Counting Hospitalists—Does it Matter?

Who is a hospitalist exactly? The study by Freed et al. in this issue looks at the long-term plans of those who are taking a hospitalist position as their first job. The authors’ rationale for this assessment is that it is “important to workforce projections regarding the magnitude of those who will function in this role.” This claim may be true, but the study itself might incompletely inform workforce projections because residents often choose a position out of residency that may not reflect their long-term career plans. This scenario is certainly true for many who take a hospitalist position, as shown by this study as well as by previous studies. Acknowledging this reality is to recognize that there are at least 2 classes of pediatricians performing hospitalist work: those biding their time and those starting a career. For residents just completing their training, it can be hard to distinguish between those 2 classes, especially when there is no clear description of what defines a hospitalist. Many residents also take temporary positions in NICUs, emergency departments, and urgent care centers, some with the intention of earning money before a fellowship in those fields while others are just waiting for another opportunity. However, the difference in those venues is that there is a fellowship structure for standardized training to achieve a well-defined credential as an American Board of Pediatrics (ABP)-recognized subspecialist. Lacking the ABP structure and recognition for pediatric hospital medicine (PHM) does not diminish the training needs for those embarking on a career in PHM. Thus, the importance to workforce projections is secondary to the fact that the field needs better definition and focus to set training standards for those who will make a career of PHM and ensuring that the roles of those who are “passing through” are well defined.

One of the most important findings in the study by Freed et al. may be lost on the reader; that is, even if it is true that only one-half of those who start a PHM job will continue in the field (and this figure does not account for those who later enter PHM or those who stay despite their original intentions), that leaves, conservatively, ~4% of the workforce in PHM long-term. This figure means that PHM is still 1 of the largest areas of pediatric practice. Ultimately, the study’s finding that less than one-half of those taking a PHM job are planning a career in PHM is difficult to interpret, given the mixed group of respondents and the lack of clarity regarding the nature of the PHM position they are assuming. Other studies, including a recent American Academy of Pediatrics survey, indicate a higher percentage of retention and more maturity of the PHM workforce than implied by the study of Freed et al. Perhaps the most interesting results were those of the respondents who identified themselves as advancing to fellowship training on the way to a career in PHM. This group is analogous to those entering other ABP-certified fellowship programs.
Freed et al state, “It is possible that those who only plan short-term forays into the field will likely be less willing to undergo additional training and may take on specific, and more limited roles…” This description mirrors the job descriptions of those who now work in NICU, PICU, and emergency department settings without subspecialty training, a largely unstudied group of individuals; the ABP may be largely unaware of this group. It is probable that PHM will mature in a similar fashion as these other subspecialties. It would also be a fair interpretation of these results that the lack of an accredited subspecialty pathway may be the reason for attrition from hospital medicine as a career choice by many of the recent graduates surveyed. The implications of this study are best pointed out by the authors as “relevant to understanding the trends in initial positions of pediatricians following residency.” Because PHM has defined a set of core competencies and developed a robust fellowship environment, it is becoming clearer that additional seasoning beyond residency is necessary to become a fully actualized hospitalist. Data from the adult hospital medicine literature indicate a learning curve of several years before achieving expected efficiencies. Given the lesser emphasis and time on inpatient services in pediatric versus adult medicine residencies, it can be assumed that at least a similar learning curve will be necessary in PHM without the benefit of fellowship training.

The critical value of the study by Freed et al is that it reinforces the need for further definition of and recognition for PHM. Within the current structure of pediatrics and academic medicine, the way forward is through formal ABP subspecialty status. This recognition will provide pediatricians and the public with clarity and specificity about how a hospitalist is defined. It will not prevent anyone from entering the field directly out of residency, as those who choose to do so will have the same opportunities as those who currently take positions in pediatric emergency departments and special care nurseries. Formal ABP status will foster further advancement of the field that will benefit all children regardless of the specific provider. Formal status will create an equal academic footing for those with long-term PHM career plans so that they may have equivalent opportunities as faculty in our teaching programs.

REFERENCES
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