

The hospitalist: a US model ripe for importing?

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TO THE EDITOR: We read with interest Hillman's editorial on the hospitalist movement.¹ As our group includes a couple of recent expatriates from the Canadian healthcare system,* we can give some historical perspective on the evolution of the hospitalist in Canada, some of which parallels what is happening in Australia.

Traditionally, family physicians (general practitioners) in Canada were able to manage their patients in hospital, either as the primary care doctor or in consultation with a specialist. Not infrequently, the specialist would assume primary care and consult with the family doctor. Continuity of care was assured, and both the family doctor and the specialist benefited socially and professionally from the interaction. The "corridor consultation" thrived and the doctor's lounge was a source of medical education and social interaction as GPs and specialists met over a morning coffee before rounds.

Around 10 years ago, the family doctor became increasingly unwelcome in the hospital, particularly in teaching centres. As there was never a financial incentive to be involved in hospital practice, this atmosphere persuaded most family doctors to resign their hospital privileges. However, it soon became apparent that a visiting-consultant-based service could not cope with the numbers of patients being admitted to hospitals. Patients with no apparent "teaching value" were becoming difficult to admit into teaching units. Consequently, those few GPs who had retained hospital privileges were increasingly being asked to accept patients primarily under their care. As the system became more stressed, they found that they were managing more and more acutely ill patients. These experienced GPs evolved to become hospitalists — essentially, primary care doctors who were prepared to look after

acutely ill inpatients, often in consultation with a specialist.

Unfortunately, attempts to encourage GPs back into the hospital system have generally proved unsuccessful. The College of Family Physicians of Canada, recognising that there may no longer be ready access to specialist services or hospital beds, is starting to train its residents accordingly.

We agree with Hillman that the complexities of acute medicine require specialists (such as emergency physicians, intensive care specialists and general physicians) with training and skills in acute medicine, resuscitation and multi-system problems. Indeed, our experience in rural Australia suggests that hospital-based multidisciplinary critical care physicians are already undertaking some of the hospitalist roles that Hillman describes. Perhaps we are witnessing the emergence of hospitalists in Australia.

*Dr Lancashire previously chaired the Northern and Isolation Allowance Committee for the government of British Columbia and was a Critical Care Physician at the Foothills Hospital, University of Calgary, the first hospital in Alberta, Canada, to institute a hospitalist program. Dr Law was previously Clinical Associate Professor of Family Medicine at the University of Calgary.

1. Hillman K. The hospitalist: a US model ripe for importing [editorial]? *Med J Aust* 2003; 178: 54-55. □

Effect of computerised prescribing on use of antibiotics

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TO THE EDITOR: I would like to comment on the recent article by Newby et al.¹ They conclude that the default settings in computerised prescription packages result in a significant increase in the use of antibiotics. I do not believe this is a valid conclusion.

As the authors state that 85% of general practitioners generating computerised prescriptions are using Medical Director (MD), it is reasonable to assume that the default settings in MD would contribute significantly to this effect if their conclusion is correct.

I have installed and tested MD v.2.3 from February 2000, MDW v.1.85 from February 2000 and MD v.2.4 from May 2000. These were the versions that

would have been in use at the time of this study.

All versions default to printing "once-only" prescriptions without repeats. In fact, when a "once-only" prescription has been selected, MD's default behaviour is to display a prompt for the quantity and repeats with the default repeats field set to "0".

This is very easy to verify simply by installing a copy of MD onto a "clean" computer and printing some scripts. As this was evidently not done, it casts doubt on the quality of the whole study. How can the authors reach a conclusion about the effect of the default settings in computerised prescription packages without first ascertaining what those default settings are? They appear to have assumed that the default behaviour of all computer prescription packages is to print the maximum number of repeats allowed by the Pharmaceutical Benefits Scheme. No attempt appears to have been made to verify whether this is the case.

Whatever the reason for the observed increase in repeat antibiotic prescriptions, it is incorrect to conclude that it is due to the default settings in computerised prescribing packages. No discussion of other possible explanations for the observed increase is presented and it appears as though the data have been used to support a conclusion that had been decided before the study was commenced.

1. Newby DA, Fryer JL, Henry DA. Effect of computerised prescribing on use of antibiotics. *Med J Aust* 2003; 178: 210-213. □

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IN REPLY: As Pyefinch notes, if the "once only" option in Medical Director (MD) is chosen during prescribing, the doctor must enter the quantity and number of repeats that he or she wishes to order. However, if the doctor chooses the "regular" medicine option (both options are offered during prescribing), then the maximum Pharmaceutical