BC's eating disorders program looks toward outpatient model

A decade ago, Dr. Laird Birmingham saw the writing on the wall. Because of reductions in the number of hospital beds, he began shifting the Eating Disorders Program at Vancouver's St. Paul's Hospital away from inpatient care and toward outpatient therapy. In the process, he cut the average length of stay from about 54 days to 19 days, and by prioritizing patients with the most serious cases of anorexia nervosa for hospital admission, the time patients had to spend on the waiting list dropped drastically.

Birmingham: 18% of these patients die

Birmingham's latest initiative is to add 3 beds to the inpatient unit, allowing the sickest patients to stay at St. Paul's for longer periods instead of paying $1500 a day at a facility in the US or UK. At a cost of about $500 000 per year, the beds will become part of a new 7-bed unit.

Birmingham, who sees 300 patients annually, says there has been a "gigantic increase" in the number of anorexia nervosa patients during the last 10 years. The initial inpatient therapy is on a par with intensive care, with 1 nurse for every 2 patients. Intensive vitamin and mineral therapy is supplemented by low levels of calories. Patients are discharged when their body fat is about 10%, and there is weekly follow-up to provide psychological support and to review meal plans. Some patients enter a residential program at the 10 bed Vista House on Vancouver's west side. They live here for about 3 months; there is 24-hour nursing care, and residents attend a day program at the hospital 4 days a week. Meal support — having a staff member with patients whenever they eat and afterwards — is one of the most important parts of the program. After leaving it, most people need therapy for another 2 years.

For the 1 in 5 anorexic patients who become chronically disabled, staff set up support services in their communities to provide follow-up. This is different from the approach taken by many centres, which offer only palliative care. Eighteen percent of Birmingham's patients die because of the illness, half by committing suicide. He is currently developing a range of educational materials to help provide better care in BC communities, including a Web site (**www.anorexianervosa.org**) and Internet teleconferencing. — *Heather Kent*, Vancouver

Canadian recruited for Cochrane Collaboration

When Dr. Terry Klassen joined the Emergency Department at the Children's Hospital of Eastern Ontario in 1987, he was surprised to find that some colleagues were not treating asthmatic children with steroids, as he had been taught to do. Moreover, the residents questioned his practice. So he did a systematic review of the literature and demonstrated that the weight of evidence favoured the use of steroids.

This experience persuaded Klassen that research synthesis is a useful tool for resolving differences of opinion in clinical practice. Such reviews have become even more important today, given the pressure on health providers to base decisions on solid evidence. Klassen, who now chairs the Department of Pediatrics at the University of Alberta, is playing a significant role in expanding the scope and availability of such reviews by heading the Child Health Section of the Cochrane Collaboration. This ambitious international effort is designed to collect, synthesize and disseminate all available evidence to clinicians.

"The Cochrane Collaboration is the single best source of high-quality evidence on which clinicians and policymakers can base their decisions," Klassen told the Canadian Association of Pediatric Hospitals last October. The extent of the UK-based project is expanding rapidly: more than 250 000 reports of controlled trials are included on the Cochrane Collaboration register today, compared with 100 000 in 1996. The mission of its recently formed Child Health Field, which Klassen chairs, is to ensure that children aged 0–18 receive services that are effective and based on up-to-date evidence. Studies from around the world are rigorously assessed, and integrated with similar studies from elsewhere.

"One of the biggest challenges," he admitted, "is not the adoption of evidence-based practice but making the findings available. We have to make it user friendly to nurses, doctors, families and patients. And we have to invest in the information technology infrastructure to get it out there." — *Charlotte Gray*, Ottawa