Time has come for single-payer system

TO THE EDITOR:

I read with interest Dr. Robert L. Barbieri's November 2003 editorial, "Universal health coverage: Maine braves a new world." As he observed, "many business and health industry leaders" in Maine considered that state's universal, single-payer health plan "too radical" and "unacceptable." But the United States as a whole employs a pluralistic system that now leaves approximately 43 million people with no insurance. Keeping that pluralism in place and reinventing the wheel is no solution.

Just because "the leaders" consider the single-payer plan too radical is hardly an argument against it. It is time for all who are interested in universal health care to recognize the need for a single payer. Those who reject this concept are accepting the status quo by default.

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DR. BARBIERI RESPONDS: I appreciate Dr. Ellison's observations, including his conviction that we should move in 1 step from our current system to a single-payer health plan. The 8,000 doctors who signed the Physicians' Working Group for Single-Payer National Health Insurance also agree with him.[1] However, many leaders in government and health care believe there are advantages to evolving to a new system through multiple smaller steps. Given the pluralistic nature of American economic and political thought, it is likely that a multistep process, however flawed, will be the practical approach in our situation.

REFERENCE

1. Proposal of the Physicians' Working Group for Single-Payer National Health Insurance. *JAMA*. 2003;290:798-805.

The case for routine fetal fibronectin sampling

TO THE EDITOR:

I agree with the premise for routine screening that Drs. George A. Macones and Alison Cahill set forth in their November 2003 article, "Is routine sampling of fetal fibronectin justified?" However, I disagree with their discussion as it applies to fetal fibronectin.

One must be able to properly diagnose a disease before effective treatment options can be considered. For example, the initial screening test for cervical cancer was first described by Dr. Papanicolaou in 1943, but it was more than 40 years before the Bethesda System uniformly defined the disease, and only recently did we come to understand the association with human papillomavirus and develop the ability to test for high-risk subtypes. A similar comparison can be made with HIV testing: The screening was developed ahead of our ability to provide proper medical care.

In 2002, 12% of deliveries in the United States were premature.[1] This certainly qualifies as a significant burden—one of the 5 requirements for routine screening given in the article. Second, the fetal fibronectin test has been shown to be highly sensitive, with a negative predictive value of 99%.[2] Third, it is easy to perform, at a relatively inexpensive cost (roughly $125 per test). Fourth, the test is safe and acceptable to patients. Fifth, treatment is available for patients who test positive—namely, tocolysis, which can delay delivery for at least 48 hours, sometimes even a week. This allows time for treatment with antenatal steroids to reduce infant morbidity and mortality and, if necessary, for transfer of the mother to a center able to care for the preterm infant.

CONTINUED

Finally, proper identification of women at higher risk of preterm delivery allows for continued study of more effective diagnostic tools and treatment options.

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1. Hamilton BE, Martin JA, Sutton PD. Births: preliminary data for 2002. *Natl Vital Stat Rep*. 2003;51(11):3.
2. Iams JD, Casal D, McGregor JA, et al. Fetal fibronectin improves the accuracy of diagnosis of preterm labor. *Am J Obstet Gynecol*. 1995;173:141-145.

DRS. MACONES AND CAHILL RESPOND: Dr. Raskauskas argues that treatment (tocolysis) is available for women who are positive for fetal fibronectin. It seems that he is confusing a screening test (used in asymptomatic subjects) with a diagnostic test (used in subjects with symptoms).

At this point, the use of fetal fibronectin (or ultrasound measures of the cervix) for screening asymptomatic women in clinical practice is not justified. There is debate, however, on the merits of fetal fibronectin testing in women with symptoms of preterm labor. In this setting, most argue that a negative test is more clinically useful than a positive test. Still, some believe that fetal fibronectin may have a role in such cases. As stated in our article, we do not use this test in our center.

Dr. Raskauskas believes there is intrinsic benefit to developing screening tests for preterm birth, and we agree. However, we feel strongly that the implementation of new tests in clinical practice should not occur until their benefit is demonstrated. Obstetrics is full of examples of how our zeal for the "newest" test/device has resulted in widespread use before clinical advantage is proven. Two classic examples are electronic fetal heart rate monitoring (responsible for tripling the cesarean rate without demonstrable benefit) and home uterine activity monitoring (shown to be of no benefit in rigorously done studies).

We should learn from the mistakes of the past rather than repeat them, and introduce new tests/therapies only when clear evidence shows that their implementation will lead to improved clinical outcomes. It is with this approach that we will provide the safest and most effective care.

Double 'punishment' deters mammographers

TO THE EDITOR:

Dr. Barbieri's January 2004 editorial, "Low reimbursement + excessive liability = long waits for mammography," reminded me that approximately 700 mammography centers have closed in the past 2 years. We all know that the Pap smear carries a false-negative rate of 20% to 30%, but it seems that fewer people sue the pathologist for delayed diagnosis of cervical cancer. Compare mammography, with a false-negative rate of 10% and a greater number of lawsuits. One reason may be that, in our society, the breast carries more weight—cosmetically and sexually—than the cervix or uterus.

Dr. Barbieri mentioned that computerized detection systems might allow for a stronger defense at trial. This sounds reasonable, but I doubt it will prevent lawsuits against companies producing those systems. The only immediate solution is increasing Medicare reimbursement for screening mammography. Radiologists need not receive double punishment: getting sued and being poorly paid.

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DR. BARBIERI RESPONDS: I agree with Dr. Li's important insights. I hope all physicians, including obstetricians and gynecologists, will be adequately reimbursed for their professional efforts. ■