Commentary on Association Between Practice Setting and Pediatric Hospitalist Career Satisfaction; Observations From Two Very Satisfied Community Hospitalists

We applaud Dr Pane and colleagues for continuing to investigate the question of career satisfaction for pediatric hospitalists. The publication of these findings is timely as we discuss the future of pediatric hospital medicine as a subspecialty. How we train, recruit, and nurture future pediatric hospitalists will determine the success of our field, and career satisfaction is a key issue in building the discipline. However, we would like to add some observations regarding the current study from a perspective outside of the academic medical center.

Being a community hospitalist differs widely among programs. With no pressure to teach or publish, many of us feel the freedom to focus on patient care or hospital operational issues that interest us. Some programs cover the emergency department, the nursery or NICU, and sedation service, as well as the pediatric floor. We have all heard the mantra, “if you have seen one hospitalist service, you have seen one hospitalist service.” The variability in practice settings and setup is, we hypothesize, much more apparent in a community hospital setting than in an academic setting, and it takes time to mature the balance recommended by the Society of Hospital Medicine in the 4 pillars of career satisfaction. One particular question absent from the current survey and which may be much more important in the community hospital setting is this: How long has your hospitalist service been in existence? Adult community hospitalist programs are often much more mature than pediatric programs and that may be 1 reason these programs have shown similar career satisfaction rates. One of us (JP) practices in a freestanding, nonacademically affiliated children’s hospital that has had a pediatric hospitalist service for >30 years. Most of the hospitalists there have found great career satisfaction because of the attention given in creating a service that provides flexibility, career challenge, and control. We all can learn valuable lessons from such experienced programs.

Another issue with the current study is that the interpretation of answers may not take into account the different interests and motivations of community hospitalists. One of us (JA) actually chose to work in a community pediatric hospitalist program for several of the reasons the article seems to identify as potential negatives. For example, why is the ability to refer to consultants/subspecialists important in career satisfaction? At many rural and community hospitals, there are no pediatric subspecialists in the local community, but this can be a good thing. Our hospitalists

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find not having consultants involved in cases to be liberating. This is a benefit of being in a community hospital, not a negative. Independence is energizing. We feel our skills are better used to diagnose and treat uncommon or rare diseases, which adds to our career satisfaction. When answering the questions in the survey, a response < 4 does not have to represent satisfaction, but rather that the topic was less important in our practice. Another example, the statement "my colleagues are a good source of professional stimulation" dose not have to be answered with a 4 or greater to be a positive. Many community hospitalists work alone, with only family practitioners or emergency department physicians as colleagues during a shift, and we like the autonomy. It can be satisfying to be the “expert,” well-respected pediatrician on staff during a night shift out in a rural community. Does lack of colleagues or isolation have to lead to dissatisfaction? Possibly, but the statement alone does not equal dissatisfaction. Under the reward/recognition pillar, differences in the 2 groups are present, but the statements in the questionnaire again fail to acknowledge the possible differences in motivation between the types of people who choose community hospitals and academic programs. There are often no designations such as associate professor or full professor in a community program, and the physicians who enter those community positions know that. The assumption, therefore, that this absence of designation leads to dissatisfaction may simply reflect a lack of emphasis on these issues among those choosing community-based positions. It may be harder to find ways to help hospitalists feel recognized in a community hospital given our often small presence within a larger hospital, but programs can work to overcome such problems as they develop. The respect community hospitalists receive from the local physician community is often a significant motivation, and although not associated with any specific title, it may contribute much to career satisfaction. The lack of rotating residents and attending physicians allows local physicians to get to know the hospitalists and trust their care. This kind of “recognition” is priceless and not measured in the current study.

To summarize the opinions of some very happy community hospital providers, although the survey results do suggest a difference in satisfaction, we think the inability to define and interpret the different motivations and interests of community hospitalists is a significant limitation that could ultimately change the conclusions of the study if further investigated. Future surveys and research to investigate the different goals, desires, and motivations in the 2 groups will be of benefit for the entire pediatric hospital medicine community. A better understanding of our own motivations in both settings will allow us to recruit the right type of physician to the right practice setting to achieve long-term career satisfaction wherever we practice.