NOTES FROM THE ASSOCIATION OF
MEDICAL SCHOOL PEDIATRIC DEPARTMENT CHAIRS, INC.
AMSPDC

Hospitalist Medicine—Chairs' Perspective of Specialty Status and Training Requirements

D. Wade Clapp, MD[1], Teresa Quattrin, MD[2], Richard F. Jacobs, MD[3], and Valerie Castle Opipari, MD[4]

Hospital medicine represents one of the fastest growing fields in US medicine with approximately 55 000 clinicians nationally.[1,2] Pediatric hospitalists now account for about 10% of the total hospital medicine physician workforce. In October 2016, the American Board of Medical Specialties approved an application sponsored by the American Board of Pediatrics (ABP) to seek subspecialty certification for pediatric hospital medicine and a procedure for certification was established. As discussions were underway at the ABP, the Association of Medical School Pediatric Department Chairs (AMSPDC) sponsored a survey to collect data and poll academic chairs on the roles and training requirements for pediatric hospitalists in this fast growing field and to determine whether pediatric chairs felt hospital medicine should have subspecialty certification. As indicated by the survey results, respondents felt that although hospital medicine met some of the criteria for subspecialty board certification, it did not meet all of the criteria. Overall consensus (84%) of pediatric chairs surveyed did not support a separate board certification for hospital medicine. The results of this survey and the questions it raises about the impact of subspecialty certification for hospital medicine in academic health centers and community hospitals are indicated below.

Hospital Medicine

Escalating costs of health care have resulted in pressure to reduce inpatient admissions and the duration of stay in hospitals, improve patient outcomes, reduce hospital-acquired conditions, and improve efficiencies in care delivery, resulting in a need for hospitalists.[3-5] In pediatric medicine, the emergence of hospital-based practice is relatively young. The Society of Hospital Medicine was first established in 1997 and the AAP only recognized hospital medicine as a division with provisional status in 1999. The Academic Pediatric Association founded hospitalist medicine in 2001 and the ABP began evaluation of potential pediatric hospitalist medicine certification status in 2016. Initially, hospitalists provided internal medicine care in community hospitals with rapid evolution into the fields of pediatric and family medicine.[6] Divisions of hospitalists in pediatric departments of academic health centers have been emerging since the late 1990s.[1,2] These divisions provide clinical care across a number of settings, including general pediatrics wards, normal newborn or level 2 nurseries, and as members of conscious sedation teams. Of the 3300 candidates taking the 2015 ABP general pediatric certifying examination, 10.5% were employed as pediatric hospitalists. Dual trained medicine-pediatrics physicians are also members of the pediatric hospital medicine workforce. More than one-quarter of recent combined medicine-pediatrics graduates pursued hospital medicine positions, with more than two-thirds of those caring for both adult and pediatric inpatients.[7]

In a survey of 112 pediatric hospitalist programs in 2006 and 2007, hospitalist directors reported that 46% of their physicians were relatively newly employed (ie, for <3 years) with an average duration of employment of 63 months.[8] Hospitalists serve as role models for medical learners on inpatient rotations, and provide hospital administrative leadership in programs such as quality, safety, and electronic health systems. Chairs of departments of pediatrics have responsibility for ensuring the training of the next generation of pediatricians and directing both general and pediatric subspecialty care within academic health centers and children's hospitals. Given the increasing and varied focus of generalist practice, many stakeholders in pediatric departments are examining the need for formalized subspecialty or certificate training in hospital medicine. This report summarizes their responses to a survey regarding the perceived role of hospitalists and feedback on whether pediatric hospital medicine meets the criteria as a board-certified subspecialty.

Survey Methods

A survey instrument was initially developed by 2 of the authors and vetted by the AMSPDC Educational Committee and Executive Board of Directors for content validity. The survey was mailed electronically to the 145 members of AMSPDC in January of 2016. A total of 77 members (53%) responded. The survey consisted of 12 structured or open-ended questions regarding current practices and opinions concerning pediatric hospitalist medicine (**Table**; available at www.jpeds.com).

ABP	American Board of Pediatrics
ACGME	Accreditation Council for Graduate Medical Education
AMSPDC	Association of Medical School Pediatric Department Chairs

From the [1]Indiana University School of Medicine, Indianapolis, IN; [2]University of Buffalo School of Medicine, Buffalo, NY; [3]University of Arkansas for Medical Sciences College of Medicine, Little Rock, AR; and [4]University of Michigan Medical School, Ann Arbor, MI

0022-3476/$ - see front matter.
https://doi.org10.1016/j.jpeds.2017.11.049

Results

Current Division Structure

Of the 77 chairs who responded to the survey, 71% of the departments had a separate division of pediatric hospitalist medicine, 25% did not, and 4% were in the planning stages (**Figure 1**). Overwhelmingly, respondents (94%) felt that general pediatrics or medicine-pediatrics Accreditation Council for Graduate Medical Education (ACGME) residency training and ABP general pediatrics board eligibility was sufficient to practice as a hospitalist in the surveyed institutions (**Figure 1**, B). Only 4% of institutions required some additional training.

Training of Hospitalists in Academic Health Centers

When respondents were asked about the need to design pediatric categorical residency training programs to include advanced training opportunities, including a focused track in hospitalist medicine, the answers were variable. One-third of respondents felt there should be a focused track, although a comparable number of respondents did not feel additional training was required. The remaining chairs had a range of comments regarding additional training they would recommend or require. This training included (in rank order): simulation training in rapid response teams and code management (90%), sedation anesthesia (69%), advanced life support training, intensive care experiences (69%), emergency medicine (56%), and newborn care and circumcision experiences (25%). The perceived benefits of the suggested advanced training included better ability to manage complex patients with chronic disease states (85%), improved procedural readiness (58%), better opportunities for quality improvement work (66%), better training opportunities for academic development (56%), and improved teaching skills (44%).

Thirty-one chairs (40%) responded that their institutions did provide some type of additional training. Of these respondents, 61% had formal mentored training experiences, 42% programs had elective experiences within the general pediatrics residency program, and 29% had additional training within the department, including an institutionally sponsored fellowship.

Need for Subspecialty Status

At the time of this survey, the ABP was considering the development of a certification process for hospitalist medicine. As a result, the survey instrument included questions related to the requirements of ABP specialty status, including whether the practice of hospital medicine was unique from general pediatrics and established pediatric subspecialties and whether it required its own subspecialty of knowledge and science. The majority of respondents noted that the discipline of pediatric hospitalist medicine is actively creating new knowledge (78%). Similarly, the majority of respondents stated that hospitalists provide unique services or procedures associated with their practice (64%). However, fewer than 50% of respondents felt that the practice of hospitalist medicine was "unique from general pediatrics and/or any other area of established subspecialty medicine." Further, only 30% of respondents believed that the practice of hospitalist medicine requires a unique body of knowledge and has a unique scientific basis. Correspondingly, only 16% of respondents supported a separate board certification and 62% of respondents thought that hospitalists' training could be accomplished without additional training and separate board certification (**Figure 2**). Approximately 20% of respondents were unsure of the implications of an ACGME requirement for a separate board of certification.

Two survey questions focused on the current and future state of credentialing of hospitalists as compared with general pediatrics for both in- and outpatient settings. Approximately 25% of respondents reported that the credentialing of hospitalists in their institutions is distinct from general pediatrics, although hospitalists' privileges are included in the remaining hospitals. The majority of respondents (56%) indicated that they anticipate that the credentialing process would change if the ACGME and ABP established separate training and board certification in pediatric hospitalist medicine. Another 25% made comments about the impact of board certification on training and/or stated that they were unsure as to whether there would be a change in process. Only 15% of respondents indicated that their credentialing processes would not change.

Finally, respondents were asked if there were any other perspectives they would like to add regarding the need for separate training and certification to practice pediatric hospitalist medicine. Of the 18 respondents who commented, more than one-half suggested that academic hospitalists would benefit from certification and additional training, particularly in quality improvement, research, and leadership. At the same time, they felt that not all hospitalists would require such training. Concern was also expressed about the availability of a workforce in community hospitals and payment issues if certification became a requirement.

Discussion

The requirements to establish a new pediatric subspecialty training program through the ACGME and the ABP include that (1) the discipline is unique from general pediatrics and/or any other area of established subspecialty medicine, (2) the discipline provides subspecialty expertise to general pediatricians and others who may care for children, (3) the subspecialty has a unique body of knowledge and scientific basis, (4) there are unique services and/or procedures associated with the discipline, and (5) the discipline is actively creating new knowledge in child health impacting the care of children. Fewer than one-half of the pediatric chairs responding endorsed the first 3 criteria, although 65%-77% endorsed the latter 2 criteria. Altogether, only 16% of pediatric chairs supported a requirement for additional ACGME training and board certification. This finding seems to indicate a significant difference in perspective as to the role of hospital medicine being a board