Hospitalists and family physicians

The editorial in the April issue of *Canadian Family Physician*[1] makes the valid point that questions about the organization of hospital care need to be asked. However, it appears to be somewhat of a stretch to compare Canadian hospitalist outcomes with US intern and resident results.

Several factors make such a comparison—although a useful exercise—less valid. First of all, hospitalist rotations vary greatly among Canadian hospitals of all sizes. There are no data that indicate Canadian hospitalist rotations are similar to intern and resident rotations. No one would argue against continuity of care being extremely important. Hospitalist programs organize themselves to maximize continuity of care and minimize the risks of transitions of care. Hospital lengths of stay are much reduced from years ago and thus continuity of care is very often preserved. Canadian data regarding outcomes are being produced and will soon be found in the peer-reviewed literature.

Second, hospitalist care in Canada is very different from what family medicine care was or currently is. Most hospitalists in Canada now function in a scope of practice that not long ago would have been considered general internal medicine (minus critical care). In Ontario, 30% of hospitalists are non–family medicine physicians (Canadian Society of Hospital Medicine, 2008, unpublished data). Comparisons with "the way medicine used to be practised" are difficult.

Finally, as evidenced by the recent Canadian Society of Hospital Medicine document "Core Competencies in Hospital Medicine,"[2] inpatient physician care is highly focused on quality improvement, safety, and medical expertise, as well as the whole range of CanMEDS roles. As chief editor of this document, I look forward to its wide dissemination and application, including in the areas of education, research, reviews, and evaluation of scopes of practice—not just by individuals who consider themselves hospitalists, but by any practitioners (including more traditional full-service family physicians) who play important roles in inpatient care.

Inpatient medicine today is very different from what it was "back in the day" when I provided full-service family medicine care. Ideally we will continue to focus on patient care, safety, and quality improvement in a collaborative fashion with hospital interdisciplinary team members and community physicians. I totally agree that the question regarding outcomes needs to be answered; however, comparisons between family medicine hospital practice and hospitalist practice are less productive. More effort should be spent on developing better systems to ease transitions of care from community to hospital, on collaboration when patients are hospitalized, and on mechanisms to ensure safe transitions back into the community.

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Competing interests
Dr Doré is Past-Chair of the Canadian Society of Hospital Medicine Core Competencies in Hospital Medicine committee.

References
1. Ladouceur R. Are attending physician rotations costing hospitalized patients their lives? *Can Fam Physician* 2017;63:264 (Eng), 265 (Fr).
2. Canadian Society of Hospital Medicine. *Core competencies in hospital medicine.* Vancouver, BC: Canadian Society of Hospital Medicine; 2015.

Long-term benefits of weight loss?

The editorial "Family Physicians and Obese Patients"[1] raises many good questions but the most important one apparently remains unasked and therefore unanswered: When we encourage patients to lose weight, whether through lifestyle modifications or medication, what are the long-term effects on important outcomes such as all-cause and cardiovascular mortality, complications of diabetes, and overall patient well-being? We should be asking not just how best to help patients lose weight, but also "Should we be encouraging them to lose weight at all?"

A task force report[2] reviewed currently available evidence, which is limited to mostly short-term (average of 12 months) studies examining changes in surrogate markers for disease (body mass index, blood pressure, blood glucose level, lipid levels).[3] Most interesting is the authors' observation that most patients will lose an average of only 3 kg and almost all will gain the weight back. What are the potential long-term psychological, metabolic,[4] financial, or other harms associated with this repeated weight cycling?

Given the lack of convincing evidence for long-term benefit and the uncertain risks, I was surprised at the conclusion that weight loss interventions are "effective."

I appreciate the difficulty in developing recommendations in the absence of adequate evidence. But there is reasonably good evidence that a healthy (eg, Mediterranean) diet and improved cardiorespiratory fitness[5] are more important than "fatness" in overall mortality risk. Until we have better evidence to show that weight loss actually makes people healthier in the

long term, it might be preferable to focus on proven diet and fitness goals while avoiding the emphasis on weight loss, which carries with it an implicit weight-shaming message and is likely to result in repeated "failure."

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Competing interests
None declared

References

1. Ladouceur R. Family physicians and obese patients. *Can Fam Physician* 2017;63:92 (Eng), 93 (Fr).
2. Brauer P, Connor Gorber S, Shaw E, Singh H, Bell N, Shane AR, et al. Recommendations for prevention of weight gain and use of behavioural and pharmacologic interventions to manage overweight and obesity in adults in primary care. *CMAJ* 2015;187(3):184-95. Epub 2015 Jan 26.
3. Peirson L, Douketis J, Ciliska D, Fitzpatrick-Lewis D, Ali MU, Raina P. Treatment for overweight and obesity in adult populations: a systematic review and meta-analysis. *CMAJ Open* 2014;2(4):E306-17.
4. Blomain ES, Dirhan DA, Valentino MA, Kim GW, Waldman SA. Mechanisms of weight regain following weight loss. *ISRN Obes* 2013;2013:210524.
5. Barry VW, Baruth M, Beets MW, Durstine JL, Liu J, Blair SN. Fitness vs. fatness on all-cause mortality: a meta-analysis. *Prog Cardiovasc Dis* 2013;56(4):382-90. Epub 2013 Oct 11.

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