We created the "Perspective" column to provide a forum that would spur intellectual debate — a feature well suited to an institution like Chicago. The column by law and ethics Professor Richard Epstein in the summer 2003 issue certainly acheived that goal. Many readers wrote to challenge Professor Epstein's views on how adopting Canada's single-payer universal health care model would only worsen America's ailing system. Below are some of those arguments. — *Editor*

More medical malaise

Richard Epstein ("No Canadian Cure for Our Health Care Malaise," *Medicine on the Midway*, summer 2003) presents a cogent argument that belies his surprising lack of appreciation for the devastating consequences of poor access to health care. Instead of debating issues like the moral imperative for providing adequate health care or the soundness of his zeal for decreasing regulation and allowing market forces to rule (Enron and WorldCom speak for themselves), I would like to respond to some of his other questionable points.

Although people are complaining about the high cost of health insurance, the idea that employees are complaining that these packages are bloated is ludicrous. On the contrary, carve outs and denial for services like mental health have raised loud objections because people with mental illnesses are being denied much-needed care.

Epstein is right: Medicare does create a two-tier system by creating an arbitrary age of entry at age 65. I see many patients who finally get to see a doctor at age 65 with untreated diseases that have already wreaked irreversible havoc on their health. The solution to this is not to cut needed services to older people but to expand these services to younger patients as well.

Epstein worries that a government program will be unresponsive to long-term social needs. Who then is supposed to be planning for long-term social needs? Will market forces with their hunger for quick profits be able to plan for the medical needs of our people 20 or 30 years down the road?

Finally, Epstein expresses concern about the political instability created by low-risk consumers subsidizing high-risk ones. Keeping a large segment of our population — the poor — sick and unhealthy because of lack of access to health care seems to me a far riskier political situation.

Daniel J. Brauner, MD
Chicago, IL

Richard Epstein's right-wing broadside, "No Canadian Cure for Our Health Care Malaise," is terribly misguided. Rather than addressing — or even mentioning — the problem of 40 million uninsured people in the United States, Epstein's recommendations focus primarily on additional ways to restrict access to care.

Epstein focuses mainly on matters that have already ceased to be important problems or were never problems in the first place. For instance, his concern with "our system of state licensure [that] prevents the movement of medical talent into the country and across state lines" should have been allayed with the introduction of the U.S. Medical Licensing Exam, a single route to licensure that is recognized in all states. He is disturbed by "heroic measures at the end of life," but the widespread use of living wills and the availability of hospice care have already greatly reduced the number of terminally ill patients who receive such measures. He frets about "massive overconsumption" in the Medicare program, but in fact the opposite is true: Medicare patients (and non-Medicare patients) are dissuaded by co-payments and deductibles from seeking needed preventive services and early treatment.

His arguments against the Canadian single-payer system are remarkably flimsy. They are: (1) the system is underfunded (a problem easily solved if Canadians were willing to spend at U.S. per-capita rates); (2) doctors must negotiate with the government (in the United States, doctors must negotiate with the government *and* insurance companies); and (3) placing everyone in the same pool requires low-risk consumers to subsidize high-risk consumers (which is, in fact, the way community-rated insurance is supposed to work). One can only gasp when Epstein criticizes the Canadian system (as compared with the U.S. system) for being "unresponsive to long-term social needs."

Medicine ON THE MIDWAY

Bulletin of the Medical and Biological Sciences Alumni Association

Spring 2004, Volume 57, No. 1

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Coincidentally, the summer issue of *Medicine on the Midway* arrived almost in the same mail delivery with the Aug. 13 issue of *JAMA*, which includes the "Proposal of the Physicians' Working Group for Single-Payer National Health Insurance," a Canadian-style plan that has been endorsed by nearly 8,000 physicians and medical students. In an accompanying editorial, the health economist Rashi Fein admonishes, "Those who like their proposal should join with them. Those who do not should develop and propose something better…" Mr. Epstein has done neither.

Daniel S. Blumenthal, MD '68, MPH
Atlanta, GA

The National Academy of Sciences estimates that 18,000 Americans die and society incurs $65 billion to $130 billion in costs annually due to our lack of national health insurance. Despite its significant problems, the Canadian health care system delivers longer life expectancy and lower infant mortality with 30 percent less spending as a percentage of gross domestic product. Professor Epstein's attack on the Canadian system may be well grounded in economic theory, but seems shortsighted as we search for ideas on how to provide basic medical care for all our citizens.

Andrew M. Davis, MD '80, MPH, FACP
Chicago, IL

The Institute of Medicine of the National Institutes of Health, in 2002, reported to the Secretary of Health and Human Services that "the U.S. health care system is incapable of meeting the present, let alone the future needs of the public."

Professor Epstein opened his remarks with an unsupported statement that "Most Americans express satisfaction with their own health care." From that throw-away remark one might conclude that "most Americans are insensate."

Professor Epstein is most disturbed by comparisons of the U.S. and Canadian health care systems. Canada, in 1967, began enacting single payer national health insurance that has lowered its per capita health care costs to 75 percent of that of the United States while providing universal access to high quality care. By eliminating the high costs of administration, advertising, stockholder-corporate profits and high executive salaries/benefits, all of which characterize managed American health care, Canada is able to achieve more services at lower costs. Canadians pay less for health care through the application of taxation than Americans pay by tying health care to family income. Most Canadian physicians prefer their system to that of the United States — if one can believe the Canadian Medical Association.

Canada has higher life expectancy and lower infant mortality statistics than the United States. In 2001, the World Health Organization, in making overall health care system ratings, ranked Canada eighth and the United States 37th. The prestigious Commonwealth Fund (May 2002) Issue Brief compared the health care systems of Australia, Canada, New Zealand, the United Kingdom and the United States. In its summary, it stated: "The United States in particular stands out as having the most severe health care access problems, the greatest medical expense burdens, and the most pervasive inequities on care between adults with above average income and below average income."

Sydney G. Bild, MD
Chicago, IL

As a retired alumnus of the University of Chicago, I was hurt, shocked and then indignant to read of the Orwellian and antediluvian views of Richard Epstein in your summer issue.

There are so many fallacies in his reasoning that it is hard to know where to begin. Perhaps his statement that "a single provider is also a single employer" is the most egregious. Obviously under Medicare the government supplies the money and the programs are administered by private organizations such as Blue Cross/Blue Shield in Montana. The government is NOT the employer!

The Hoover Institution is dedicated to restricting the intrusion of the federal government into the lives of individuals, yet the professor would deny people the right to decide the level of treatment in their final days. He says, "We need to curtail access in most terminal cases." How much more "Big Brother" can one get!

Edwin L. Stickney, MD '54
Billings, MT

It is true that some of the remedies Professor Epstein proposes for our current deplorable situation (e.g. revision of professional

liability) are laudable and would help, but they are unlikely to address the fundamental weaknesses in the "market" approach to health care.

To some extent Epstein was shooting at a straw man, as we could not and would not copy and paste the Canadian system on to the U.S. system. But a thoughtful description of one approach to how a single-payer system could be implemented was published recently by the Physicians' Working Group for Single-Payer National Health Insurance (*JAMA*, Aug. 13, 2003).

But this approach is unlikely to have much attraction for Epstein, who complains that "placing everyone within a single insurance pool requires low-risk consumers to subsidize high-risk consumers." But of course! Spreading the risk by having individuals who do not need medical care subsidize those unfortunate enough to need medical care is just what insurance is all about — whether it is medical insurance or any other kind! The attempt by private insurers to compete by lowering their financial liability through excluding sicker (high-risk) patients is one of the main reasons for the failure of our current system.

Robert H. Palmer, MD
Jersey City, NJ

To err is human

A couple of minor carps about your otherwise enjoyable magazine, which recently came to my mailbox.

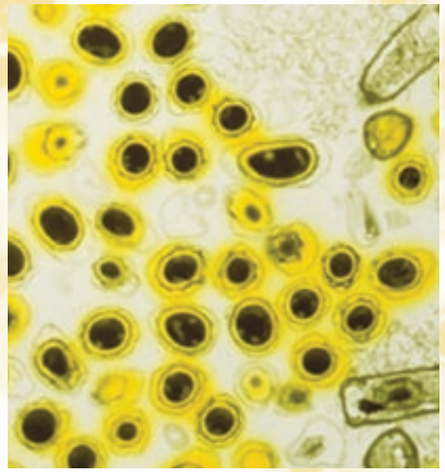
A caption to the photograph of James D. Watson refers to "...the double helix structure of genes." This is not correct. A gene is in RNA, which is transcribed from DNA, whose double helix structure was deduced by Watson and Crick.

In "New path to an old bug," the first paragraph reads: "Capturing iron is a crucial step... in how... the microbe has grown ominously resistant to antibiotics." Capturing iron is a process that the bacterium must have been doing for millions upon millions of years; it is fundamental to its survival. That's the way it lives, but what has it to do with growing "ominously resistant to antibiotics"? The resistance, by whatever mechanism, is a very recent adaptation to the assaults of antibiotics. Unless you can state that the iron-capturing is a new phenomenon in the life of the bacterium, the sentence as written is incorrect.

Robert Evans, PhD
Davis, CA

Evans is correct; the caption to the story "After the double helix" should have read: "Watson and Crick discovered the double helix structure of DNA." And to clarify the story titled, "New path to an old bug," capturing iron is a critical step in how this disease-causing bacterium causes life-threatening infections and knowing how could provide a new target to treat this persistent pathogen.
– *Editor*

Chicago's RCE will focus on the development of diagnostic, therapeutic and vaccine products for anthrax *(below)*, botulism, tularemia, hemorrhagic fever viruses and bubonic plague.



Disease initiatives

The National Institute of Allergy and Infectious Diseases (NIAID), part of the National Institutes of Health, has awarded more than $50 million to the University of Chicago for two major projects to combat infectious diseases.

Chicago will be the lead institution for a Regional Center of Excellence (RCE) for Biodefense and Emerging Infectious Diseases Research. The other major project is to help build a Regional Biocontainment Laboratory.

The RCE, a collaborative effort including researchers from the University of Chicago, Northwestern University, Argonne National Laboratory and 11 additional upper-Midwestern universities, hospitals and research organizations, will be one of eight regional centers funded by the NIAID to battle infectious disease.

A five-year, $35 million grant will support the Midwestern RCE, which will be headed by Olaf Schneewind, MD, PhD, professor of molecular genetics and cell biology and chairman of the committee on microbiology at the University of Chicago, and Robert Murphy, MD, the John P. Phair Professor of Infectious Diseases at Northwestern University Medical School.

"While this project has been driven by recent concerns about bioterrorism, the knowledge we will gain from it could have a significant impact on humanity's eternal battle against all infectious diseases," Schneewind said. "The NIH is placing high priority on research on the diseases caused by organisms that could be used as bioterror agents, as well as diseases that are emerging or re-emerging threats to public health."

The regional centers are a key element in NIAID's effort to expand research in the detection, prevention and treatment of potentially lethal illness that can be caused by biological agents — ranging from the known pathogens that could be used for bioterrorism to new and as yet little-known emerging diseases that develop naturally, such as SARS, West Nile virus, drug-resistant bacteria and many others.

The Midwestern RCE will focus on the development of diagnostic, therapeutic and vaccine products for anthrax, botulism, tularemia, hemorrhagic fever viruses and bubonic plague.

Such research, based on genomics, proteomics and a molecular-level understanding of cell function, is expected to have profound and far-reaching consequences over the next decade and beyond.

"Much of what we know about the biology of our own cells comes from the study of microbes that disrupt those processes," said James Madara, MD, dean of the Division of the Biological Sciences and the Pritzker School of Medicine at the University of Chicago. "What better way to learn more than to focus on the organisms that have the maximum effect on those critical cellular pathways?"

The Midwestern RCE pulls together research teams from 14 institutions in the six states in the federally designated Region V. The research teams will involve more than 300 scientists, including a core of more than 60 specialists in microbiology, infectious diseases, public health, medicine, vaccine research and pharmacology, as well as related disciplines such as biochemistry, computer science, engineering, mathematics and nano-technology.

"This fits well into our continuing efforts to encourage innovative research that crosses boundaries, bringing together specialists from many different disciplines, including the physical and even the social sciences," Madara said. "The RCE will extend that approach to crossing institutional boundaries."

While this project has been driven by recent concerns about bioterrorism, the knowledge we will gain from it could have a significant impact on humanity's eternal battle against all infectious diseases.

— Olaf Schneewind, Professor of Molecular Genetics and Cell Biology

In addition to performing research, the RCE will act as a regional resource for public health officials, providing expertise, rapid diagnosis, support and advice about containment and treatment in the event of a bioterror outbreak or the emergence of new diseases. It also will teach young scientists and technicians how to conduct productive and safe research on infectious disease.

Emerging pathogen to be studied

The Centers for Disease Control and Prevention has awarded four universities, including the University of Chicago, a $3 million grant to study community-acquired methicillin-resistant *Staphylococcus aureus* (CA-MRSA). Concerned about increasing reports of the disease, the CDC is placing the pathogen high on its priority list. The university's principal investigator, Robert Daum, section chief for pediatric infectious diseases, has assembled a team that will use a variety of molecular techniques to assess isolates of MRSA for their virulence. Daum's team will receive $250,000 annually for three years to study clinical, epidemiological and molecular characteristics of CA-MRSA. Also participating in the project are Columbia University, Harbor-UCLA Research & Education Institute and the University of California, San Francisco.

GERD

A new minimally invasive procedure is helping children with gastroesophageal reflux disease (GERD). Performed in Chicago only at the University of Chicago Children's Hospital, the Stretta procedure is a one-hour outpatient surgery that allows most patients to resume normal activities the next day. According to pediatric surgeon Donald Liu, each year several thousand American children are diagnosed with GERD, which causes irritation and pain in the esophagus and, if left untreated, can lead to esophagitis or cancer. The Stretta System lowers a tiny video camera through the mouth along with a catheter that emits radiofrequency energy, which narrows the opening in the area where the esophagus meets the stomach. A tighter valve in the gastroesophageal junction helps prevent reflux and, in most patients, reduces esophageal acid by 50 percent within six months. Children ineligible for Stretta can be helped with laproscopic surgery, which requires only tiny keyhole incisions in the abdomen.