

Physicians' Corner

The Good Old Days Were Not So Good for Inpatient Care

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In medicine we are living in a time of warp-speed advances, and yet we are no less disinclined to rehash the “good old days” than our colleagues in any other discipline. It is just human nature to recall how things used to be—“back when.” But the problem with the “good old days” is that they are old—they always have been, and they always will be. I routinely drive a 1931 Model A Ford Cabriolet. It’s a good old car that I love. It’s very distinctive, and it gets me where I’m going. But it’s old—it has no power steering, no heat or air conditioning, no radio (much less satellite or CD), and not even any seat belts. It’s clearly old, for sure, and it is not very desirable or safe in 2007, especially when one considers the seat belt situation. I hope you see where I’m headed here.

In the good old days, we didn’t routinely pay a lot of attention to inpatient blood glucose levels as long as the patient wasn’t experiencing diabetic ketoacidosis or suffering from such a degree of polyuria that the nurse called us in the middle of the night. Sometimes I can relate to Ebenezer Scrooge; the “ghost of Christmas past” haunts me with the many orders I wrote over the years saying to “call MD if glucose is >250 mg/dL.” I’m not sure if I wrote those orders out of a conviction for good diabetes mellitus (DM) care or because of a desire for a good night’s sleep and one less problem to grapple with, but I fear I know the answer. I do remember rationalizing all this by saying that the patient was in the stressful hospital environment and everything would change after discharge, so why waste the effort and resources to attain good glycemic control while in the turmoil of inpatient status? Maybe the good old days weren’t so good for inpatients with DM after all.

So, fast forward to 2007, and we find ourselves much more advanced, correct? Well, would that it were so. Levetan et al¹ showed, in a review of 1034 consecutively hospitalized patients, that 36% of hyperglycemic patients did not have DM recognized on the discharge summary despite 33% of these patients having hyperglycemia mentioned in the progress notes. In my experience, few patients even adequately documented as having DM leave the hospital having received DM education and a coordinated action plan for excellent glycemic control as an outpatient. Remember, it is in the inpatient setting that many of our primary care patients first learn that they have DM.

We have advanced beyond the ethereal concept of “good control” of blood glucose. Now there are studies pointing to better morbidity and mortality outcomes for inpatients whose glycemia is aggressively controlled. It is clear from the study of intensive insulin therapy in critically ill patients by Van den Berghe et al² that better glycemic control produced better mortality results, in part by reducing septicemia, acute renal failure, number of transfusions, and need for mechanical ventilation. The same author’s study in the medical intensive care unit (MICU) showed a reduction in morbidity among all patients in the MICU.³ Clement et al⁴ summarized their review of management of DM and hyperglycemia in hospitals by saying that “aggressive blood sugar control in the hospital may provide an opportunity to improve patient outcomes.”

As *the* primary care provider, we are the chief advocate for our patients. We are the ones who must insist and oversee that our inpatients are aggressively managed, and we must stress this concept to all those responsible for our inpatients. Recently I had just this conversation with a urologist colleague. He was preparing to do a nephrectomy on a patient of mine who has DM, and we were discussing inpatient DM management strategy. The urologist was concerned that intensive inpatient management of DM would be too burdensome and possibly risky. The irony here is that the urologist has type 2 DM himself. After a few minutes reviewing the emerging data regarding hospital outcomes in patients with DM who are treated aggressively, he seemed to change his tune.

The surgical intensive care unit and MICU studies of Van den Berghe et al^{2,3} leave us in an unequivocal position—DM must be recognized and aggressively managed in the inpatient setting. We primary care providers must understand the beneficial implications of good inpatient glycemic control. If we have outsourced our inpatient care to hospitalists, as is the growing trend, then we must make sure our hospitalist colleagues understand that DM in the inpatient setting must be taken seriously, and we must coordinate with them to develop a mutually agreeable inpatient strategy and a “hand-over” approach that ensures continued excellent glycemic control from the inpatient to the outpatient setting. Your hospitalists need to know what you, the primary care provider, expect from them regarding inpatient glycemic control. I challenge you to take the time to clearly communicate this concept to them.

How it was done in the “good old days” just won’t hold up in 2007, as data regarding improved outcome with excellent inpatient glycemic control are scrutinized. What is best for our patients is a heightened awareness of inpatient

glycemic status and an aggressive plan of action to ensure euglycemia in the hospital setting, as well as a smooth transition from inpatient to outpatient status. Gone are the days of "Christmas past." We must look to the future and strive for better outcomes for our patients with DM, whether we see them in our office or in the hospital. We in primary care must be up-to-date and prepared to be our patients' advocate, regardless of the setting.

This issue of *Insulin* focuses on inpatient management; every primary care physician must realize that inpatient control not only influences inpatient outcome but also establishes the foundation for future outpatient treatment and is, therefore, a critical element in the overall treatment plan for our patients.

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