

Institutions and Individuals: What Makes A Hospitalist “Academic”?

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academic, academic center, community hospital, hospitalist

ABBREVIATION

PHM: pediatric hospital medicine

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As pediatric hospital medicine (PHM) develops and matures, attempts have been made to describe the field and the individuals who practice it.¹⁻³ Defining what PHM practitioners do is complex, and descriptive categories are often presented with dichotomous alternatives regarding responsibilities (eg, teaching or not, research/scholarly activity or not) and scope of practice (eg, limited to inpatient service or broader, full array of resources or not). Frequently, the differences are overly simplified according to the type of institution in which the pediatric hospitalists work, labeled “academic centers” and “community hospitals.”^{1,3,4} However, the designation of 1 setting as “academic” implies that the alternative (community hospitals) is not academic, a distinction that spills over to labeling individual hospitalists as academic or nonacademic. According to Freed and Dunham,¹ academic hospitalists are those with a full-time faculty appointment, whereas hospitalists with a part-time or no faculty appointment are considered nonacademic. Appointments are conferred by universities, however, so this definition of academic largely reverts to the type of institution in which the pediatric hospitalist works rather than the type of work the pediatric hospitalist does. We propose that the alternative to community hospitals is better described as “university/children’s hospitals” than academic centers because hospitalists may perform academic functions in both types of institutions.

We agree that there are important differences regarding what hospitalists do that are related to the type of hospital in which they work. Although the differences include whether salary, rank, and retention depend, at least in part, on scholarly activity, major differences go beyond whether the institution is considered an academic center and focus more on whether it is a university/children’s hospital. Such differences include scope of practice and the breadth and depth of resources available (medical and surgical subspecialists, specialized nurses, equipment, and facilities). The breadth of resources is expected to be considerably greater in university/children’s hospitals than in community hospitals, with implications such as a greater need for hospitalists in the latter to be skilled in effecting safe, timely, appropriate transfers to more resource-rich facilities when such resources are needed. Hospitalists in community hospitals are more likely to be called on to provide resuscitative services in delivery rooms, newborn nursery care, and consultations in emergency departments than their counterparts in university/children’s hospitals, with implications for the scope of their clinical skill set. In addition, hospitalists in community hospitals may need to be the major advocacy voice for children and families. Referring to university/children’s hospitals as academic centers blurs these important differences from community hospitals

and puts undue emphasis on teaching and research/scholarly activity as the main considerations. But even these responsibilities—teaching and research/scholarly activity—deserve closer inspection.

Responsibility for teaching is not limited to university/children's hospitals. According to data from the Accreditation Council for Graduate Medical Education, the 199 accredited pediatrics residency programs use 443 hospitals for training, a number far in excess of the number of university/children's hospitals (C. Fischer, MBA, personal communication, 2013). This arrangement affords the opportunity and responsibility for pediatric hospitalists in many community hospitals to teach pediatric residents. Moreover, the teaching influence of pediatric hospitalists likely benefits many family practice residency programs in such settings as well. Medical schools also use multiple sites. All of the ~18000 students who graduated from the 141 accredited medical schools in the United States in 2013 had a clinical clerkship focused on caring for children.⁵ Although the exact number of hospitals used by each medical school to provide a pediatrics inpatient experience to medical students is not known, leaders of the Council on Medical Student Education in Pediatrics suggest that multiple sites are required and used (M. Barone, MD, MPH, personal communication, 2014). Many of the students are supervised and taught in university and children's hospitals, to be sure, but many experience inpatient pediatrics in community hospitals, again creating the opportunity and responsibility for pediatric hospitalists in all settings

to be influential teachers of medical students. Moreover, hospitalists teach staff who care for children in hospitals and parents and families. Therefore, although teaching and not teaching are dichotomous terms, the dichotomy at the hospital level is not academic centers versus community hospitals or even "teaching hospital" versus "not a teaching hospital." The presence of residents affects the role of the hospitalist; services might be differentiated on that basis ("resident service" versus "non-resident service"), but more important to the scope of practice and required clinical skill set of hospitalists than the presence or absence of residents are the resources immediately available, and these are best captured in the distinction between university/children's hospitals and community hospitals.

As for research/scholarly activity, this distinction may largely be a matter of degree but also is not limited to university/children's hospitals. Particularly now that the American Board of Pediatrics Maintenance of Certification Program requires all enrolled pediatricians to be academic, including having an appropriate fund of knowledge (Part 3) and conducting quality improvement projects (Part 4), it is inappropriate to suggest that academics is solely a function of the type of hospital in which one works. Buildings are not academic; people are.

To appreciate the important distinctions between PHM and pediatric hospitalists in different types of hospitals, optimal nomenclature should highlight considerations such as breadth of resources and scope of practice rather

than using the descriptor academic. In the summer of 2013, the authors of this editorial conferred by conference call and concluded that the term academic centers should be replaced by university/children's hospitals as the alternative to community hospitals, doing away with the implication that community hospitals (and hospitalists who practice there) are nonacademic. This proposal was accepted by the Executive Committee of the American Academy of Pediatrics Section on Hospital Medicine to be used henceforth in place of labels that include the word academic. Regardless of where we work, it is clear that, for the sake of our patients, we all need to carefully weigh evidence, implement best practices, improve quality, and remain current—in short, be academic.

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