hospital use is increasing over time, with a concomitant increase in related costs, calling attention to the increasingly important role these hospitals play in the US health care system.

Drs Votto and Hotes and Dr Muldoon correctly state that our study cannot be used to infer whether care in a long-term acute care hospital is beneficial or harmful compared with an alternative site of care. As we stated in our discussion, there are plausible reasons why long-term acute care hospitals might either improve or worsen outcomes after critical illness. The studies quoted by Votto and Hotes, as well as others, provide important preliminary evidence but do not offer definitive conclusions. Rigorous comparative effectiveness research is needed to determine not only which patients may benefit from the services long-term acute care hospitals provide, but also the optimal site of care for these services.

We disagree with the letter writers that MedPAR files lack sufficient “clinical nuances” or are “necessarily dated” and thus are unable to contribute to the policy debate. Despite their well-known limitations, for decades administrative data such as MedPAR have been an essential resource for important questions concerning US health policy.2,3 By suggesting an implausible evidentiary standard, the writers create a world in which the structures and processes that comprise the health care system cannot be critically evaluated. Such a scenario is neither practical nor tenable.4 For matters so consequential to patient welfare and public finances as the care of critically ill individuals, real-world effectiveness research using the best available data are urgently needed.

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Vital Conflicts in Medical Ethics: A Book Review

To the Editor: Having recently brought Martin Rhonheimer’s Vital Conflicts in Medical Ethics: A Virtue Approach to Craniotomy and Tubal Pregnancy1 into English, I was pleased to see the recent review by Ms Townsend.2 The review gives a generally correct account of the basic argument and conclusions of the book, but I would like to clarify the following points.

First, the book should not be read as semiofficial Catholic teaching, but as Rhonheimer’s views on these matters, which he states in the book were “carefully studied” by the Roman Congregation for the Doctrine of the Faith and by its then-prefect, Cardinal Joseph Ratzinger. He notes that “the Congregation in turn asked that it be published, so that the theses it contains could be discussed by specialists.”1

Second, I would like to clarify the use of the term abortion. Whereas it might be used in reference to any expulsion of a fetus, the Catholic prohibition of abortion concerns more specifically what is sometimes called procured or elective abortion. Such abortions are cases in which the embryo or fetus is deliberately killed either as an end in itself or more frequently as a means to some other end. An important goal of the book is to explain the wrongness of such acts as violations of justice, in which one person chooses to deliberately end the life of another. Cases of vital conflict, on the other hand, are not unjust choices to take the life of the child, who is already unsavable.

Third, this point about the unjust taking of unborn life leads to Townsend’s appeal to the work of Ronald Dworkin, through which she contests Rhonheimer’s “unquestioned but highly contentious premise . . . that a fetus must be considered a human being, a child.”2 Because it is beyond the scope of the present letter, I refer readers to a related and recently published volume of Rhonheimer’s work that I have also edited.3 The sixth and seventh chapters of that work include detailed responses to the arguments of Dworkin, among others.

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Financial Disclosures: Dr Murphy reported receiving compensation for sales of the 2 books he edited that are mentioned in this letter.


Editor’s Note: This letter was shared with Ms Townsend, who declined to reply.
Methods. Survey data were analyzed for all Idaho PCPs (defined as general practitioners and family physicians [combined for these analyses], general internists, and pediatricians) between 1996 and 2009. In Idaho, all PCPs are interviewed every 3 to 5 years, with state workers identifying physicians using the Idaho Board of Medicine and other publicly available sources. Physicians or office managers completed a questionnaire on practice characteristics. Residency programs identified current trainees. Veterans Affairs–based physicians were excluded from the analysis. Population statistics were obtained from the US Census Bureau.2,3

The survey questions were, “How many hours per week is the practitioner engaged in outpatient (office visits) care activities at this location? How many hours a week does the practitioner work providing hospital inpatient care?” and included practice location. Changes in work hours for inpatient and outpatient care as well as patient waits for nonurgent clinic appointments were analyzed. Only respondents with complete data for the variable of interest were included in each analysis.

Linear regression was used to measure the relationship between wave of interview and change in work hours or appointment waits. Because of data skewing, log transforma-

Table 1. Idaho Primary Care Physician Characteristics by Specialty and Clinic Type, 1996-2009

<table>
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<tbody>
<tr>
<td>Family medicine/general practice</td>
<td>368 (66.0) [61.9-70.0]</td>
<td>457 (70.0) [66.2-73.4]</td>
<td>478 (67.8) [64.2-71.2]</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>114 (20.4) [17.2-24.0]</td>
<td>115 (17.6) [14.7-20.7]</td>
<td>140 (19.9) [17.0-23.0]</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>76 (13.6) [10.9-16.8]</td>
<td>82 (12.5) [10.1-15.3]</td>
<td>87 (12.3) [10.0-15.0]</td>
</tr>
<tr>
<td>Physician in traininga</td>
<td>44 (7.3) [5.4-9.7]</td>
<td>38 (5.5) [3.9-7.5]</td>
<td>47 (6.3) [4.6-8.2]</td>
</tr>
</tbody>
</table>

Clinic typeb
| Rural health clinic | 20 (3.3) [2.0-5.1] | 47 (6.8) [5.0-8.9] | 66 (8.8) [6.9-11.0] |
| Federally qualified health clinic | 13 (2.2) [1.2-3.7] | 30 (4.3) [2.9-6.1] | 59 (7.9) [6.0-10.0] |

Abbreviation: CI, confidence interval.
aIdentified using rosters of trainees provided by residency programs. Includes 1 pediatrics resident during 1996-2000 and 1 internal medicine resident during 2005-2009. Otherwise, all were residents in family medicine.
bRural health clinic based on Centers for Medicare & Medicaid Services definition; federally qualified health clinic based on Health Resources and Services Administration definition.6

Table 2. Idaho Primary Care Physicians’ Weekly Hours Worked and Patient Waits, 1996-2009

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<tbody>
<tr>
<td>All PCPs, h</td>
<td>47.7 (46.4-49.1)</td>
<td>40.0 (38.8-41.2)</td>
<td>38.9 (38.0-39.9)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Inpatientd</td>
<td>11.8 (10.9-12.8)</td>
<td>8.3 (7.7-8.9)</td>
<td>7.1 (6.6-7.5)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Outpatienta</td>
<td>35.4 (34.4-36.4)</td>
<td>31.7 (30.8-32.6)</td>
<td>31.9 (31.1-32.6)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Physician specialty, h Family medicine/general practice</td>
<td>48.0 (46.3-49.7)</td>
<td>39.0 (37.5-40.5)</td>
<td>38.4 (37.2-39.6)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Inpatient</td>
<td>11.4 (10.2-12.6)</td>
<td>7.8 (7.1-8.5)</td>
<td>6.4 (5.9-7.0)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Outpatient</td>
<td>36.3 (35.1-37.5)</td>
<td>31.3 (30.2-32.4)</td>
<td>32.0 (31.0-32.9)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>50.3 (47.7-52.8)</td>
<td>42.6 (39.9-45.2)</td>
<td>39.7 (37.8-41.5)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Inpatient</td>
<td>14.0 (11.8-16.2)</td>
<td>10.1 (8.7-11.5)</td>
<td>8.4 (7.3-9.4)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Outpatient</td>
<td>35.4 (33.4-37.4)</td>
<td>32.5 (30.6-34.4)</td>
<td>31.3 (29.9-32.7)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>41.8 (38.2-45.3)</td>
<td>42.8 (39.5-46.1)</td>
<td>40.5 (38.7-42.3)</td>
<td>.47</td>
</tr>
<tr>
<td>Inpatient</td>
<td>10.7 (8.4-13.0)</td>
<td>8.5 (7.5-9.6)</td>
<td>8.4 (7.2-9.7)</td>
<td>.20</td>
</tr>
<tr>
<td>Outpatient</td>
<td>29.9 (26.9-32.9)</td>
<td>33.5 (30.8-36.1)</td>
<td>32.1 (30.6-33.5)</td>
<td>.69</td>
</tr>
<tr>
<td>Patient waits for nonurgent appointments, d New patientsf</td>
<td>10.1 (8.6-11.6)</td>
<td>13.4 (12.1-14.8)</td>
<td>12.1 (10.6-13.6)</td>
<td>.01</td>
</tr>
<tr>
<td>Established patientsg</td>
<td>6.4 (5.5-7.3)</td>
<td>9.5 (8.5-10.5)</td>
<td>7.0 (6.3-7.6)</td>
<td>.003</td>
</tr>
</tbody>
</table>

Abbreviations: CI, confidence interval; PCPs, primary care physicians.
aIncludes only attending physicians.
bCalculated from linear regression using years since previous wave of survey as an independent variable. Log transformations of work hours and wait time data performed to test for proportional trends.
cAmong 1693 PCPs reporting both inpatient and outpatient work hours (81.3%).
dAmong 1695 PCPs reporting inpatient work hours (81.3%).
eAmong 1804 PCPs reporting outpatient work hours (86.6%).
fAmong the 1753 PCPs (82.3%) accepting new patients who also reported waits for new patients (n=1681).
gAmong 1899 PCPs reporting wait time for established patients (89.2%).

LETTERS

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tions were used to normalize data, which were tested for proportional trends. For weeks worked yearly, tests were performed directly on weeks and linear trends reported in hours. Time was analyzed as an independent continuous variable. Significance was defined as a 2-sided \( P < .05 \). SAS version 9.2 (SAS Institute, Cary, North Carolina) was used for analyses. The University of Washington institutional review board approved this study, and oral participant consent was provided at the time of the survey.

**Results.** State workers attempted to interview 2084 PCPs in 3 waves between 1996 and 2009 and completed 2046 surveys, for a response rate of 98.2%. Physician characteristics are shown in Table 1. The number of PCPs increased from 602 between 1996 and 2000 to 752 between 2005 and 2009. Because of inconsistent work hour reporting, resident physician data were excluded from subsequent analyses.

Overall weekly clinical work hours decreased from a mean of 47.7 hours (95% confidence interval [CI], 46.4–49.1) in 1996–2000 to 38.9 hours (95% CI, 38.0–39.9) in 2005–2009 (\( P < .001 \)) (Table 2). There were significant decreases for family medicine/general practice and internal medicine, but not for pediatrics. Number of weeks worked yearly remained stable, from 48.0 weeks (95% CI, 47.7–48.4) in 1996–2000 to 47.8 weeks (95% CI, 47.6–48.1) in 2005–2009 (\( P = .38 \)). Patient waits for nonurgent appointments increased (Table 2). Over the study period, the population of Idaho increased 30.2%, from 1,187,706 to 1,545,801.

**Comment.** Clinical hours worked by PCPs in Idaho decreased between 1996 and 2009 despite an increase in the state population, while patient waits increased. The total and percentage decrease in work hours was larger than that documented by Staiger et al. Primary care physicians may be performing more nonclinical functions, such as administration or management duties, or may be actually working less overall. If national trends are similar, it is plausible that PCP changes were largely responsible for the observed decrease in physician work hours, and that access to these physicians’ services declined as a result.

These results should be considered with the study limitations. Data are based on self-report, although there is no reason to believe that the accuracy would have varied systematically over the study period. Idaho is rural, with relatively few PCPs per capita and little managed care, and may not be representative of other states. There may have been too few pediatricians in the study to detect a significant change in work hours. Research with nationally representative data is needed to confirm these findings.

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**Author Contributions:** Dr Wilper had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis. Study concept and design: Wilper, Smith. Acquisition of data: Wilper. Analysis and interpretation of data: Wilper, Weppner. Drafting of the manuscript: Wilper. Critical review of the manuscript for important intellectual content: Weppner, Smith.

**Statistical analysis:** Wilper, Weppner, Smith. Obtained funding: Wilper. Administrative, technical, or material support: Wilper.

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