Bugs, Drugs, Hospitalists, and a New Chapter

John J. Frey III, MD, Medical Editor

The decision of health systems and hospitals to parse the care of patients into smaller and smaller pieces has used the argument that more intensive management by fewer people will improve outcomes and increase efficiency. Most visibly the hospitalist—who has been taking the place of generalist and, increasingly, specialist physicians—has expanded from community hospitals to academic health centers. While changing the career trajectory of many physicians toward more limited practice areas (the term “nocturnalist” conjures for me the image of doctors who come from Transylvania with long capes) the research on hoped-for results has not been convincing. However, this train has left the station, since the large majority of young general internists are populating the hospitalist groups.

The study by Raghavendra and colleagues1 sheds some light on the process through a very nice analysis of the role of hospitalists on a very narrow, specialty-heavy, topic: neutropenic fever. Their natural experiment at the Gundersen Health System used chart review to look at changes in patient care management as the system migrated from hematologists/oncologists to hospitalists over almost 6 years. They found that adherence to treatment guidelines for neutropenic fever was much higher in the hospitalist era than previously, and antibiotic treatment was more aggressive and consistent. Hospitalists got more consults in the process, as well. However, the drastic changes in the underlying pathology of patients treated—from lymphoma to other more serious malignancies—makes some of the hard outcomes difficult to interpret. The success of generalists managing what had been subspecialist diseases seems to indicate that there is an important role for them in large tertiary hospitals in more than general admissions.

The article from the State Public Health Department by Harless and colleagues2 demonstrates the value of having a statewide look at MRSA antibiotic sensitivity, a serious and increasingly common problem in all practice settings. They found a pocket of MRSA resistance in Southern Wisconsin that should raise an alarm for all physicians who practice there. I was encouraged by a recent interaction with one of our residents when we were discussing antibiotic choice in a patient we suspected might have MRSA. He knew of the local increase in clindamycin resistance through the hospital bulletins, so data are being shared and disseminated. The question raised by Harless’s article, however, is why Southern Wisconsin is so different from the rest of the state? To find the answer, public health and the practicing community must work together. The presence of a single EHR dominating the region should make a chart review possible to look at patients and physician behavior that might have led to this trend. We are all aware of the challenges of electronic charting on daily work, but this might be one example of how it could help understand a dangerous trend.

When I was a senior medical student in a remote town on the US/Mexico border in the 1960s, I had the humbling experience of finding out that a “folk medicine” tea used for treating diarrhea, which I felt had no scientific basis, produced the same results with fewer side effects than the stuff I was prescribing. While some traditional medicines are now being subject to randomized trials to test their effectiveness, those that have endured and are widely used are products of a different type of research—trial and error over centuries. So Kiefer and colleagues’ article3 describing widely used traditional treatments in the Wisconsin Latino community is of great value, not only as information that can be used when we populate our patients’ medication lists correctly, but as a stimulus to know more about less potentially toxic ways we can treat patients in their cultural context.

The movement of immigrants into areas far from their countries of origins and the urge to travel that seems to affect Americans…raise the risk of seeing diseases that are not exotic in many countries around the world but are quite exotic in the Midwest.
The Wisconsin Medical Society seeks a qualified physician to serve as Medical Editor of *WMJ*, the Society’s peer-reviewed, scientific journal. Primary focus is on guiding the journal to consistent high quality and fulfillment of its mission: to provide a vehicle for professional communications and continuing education for Midwest physicians and other health professionals.

www.wmjonline.org

REFERENCES

The mission of *WMJ* is to provide a vehicle for professional communication and continuing education for Midwest physicians and other health professionals.

*WMJ* (ISSN 1098-1861) is published by the Wisconsin Medical Society and is devoted to the interests of the medical profession and health care in the Midwest. The managing editor is responsible for overseeing the production, business operation and contents of the *WMJ*. The editorial board, chaired by the medical editor, solicits and peer reviews all scientific articles; it does not screen public health, socioeconomic, or organizational articles. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither *WMJ* nor the Wisconsin Medical Society take responsibility. *WMJ* is indexed in Index Medicus, Hospital Literature Index, and Cambridge Scientific Abstracts.

For reprints of this article, contact the *WMJ* at 866.442.3800 or e-mail wmj@wismed.org.

© 2014 Wisconsin Medical Society