticosteroids were not being used widely after PPROM, we decided to prohibit corticosteroid administration. This offered the benefit of allowing us to evaluate antibiotic effect independent of other potentially confounding factors. After the National Institutes of Health Consensus Development Conference on corticosteroid administration, the option of altering the study to require corticosteroid administration was considered. We felt that such a protocol change, late in the study, could lead to a potentially confusing and confusing result. The study was discontinued after 83% of anticipated recruitment. The data monitoring board recommended discontinuation of the study not only because of changing practice regarding corticosteroid administration within the study centers but also because adequate power had been achieved to evaluate the primary outcome. We believe the combination of antibiotics and corticosteroids may have synergistic benefits regarding fetal pulmonary maturation. A recent publication by Lewis et al supports the hypothesis that there is a potential benefit of corticosteroid administration among gravidas with PPROM who are receiving antibiotics (RDS, 18% vs 44% in the control group who received antibiotics alone; \( P < .05 \)). The National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network has considered a randomized trial of corticosteroid administration in patients receiving antibiotics for PPROM but felt it impractical given their recent recommendations.

We agree with Dr Cimolai that excessive perinatal antibiotic treatment could lead to antibiotic resistance. In our study, there was no increase in maternal pseudomembranous colitis or neonatal candidal sepsis with maternal antibiotic administration. The PPROM complicates approximately 140,000 deliveries annually in the United States, with the majority occurring near term. Most of these gravidas are better served by expedient delivery. Many pregnant women will receive antibiotics for asymptomatic bacteriuria, urinary tract infections, *Neisseria gonorrhoeae* and chlamydia infections, group B streptococcus prophylaxis, bacterial vaginosis, chorioamnionitis, and nonurogenital infections. Regarding the neonate delivered remote from term, many will receive routine antibiotic prophylaxis. The majority will be treated if there is prolonged membrane rupture, empirical group B streptococcus prophylaxis, or intrapartum maternal fever. While the issues of antimicrobial resistance and superinfection are important, it is unlikely that antepartum treatment of the relatively small number of gravidas with PPROM remote from term will play a major role in altering antimicrobial susceptibility in the nursery. We believe that the benefits of maternal antibiotic treatment for a limited time outweigh the potential risks.

Brian M. Mercer, MD
University of Tennessee
Memphis
Elizabeth A. Thom, PhD
George Washington University
Washington, DC
Robert L. Goldenberg, MD
University of Alabama at Birmingham


Journal Review: Mind/Body Medicine

To the Editor.—In their review of the new journal, *Mind/Body Medicine*, Ms McKnight and Dr Pickens correctly noted that a reduced subscription price to *Mind/Body Medicine* is a benefit of membership in the Society of Behavioral Medicine; however, we wish to clarify 2 points.

First, the flagship publication of the society is the *Annals of Behavioral Medicine*. The *Annals* is a peer-reviewed journal that publishes empirical research involving the integration of biological, psychosocial, and behavioral factors as they influence health promotion, disease prevention and progression, risk factor modification, and adjustment to physical disorders. The *Annals* begins its 20th year of publication in 1998 and is distributed to all members of the society.

Second, the *Annals* has been accepted for inclusion in *Index Medicus* and MEDLINE, beginning with volume 19. Thus, authors can be assured that the contents of the *Annals* will be distributed widely to the scientific community. The editorial board of the *Annals* includes a number of distinguished scholars who represent our interdisciplinary society. Members of the society and other readers of the *Annals* include physicians, nurses, psychologists, epidemiologists, health educators, and other allied health professionals who engage in research sponsored by the National Institutes of Health, publish their research in high-caliber biomedical journals, and testify regularly before Congress regarding behavioral medicine research, practice, and policy.

Thomas G. Pickering, MD, DPhil
Arthur Stone, PhD
The Society of Behavioral Medicine
Rockville, Md


In Reply.—Given the position of the *Annals of Behavioral Medicine* in its field, it is good to know that the National Library of Medicine will index it for *Index Medicus* and MEDLINE beginning with volume 19. That was not true at the time we wrote the review of *Mind/Body Medicine*.

Michelynn McKnight, MS/LIS, AHIP
Norman Regional Hospital
Norman, Okla
Calcium Carbonate and Reduction of Levothyroxine Efficacy

To the Editor.—I would like to report an interaction between 2 commonly prescribed drugs, levothyroxine sodium and calcium carbonate, which reduces levothyroxine efficacy. This inhibition may be reversed by separating the administration of these 2 medications.

In a recent evaluation of 3 women with thyroid cancer who were receiving levothyroxine to suppress serum thyroid-stimulating hormone (TSH) levels, it was noted that simultaneous ingestion of some calcium formulations reduced levothyroxine effectiveness (Table). For example, patient 1 took levothyroxine (125 µg/d) and had a baseline serum TSH concentration of 0.08 mU/L (normal, 0.5-4.0 mU/L). She subsequently began to take calcium carbonate (in the form of Tums) for prevention of osteoporosis, often taking it together with levothyroxine. She experienced fatigue and a 4.5-kg weight gain over the next 5 months, and her serum TSH level was found to have risen to 13.3 mU/L. She then stopped taking calcium carbonate but maintained her levothyroxine regimen. Three weeks later her serum TSH level had declined to 0.68 mU/L.

In patients 2 and 3 (Table), there was also loss of efficacy of levothyroxine when it was taken simultaneously with oyster shell calcium carbonate (in the form of Os-Cal). In both patients, levothyroxine activity was restored by administering it in the morning and administering calcium carbonate after lunch and dinner. Interestingly, patient 3 previously took a different form of calcium carbonate (Giant brand) with levothyroxine before changing to Os-Cal.

Decreased bioavailability induced by simultaneous intake of other medications (eg, aluminum-containing antacids, iron, cholestyramine, sucralfate) is a well-known occurrence with levothyroxine therapy.1 Decreased absorption could similarly account for the calcium carbonate effect. Calcium carbonate itself or, alternatively, excipients or contaminants in the preparation2 could form insoluble chelates with levothyroxine.3 Differences in excipients or contaminants or variations in rates of dissolution2 could explain the discrepant effects of the 2 calcium carbonate preparations used by patient 3.

Given that both calcium and levothyroxine are used together in a large number of patients, this phenomenon is likely to be widespread. Special attention should be directed toward postmenopausal women, as these individuals most frequently use calcium supplements to prevent osteoporosis and, in addition, often require therapy with levothyroxine.4 Separating administration of these medications by at least 4 hours should provide a simple method for maintaining levothyroxine efficacy.

Christine R. Schneyer, MD
Sinai Hospital of Baltimore
The Johns Hopkins School of Medicine
Baltimore, Md

I thank Pnina Schwartz, RN, for assistance in evaluating these patients; Ralph Shangraw, PhD, Stephen Sherman, MD, and Paul England, PhD, for valuable discussions; and David Cooper, MD, for much advice and encouragement.