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Pediatric Hospitalists: Report of a Leadership Conference

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ABSTRACT

OBJECTIVES. To summarize a meeting of academic pediatric hospitalists and to describe the current state of the field.

METHODS. The Ambulatory Pediatric Association sponsored a meeting for academic pediatric hospitalists in November 2003. The purpose of the meeting was to discuss and to define roles of academic pediatric hospitalists, including their roles as clinicians, educators, and researchers, and to discuss organizational issues and unique hospitalist issues within general academic pediatrics. Workshops were held in the areas of organization and administration, academic life, research, and education. A literature review was also conducted in the areas discussed.

RESULTS. More than 130 physicians attended. Thirteen workshops were held, and all information was summarized in large-group sessions for all attendees.

CONCLUSIONS. Pediatric hospital medicine is a rapidly growing field, with an estimated 800 to 1000 pediatric hospitalists currently practicing. Initial work has defined the clinical environment and has begun to stake out a unique knowledge and skill set. The Pediatric Hospitalists in Academic Settings conference demonstrated the audience for additional development and the resources to move forward.
Pediatric hospitalist jobs have grown in scope as well as number. Early hospitalist positions were almost entirely clinical, created to increase hospital efficiency. Clinical expertise in inpatient medicine remains the cornerstone of hospitalists’ identity, but participation in education, systems improvements, administration, and scholarly work, particularly in academic settings, has become common.

It is in this context that the Ambulatory Pediatric Association convened a conference at which hospitalists from the United States and Canada gathered to define and to promote the field of pediatric hospitalists in academic settings. The meeting in San Antonio, Texas, in November 2003, was attended by >130 medical professionals.

Workshop objectives were to (1) define the pediatric hospitalist role, (2) understand how to integrate hospitalists into general pediatrics divisions, (3) view the hospitalist in a variety of teaching roles, and (4) determine the next steps for organizing this new specialty area. Workshops were held in the areas of organization/administration, academic life, research, and education. Presented here are the results of that meeting, as a statement of the current state of the field and how it is likely to evolve.

DEFINITION AND DEMOGRAPHIC CHARACTERISTICS

“The general pediatrician who specializes in inpatient practice rides the wave of the future.” As Dr Menna was writing that article in 1990, there was already emerging evidence that inpatient care was being managed by a limited subset of pediatricians. This was followed by the 1996 landmark article by Robert Wachter and Lee Goldman that introduced the term “hospitalist.” Later, Dr Wachter offered the following definition: “physicians who spend at least 25% of their time serving as the physician of record for hospitalized patients who have been referred by primary care physicians and who are referred back to their primary care physicians at the time of discharge.”

Pediatric hospital medicine is growing at a rapid pace. Fully 50% of academic pediatric departments had adopted hospitalist systems by 1999, and nearly 80% were expected to have hospitalist systems within the next several years. The Society of Hospital Medicine, which includes both adult and pediatric hospitalists, grew from 23 members in 1997 to 4300 in 2004. It is estimated that 10% of the 10 000 to 12 000 hospitalists currently in practice are pediatricians. A study of workforce needs has projected that ultimately 30 000 hospitalists will be required if they assume the care of all inpatients in the United States.

Currently, 35% of pediatric hospitalists work in academic settings. Most of these hospitalists are part of the general pediatrics division. Nationally, 45% of general pediatrics divisions have clinical responsibilities in the inpatient units. Some hospitalists are a part of the critical care or emergency medicine divisions, and a few have formed their own divisions. Having one’s own division makes it more evident that inpatient issues are prioritized. One barrier to having independent divisions is the limited number of faculty members. At the conference, the consensus was that staying in the general pediatrics division is the best choice currently, for logistical reasons. In addition, hospitalists share common goals and backgrounds with other academic generalists, in both their clinical and scholarly work.

CLINICAL ISSUES

Pediatric hospitalists differentiate themselves from other primary care and specialty pediatricians because of the amount of time spent caring for patients in the inpatient units, as well as their expertise. Hospitalists are specialists in providing inpatient care for children with common pediatric disorders but also in consulting on and coordinating care with subspecialists for complex cases and in stabilizing the condition of acutely ill children. The pediatric hospitalist model differs from that of traditional ward attending physicians, who spend 1 or 2 months on service but spend the majority of their time in their clinics. The hospitalist’s clinical and nonclinical focus is to improve the care of hospitalized patients by addressing systems issues such as timeliness and necessity for admission, discharge planning, communication, coordination of care, quality of care, patient safety, utilization review, education, and research.

The pediatric hospitalist’s clinical roles in providing direct patient care and improving systems of care are the driving forces for the movement in pediatrics, just as in internal medicine. However, the term “hospitalist” holds different meanings in different institutions. In a recent survey, there was marked variability in the job description of hospitalists working in different settings around the country. On average, hospitalists spend 75 ± 32% of their time engaged in inpatient clinical work. Some work exclusively in general inpatient units, whereas others spend part of their time in specialty wards, the emergency department, the NICU, and primary care clinics. Some work in community hospitals, others in major academic centers. Some have subspecialty training and some do not.

Pediatric hospitalist staffing models include traditional 2- to 4-week blocks of daytime in-house coverage with night call at home, 8- to 24-hour shifts without home call, and hybrid models. Academic hospitalists typically work with housestaff members, but staff-only hospitalist models also exist. An advantage of the shift model is that patients can be treated and billed 24 hours per day, in contrast to noncompensated calls from home. Another advantage is that work time and nonwork time are defined more clearly so that there is less potential for “job creep,” with nonclinical responsibilities encroaching.
on free time. Generally the shift model does not give credit for nonclinical work, especially research and teaching, which are necessary for academic career advancement. There is also greater continuity of care with the traditional staffing model.

A hospitalist must devote enough time to have the knowledge and skill to provide expert care for hospitalized patients with complex conditions, to decrease morbidity and mortality rates, to decrease costs and to improve satisfaction for patients, hospitals, and primary care pediatricians, and to support the transition from inpatient care to outpatient care. This may require more on-service time, to develop knowledge and skills, for a novice hospitalist than for a more experienced clinician. Twelve weeks was a suggested minimal amount of time, in keeping with the definition of a hospitalist, as derived from discussions at the conference and review of the national data.3

The Pediatric Hospitalist Section of the Society of Hospital Medicine has established a task force to define core competencies. Examples of clinical competencies include stabilization of critically ill patients, evidence-based management of common inpatient conditions, pain management and procedural sedation, inpatient care of technology-dependent patients with complex conditions, communication with primary care providers and families, coordination of care with specialists, and discharge planning.

A common challenge facing hospitalists is the issue of being the primary attending physician, as opposed to being a consultant. Practices vary substantially. In some programs, the operating premise is that nearly all or all patients are admitted to the hospitalist service and specialists are always the consultants. In other institutions, the hospitalist serves as the primary attending physician when the primary problem is in general pediatrics or when many services are involved and the hospitalist coordinates the overall care. The following principles should be considered when determining which service model to use. (1) Quality of care should be the key issue that determines the primary service. (2) Hospitalists can improve care in most situations. (3) The hospitalist should be an active voice in seeking the best care and facilitating communication among all of those involved.

Excellent communication among physicians and other hospital and community health care providers is critical to both the effectiveness and the acceptability of evolving hospitalist systems. A recent study underscored the need to tailor hospitalist systems to address this issue.10 Sixty percent of community physicians expressed concern that a pediatric hospitalist system might affect the doctor-patient relationship adversely. Although community physicians were approximately equally divided regarding the belief that a hospitalist service improves quality of care, one half also found caring for hospitalized patients to be an inefficient use of their time and 98% (significantly more than hospital-based physicians) were less comfortable caring for inpatients than outpatients.10 In a similar study among internists before and 2 years after implementation of a hospitalist system, hospital-affiliated physicians expressed significantly more favorable beliefs over time about the impact of the hospitalist system on their own relationships with patients and on quality of care.11 In a California survey of primary care physicians, respondents perceived hospitalists as improving (41%) or not changing (44%) the overall quality of care.12

There are wide variations among hospitalist systems around the country. It is possible that some will prove advantageous while others will not. Program success will be affected by differences in personnel and in the organization of care. Determining an appropriate amount of time on service should not be based solely on financial criteria but should consider other factors, such as the complexity of cases, whether residents and students are involved, and the number of hours of in-house coverage. Resources for calculating staffing needs, such as a manual titled Hospitalist Program Financial Fundamentals from the Advisory Board Company, are useful for understanding staffing issues (copies can be obtained at www.advisoryboardcompany.com).

Sharing results among institutions is essential. Descriptions of individual programs, such as the description of the hospitalist system at the University of Cincinnati by Bellet and Whitaker,14 provide a foundation for future studies. Ultimately a systematic characterization of hospitalist systems will be required, to compare different systems rationally.15 The structure of the hospital and the nature of its services, demographic features, and case mixture, competitiveness of the local health care environment, the nature of reimbursement systems, and interactions of hospitalists with other health care providers should all be studied carefully. Incentive systems for hospitalists may also affect performance. Determining the satisfaction of the diverse stakeholders affected by pediatric hospitalists will be necessary to define success.

EDUCATION

Students and Residents
Many hospitalists derive their academic identity primarily from their role in teaching trainees on the hospital units16 and in directing training programs.8 Training future hospitalists and directing continuing medical education (CME) programs to enable current hospitalists to update their knowledge and skills are emerging educational opportunities.

The literature suggests that hospitalists possess essential skills for teaching effectively.17,18 To be most effective, a hospitalist must be able to teach key concepts within the context of patient care. The ability to “think in the
midst of action”19 and to demonstrate “careful listening, with limited clarifying questioning.”20 as well as using “a patient-oriented approach”21 and “being supportive of the learning process,”22 are crucial to success. Teaching methods and formats used include small-group facilitation, reflection, provision of feedback,23 use of teaching scripts,24 different types of questioning (broadening, justifying, hypothetical, and alternative),20,21 and modeling processes such as interdisciplinary coordination.

Precepting and providing timely feedback to individuals and teaching groups of learners at different levels, while providing family-centered, effective, and efficient patient care, are challenges to the hospitalist. Teaching trainees how to present cases efficiently while assessing and addressing their learning needs during morning rounds is an example of such a challenge. Presenting a case requires sophisticated communication and clinical decision-making skills. Trainees must learn to organize and sequence data and must understand how key features of the presenting problem relate to the differential diagnosis in order to present the pertinent positive and negative findings of the case.

Bedside teaching is a challenging but highly regarded teaching format for most trainees and hospitalists, because it provides a patient-centered focus for teaching. The attending physician can observe trainees’ skills in eliciting interesting examination findings and can model skills such as how to elicit missing historical data. Another advantage to conducting rounds at the bedside is that the family hears a consistent message from the whole team, and it is defined clearly that the doctor has seen the patient. Timing bedside rounds so that the patient is available and is willing to be examined can be a challenge. Preparation is crucial, to gain the patient’s and parent’s permission to include them and to gain an understanding of what aspects of the case should be saved for private discussion with the attending physician. Large teams with high censuses may need to limit bedside rounds to 1 or 2 new patients. The hospitalists’ availability to interact with trainees and to observe their patient encounters because of their greater presence on the unit, compared with colleagues who leave to treat patients in the clinic, is perceived as an advantage by interns, whereas some senior residents expressed concern that hospitalists usurp their authority to make independent decisions.23,25 Managing the dynamics of leading a multidisciplinary team while promoting leadership skills among senior residents is another challenge.

Although hospitalists offer a generalist perspective toward education, care must be taken to incorporate subspecialists into the teaching milieu, so that trainees can learn from their expertise, and to expose trainees to other career models.26 Content areas taught by hospitalists include expertise in inpatient care (disease management, transition to outpatient care, and procedures), evidence-based medicine (clinical queries, use of the literature, and pathway development/best practices), and resource utilization (diagnostic testing, costs, consultants, and efficiency in using the hospital’s services).

Teaching about communication with colleagues, especially effective “hand-off” communication at admission and discharge, is another area in which hospitalists can lead educational efforts. Assessing trainees’ acquisition of the new Accreditation Council for Graduate Medical Education competencies is an important and evolving educational need. Preliminary data suggest that hospitalists may be able to assume a key role in this assessment.27

Hospitalists are the ideal faculty members to teach medical students and residents on inpatient units, but the environment in which they teach offers challenges that necessitate postresidency training. To be most successful, institutions enlisting hospitalists to teach trainees must be willing to support faculty development and to provide compensated time for planning, implementing, and evaluating teaching activities.

Fellowships and CME
Although a survey of pediatric department chairs revealed that few thought that additional training was required beyond a basic pediatric residency,4 this was disputed by a recent survey of those in the field. Recently, 92% of pediatric hospitalists surveyed through the Pediatric Research in Inpatient Settings (PRIS) Network wanted additional training beyond residency.8 The type of postresidency training desired depended on the area assessed. Respondents were most comfortable with their clinical training and rated creating a special track during residency as the preferred method to teach these skills. Greater skill in performing critical care procedures was rated as the most needed area. A pediatric hospitalist fellowship was rated as the best way to learn necessary skills in teaching, research, and administration.

The dearth of formal postresidency training programs and lack of credentialing are barriers to decreasing practice variability and ensuring professional competence and quality for pediatric hospitalists. Board certification by the American Board of Pediatrics is unlikely in the near future. Partly because of a lack of board certification, obtaining funding for current fellowships or training programs is a challenge. Currently, most programs are funded on the basis of clinical revenue generated from direct patient care by trainees, who are treated as junior faculty members with ample clinical and nonclinical mentorship. It is difficult for trainees to balance the clinical requirements necessary to generate sufficient revenue to support their salaries while devoting time to mastering nonclinical skills crucial to long-term academic success.

The Children’s National Medical Center and Boston Children’s Hospital began the first pediatric hospitalist training programs in July 2003, with Children’s Hospital
of San Diego and the Hospital for Sick Children in Toronto beginning programs in July 2004. These programs are 2 years in duration and combine clinical and non-clinical education and skill training. Each program has \(~24\) weeks of clinical work each year, including gaining greater expertise in evidence-based management of common inpatient pediatric illnesses and receiving additional training in critical care procedures and principles of stabilization, transport, and initial treatment of critically ill patients.

Administrative training includes gaining an understanding of the quality improvement process and membership on hospital committees. Formal financial training includes proper billing and day-to-day management of the service and third-party payers. Leadership training is also woven into the daily clinical work of leading an inpatient team, as well as learning how to assume leadership roles on hospital committees.

Principles of adult learning theory, providing proper orientation and feedback, and balancing senior resident autonomy with that of the attending hospitalist are components of the educational portion of the curriculum. Additional teaching skills training includes how to teach/model evidence-based practice most effectively and teaching in settings common to hospitalist practice.

Formal research training includes courses in epidemiology, biostatistics, decision analysis, and health policy. These courses are taught in collaboration with an affiliated school of public health, emphasizing health outcomes research. Under the mentorship of a more experienced researcher, fellows are expected to design and to implement a research project, to evaluate the results, and to present the results at a national meeting by the completion of the second year of training. Fellows can also obtain a master’s degree in public health during the course of their training.

To meet certification by the American Board of Pediatrics, training programs would need to expand from 2 years to 3 years and fellows would be required to produce scholarly work by the conclusion of their training. The same type of training may not fit well for pediatric hospitalists in nonacademic hospitals.

CME courses should enable current hospitalists to advance and to maintain their skill sets independently. Lifelong learning is the solution, as it is in most areas of medicine. Current resources include meetings with a focus for hospitalists, meetings with a focus on topics of interest, advanced training in management, research, and/or education, topics/skills discussed at division meetings, ongoing learning with other physicians (in the group and from other disciplines), fellowship experiences, and the American Academy of Pediatrics Section on Hospital Medicine listserv.

Proposed, tangible, 5-year goals to meet the CME goals of pediatric hospitalists are arrangement of a jointly sponsored, multiday, hospitalist/inpatient pediatric re-

view, continued hospitalist programming at individual meetings (Society of Hospital Medicine, American Academy of Pediatrics, and Ambulatory Pediatric Association meetings), regional pediatric hospitalist activities that are multi-institutional and hospitalist driven, promotion of the publication of important research, making use of the electronic word, and PRIS Network participation to hone research skills. Visionary 5-year goals are developing self-declared competencies for pediatric hospitalists, working with the American Board of Pediatrics to emphasize inclusion of appropriate inpatient subject matter on written tests of cognitive knowledge and demonstration of self-monitored quality improvement activities, and exploring ways to maintain and to document procedural competency.

**RESEARCH AND QUALITY IMPROVEMENT**

Studies have begun to reveal the impact and mechanisms through which hospitalist systems can contribute to the 6 aims for quality improvement in the US health system proposed by the Institute of Medicine,\(^28\) ie, that care be safe, effective, patient-centered, timely, efficient, and equitable. To realize these goals fully, extensive research into the processes and outcomes of inpatient care will be needed. Pediatric hospitalists are uniquely positioned to create dramatic improvements in the care of hospitalized children, provided they are afforded adequate tools, time, and resources. This new cadre of generalists with a primary focus on inpatient care can be expected to demonstrate expertise in managing conditions seen infrequently by community pediatricians, to become proficient in communication and navigation through a hospital’s systems, and to monitor inpatient treatment and progress closely.\(^29\) Furthermore, they have an opportunity to conduct research to improve the quality of inpatient care and are positioned to adopt emerging research and quality improvement approaches to make lasting improvements.\(^30\)

The earliest pediatric hospitalist studies focused on the characteristics and rapid emergence of pediatric hospitalist systems\(^4,13\) and their increases in timeliness and efficiency. A preponderance of these reports showed that length of stay and cost per case were 9% to 16% lower in pediatric hospitalist systems than in traditional systems, with no difference observed in mortality among hospitals, hospitalists, and other stakeholders related.

Financial gains from increased throughput (patients discharged per unit time) can be substantial.\(^36\) The financial distribution of these gains among hospitals, hospitalists, and other stakeholders remains unstudied.

The need and opportunities for hospitalists to design
and to study proposed improvements in safety and effectiveness of care are clear. Research is needed to extend the evidence base and to increase uptake of evidence-based medicine for both common and unusual conditions treated by hospitalists. Wide variation in the management of even the most common inpatient pediatric conditions has been documented. The inpatient management of many common conditions, such as bronchiolitis and complex pneumonia, remains understudied. Moreover, safety and quality issues across the spectrum of inpatient conditions require additional study. Medication errors occur in the pathway of >1 in 20 inpatient pediatric drug orders. Only 5 of 40 controlled trials of quality improvement efforts for children published between 1980 and 1998 addressed inpatient problems. Although new process and outcome measures, both general and disease-specific, are emerging, pediatric quality measures are challenging to develop and are particularly lacking in the areas of safety, chronic illness, end-of-life care, and disparities.

Patient-centered care deserves study in hospitalist systems, particularly with respect to coordination of care. Problems in discharge planning, coordination of care, and lack of information given to the child are the concerns most frequently expressed by parents about their children’s care in hospitals. In both a local study and a national study, parent communication problems were correlated most strongly with parents’ less favorable ratings of overall quality of care.

Finally, research is needed to ensure high-quality care for our most vulnerable children, including children with special health care needs with medically complex conditions and those who may experience inequities related to race, ethnicity, or poverty. Children with disabilities experience 4 times the number of hospitalizations and 8 times as many hospital days as other children, increasing their exposure to potential mishaps. Because children with disabilities receive 3 times as many prescribed medications as other children, they are at increased risk for medication errors. The 7.3% of US children with disabilities accounted for 22.7% of health care expenditures for all children in 1999 to 2000. Among the more broadly defined 12.8% of children with special health care needs, only 67% of families (and only 50% of those who were poor) reported receiving family-centered care, and many lacked effective care coordination when it was needed. Newly developed measurement tools such as the Barriers to Care Questionnaire will be useful in this regard. Pediatric hospitalists have the opportunity to address the requirements of these widely dispersed children who share hospitalization as a common need. By focusing research on improving care for highly vulnerable children, we can design interventions that may enhance care and outcomes for these children and others as well.

Studies of interventions to improve the management of inpatient diseases and studies of the overall quality, processes, and outcomes of hospital care are essential. Much of this work will be possible in individual hospitals, but effective research into many unusual conditions, or unusual outcomes of common conditions, will require larger, collaborative, research efforts. The PRIS Network is a newly formed research network of pediatric hospitalists, whose mission is to improve the care of hospitalized children by developing the evidence base for inpatient pediatric care. To date, it has produced studies of hospitalist training needs, finances, and care variability. It plans to conduct large, multi-institutional studies of inpatient pediatric care, which to date has been addressed inadequately through smaller studies. The PRIS Network and similar collaborative efforts provide an important avenue through which hospitalists can become directly involved in generating new knowledge to improve care. Generation of such an evidence base represents an important new direction for research by hospitalists that should lead to breakthroughs in the care of hospitalized children in the years to come.

FINANCIAL ISSUES
There are 2 “facts” that best capture the current financial state of hospital medicine across the country. (1) As measured by the number of people who call themselves hospitalists, hospital medicine is growing at an incredibly fast rate. (2) The overwhelming majority of hospitalist programs depend on some sort of external funding beyond the revenues they generate to support their program. At first glance, these statements seem to be completely contradictory. How can programs that are apparently losing so much money be thriving as well as they are?

Even a more-detailed look at the finances of running a hospitalist program seems to support the notion that programs are destined to lose money. A single hospitalist, salaried at $130 000 per year, who generates $10 000 to $15 000 dollars in postexpense collections monthly would have to be on service 12 to 17 months per year to support his or her own salary with fringe benefits. Given this “losing equation,” it is interesting that hospitalist programs continue to grow in number across the country.

A review of other measures of value is necessary to reveal that hospitalist programs are beneficial to a health care system’s finances. One such measure is adjusted length of stay (ALOS). In a capitated system, reducing ALOS saves money because the hospital spends less per patient admission while receiving a “fixed” income. In a fee-for-service system, revenues actually can decrease for any given patient as ALOS is reduced (ie, billing for fewer days). However, this loss is offset by increased hospital throughput, which results in either more initial assessments (which are billed at a higher rate) or increased numbers of revenue-generating admissions (eg.
operations). Through 2002, the overwhelming majority of studies on the effect of hospitalist systems showed a benefit in reducing ALOS. The 2 studies that showed no difference both used “quasi-hospitalist” control groups and were in reality comparing one hospitalist program with another.

Finally, hospitalist programs create savings for those who no longer need to care for the hospitalized patients. As an example, the Advisory Board Company in 2002 estimated that a practitioner could generate an additional $20 000 to $40 000 annually simply by not taking the time to come in and perform rounds but spending that time seeing patients in the office.

It is still the fiscal responsibility of a hospitalist program to come as close as possible to being revenue neutral or revenue positive. There are 3 basic strategies to reach this goal. First, the revenue received for the services provided currently must be maximized, which can be done in many ways. Hospitalists can develop process improvement and performance measurement initiatives for billing and collections, ensuring timely adequate collections. Using selected technology to assist in billing, developing strategies to collect self-pay balances, and changing operational practices to fulfill the needs of third-party payers all are methods to increase reimbursement. Developing, monitoring, and supporting a quality-driven compliance program and creating strategies for denial management and prevention also help.

Second, the number of revenue-generating clinical services can be expanded. Certainly expanding into new markets and increasing referrals can generate a larger volume of patients. Consultation to other medical and surgical services and coverage of other units or clinics (such as the emergency department, newborn nursery/delivery room, second-opinion clinic, urgent care, and ICU) also can increase volume. Pain control is a Joint Commission on Accreditation of Healthcare Organizations focus; therefore, a procedural sedation service may be welcomed by the institution. Follow-up care of previously admitted patients is another possibility, but one that must be addressed carefully with the referring physicians.

Third, a program can seek revenue from external sources, either from research or from other nonclinical services. Research funding is available from the National Institutes of Health and other government programs, national programs, foundations, or collaborative research groups, industry, and locally initiated programs through the hospital/medical center/health network/medical school. Nonclinical services that can produce revenue include program or clerkship directorships, quality-of-care initiatives, patient safety initiatives, risk management, information technology, and utilization review. All of these tasks must be performed by the hospital, and hospitalists are clearly best positioned to perform them. These tasks also represent considerable effort and time spent that should be valued by the hospital.

CONCLUSIONS

With an estimated 800 to 1000 pediatric hospitalists, the field is already as large or larger than 8 American Board of Pediatrics–certified subspecialties, and it would qualify as the fastest growing subspecialty. The early stages of pediatric hospital medicine have mirrored the development of emergency medicine and critical care medicine, in defining a clinical environment and beginning to stake out a separate knowledge and skill set. The San Antonio conference demonstrated the audience for additional development and the resources to move forward.

Many of the next steps have already been outlined. More conferences, textbooks, and specialty training and an emerging literature are already happening. For individuals who have chosen this field as a career, the challenge is to be recognized as a hospitalist in the course of advancement, so that there will be a core of senior faculty members to mentor tomorrow’s residents and students. The character of this emerging field is still being shaped. It is our hope that pediatric hospitalists will remain aligned closely with general pediatrics, as a “branch” of the “pediatric tree.”

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REFERENCES


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**LACKLUSTRE TRIAL FINDINGS**

“Sessions at the major heart associations’ annual meetings featuring ‘late-breaking’ results from clinical trials are highly anticipated occasions offering clinicians glimpses at important findings that could have practice-changing implications. But at the American Heart Association’s (AHA’s) annual meeting in Dallas, the perception, at least among some attendees, was that for an unusually large number of ‘late-breaking’ clinical trials that were given the spotlight, researchers found no benefit from the intervention being studied. For some, the occasion raised interesting questions: Does the relative dearth of positive findings emerging from a number of current therapeutic trials signal some type of shift for cardiovascular disease research or is it merely an aberration? And, given the history of sponsors failing to publish negative trial results, is this a move to more openness?”

*Mitka M. JAMA.* 2006;295:611

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