serious influenza pandemic, we focused primarily on disasters causing numerous medically critically ill victims. The composition of our group was deliberately conceived to bring medicine, ethics, and public health experts together to collaboratively develop pragmatic, optimal clinical guidance. We knew that future work on critical care surge capability and triage for pediatric and trauma issues would be necessary, and work by Subbarao and colleagues7 has advanced additional, essential elements of triage planning.

The challenges of optimal triage across the entire health-care system spectrum are many. Even the goals of triage, such as mortality vs life-years saved or other outcomes, have not received sufficient professional consideration or input from community members. Furthermore, health system situational awareness (i.e., patient needs and resource availability) needs much more real-time and detailed clinical information to optimally inform centralized triage recommendations. The capability to rapidly understand the course of a disease, identify prognostic variables, and determine treatment effectiveness across the entire health-care system remains elusive for most communities. This information will be essential for sustained-response events such as epidemics, when data-driven revisions of triage guidance would be expected to ensure that our community members get the best possible care in resource-limited circumstances. Finally, regional coordination of health-care system triage will require input from many different clinical specialties and professions as well as from nonclinical community members, such as elected officials, community advocates, and at-large community members, among whom are many of the same people who must provide consultation during responses. The majority of communities must still further develop their regional health-care system coordination infrastructure to assure such clinical expert involvement.

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REFERENCES


Reflections From the Field Regarding the Clinical Commentary for Augmentation Therapy in the MZ Phenotype

To the Editor:

We read with interest and great anticipation the clinical commentary in a recent issue of CHEST (October 2008) regarding α1-augmentation therapy for PI MZ heterozygotes, but disagree with the conclusions reached by the Medical and Scientific Advisory Committee of the Alpha-1 Foundation in the strongest terms.

The authors acknowledged, although their evidence is somewhat anecdotal, the existence of patients with MZ phenotype who have severe obstructive disease despite being nonsmokers. They also acknowledged the difficulties involved in enlisting a subset of rapidly declining MZ phenotype patients in a trial to be “daunting.” There are also no data available that have looked at the quantity of Z or M α1-antitrypsin (AAT) within a given patient and the protectiveiveness of the level of each subtype in preventing disease.

The authors reiterated the fact that physicians legally enjoy the privilege of prescribing medications that have not been approved by the US Food and Drug Administration. They failed to realize that the physician is the greatest advocate for their patients, and that the doctor-patient relationship is an ethical one that is above any legal obligations and goes beyond any approval by a third party. We have for centuries advocated for our patients and have not placed an economic value on each individual’s life, though it is common knowledge that third-party payers have done so.

Given this background and the bleak prospects for any new knowledge being imminently available in a randomized prospective trial, we believe that the interim recommendation to clinicians by Sandhaus et al1 to avoid prescribing augmentation therapy for MZ heterozygotes is a disservice to patients and physicians alike. Patients who in today’s economy can hardly afford to reach the office (due to gasoline prices and increasing rates of copays) will never be able to reach specialists with experience in treating AAT deficiency (whatever the definition of an AAT deficiency specialist might be), and it is fair to say that deserving patients will be denied treatment based on this article.1

To ask the insurance industry to closely evaluate reimbursements for such a scenario is at the least an irresponsible recommendation after a doctor-patient relationship has been set up and a decision to treat has been made based on the best available knowledge. To our knowledge, this is the first time in a

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In discussing the diffusing capacity of the lung for carbon monoxide (DLCO), Dr. Plummer\textsuperscript{1} points out the difficulty in