

LETTERS TO THE EDITOR

Hospitalism Debate

To the Editor:

The article by Saver and Doescher¹ on the rising tide of hospitalism brings up some excellent points. I am writing, however, to clarify one area. I am a family physician who gave up hospital work to improve the care of my patients through increased availability. I would not be as effective in my office practice had I not had years of hospital experience.

The authors bring up the issue of training doctors differently for ambulatory and hospital medicine in family practice. I suggest that there is an impossibility to provide either training without the knowledge of the other. While I do not practice oncology in my practice as a primary skill, I would have done very poorly without that training in my residency. When I left my residency, I had full privileges to place Swan-Ganz catheters, central line catheters, and temporary pacemakers at 4 major hospitals in Columbia, South Carolina. While I do not use these skills in my office-based practice, they have provided very valuable training that has helped me to improve my ambulatory patient care. The paradigm that Saver and Doescher outline in their article does not fit with my views of an absolute division between hospitals and ambulatory medicine. Well-rounded training is needed by all to provide primary care services, and we should base our decisions more on patients' needs, and not on traditions or perceived threats to our profession.

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To the Editor:

The concept of the upkeep of skills becomes pertinent to the debate about hospitalists: whether family

practice residencies should train for inpatient care and whether family doctors should do it. My opinion is that the answer must be yes to both. A negative answer speaks a death knell to our specialty, our knowledge base, our credibility, our ability to handle severe sickness and life-or-death situations, our self-esteem, and our patients' needs for appropriate, sensitive, timely, and optimal care.

Once an individual has mastered a given procedure or process, it takes a minimum of reinforcement to maintain. For example, I learned blood-drawing as a medical student from an IV nurse by following her around and gleaning her tricks. I learned well. Drawing blood is not rocket science, but not everyone gets good at it.

Now in my office, two medical assistants draw blood, hardly ever missing. I will draw those they miss, maybe one a month, always the hard ones. So much for the theory of requiring large numbers of procedures to keep up your skill. Though this is probably true for some teams, such as in heart surgery, where working together is all-important and takes reinforcement and practice with all the newer players.

The danger comes when more mishaps and missed diagnoses are expected because of the multiple pressures on the practice of careful and caring medicine. Far from removing the family doctor from the hospital, this suggests involving him or her in every hospital and ICU case as a consultant if the patient has no personal family physician, and as captain of the team if he or she had a long-standing relationship.

Why would I make such a suggestion? Three reasons: (1) Sick

patients often have or will develop multisystem disease. Nurses are entrusted with alerting us to ominous vital signs but cannot recognize early nonapparent pathology. Recent understaffing undermines even the best nurses' attention. (2) Apparent changes in hospital medicine and procedures are more often superficial than substantial, more like changing the jargon than learning a new language. Outside physicians do not get in-services on new gadgets and forms, so it seems that the specialists, the ICU nurses, and now the hospitalists "know" a lot more than we do. But even the specialists do not know the details of certain machines. And none of them know as much as we do outside their own fields. They are focused on depth, not breadth. (3) When other specialists are called in, they do not see their role as pulling together all disparate parts of the patient's care.

We generalists cannot know everything. But we have a better chance of pinpointing evolving pathology in all organ systems in very sick hospitalized patients, especially if we have known these patients before — but even if we have not. Aha, you say, that is exactly what a hospitalist is for. . . and he can do it better. I doubt that turning my patient over to a hospitalist would be better for the patient. I suggest that my seeing him through his acute illness in the hospital will save the system money, since multiple other specialists will not need to be called in by the limited subspecialist. My presence will bring my knowledge of this patient and of general medicine to the specialist. It will refresh my hospital skills and my

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comfort level within the hospital culture. It will reinforce new learning and will bring to the patient my ongoing concern for him and his family. A major benefit is observing at close hand the skills and conscientiousness of the specialists to which we refer. Without being on cases together, there is no way to know how other doctors care for our patients.

I suggest that the same loss of skill by a generalist who does not spend enough time in the hospital, pertains to a hospitalist who is never in the office. The first will lose fluency in jargon, familiarity with acute drugs, and comfort around very sick patients; the second will lose fluency in continuity of care, familiarity with outpatient drugs, and comfort in recognizing acute, but not severe, illnesses occurring while a patient is in the hospital with his major illness — such as rashes; allergies; ear, nose, and throat disorders; psychologic disorders; gynecologic disorders; urinary problems; and others.

Just because emergency room physicians exist, family physicians do not cease learning about and treating emergencies. Just because hospitalists exist, family physicians should not abdicate their own hospital role. That this happens because they are not paid, and in fact, are penalized (capitation) is no reason to acquiesce to the results of a system that encourages this perversion of our whole profession and specialty. It is a reason to encourage the wisdom and courage of all of us to change the system to preserve what is good, even in the face of adverse and probably transient conditions.

Our hospital and office perspectives enhance one another, making us more valuable in both places. As with phlebotomy, if we were once skilled at taking care of hospital patients, our medical management expertise and our concern will carry us through, even if we do not practice those skills all day every day. Our patients need our skill and

advocacy most when they are the most ill.

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The preceding letters were referred to Dr Saver and Dr Doescher, who respond as follows:

Dr Epperson raises the question of whether it is important to acquire inpatient skills, even though they may not subsequently be used. We see value in gaining experience with invasive procedures that our patients are likely to undergo, if only so that we can better prepare patients for what they are facing. However, whether acquiring personal proficiency in a procedure that will not be performed in practice is a good use of valuable training time is debatable. How are skills in the placement of Swan-Ganz catheters useful in ambulatory practice (ignoring the issue of whether *anyone* should be using these devices)? Some skills in the medical management of inpatients may translate to better outpatient care, especially in the current environment of discharging patients “quicker and sicker” from the hospital, but judgment of appropriate care based on the skewed population of inpatients may not always apply to outpatients. Given the limitless amount of knowledge that could be helpful for practice, it might be a better use of training time to improve family therapy skills or learn procedures such as colonoscopy than to acquire inpatient skills that will not be used.

Dr Granat makes a good case for the value of primary care physician involvement, even when patients are receiving specialized care in the ICU. Our editorial attempted to highlight the fact that the shift toward hospitalism is happening in the relative absence of outcome data. Given the economic, structural, and convenience factors involved, it seems unlikely that the tide will be turned in most urban centers, unless research

demonstrates that important outcomes are, in fact, worse when primary care providers are not involved with inpatient care. It could also be that the benefits for patients outweigh any costs. The research simply has not been done, and time and tide seem unlikely to wait for good studies.

As for Dr Granat's assertion that, “Once an individual has mastered a given procedure or process, it takes a minimum of reinforcement to maintain”: this is likely true for some procedures and some people and untrue for others. We cited some of the volume-outcome literature in our editorial, and the findings are mixed. Would Dr Granat agree to fly on an airliner whose pilot had worked regularly in the past, but who had flown only a few times per year for the past 10 years? How much experience is needed to become proficient with a procedure, how much is necessary to maintain proficiency, and how do we evaluate proficiency? These are other questions that clearly beg for more research.

Hospitalism is changing the nature of practice for many generalist physicians, and its reduction of time demands outside the office is certainly seductive. Whether it is good or bad for patients needs careful controlled study, and we fear that those rigorous evaluations may never take place. It also has implications for family medicine and residency training that cannot be ignored unless the tide rapidly begins to ebb, an eventuality that currently seems unlikely.

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Antibiotics for Acute Bronchitis

To the Editor:

I found the article by Oeffinger et al¹ about the treatment of acute bronchitis in adults very interesting. In a 1997 article from Iceland in which

serologic test results from adults with acute bronchitis were analyzed, 84% had negative serology, 14% had viral serology, and only 2% had bacterial serology.² This confirms that acute bronchitis in most cases is a viral disease. Also, in Norway, acute bronchitis is treated with antibiotics in a vast majority of cases³ despite the evidence⁴ that antibiotics are of no clinical value to the duration of symptoms or complications.

The differential diagnosis and treatment of lower respiratory tract infections is difficult, when the diagnosis is based on clinical evaluation alone. In a recent study,⁵ we demonstrated that a rapid test of C-reactive protein, done in the general practitioner's office and providing an answer within 10 minutes, can be helpful in determining patients with respiratory tract infections who are in need of antibiotic treatment. The test contributed to the reduction of antibiotic consumption by one fourth in our investigation. We feel that this test is one of the best tools to exclude bacterial causes of acute bronchitis, and is also a good pedagogic way to explain to the patient that he will not benefit from using antibiotics.

Most antibiotics are prescribed in general practice, and I agree with the authors' concern that the way general practitioners deal with this is crucial. Still, we have few problems with antibiotic resistance in Norwegian primary care. Pneumococci are still sensitive to penicillin V, and the frequency of resistant *Haemophilus influenzae* has constantly been 7% to 10% during the last years. The main reason for this favorable situation is most likely the use of penicillin V as the drug of choice in the treatment of the most common respiratory tract infections, such as acute otitis media, sinusitis, tonsillitis, and acute bronchitis.

Antibiotic resistance is closely related to the total amount of antibi-

otics prescribed and the proportion of broad-spectrum antibiotics. The most important issues are to reduce the total amount of antibiotics and to use narrow-spectrum antibiotics like penicillin V in most cases. Even in Norway, we can reduce the use of antibiotics, especially in patients with acute otitis media or acute bronchitis.

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The preceding letter was referred to Dr Oeffinger, who responds as follows:

We appreciate Dr Lindbaek's interest in our work and his thoughtful input. To date, there has not been widespread use of this test in the management of acute bronchitis in the United States. The potential usefulness of the rapid C-reactive protein test is interesting and should be further evaluated prospectively in a randomized trial to see if patients treated with antibi-

otics for a positive test result have better outcomes compared with those with a negative test result. We agree that this could be an excellent way to reinforce to patients that antibiotics are not warranted.

Dr Lindbaek's comments regarding the use of penicillin and the prevalence of bacterial resistance reminds us to be aware of our different geographic locations when making a clinical decision. As mentioned in our article, 23.6% of outpatient isolates of *Streptococcus pneumoniae* collected in 30 different medical centers in the United States were resistant to penicillin.¹ As Dr Lindbaek notes, the incidence is different from locale to locale. This point is well demonstrated in a recent multinational study of the prevalence of antimicrobial-resistant pathogens in the middle-ear fluid of children with otitis media. *S pneumoniae* susceptibility to amoxicillin ranged from 62% in the United States to 95% in eastern and central Europe.²

In summary, the points offered provide interesting areas for further investigation. In the meantime, one must still question the use of antibiotics, particularly amoxicillin, in the United States for the treatment of acute bronchitis in the otherwise healthy adult.

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