Should Pediatric Hospitalists Seek Formal Subspecialty Status?

PRO: Subspecialty status is the optimal path for PHM

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Is it time for pediatric hospital medicine (PHM) to become a full-fledged subspecialty? Yes! The Accreditation Council for Graduate Medical Education (ACGME) defines a subspecialty as “That which provides advanced GME in a narrow field of study within a medical specialty, eg, geriatric medicine within the field of internal medicine.” In addition, many authorities feel that a robust research agenda may be the sine qua non of a subspecialty. Does PHM meet these definitions? In April 2010, the Pediatric Hospital Medicine Core Competencies were published as a supplement in the Journal of Hospital Medicine, codifying our contribution to advanced graduate medical education. Of course the words you are reading reside in the inaugural issue of Hospital Pediatrics, the only official American Academy of Pediatrics (AAP)–sponsored journal other than the flagship Pediatrics. While quality improvement literature from pediatric hospitalists has been appearing in journals such as Pediatrics and the Journal of Hospital Medicine the volume of research has reached a point where a specific journal for pediatric hospitalists is now viable. Surveys of pediatric hospitalists show that we are interested in research, but we need more skills and mentors. Where will these come from? We must create them in fellowships. Not every pediatric hospitalist has to be fellowship trained (look at the current state of pediatric emergency medicine), but we need a core of clinician investigators who can expand our knowledge and add to the evidence base of inpatient pediatrics. There can be no doubt that care in pediatric and neonatal intensive care units and emergency rooms has improved dramatically since the advent of these subspecialties. While the current generation of pediatric hospitalists is actively engaged in quality improvement in local, regional, and national venues, the discipline will not truly advance until we can begin generating new knowledge by performing high-quality research. National databases such as Kids’ Inpatient Database (KID) and Pediatric Health Information System (PHIS), and national research/quality improvement networks such as Pediatric Research in Inpatient Settings (PRIS) and Value in Inpatient Pediatrics (VIP) provide a data and research infrastructure waiting to be used by appropriately trained pediatric hospitalists.

The explosive growth and enthusiasm for our discipline mirrors the experience of pediatric emergency medicine which now has more than 1,300 board-certified practitioners. We are one of the largest and fastest growing sections in the AAP. We have a very successful tri-sponsored (AAP, Society of Hospital Medicine [SHM],
Academic Pediatric Association [APA]) annual conference, and a PHM council, a separate organization with representation from those three societies meant to further the interests of PHM.

What about maintenance of certification (MOC)? The American Board of Pediatrics (ABP) recently dropped the mandate that pediatric subspecialists be board-certified both in general pediatrics and their subspecialty. In other words, a pediatric nephrologist no longer has to answer questions about bronchiolitis to maintain certification in pediatric nephrology. Pediatric hospitalists have begun to complain about the scope of the certifying examination. Must we know the nuances of attention-deficit/hyperactivity disorder (ADHD) diagnosis or the catch up schedule for immunizations? Our time would be better spent perfecting our management of complicated pneumonia and mastering comanagement skills. In addition to the certification examination, other parts of MOC, namely part 4 (evidence of satisfactory performance in practice) have come under scrutiny by subspecialists and hospitalists. At the 2010 AAP National Conference and Exhibition, representatives from pediatric gastroenterology, neonatology, and hospital medicine met with members of the ABP to discuss part 4. The concerns were that most ABP-preapproved part 4 activities, eg, education in quality improvement for pediatric practices (EQIPP) modules for ADHD, were geared toward primary pediatricians and not relevant to other specialties, including hospital medicine. While hospitalists have been successful in creating more relevant part 4 activities, the divide with office-based pediatricians, and the solidarity with other pediatric subspecialists underscores our different needs and requirements.

A recent article by Rochlin and Simon in Pediatrics\(^1\) proposed that most pediatric subspecialists will suffer financially compared with primary care pediatricians, ie, the potential earnings forfeited during fellowship will outweigh the increased reimbursement as a subspecialist. While more detailed analyses are needed to confirm or refute this proposition, the other rewards of subspecialty status—the ability to perform high-quality research, the respect of patients and peers who see us as the specialist and not the “super chief resident,” and not having to answer all those ADHD questions—are ample motivation for future hospitalists.

**CON: Subspecialty status will have unintended consequences**

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Pediatric hospital medicine stands at a crossroads. As we who identify ourselves as pediatric hospitalists begin to reach a critical mass, we are beginning to confront questions about our group identity. Do we follow the path of pediatric emergency medicine and establish ourselves as a subspecialty, including formal academic fellowships and subspecialties? Do we follow the lead of adult hospital medicine and remain generalists with “focused practice?” Or do we seek some alternative path, as yet undiscovered? There are many valid arguments that support the possibility that inpatient pediatrics is already its own subspecialty, not the least of which is the existence of this journal, as well as the existence of multiple academic pediatric hospitalist fellowships; however, I would like to argue against a complete embrace of subspecialty status.

Recently, a bombshell economic analysis of pediatric fellowship training was published by Rochlin and Simon in the February 2011 issue of Pediatrics\(^1\). Of 11 pediatric subspecialties analyzed, only three (cardiology, critical care, and neonatology) provided a positive return on investment. If you accept the premise of the article, making the 3-year commitment to any other subspecialty will cost you money over entering into general pediatric practice. While there are many points to quibble over assumptions made in the article, we all know that on some level the basic assertion made in it is accurate. Deferring a full salary and repayment on educational loans to become a subspecialist is costly. Pediatric subspecialists are not paid on a scale with adult subspecialists. If this were not true, many of us would be installed as pulmonologists, endocrinologists, or infectious disease specialists somewhere instead of making our way as hospitalists. Also, in case there is any doubt as to where PHM would fall on the Rochlin and Simon scale, consider the fact that even pediatric emergency medicine did not provide a positive return on personal investment. Given that reimbursement for inpatient services is often lower than for emergency department codes based on volume and typical billable services, it stands to reason that
pediatric hospitalists will fall somewhere below pediatric emergency medicine, well into negative territory. However, a purely economic argument will leave many readers cold. While financial pressures certainly affect career decisions, consciously or unconsciously, we would all like to believe we follow our heart down a particular career path. On some level, hospitalists are hospitalists because they love the generalist approach to patient care rather than the subspecialist approach. We love the lure of the undiagnosed patient and once the diagnosis is made, let’s face it, sometimes our attention wanes. As hospitalists we generally pride ourselves on a logical, step-wise approach to patients. We are skeptical and judicious; we like to think that we actually can see the forest and the trees. We are apt to quote the following (humorous) definition of subspecialization with approval: “The specialist is someone who knows more and more about less and less.” So, how then would becoming a formal subspecialty change us? Maybe not by much, but nevertheless we would be forced to redefine our scope of practice which is the same thing as limiting it in many cases. Formal academic fellowships will result in a multitude of governing bodies involved in oversight, defining curricula, and requirements. Is there anybody out there who is happy with the residency review committees or the ABP right now? Why invite them to add to our burden? What will we gain by their involvement?

Finally, because nearly two-thirds of recently trained pediatric subspecialists practice in an academic environment, perhaps the most important plea to remain free from formal subspecialty status comes from patients in small-town USA, where most pediatric patients are hospitalized. We might take a lesson from pediatric emergency medicine here as well. Currently, hundreds of pediatric emergency medicine jobs are available in this country, and many hospitals cannot staff their emergency department with pediatrics-trained individuals. We are almost certain to have significant shortages of board-certified hospitalists in the same way as pediatric emergency medicine. This may lead to a two-tiered system with many positions filled by providers working on an ad hoc basis, which can only foment discord as it does in some emergency settings. This type of system is bad for morale, bad for job security, and leads to high turnover. Unfortunately, this seems likely to be the unintended consequence of formal subspecialty status. On the other hand, academic hospitalists can train to do research through research fellowships in a similar manner to many general academic pediatricians. In the end, it makes much more sense to push for the creation of an inpatient track during residency for most hospitalists because clinical care will be their major focus. At a time when many are re-evaluating the need for so much formal research experience in almost every pediatric subspecialty, we would be wise to heed some of their arguments. If we can rise above the egotistical desire to gain respect through achieving subspecialty status, we will likely be better off in every other way.

References