Prevention, after some prodding by the US Congress [12], have developed rational public health plans to combat antimicrobial resistance. We should follow their advice. We need to be aware, however, that the emphasis on surveillance of antibiotic resistance can be a double-edged sword. On the one hand, it is essential to help guide therapy. On the other hand, it can be used as a powerful marketing tool to influence inappropriate use of new drugs that need to be reserved for the treatment of severe infections.

The “old” literature is rarely if ever referenced by the “new generation” of experts. George Santayana’s famous statement “Those who cannot remember the past are condemned to repeat it” is as true as ever [13, p. 284]. Thank goodness that the message has finally gotten through. The torch has been passed to a new generation. We can only hope that it is not too late.

Acknowledgments

I thank my numerous colleagues in adult, pediatric, and surgical infectious diseases, clinical microbiology, and hospital epidemiology who have described in its commentary [2] as an ad-

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Reply to Kunin: Rationale for Antibiotic Development Incentives

To the Editor—We appreciate the thoughtful comments of Dr. Kunin and all of his efforts through the years to promote the proper use of antibiotics [1]. We would like to respond with several points. Dr. Kunin reminds us that the Infectious Diseases Society of America (IDSA) has been addressing the problem of antimicrobial resistance for over 40 years. In combination with the National Institutes of Health, the Centers for Disease Control and Prevention, the US Department of Veterans Affairs, and the World Health Organization, extensive efforts have been made to avert the problem of microbial resistance as much as possible. These efforts have been primarily through sur-

veillance, attempts by the IDSA to promote “antibiotic stewardship,” direct interaction with legislators, scholarly publications regarding concerns about antibiotic resistance, and consultations with regulatory agencies on clinical research design. The recent IDSA Public Policy Commentary [2] stresses how these efforts have had limited success to date, considering that the level of antimicrobial resistance is now greater than it has been in the history of anti-infective agents and that we are witnessing a dramatic egress of the major pharmaceutical companies from the development of newer anti-infectives. The promotion of “antibiotic stewardship” is a critical role for the IDSA, and considerable efforts are ongoing. This guidance [3] is just one example of multiple current efforts. However, the IDSA is an organization of ~9,000 professionals and currently has no regulatory authority for “antibiotic stewardship” for the ~1,000,000 licensed physicians and health care workers who are entitled to use antibiotics in any way that they feel is appropriate. The complex problem that these unregulated physicians and health care workers face is that of being asked to place a subset of their patients at risk for mortality due to curable infectious diseases by either withholding antibiotics or shortening the course of therapy. In addition, unlike in many other countries, they are asked to take this potentially high-risk, conservative medical approach in a nation in which medical law suits are frequent and risk avoidance strategies are highly valued by the general population. Against this background of biologically inevitable antimicrobial resistance, the failure of previous strategies to minimize microbial resistance development, the lack of significant anti-infective development through federal government agencies, and the egress of the major pharmaceutical companies from anti-infective development, the IDSA, after considerable research involving the top executives in the pharmaceutical industry, has suggested the financial incentives as described in its commentary [2] as an ad-
ditional approach. In addition, it emphasizes the importance of educating the general population to influence our policy makers to take action against this developing crisis.

Regarding Dr. Kunin’s comments that the IDSA leadership has “conflicts of interest,” it is our belief that the most appropriate solution to possible perceived conflicts of interest is disclosure. The readers can then decide for themselves whether the personal benefits that result from the IDSA leadership’s interaction through shared research, professional education, and consultation with the pharmaceutical industry are their motivation or whether trying to stem a public health crisis and save the lives of thousands of children and adults dying from infections due to resistant organisms is their primary goal.

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Reply to Kunin: Infectious Diseases Society of America’s Efforts to Contain Antibiotic Resistance

To the Editor—The leaders of the Infectious Diseases Society of America (IDSA) appreciate Dr. Kunin’s [1] historical perspective on how the infectious diseases community has struggled to deal with antimicrobial resistance, and we share his desire to learn from that perspective as we move forward. However, we must take issue with the notion that the IDSA is late in addressing resistance and off-base in our recent efforts to stimulate anti-infective discovery as part of the solution to this problem. The IDSA has a long history of highlighting concerns about resistance and the importance of antimicrobial stewardship, including those activities, which Dr. Kunin proudly cites in his letter [1], that occurred during his tenure as IDSA President in the mid-1980s. The IDSA’s recent growth in membership and our resultant enhanced ability to speak more forcefully and effectively about important public health policy matters during the past few years has allowed us to play a larger, more visible, and we believe more effective role than in the past. We are not late; we are just more capable.

We strongly agree with Dr. Kunin on the need for more-effective efforts to promote better use of existing drugs. The IDSA joined with the Society For Healthcare Epidemiology of America to develop new antibiotic stewardship guidelines, and together, we are actively encouraging their implementation. Infectious diseases specialists should play a role in fostering appropriate use of antibiotics; however, we are only a few thousand among several hundreds of thousands of physicians and other health care providers who prescribe anti-infective agents. We are well armed with the knowledge to educate, but we are hampered by a health care delivery system in which patients expect more rather than less treatment and in which physicians are ever more mindful of potential medical liability dangers. In addition, neither the IDSA nor individual infectious diseases specialists have any real authority to control the use of antibiotics; education and advocacy are our only real tools. Moreover, it must be acknowledged that tens of millions of dollars have been expended over the past several decades in trying to educate physicians and the public about the judicious use of antibiotics with only limited success, as evidenced by the increasing problem of drug resistance.

Even with improved use of antibiotics, we are still going to need new agents in the future. Clearly, combating antimicrobial resistance requires a multifaceted set of solutions. That is why we are also calling for a more robust research agenda involv-