EDITORIALS

Hospital Care of General Medicine Patients: The Importance of Evidence

Hospital care of general medicine patients has been an important part of general internal medicine since its inception, but has received increased attention since the advent of the hospitalist movement in the United States.¹ Three papers in this issue address issues of importance to hospitalized general medicine patients and illustrate areas of challenge and opportunity in this important area of general internal medicine.

Abourizk et al. issue a “call to action” toward intensification of diabetes care for hospitalized general medicine patients. Though the authors point out that there is not evidence from randomized trials showing clinical or economic benefits and argue for further study, they suggest that existing evidence is compelling enough for clinicians to eliminate the use of pure sliding scales and move toward regimens based on longer acting insulin or continuous insulin infusions (CII). Though Abourizk et al. recognize that the costs and potential side effects of these approaches require further study, their article reminds us that inpatient medicine is not static, and that clinicians often take much longer to adopt important practices than would seem ideal.²

The article by Lucas et al. may provide some insight into why innovations can take so long to become routine practice. The article presents intriguing data from an interesting intervention in which the authors provided evidence-based recommendations to attendings supervising teams caring for hospitalized general medicine patients. In short, they find that although 86% of patients received evidence-based care initially, attending physicians said they would change care for 18% of patients following recommendations, and 80% of those changes were viewed by the majority of expert assessments as reflecting improvements in care. The implication is that 1 in 6 of the patients cared for by these teams would have their care improved by a literature search.³

Such findings seem to suggest that such searches should be done routinely but may not be because the searches uncovered new findings when they were done. The findings also provide some insight into why they might not be done; each search took about 45 minutes. With the great diversity of diagnoses cared for on a general medicine service, and assuming almost every patient requires a new search and with teams admitting 12 to 14 patients every 4 days, this requires a commitment of about 8 or 9 hours every fourth day. This calls out for creative approaches to improve the efficiency of the process. Some possibilities

include determining whether searches can be done by both house staff and attendings, to what extent a search done recently for a similar patient can substitute for a repeat search, or whether searches could be targeted to diagnoses in which searches would most likely change behavior.

One possible perspective on this problem might be provided by the article by Parekh et al., which adds to the literature on the effect of physician specialty and experience on outcomes and resource use for general medicine patients.⁴ Consistent with several recent studies, they find evidence that hospitalists had lower resource use than other general medicine attendings, and, as in some other recent studies, particularly lower resource use than medical subspecialists. The top 10% and 20% of attendings in inpatient experience were found to have lower resource use than other attendings. This suggests the potential importance of experience, as has been suggested in other studies of hospitalists,⁵ but does not exclude the possibility that the findings are confounded by subspecialty status because subspecialists appear to have had fewer general medicine months. In addition, the lack of statistically significant differences in outcomes needs to be interpreted with caution because the standard errors on outcomes rates are large. This concern is reinforced by findings such as those of Lucas et al. that care by internists may more than infrequently fail to fully utilize the insights of the literature.³ While we do not know whether specialists or generalists fare better in such assessments in most contexts, such findings do somewhat dampen enthusiasm about reductions in resource use in the absence of clear data on quality of care, and the study by Parekh et al. does not supply data about process of care to provide assurance that savings do not come at the expense of quality.⁴ These limitations point to the continuing need for larger studies that can support detailed multivariate analyses of the effects of physician experience and specialty on the process, cost, and outcomes of care. While we await such studies, the studies by Abourizk et al. and Lucas et al. remind us that the evidence base of medicine continues to advance and that the quality of care we can provide depends on our continued investment in knowing that evidence. Though the higher volume of inpatients cared for by hospitalists may make keeping up with the newest evidence somewhat easier for hospitalists, only data will prove whether such theoretical differences translate into actual differences in practice. Regardless, all internists—hospitalists or nonhospitalists—

are well served by these reminders of the importance of evidence in medicine.—**DAVID MELTZER, MD, PhD**, *Section of General Internal Medicine, Department of Economics, Irving B. Harris Graduate School of Public Policy Studies, University of Chicago, Chicago, Ill.*

REFERENCES

1. Wachter RM, Goldman L. The emerging role of "hospitalists" in the American health care system. *N Engl J Med*. 1996;335:514–7.
2. Abourzik NN, Vora CK, Verma PK. Inpatient diabetology: the new frontier. *J Gen Intern Med*. 2004;19:466–71.
3. Lucas BP, Evans AT, Reilly BM, et al. Is treatment of medical inpatients evidence-based? *J Gen Intern Med*. 2004;19:402–9.
4. Parekh V, Saint S, Furney S, Kaufman S, McMahon L. What effect does inpatient physician specialty and experience have on clinical outcomes and resource utilization on a general medical service? *J Gen Intern Med*. 2004;19:395–401.
5. Meltzer D, Manning W, Morrison J, et al. Effects of physician experience on costs and outcomes on an academic general medicine service: results of a trial of hospitalists. *Ann Intern Med*. 2002;137:866–74.