

The Med-Peds Hospitalist Workforce: Results From the American Academy of Pediatrics Workforce Survey

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OBJECTIVE: There is no published literature about the med-peds hospitalist workforce, physicians dually trained in internal medicine and pediatrics. Our objective was to analyze this subset of physicians by using data from the American Academy of Pediatrics (AAP) workforce survey to assess practice patterns and workforce demographics. We hypothesized that demographic differences exist between hospitalists and nonhospitalists.

METHODS: The AAP surveyed med-peds physicians from the Society of Hospital Medicine and the AAP to define workforce demographics and patterns of practice. We compared self-identified hospitalists with nonhospitalist physicians on multiple characteristics. Almost one-half of the hospitalists self-identified as being both primary care physicians and hospitalists; we therefore also compared the physicians self-identifying as being both primary care physicians and hospitalists with those who identified themselves solely as hospitalists.

RESULTS: Of 1321 respondents, 297 physicians (22.4%) self-reported practicing as hospitalists. Hospitalists were more likely than nonhospitalists to have been practicing <10 years ($P < .001$), be employed by a health care organization ($P < .001$), work >50 hours per week ($P < .001$), and see only adults ($P < .001$) or children ($P = .03$) in their practice rather than a mix of both groups. Most, 191/229 (83.4%), see both adults and children in practice, and 250/277 (90.3%) stated that their training left them well prepared to practice both adult and pediatric medicine.

CONCLUSIONS: Med-peds hospitalists are more likely to be newer to practice and be employed by a health care organization than nonhospitalists and to report satisfaction that their training sufficiently prepared them to see adults and children in practice.

ABSTRACT

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Although patients have been cared for within the hospital for decades, recognition of specialists who practice inpatient medicine did not consistently occur until the term *hospitalist* was described in the medical literature by Wachter in 1996.¹ The hospitalist movement has grown exponentially since its inception and is one of the fastest-expanding medical specialties in the United States, with an estimated 44 000 US hospitalists practicing in 2014.² Hospitalists provide general inpatient care for both adults and children but are increasingly subspecializing to provide care to more narrowly defined groups of patients.³ Physicians trained in both internal medicine and pediatrics who practice hospital medicine, known as med-peds hospitalists, are an emerging subset of hospitalists.

Combined med-peds training programs were formally recognized in 1967 when the American Board of Internal Medicine and the American Board of Pediatrics allowed integrated training experiences to fulfill board requirements for physicians to be eligible to earn certification after residency. As part of their combined training, med-peds trainees are required to complete extensive inpatient rotations in internal medicine and pediatrics, including significant exposure to ICU settings. The intensity and depth of inpatient experiences make med-peds physicians uniquely suited to practice hospital medicine. Interestingly, although the 1999 study by Lannon et al⁴ showed that 85% of med-peds graduates provided care for hospitalized patients, the majority (75%) spent <20% of their time in the inpatient environment. These practice patterns suggested that at that time many of these people were not practicing primarily as hospitalists, although their clinical responsibilities included care for hospitalized patients.

In recent years, practice patterns have shifted, and an increasing number of med-peds trained physicians practice hospital medicine. The American Medical Association reported that there were 422 hospital-based physicians out of a total of 5317 self-

designated med-peds physicians in the United States as of 2013,⁵ and the Society for Hospital Medicine (SHM) reports that it has 360 med-peds physicians within its membership.² However, no formal research has been published about this group. To investigate this rapidly expanding subset of physicians, we developed a survey instrument to assess practice patterns, job satisfaction, and workforce demographics for med-peds hospitalists in the United States. To our knowledge, this is the first publication to specifically describe the med-peds hospitalist workforce.

METHODS

Survey Design

We developed a survey in conjunction with the American Academy of Pediatrics (AAP) Workforce Survey of Pediatric Medical Subspecialties and Surgical Specialties to assess workforce characteristics for med-peds physicians across the nation. The first portion of the survey, developed by AAP staff, consisted of a standard set of 44 questions completed by all physicians in participating specialties, which included questions about demographics, board

TABLE 1 Characteristics of Self-Reported Internal Medicine–Pediatrics (Med-Peds) Hospitalist Physicians, 2014

	N	%
Gender		
Male	134/272	49.3
Female	138/272	50.7
Race		
African American	17/285	6.0
Asian	43/285	15.1
Hispanic	8/285	2.8
Other	20/285	7.0
White	197/285	65.6
Medical school location		
US	242/268	90.3
Canada	1/268	0.4
Other	25/268	9.3
Professional degree		
MD	278/295	93.6
DO	13/295	4.4
Other	4/295	1.3
Academic appointment		
Yes	155/176	88.1
Academic rank for those with appointments		
Instructor	30/156	19.2
Instructor	99/156	63.5
Associate professor	21/156	13.5
Full professor	1/156	0.6
Other	5/156	3.2
Job changes since end of residency		
None	122/277	44.0
1–2	116/277	41.8
3–5	33/277	11.9
>5	6/277	2.2
Years since graduation		
Mean 11.9 y	Range 1–37 y	

certification, type of employment, and clinical practice characteristics.

We developed an additional 20 questions for med-peds physicians based on review of the literature^{4,6} and consultation with experts on the med-peds workforce. Respondents were queried about practice patterns and age distribution of patients, satisfaction with and adequacy of dual training, and the effects of dual practice on job satisfaction and salary. Eleven survey items captured features of practice and relevant training issues and queried respondents about which professional services they wished the AAP Section on Internal Medicine–Pediatrics (SOMP) would provide. The survey included free text fields allowing respondents to elaborate on their likelihood of choosing med-peds training again, the effect duty hours had on their training, and the likelihood and reason why they might choose to decrease clinical practice within the next 5 years. We piloted the survey with several members of the SOMP executive committee and members of the Medstar Georgetown University Hospital Med-Peds Section.

Setting, Administration, and Analysis

We surveyed members of the AAP SOMP and members of the SHM who were classified as med-peds. Lists were reviewed by AAP SOMP staff to prevent duplicate responses. Potential respondents ($N = 3378$) received an individual e-mail link to an anonymous online survey (SurveyMonkey.com, Palo Alto, CA). Five reminder e-mail messages were sent to nonrespondents. Each mailing included a message from SOMP leaders emphasizing the importance of the survey and an individualized link to the survey. We collected data from September 2013 to February 2014.

We set out to determine whether the reported satisfaction with training, demographics, type of employment, patient age distribution, and other practice patterns of self-reported hospitalists in the survey were significantly different from those of all other med-peds trained physicians in our sample. In addition, many hospitalists in our sample self-reported being primary care physicians; we therefore

analyzed these same parameters to see whether hospitalists who considered themselves more generalist physicians were different from those who solely reported that they were hospitalists.

We analyzed responses using statistical software (SPSS 18.0; IBM SPSS Statistics, IBM Corporation) and the GraphPad statistical calculator (www.graphpad.com; GraphPad Software Inc, La Jolla, CA). We used χ^2 testing

TABLE 2 Practice Demographics of Self-Reported Internal Medicine–Pediatrics (Med-Peds) Hospitalist Physicians, 2014

	N	%
Practice ^a		
Self-identify as a primary care physician	138/277	49.8
Subspecialty boarded	22/290	7.4
Practice setting		
Medical school, hospital, or parent university	117/292	39.4
Community or staff model hospital	110/292	37.0
Multispecialty group	20/292	6.7
Other	14/292	4.8
Community health center or health department	8/292	2.7
Health maintenance organization staff or group model	7/292	2.4
Specialty group practice	7/292	2.4
Solo practice	5/292	1.7
Pediatric group practice	4/292	1.4
Practice locale		
Urban, not inner city	93/295	31.5
Urban, inner city	83/295	28.1
Rural	61/295	20.7
Suburban	58/295	19.7
Average hours worked per week		
Median	60.0	
Hours worked per week		
<20	3/276	1.1
20–40	21/276	7.6
41–50	81/276	29.3
51–60	86/276	31.2
>60	85/276	30.8
	Mean, %	
Type of work ¹		
Direct patient care	72.7	
Administration	12.9	
Teaching	11.2	
Research	3.88	
Other medical activities	4.24	
Percentage of patient load by age group		
<2 y	16.8	
3–17 y	15.5	
18–25 y	8.4	
26–40 y	12.0	
41–65 y	21.1	
>65 y	34.7	

^a Numbers do not sum to 100% because of rounding or duplicate responses.

where appropriate to compare different aspects of practice for physicians in practice for more or fewer than 10 years.

The AAP Institutional Review Board exempted this survey protocol from additional review.

RESULTS

Response Rate and Demographics

The survey was completed by 1321 of 3378 physicians, yielding a response rate of 39.1%. Two hundred ninety-seven physicians (22.5%) self-reported practicing as hospitalists. Among our hospitalist respondents, 200/297 (67.3%) belonged to the AAP, 209/297 (70.4%) were members of the American College of Physicians, and 158/297 (53.2%) were members of the SHM. Five respondents (5/297, 1.7%) reported that they had completed training in a hospital medicine fellowship (4 in adult hospital medicine, 1 in pediatric hospital medicine).

The hospitalist sample was majority female, in keeping with overall med-peds workforce data,⁷ and consisted predominantly of US medical graduates who practice in an urban area and hold an academic appointment. We collated data on physician demographics (Table 1), aspects of physician practice (Table 2), and attitudes about training and practice (Table 3). The denominators presented are not all equal because of variable response rates to each individual question.

Training Satisfaction

In light of recent attempts to establish fellowships in pediatric hospital medicine, we asked respondents how satisfied they were that med-peds training adequately prepared them to see both adults and children in practice. It is interesting to note that >90% of respondents in our sample stated that their training left them well prepared to practice both adult and pediatric medicine, with 214/277 (77.3%) of respondents reporting that they felt “very satisfied” with their preparation during training.

Trends in Comparison to Nonhospitalists

We found several significant differences when we compared med-peds hospitalists with nonhospitalists in the general survey (Table 4). Hospitalists were more likely to be

TABLE 3 Dual Certification Characteristics and Career Attitudes of Self-Reported Internal Medicine–Pediatrics (Med-Peds) Hospitalist Physicians, 2014

	N	%
Effect on salary		
Positive	113/276	40.9% ^a
Neutral	132/276	47.8%
Negative	31/276	11.2%
Satisfaction with training		
Satisfied	250/277	90.3%
Neutral	7/277	2.5%
Unsatisfied	20/277	7.2%
Effect of duty hours on training		
Did not train under	114/277	41.2%
Positive	46/277	16.6%
Neutral	71/277	25.6%
Negative	46/277	16.6%
Would you choose to train in med-peds again?		
Likely	222/265	83.8%
Neutral	11/265	4.2%
Unlikely	32/265	12.1%
Satisfaction with work–life balance		
Satisfied	204/278	73.4% ^a
Neutral	17/278	6.1%
Unsatisfied	57/278	20.5%
Workforce retention: likelihood of reducing med-peds workload, retiring, changing jobs in the next 5 y		
Yes	45/264	17.0%
No	167/264	63.3%
Do not know	52/264	19.7%

^a Numbers do not sum to 100% because of rounding or duplicate responses.

in their first decade of practice (169/271 [62.4%] vs 438/887 [49.4%]; $P < .001$). They were also more likely to work >50 hours per week (450/893 [50.4%] vs 105/276 [38%]; $P < .001$), be employed rather than self-employed or be in a group practice model (242/278 [87.1%] vs 435/786 [55.3%]; $P < .001$), and work in an urban setting (176/295 [59.7%] vs 481/920 [52.3%]; $P = .03$). Although they were also more likely to see only adult or pediatric patients (38/229 [16.5%] vs 36/825 [4.3%]; $P < .001$), 191/229 (83.4%) still saw both adults and children in their practice.

Trends: Primary Care Physician–Hospitalists Versus Hospitalists

A significant number of the hospitalist physicians in our sample characterized

themselves as both primary care physicians and hospitalists (138/277, 49.8%). Therefore, we sought to determine whether there was a between-group difference in self-described PCP-hospitalists (generalists) and those who self-identified only as hospitalists (Table 4). We found that the hospitalist-only group was more likely to be subspecialty boarded (14/135 [10.4%] vs 5/136 [3.7%]; $P = .03$), more likely to be in their first 10 years of practice (94/135 [69.6%] vs 74/135 [54.8%]; $P = .02$), and more likely to practice in an urban setting (93/139 [66.9%] vs 74/137 [54.0%]; $P = .04$). The difference in the subspecialty certifications was probably caused by the fact that the most commonly reported fellowships were in hospice and palliative care (10 physicians) and critical care (3 pediatric, 1 adult, and 1 both pediatric and adult).

TABLE 4 Characteristics of Self-Reported Med-Peds Hospitalists Versus Nonhospitalists and Self-Reported Exclusively Hospitalists Versus Self-Reported Hospitalists and PCPs

	Hospitalists Versus Nonhospitalist Med-Peds Physicians ^a	<i>P</i> ^b	Exclusively Hospitalist Versus Hospitalist and PCP ^a	<i>P</i> ^b
Female gender	134/272 (49.3%) vs 412/891 (46.2%)	<i>P</i> = .405	63/136 (46.3%) vs 74/135 (54.8%)	<i>P</i> = .182
Is a self-reported PCP	138/277 (49.8%) vs 689/899 (76.6%)	<i>P</i> ≤ .001	N/A	N/A
Is subspecialty boarded	22/290 (7.6%) vs 229/926 (24.7%)	<i>P</i> ≤ .001	14/135 (10.4%) vs 5/136 (3.7%)	<i>P</i> = .034
Trained in the last 10 y	169/271 (62.4%) vs 438/887 (49.4%)	<i>P</i> ≤ .001	94/135 (69.6%) vs 74/135 (54.8%)	<i>P</i> = .017
Is satisfied that training prepared them for dual fields	250/277 (90.3%) vs 843/899 (93.8%)	<i>P</i> = .059	126/139 (90.6%) vs 123/137 (89.8%)	<i>P</i> = .842
Believes there is a positive salary effect of dual training	113/276 (40.9%) vs 347/894 (38.8%)	<i>P</i> = .149	56/138 (40.6%) vs 57/137 (41.6%)	<i>P</i> = .948
Works <50 h per week	105/276 (38%) vs 450/893 (50.4%)	<i>P</i> ≤ .001	55/137 (40.1%) vs 50/138 (36.2%)	<i>P</i> = .536
Sees only pediatric patients	11/229 (4.8%) vs 17/825 (2.1%)	<i>P</i> = .034	6/106 (5.7%) vs 5/122 (4.1%)	<i>P</i> = .76
Sees only adult patients	27/229 (11.8%) vs 29/825 (3.5%)	<i>P</i> ≤ .001	14/106 (13.2%) vs 13/122 (10.7%)	<i>P</i> = .682
Would train again in med-peds	228/271 (84.1%) vs 762/890 (85.6%)	<i>P</i> = .557	117/137 (85.4%) vs 111/134 (82.8%)	<i>P</i> = .620
Is satisfied with work–life balance	202/276 (73.2%) vs 664/898 (73.9%)	<i>P</i> = .815	102/139 (73.4%) vs 100/136 (73.5%)	<i>P</i> = .978
Practices in an urban setting	176/295 (59.7%) vs 481/920 (52.3%)	<i>P</i> = .032	93/139 (66.9%) vs 74/137 (54.0%)	<i>P</i> = .036
Employed (vs self-employed or group practice)	242/278 (87.1%) vs 435/786 (55.3%)	<i>P</i> ≤ .001	121/132 (91.7%) vs 105/126 (83.3%)	<i>P</i> = .058
Performed any research	36/175 (20.5%) vs 108/521 (20.7%)	<i>P</i> = .964	24/93 (25.8%) vs 12/76 (15.7%)	<i>P</i> = .133
Holds an academic appointment	121/276 (43.8%) vs 405/887 (45.7%)	<i>P</i> = .628	54/137 (39.4%) vs 66/138 (47.8%)	<i>P</i> = .182
Spends any time teaching	177/252 (70.2%) vs 463/703 (65.8%)	<i>P</i> = .212	89/125 (71.2%) vs 78/113 (69.0%)	<i>P</i> = .777
Likely to decrease workload in the next 5 y	45/264 (17%) vs 147/868 (16.9%)	<i>P</i> = .967	21/131 (16%) vs 23/132 (17.4%)	<i>P</i> = .405

^a Numbers do not sum to 100% because of rounding or duplicate responses.

^b For each item in the table, we computed a χ^2 statistic.

DISCUSSION

These survey results demonstrate the breadth of the med-peds hospitalist workforce. Though slightly more likely than their nonhospitalist counterparts to be practicing only internal medicine or pediatrics, >80% of med-peds hospitalists care for both adults and children (86/106 [81.1%] of the hospitalist-only group and 104/122 [85.2%] of the PCP-hospitalist group, *P* = .48 for a between-group difference). Additionally, >90% of med-peds hospitalists though their training had prepared them well to provide care for both groups. With regard to caring for these diverse populations in the inpatient setting, several respondents commented that they specifically felt prepared to have a career as a hospitalist, with 2 indicating they felt prepared to practice hospital medicine without a hospitalist fellowship. These comments probably reflect the rigorous inpatient training experienced by med-peds graduates, which is necessary to meet requirements for both the American Board of Internal Medicine and the American Board of Pediatrics. This versatility and

comfort in the inpatient setting makes the med-peds hospitalist an important addition to the workforce, especially in hospitals where small pediatric volumes may not support full pediatric hospitalist teams.

Remarkably, despite working more hours than their nonhospitalist med-peds colleagues, med-peds hospitalists in our sample reported levels of work–life balance satisfaction comparable to those of med-peds physicians who are not hospitalists. When queried about whether they would pursue the same career if starting over, >80% of the survey's hospitalist respondents stated that they would be “likely” to choose med-peds training again. These numbers are consistent with previous findings, including the recent report by Hinami et al⁸ in which 62.6% of hospitalist respondents reported “high satisfaction” with their job. Although our survey did not specifically explore career satisfaction, an interesting hypothesis is that the diversity of practice may allow med-peds hospitalists to avoid some of the burnout experienced by hospitalists who see only adults or only children. It is also notable that

med-peds hospitalists are more likely to have graduated more recently from medical school than other med-peds physicians, another factor that may contribute to job satisfaction.

This study has several limitations. Even with our large number of respondents, we cannot be sure how well they represent med-peds hospitalists practicing in the United States because their number, our true denominator, is unknown. Because AAP members made up the majority of respondents, it is possible that our results are biased toward physicians who see children in their practice, which may overestimate the percentage of physicians using their dual training (although >70% of respondents also belonged to the American College of Physicians). We surveyed all med-peds members of the SHM to capture hospitalists caring for adults, children, and both to address this potential source of bias. Finally, we have little knowledge of factors that may have led some recipients of the survey to respond and others to ignore the invitation, so we cannot rule out the possibility of nonresponse bias.

The med-peds hospitalist workforce represents a rapidly expanding subset of physicians who self-report being well prepared to care for both adults and children in the inpatient setting. Given that there are hospitals with pediatric volumes that are too low to support separate services, this workforce could play an increasing role in the care of hospitalized children in this country. By practicing in diverse clinical settings and locales, med-peds hospitalists are uniquely suited to augment the hospitalist workforce. The practice patterns and employment trends of this group are an interesting topic for additional study.

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