The hospitalist: a US model ripe for importing?

William Lancashire,* Craig Hore† Jennifer A Law‡

*Conjoint Senior Lecturer, † Senior Lecturer, ‡ Lecturer, School of Rural Health, University of New South Wales, PO Box 2466, Port Macquarie, NSW 2444.
Bill.lancashire@maynegroup.com

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 multisystem 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

F Frank Pyefinch

Director of MD Development, Health Communication Network, 2 Santa Fe Drive, Bundaberg, QLD 4670
frank.pyefinch@hcn.com.au

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. ❑

David A Newby,* Jayne L Fryer,† David A Henry‡

* Lecturer, † Statistical Analyst, ‡ Professor, Department of Clinical Pharmacology, University of Newcastle, Newcastle Mater Misericordiae Hospital, Newcastle, NSW 2298
mddan@alinga.newcastle.edu.au

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

Benefits Schedule quantities and repeats are inserted.

There are various reasons why doctors may be using the "regular" option rather than the "once only" option when prescribing antibiotics using MD. Some of these have been discussed on the General Practice Computing Group Listserv,[1] and include factors such as confusion regarding the terms "regular" and "once only" and difficulties recalling patient medication histories if the "once only" option is used. Another explanation is that doctors commonly prescribe chronic medications, and therefore use of the "regular" option may become a habit. Whatever the cause, there is no obvious explanation for the differences observed, except for the use of prescribing software. Our recommendation that prescribing software be altered to avoid these shortcuts was made because it represents the most immediate way of resolving the problem.

1. General Practice Computing Group Listserv. Available at: http://www.gpcg.org/listservs/index.html (accessed Mar 2003). ❑

Differences in overweight and obesity among Australian schoolchildren of low and middle/high socioeconomic status

Jennifer A O'Dea

Senior Lecturer, Faculty of Education, University of Sydney, Building A35, Sydney, NSW 2006.
j.o'dea@edfac.usyd.edu.au

TO THE EDITOR: As part of a large, national nutrition study, height and weight were measured among 4441 students from 38 schools randomly selected from lists of all state and territory schools in Australia in 2000. Public, private and Catholic schools, in both rural and urban areas, were represented.

Schools were categorised as being of low or middle/high socioeconomic status (SES),[1] based on direct measurement of parental income. Parental consent was obtained, and the study was approved by the University of Sydney Ethics Committee and all state departments of education.

Overweight and obesity, as defined by an international standard definition,[2] were identified in 17.3% and 6.4% of participants, respectively. These characteristics showed a trend towards greater prevalence among students from low-SES backgrounds compared with those from middle/high-SES backgrounds for the total group (19% v 16.8% overweight [$P = 0.09$]; 8.9% v 5.8% obese [$P = 0.02$]), females (19.7% v 17.2% overweight [$P = 0.2$]; 6.9% v 6.2% obese [$P = 0.56$]), and males (18.5% v 16.3% overweight [$P = 0.23$]; 9% v 5.5% obese [$P = 0.003$]), although not all differences were statistically significant.

School students classified as overweight or obese* according to socioeconomic status (SES), school level and sex

	Males (n=2232)		Females (n=2209)	
	Low SES (n=574)	Middle/high SES (n=1658)	Low SES (n=508)	Middle/high SES (n=1701)
Primary school students (grades 1–6; ages 6–13 years)				
Overweight students	19.4% (42/216)	16.2% (110/680)	23.2% (51/220)	17.8% (136/766)
Obese students	6.9% (15/216)	5.3% (36/680)	6.4% (14/220)	5.7% (44/766)
High school students (grades 7–12; ages 13–18 years)				
Overweight students	17.6% (63/358)	16.4% (160/978)	17.0% (49/288)	16.8% (157/935)
Obese students	10.1% (36/358)	5.6% (55/978)	7.3% (21/288)	6.5% (61/935)

* Overweight and obesity are classified according to the international standard definition.[2]

After controlling for SES differences in age and height, mean body mass index (BMI) was significantly higher among low-SES than middle/high-SES participants for the total group (20.3 kg/m^2 [95% CI, 20.1–20.5 kg/m^2] v 19.7 kg/m^2 [95% CI, 19.6–19.9 kg/m^2]; $P < 0.001$), females (20.4 kg/m^2 [95% CI, 20.1–20.7 kg/m^2] v 19.8 kg/m^2 [95% CI, 19.6–19.9 kg/m^2]; $P < 0.001$), and males (20.2 kg/m^2 [95% CI, 20.0–20.5 kg/m^2] v 19.6 kg/m^2 [95% CI, 19.5–19.8 kg/m^2]; $P < 0.001$). A breakdown of results by SES, sex and school level is shown in the Box.

Low-SES primary school children were also 1–2 cm shorter, on average, than middle/high-SES primary school children (boys: mean 141.5 cm [95% CI, 140.6–142.5 cm] v 143.5 cm [95% CI, 143.0–144.0], $P < 0.001$; girls: mean 141.0 cm [95% CI, 140.8–142.6 cm] v 143.3 cm [95% CI, 142.5–143.6 cm], $P = 0.01$).

The average proportions of overweight and obese children and adolescents in the study were similar to those found in other Australian studies.[3-5]

The results suggest that SES is a factor in the development of overweight and obesity among Australian school children. This may be a relatively recent trend, as these data were obtained in late 2000. Low SES in children may also be associated with nutritional deprivation and height retardation. Further research should clarify these relationships among children from low, middle and high SES backgrounds, as well as examining the combined impact of both SES and ethnicity.

Acknowledgement: This study was supported by a Kellogg Australia Nutrition Research Grant.

1. Priority Schools Funding Program. Operational guidelines 2003. Sydney: NSW Department of Education and Youth Affairs, 2003.
2. Cole TJ, Bellizzi MC, Flegal KM, Dietz WH. Establishing a standard definition for child overweight and obesity worldwide: international survey. *BMJ* 2000; 320: 1240-1243.
3. O'Dea JA, Caputi P. Association between socioeconomic status, weight, age and gender, and the body image and weight control practices of 6- to 19-year-old children and adolescents. *Health Educ Res* 2001; 16: 521-532.
4. Magarey AM, Daniels LA, Boulton TJC. Prevalence of overweight and obesity in Australian children and adolescents: reassessment of 1985 and 1995 data against new standard international definitions. *Med J Aust* 2001; 174: 561-564.
5. Booth ML, Macaskill P, Lazarus R, Baur LA. Sociodemographic distribution of measures of body fatness among children and adolescents in New South Wales, Australia. *Int J Obes Relat Metab Disord* 1999; 23: 456-462. ❑

Salmonella outbreak associated with chicks and ducklings at childcare centres

Tony D Merritt,* Carolyn Herlihy†

* Epidemiologist/Biostatistitian, † Environmental Health Officer, Hunter Public Health Unit, Hunter Area Health Service, LMB 119, Wallsend, NSW 2287.
tmerritt@doh.health.nsw.gov.au

TO THE EDITOR: Travelling animal shows, with animals such as young poultry, rabbits and reptiles, commonly visit childcare centres in Australia. Transmission of *Salmonella* infection to children from ducklings and chickens is well doc-