AIDS Treatment Center: Is the Concept Premature?

To the Editor—Bennett et al1 of The RAND Corporation examined hospitalizations for acquired immunodeficiency syndrome (AIDS)-related Pneumocystis carinii pneumonia (PCP) at 15 California hospitals and found lower mortality rates at the hospitals with “high AIDS familiarity.” However, because of methodological problems that cast doubt on this finding, policymakers should be cautious about the authors’ recommendations, particularly with regard to the regionalization of acute care for AIDS.

See also p 2572.

The sample of hospitals used for this study may not have been suitable for a comparison between high and low levels of AIDS familiarity, because none of the hospitals in California with the highest AIDS familiarity were included. In particular, none of the five most experienced hospitals in San Francisco, which provided 80% of that city’s acute AIDS care in 1986, were among the study hospitals.2 We base this conclusion on the human immunodeficiency virus–related volume statistics presented by the authors in Table 1 of their article. In addition, as noted by the authors, all 15 hospitals were private, which accounts for the atypically low level of MediCal coverage among the PCP cases (16.6%).

Because patients in this study were considered to have died of PCP only if the death occurred in the hospital, the mortality rates reported exclude terminal AIDS patients who were discharged to hospice care. Hospitals with high AIDS familiarity may have better links with hospice programs than their counterparts with low AIDS familiarity, resulting in lower rates of in-hospital death without any real difference in PCP mortality. At San Francisco General Hospital, when PCP mortality was defined as death within 30 days of admission, whether in or out of the hospital, the mortality rate was 27%, much higher than the in-hospital PCP mortality rate.

A logistic regression model was used by the authors to estimate relative risk of death from PCP at the hospitals with low AIDS familiarity, but the power of this model was limited by the small number of deaths (12) at those hospitals and by the lack of an explicit measure of severity of illness. The severity proxies used by Bennett et al (admission source and previous hospitalization) are better than no adjustment, but do not warrant these authors’ claim to have adjusted their results for severity. An explicit clinical severity measure could have had a large effect on a mortality model; for example, Rainer et al3 reported a mortality rate of 14% for patients with Po2 levels above 60 mm Hg compared with 50% otherwise.

The importance of the study by Bennett et al is that it is one of the first to address the factors that may contribute to differential outcomes of AIDS care. Familiarity with AIDS may be such a factor, but this study’s findings could be due to other factors, such as use of outpatient hospices and/or clinical severity. Until those alternatives are controlled for in a study of a broader cross section of AIDS providers, it is premature to conclude that better outcomes would result from a program designed to concentrate AIDS care in regional centers. We believe policymakers would be unwise to interfere with what appears to be the wider dispersion of AIDS care to a large number of hospitals.” As noted recently by several authors4 (including Green et al themselves), there is little evidence that AIDS care is undergoing widespread dispersion. As Cotton noted in commenting on our article, the need for sound policy on the treatment of this disease can only intensify as the number and geographic diversity of AIDS cases grow; we hope that work of the type we reported in our article will be continued and extended by other authors in answer to this policy imperative.

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In Reply.—We would like to thank Green et al for underscoring both the importance and the limitations of our study. However, we disagree with some of their specific comments. With respect to choice of hospitals for the study, we made no attempt to make a complete survey. Future studies will address these issues. The sample represented hospitals with varied characteristics, and the strength of our results suggest that the conclusions are generalizable.

We agree with their view that mortality should be studied on the basis of a fixed time window because of confounding factors such as hospices. In our study, this was unlikely to be a significant factor, as well-developed outpatient networks were not available in the study hospitals during the study years.

Finally, we think that Green et al have misrepresented our policy implications. In our study, we outlined three recommendations that apply to both regionalization and dispersion of AIDS care. We cannot understand their warning that “policymakers would be unwise to interfere with what appears to be the wider dispersion of AIDS care to a large number of hospitals.” As noted recently by several authors4 (including Green et al themselves), there is little evidence that AIDS care is undergoing widespread dispersion. As Cotton noted in commenting on our article, the need for sound policy on the treatment of this disease can only intensify as the number and geographic diversity of AIDS cases grow; we hope that work of the type we reported in our article will be continued and extended by other authors in answer to this policy imperative.

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