LETTERS

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,² 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 resist 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 specialty (such as emergency physicians, intensive care specialists and general physicians) would contribute significantly to this problem. 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.


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 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.


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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
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 Listerv,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.


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

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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 to 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.

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/m² [95% CI, 20.1–20.5 kg/m²] v 19.7 kg/m² [95% CI, 19.6–19.9 kg/m²]; P<0.001), females (20.4 kg/m² [95% CI, 20.1–20.7 kg/m²] v 19.8 kg/m² [95% CI, 19.6–19.9 kg/m²]; P<0.001), and males (20.2 kg/m² [95% CI, 20.0–20.5 kg/m²] v 19.6 kg/m² [95% CI, 19.5–19.8 kg/m²]; 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 141.3 cm [95% CI, 140.6–142.5 cm] v 143.5 cm [95% CI, 143.0–144.0 cm]; 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.1,3

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.


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

<table>
<thead>
<tr>
<th></th>
<th>Low SES (n=574)</th>
<th>Middle/high SES (n=1658)</th>
<th>Low SES (n=508)</th>
<th>Middle/high SES (n=1701)</th>
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<tbody>
<tr>
<td>Primary school students (grades 1–6; ages 6–13 years)</td>
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<tr>
<td>Overweight students</td>
<td>19.4% (42/216)</td>
<td>16.2% (110/680)</td>
<td>23.2% (51/220)</td>
<td>17.8% (138/766)</td>
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<tr>
<td>Obese students</td>
<td>6.9% (15/216)</td>
<td>5.3% (36/680)</td>
<td>6.4% (14/220)</td>
<td>5.7% (44/766)</td>
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<tr>
<td>High school students (grades 7–12; ages 13–18 years)</td>
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<tr>
<td>Overweight students</td>
<td>17.6% (63/358)</td>
<td>16.4% (160/978)</td>
<td>17.0% (49/288)</td>
<td>16.8% (157/935)</td>
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<tr>
<td>Obese students</td>
<td>10.1% (36/358)</td>
<td>5.6% (55/978)</td>
<td>7.3% (21/288)</td>
<td>6.5% (61/935)</td>
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* Overweight and obesity are classified according to the international standard definition.2

### Salmonella outbreak associated with chicks and ducklings at childcare centres

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TO THE EDITOR: Traveling 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-