Infectious Diseases: A Friend in Need

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(See the Major Article by Schmitt et al on pages 22–8.)

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Schmitt et al must be congratulated for their effort to provide evidence to third-party payers on the convenience and advantages to consult infectious diseases specialists early, at least for patients with severe, nosocomially acquired infectious complications [1]. In a very interesting article published in this issue of the journal, they demonstrated that "ID interventions are associated with improved patient outcomes... and reduced costs" [1]. Their article has the added value of raising old and new issues that are not always approached similarly in different countries and in different situations.

The first issue that I would consider is the need for infectious diseases specialists at the present time. We are far from the years in which, in the pages of this very journal, prestigious physicians such as Petersdorf and Beeson bitterly discussed the need for more infectious diseases specialists [2–4]. In 1980, Beeson [5] claimed that our specialty lacks every attribute needed for successful practice: special technology, chronicity of disease, and balanced remuneration. Petersdorf, at that same time, suggested, "It is my conclusion that infectious disease is destined to function best as an academic specialty whose trainees should pursue careers primarily as investigators. The number of clinicians leaving infectious diseases training programs should be reduced and not glut the marketplace further" [2]. Ervin also stated, "Unfortunately, the social evolution of the infectious diseases clinician is accelerating towards extinction. Personal experience, discussions with colleagues, and close attention to the winds of change buffeting the health care community herald so bleak a vision of the future that I believe it is only fair that prospective trainees be so informed" [4].

I am one of those foreign physicians trained as infectious diseases specialists in the United States in the 1970s. In the last 40 years, I had plenty of space to develop my infectious diseases career and to create a large working group in my country that has, humbly, provided, on top of research and teaching, daily advice to patients and physicians in the best care of infections. In my opinion, not many people still doubt that infectious diseases is necessary and that it pays for itself. It is also clear to me that even very prestigious physicians are occasionally wrong.

One limitation of the article by Schmitt et al [1] is that their evidence comes from a few severe infectious diseases in hospitalized patients. The field of infectious diseases is much broader, and the impact of infectious diseases consultation in areas such as community-acquired infections, infections acquired in healthcare-related institutions, travel medicine, vaccines, and antimicrobial stewardship is probably at least as important and economically sound as the ones addressed in their article. I wonder whether the impact of an infectious diseases consultation is not even greater in the less cut cases in which the use of antimicrobial agents is selected on empirical bases and no etiologic agent is present. In these cases, the physician in charge has more difficulty than the infectious disease specialist in finding proper information in practice guidelines and official recommendations. Detailed analyses of such cases could yield evidence in favor of early infectious diseases consultation.

Previous studies have demonstrated that bedside consultations can improve the prognosis of patients with infectious diseases, as well as reduce the duration of treatment with antibiotics [6–10]. A good example of the beneficial effect of infectious diseases consultation is Staphylococcus aureus bacteremia, where consultation is associated with a better diagnostic workup and reduces complications and mortality [11, 12]. Other studies have shown that consultations by infectious diseases...
specialists in antimicrobial stewardship can reduce the use of antibiotics, induce better adherence to guidelines, and decrease treatment costs [10, 13, 14].

Another important issue involves compliance with the infectious diseases specialist’s recommendations and the consulting physician’s appreciation of the consultation. Compliance with infectious diseases recommendations about diagnosis and antimicrobial treatment are very high, and several studies show that our colleagues are very appreciative of them [12, 15–25]. There is observational evidence that informal consultations result in levels of compliance with recommendations comparable to level for formal recommendations, without compromising patient safety [15]. In the case of Staphylococcus aureus bloodstream infections, although telephone consultation is inferior to bedside consultation, it is superior than not consulting at all [26].

To respond to the increasing requests of non–infectious disease physicians for access to infectious diseases expertise, a telephone hotline was created in the infectious diseases consultation service of a French hospital. Of 7863 consultations that were requested by physicians over 1 year, the majority were requested via cellular phone (58.7%) [27]. The main problem of the curbside or telephone consultation is the fear of not being well-informed or of being misinterpreted by the consulting physician. A side issue is the inconvenience of giving a consultation for free in a system where the consultant gets paid per consultation. This problem is less striking in systems with more-socialized medicine, where many physicians receive a monthly salary and direct financial charges for the patient or for an insurance company are not present. The consultation in the latter system, more common throughout Europe and other countries, is more frequent, and follow-ups by the infectious diseases specialist can be performed more liberally.

Another gap related to infectious diseases consultation is the need for evidence of the value of follow-up consultations and clarification of the role of the infectious diseases specialist in following patients with very specific problems associated with infectious diseases.

This important article by Schmitt et al [1] vindicates what infectious diseases specialists have believed all along. I end with a plea to third-party payers that they not require more evidence about the infectious diseases event before reimbursing infectious diseases specialists in the routine management of many infections. Again, I turn to Dr Ervin, who wrote that “the cheapest test to order is a consultation” [4].

Note

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