The Strategic Planning Committee Report: The First Step in a Journey to Recognize Pediatric Hospital Medicine as a Distinct Discipline

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The field of pediatric hospital medicine (PHM) has experienced phenomenal growth over the past decade. Academic contributions by pediatric hospitalists include the creation of PHM core competencies,1 national collaborative PHM networks for both research (the Pediatric Research in Inpatient Settings network2) and quality improvement (the Value in Inpatient Pediatrics network3), a robust and well-attended annual scientific meeting,4 and an increasing number of divisions or sections of PHM in pediatric departments across the country. Many pediatricians are choosing to pursue careers in PHM,5,6 and several postgraduate training programs for PHM have emerged.7 Similar to other generalist pediatric fields,8–11 the question as to how best for PHM to evolve as a distinct discipline has arisen. Several training and/or certification options are feasible and have been examined by the pediatric hospitalists who constitute the Strategic Planning (STP) Committee. The objectives of this commentary are to (1) describe the work done to investigate these options to date, (2) provide a framework for evaluating
them, and (3) describe next steps. This commentary will neither justify subspecialty status for PHM, which is currently still debated within the field, nor will it compare the development of PHM as a subspecialty with other generalist fields because such a comparison is premature.

**THE STP COMMITTEE PROCESS**

In an effort to achieve adequate representation among a highly diverse community, a group of hospitalist leaders requested volunteers from the PHM community to join the STP Committee in September 2010. In December 2010, STP Committee cochairs were selected from the volunteers. Cochair selection was achieved by consensus among 1 representative from each of the 3 societies of PHM: the American Academy of Pediatrics Section on Hospital Medicine (AAP SOHM), Academic Pediatric Association (APA), and the Society of Hospital Medicine (SHM).

The goal of the STP Committee was to evaluate the training and/or certification options for PHM to proceed as a distinct discipline. Core values of the STP Committee included having input from all diverse constituents that comprise practicing pediatric hospitalists, as well as functioning in a self-reflective, transparent, and engaged fashion.

STP cochairs asked the nearly 50 other volunteers to draft their individual vision of the future of PHM in terms of subspecialty status and training. The 37 who responded made up the earliest STP Committee; an additional 8 members were identified during the July 2011 survey described below, bringing the committee total to 45 members. These 28 women and 17 men represent 36 academic and community hospitals in 22 states and Canada.

STP cochairs identified 4 themes from the respondents’ vision statements (traditional subspecialty certification, extra training, residency track, and no change) and subcommittees were created based on these themes. The STP Steering Committee, consisting of the overall and subcommittee cochairs, was also created. Each subcommittee further explored potential training and/or certification options under their theme, which are shown in Table 1. The groups used a modified Delphi method to create “Strengths, Weaknesses, Opportunities, and Threats” (SWOT) analyses for each training option. Work was conducted over the next 6 months through conference calls and in-person meetings.

Over a 2-week period in early July 2011, the STP Committee distributed a survey to the PHM community through listserves of the 3 sponsoring societies of PHM: the APA, the AAP SOHM, and the SHM. The survey asked respondents which training and/or certification option in Table 1 they preferred and if they wanted to participate on the STP Committee. Of the 132 respondents in this convenience sample, 33% preferred Recognition of Focused Practice, 30% opted for a 2-year fellowship with subspecialty designation, and 17% chose a hospital medicine track within pediatric residency.

In late July 2011, the STP Committee’s SWOT analyses and survey findings were presented at the PHM annual conference. Feedback was to revise the SWOT analyses into a pro/con format and to include the 2 options that had not yet been well explored, the Recognition of Focused Practice and the 2-year fellowship. Over the next several months, the STP subcommittees and Steering Committee integrated the feedback and created revised documents presenting a list of

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<th>Original Themes Identified</th>
<th>Specific Training and/or Certification Options Considered</th>
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<td>Traditional subspecialty certification</td>
<td>3-y fellowship under ABP guidelines</td>
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<tr>
<td>Extra training</td>
<td>Alternate route to subspecialty certification</td>
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<td></td>
<td>2-y fellowship under ABP guidelines</td>
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<td></td>
<td>Hospital medicine residency track plus 1-y fellowship</td>
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<td>Fast track model (2-y residency plus 2–3 y fellowship)</td>
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<td>Residency track</td>
<td>1-y fellowship under ABP guidelines</td>
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<td>No change</td>
<td>Hospital medicine track during general pediatrics residency</td>
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<td></td>
<td>Status quo with option for specialized training</td>
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<td></td>
<td>Mandatory mentorship program</td>
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<td>Recognition of Focused Practice (equivalent to American Board of Internal Medicine option)</td>
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ABP, American Board of Pediatrics.
pros and cons for each training and/or certification option.

On March 5, 2012, the STP Steering Committee distributed updates to the 3 sponsoring societies’ listserves. The full report, including more detail about each option outlined in Table 1, is available at http://stpcommittee.blogspot.com/.

THE STP COMMITTEE FINDINGS: A FRAMEWORK FOR EVALUATING PHM TRAINING AND/OR CERTIFICATION OPTIONS

During this dynamic time in medicine, we must develop robust strategies to ensure an adequate workforce with appropriate skills to advance the practice of PHM. The field emerged because of increasing complexity of hospitalized children and hospital systems\(^\text{13}\) and reimbursement driving compartmentalization of general pediatricians to either the ambulatory or inpatient setting. Furthermore, PHM is evolving both within, and in many ways as a result of, large-scale changes in pediatric residency training. These changes include but are not limited to duty-hour restrictions, increasing scope and breadth of attending supervision, and the call for individualized resident education. Also, we need more research and quality improvement efforts in the inpatient setting.\(^\text{14}\)

Our field must be positioned to continue to evolve within constant change.

In considering an evolution to require training beyond pediatric residency, PHM must identify the unique set of skills and body of knowledge that are needed to practice PHM that are not obtained during pediatric residency. Currently, pediatric hospitalists obtain expertise during the early years of practice that could instead be obtained during postresidency training in areas including, but not limited to, advanced clinical skills such as sedation, research, teaching skills, quality improvement, and business management.

Although a natural first reaction is to focus on what each option means for an individual already within the field, any proposed training and/or certification option will need to provide a mechanism for certification for those with suitable experience (eg, a “grandfathering” mechanism for those already in the field). Instead, these options must be evaluated in the context of the future of our field and should not be limited by any current lack of formal training opportunities.

Of note, the training and/or certification options are not necessarily mutually exclusive of one another. The impact of each training and/or certification option on the existing and future workforce, the opportunity costs for future physicians embarking upon additional training, and the cost to the organizations training future pediatric hospitalists were considered by the STP Committee. Finally, the impact of each training and/or certification option on hospitalized children is of prime importance.

NEXT STEPS

We believe the STP Committee’s work to date to be as representative of the PHM community as possible. Moving forward, continued feedback from practicing and future pediatric hospitalists is essential.

When the STP Committee presented at the PHM meeting in July 2011, initial feedback was that the material needed to be reviewed by the broader community. The STP Committee has now responded with its report for comment by the PHM community and is requesting public comments at http://stpcommittee.blogspot.com/ and private feedback by e-mail at PHM.StrategicPlanning@gmail.com. Two “Charting the Future” sessions at the PHM meeting in July 2012 provided a forum for additional public discussions, and a clear majority felt the field should move forward soon.

The newly created Joint Council of Pediatric Hospital Medicine, consisting of representatives from the APA, AAP SOHM, and SHM, as well as the Pediatric Research in Inpatient Settings network and several still-to-be-elected at-large members, has received the STP Committee’s report. In the interim, each society’s representatives are reviewing options and soliciting feedback from the leadership of the APA, AAP, and SHM. The STP Committee will collate all comments during the spring and summer of 2012 into a final report. The Joint Council of Pediatric Hospital Medicine will use the final report and information from the discussions within the PHM community and the sponsoring societies to prioritize options and pursue appropriate next steps.

ACKNOWLEDGMENTS

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REFERENCES