Published in final edited form as:

Hosp Pediatr. 2012 October 1; 2(4): 187–190. doi:10.1542/hpeds.2012-0048.

The Strategic Planning Committee Report: The First Step in a Journey to Recognize Pediatric Hospital Medicine as a Distinct Discipline

Christopher G. Maloney, MD, PhD¹, Suzanne Swanson Mendez, MD², Ricardo A. Quinonez, MD³, Ryan S. Bode, MD⁴, Chad K. Brands, MD⁵, Steven Eagle, MD⁶, Snezana Nena Osorio, MD, MS⁷, Daniel Rauch, MD⁸, and Tamara D. Simon, MD, MSPH^{9,10}

¹Department of Pediatrics, University of Utah/Primary Children's Medical Center, Salt Lake City, Utah

²Department of Pediatrics, Santa Clara Valley Medical Center, San Jose, California

³Section of Pediatric Hospital Medicine, Department of Pediatrics, Baylor College of Medicine/Texas Children's Hospital, Houston, Texas

⁴Phoenix Children's Hospital, Phoenix, Arizona

⁵Office of Medical Education, All Children's Hospital Johns Hopkins Medicine, St. Petersburg, Florida

⁶Department of Pediatrics, Hackensack University Medical Center, Hackensack, New Jersey

⁷Department of Pediatrics, The New York Presbyterian-Weill Cornell Medical Center, New York, New York

⁸Department of Pediatrics, Mount Sinai School of Medicine/Elmhurst Hospital Center, New York, New York

⁹Department of Pediatrics, University of Washington/Seattle Children's Hospital, Seattle, Washington

¹⁰Seattle Children's Hospital Research Institute, Seattle, Washington

Abstract

The field of pediatric hospital medicine (PHM) has experienced phenomenal growth over the past decade. Academic contributions by pediatric hospitalists include the creation of PHM core competencies,¹ national collaborative PHM networks for both research (the Pediatric Research in

Copyright © 2012 by the American Academy of Pediatrics

Drs Maloney and Mendez shared first coauthorship and cochairmanship.

FINANCIAL DISCLOSURE: Dr Rauch has served as a consultant for Baxter Pharmaceuticals. Ongoing support for Dr Simon includes award K23NS062900 from the National Institute of Neurologic Disorders and Stroke, Seattle Children's Center for Clinical and Translational Research and CTSA grant ULI RR025014 from the National Center for Research Resources (NCRR), a component of the National Institutes of Health (NIH), and the Child Health Corporation of America via the Pediatric Research in Inpatient Setting Network Executive Council. The other authors have indicated they have no financial relationships relevant to this article to disclose. None of the sponsors participated in design and conduct of the study; collection, management, analysis, and interpretation of the data; or preparation, review, or approval of the manuscript. Its contents are solely the responsibility of the authors and do not necessarily represent the official view of the NCRR or NIH.

Inpatient Settings network²) and quality improvement (the Value in Inpatient Pediatrics network³), a robust and well-attended annual scientific meeting,⁴ and an increasing number of divisions or sections of PHM in pediatric departments across the country. Many pediatricians are choosing to pursue careers in PHM,^{5,6} and several postgraduate training programs for PHM have emerged.⁷ Similar to other generalist pediatric fields,⁸⁻¹¹ the question as to how best for PHM to evolve as a distinct discipline has arisen. Several training and/or certification options are feasible and have been examined by the pediatric hospitalists who constitute the Strategic Planning (STP) Committee. The objectives of this commentary are to (1) describe the work done to investigate these options to date, (2) provide a framework for evaluating them, and (3) describe next steps. This commentary will neither justify subspecialty status for PHM, which is currently still debated within the field, nor will it compare the development of PHM as a subspecialty with other generalist fields because such a comparison is premature.

THE STP COMMITTEE PROCESS

In an effort to achieve adequate representation among a highly diverse community, a group of hospitalist leaders¹² requested volunteers from the PHM community to join the STP Committee in September 2010. In December 2010, STP Committee cochairs were selected from the volunteers. Cochair selection was achieved by consensus among 1 representative from each of the 3 societies of PHM: the American Academy of Pediatrics Section on Hospital Medicine (AAP SOHM), Academic Pediatric Association (APA), and the Society of Hospital Medicine (SHM).

The goal of the STP Committee was to evaluate the training and/or certification options for PHM to proceed as a distinct discipline. Core values of the STP Committee included having input from all diverse constituents that comprise practicing pediatric hospitalists, as well as functioning in a self-reflective, transparent, and engaged fashion.

STP cochairs asked the nearly 50 other volunteers to draft their individual vision of the future of PHM in terms of sub-specialty status and training. The 37 who responded made up the earliest STP Committee; an additional 8 members were identified during the July 2011 survey described below, bringing the committee total to 45 members. These 28 women and 17 men represent 36 academic and community hospitals in 22 states and Canada.

STP cochairs identified 4 themes from the respondents' vision statements (traditional subspecialty certification, extra training, residency track, and no change) and subcommittees were created based on these themes. The STP Steering Committee, consisting of the overall and subcommittee cochairs, was also created. Each subcommittee further explored potential training and/or certification options under their theme, which are shown in Table 1. The groups used a modified Delphi method to create "Strengths, Weaknesses, Opportunities, and Threats" (SWOT) analyses for each training option. Work was conducted over the next 6 months through conference calls and in-person meetings.

Over a 2-week period in early July 2011, the STP Committee distributed a survey to the PHM community through listserves of the 3 sponsoring societies of PHM: the APA, the AAP SOHM, and the SHM. The survey asked respondents which training and/or

certification option in Table 1 they preferred and if they wanted to participate on the STP Committee. Of the 132 respondents in this convenience sample, 33% preferred Recognition of Focused Practice, 30% opted for a 2-year fellowship with subspecialty designation, and 17% chose a hospital medicine track within pediatric residency.

In late July 2011, the STP Committee's SWOT analyses and survey findings were presented at the PHM annual conference. Feedback was to revise the SWOT analyses into a pro/con format and to include the 2 options that had not yet been well explored, the Recognition of Focused Practice and the 2-year fellowship. Over the next several months, the STP subcommittees and Steering Committee integrated the feedback and created revised documents presenting a list of pros and cons for each training and/or certification option.

On March 5, 2012, the STP Steering Committee distributed updates to the 3 sponsoring societies' listserves. The full report, including more detail about each option outlined in Table 1, is available at <http://stpcommittee.blogspot.com/>.

THE STP COMMITTEE FINDINGS: A FRAMEWORK FOR EVALUATING PHM TRAINING AND/OR CERTIFICATION OPTIONS

During this dynamic time in medicine, we must develop robust strategies to ensure an adequate workforce with appropriate skills to advance the practice of PHM. The field emerged because of increasing complexity of hospitalized children and hospital systems¹³ and reimbursement driving compartmentalization of general pediatricians to either the ambulatory or inpatient setting. Furthermore, PHM is evolving both within, and in many ways as a result of, large-scale changes in pediatric residency training. These changes include but are not limited to duty-hour restrictions, increasing scope and breadth of attending supervision, and the call for individualized resident education. Also, we need more research and quality improvement efforts in the inpatient setting.¹⁴ Our field must be positioned to continue to evolve within constant change.

In considering an evolution to require training beyond pediatric residency, PHM must identify the unique set of skills and body of knowledge that are needed to practice PHM that are not obtained during pediatric residency. Currently, pediatric hospitalists obtain expertise during the early years of practice that could instead be obtained during postresidency training in areas including, but not limited to, advanced clinical skills such as sedation, research, teaching skills, quality improvement, and business management.

Although a natural first reaction is to focus on what each option means for an individual already within the field, any proposed training and/or certification option will need to provide a mechanism for certification for those with suitable experience (eg, a "grandfathering" mechanism for those already in the field). Instead, these options must be evaluated in the context of the future of our field and should not be limited by any current lack of formal training opportunities.

Of note, the training and/or certification options are not necessarily mutually exclusive of one another. The impact of each training and/or certification option on the existing and

future workforce, the opportunity costs for future physicians embarking upon additional training, and the cost to the organizations training future pediatric hospitalists were considered by the STP Committee. Finally, the impact of each training and/or certification option on hospitalized children is of prime importance.

NEXT STEPS

We believe the STP Committee's work to date to be as representative of the PHM community as possible. Moving forward, continued feedback from practicing and future pediatric hospitalists is essential.

When the STP Committee presented at the PHM meeting in July 2011, initial feedback was that the material needed to be reviewed by the broader community. The STP Committee has now responded with its report for comment by the PHM community and is requesting public comments at <http://stpcommittee.blogspot.com/> and private feedback by e-mail at PHM.StrategicPlanning@gmail.com. Two "Charting the Future" sessions at the PHM meeting in July 2012 provided a forum for additional public discussions, and a clear majority felt the field should move forward soon.

The newly created Joint Council of Pediatric Hospital Medicine, consisting of representatives from the APA, AAP SOHM, and SHM, as well as the Pediatric Research in Inpatient Settings network and several still-to-be-elected at-large members, has received the STP Committee's report. In the interim, each society's representatives are reviewing options and soliciting feedback from the leadership of the APA, AAP, and SHM. The STP Committee will collate all comments during the spring and summer of 2012 into a final report. The Joint Council of Pediatric Hospital Medicine will use the final report and information from the discussions within the PHM community and the sponsoring societies to prioritize options and pursue appropriate next steps.

Acknowledgments

The authors are grateful for the efforts of the STP Committee, cochaired by Chris Maloney and Suzanne Swanson Mendez. Members are listed below in alphabetical order following the name of each subcommittee and its cochairs. Traditional subspecialty certification: Cochaired by Chad Brands and Clifford Chen; members included Lindsay Chase, Shelley Collins, Munirah Curtis, Carrie Daymont, Jane Everist, Paul Fu Jr, Robyn Kuroki, Rachel Marek, Mary Ann Queen, Ricardo Quinonez, Geeta Singhal, Eric D. Thompson, Stephen Whitney, and Kelly Wood. Extra training: Cochaired by Ruben Nazario and Snezana Nena Osorio; members included Justen Aprile, Karen Jerardi, Martha Nicholson, James O'Callaghan, Stacy Pierson, Patricia D. Quigley, Mahesh Sharman, Joyee Goswami Vachani, Diji Vaughan, and Kavita Warriar. Residency track: Cochaired by Ryan S. Bode and Tetyana Vasylyeva; members included Francine Bynum, Alex Hamling, Marta King, Sangeeta Krishna, Kenneth Pituch, Jasna Sesarinac, and Angela F. Veesenmeyer. No change: Cochaired by Steven Eagle and Nora Esteban-Cruciani; members included Jeff Brown, Barrett Fromme, Amy Hepper, Erin Leopold, Michael Rinke, and Wendy Van Ittersum.

References

1. Stucky ER, Maniscalco J, Ottolini MC, et al. The Pediatric Hospital Medicine Core Competencies Supplement: a Framework for Curriculum Development by the Society of Hospital Medicine with acknowledgement to pediatric hospitalists from the American Academy of Pediatrics and the Academic Pediatric Association. *J Hosp Med.* 2010; 5(suppl 2):i–xv. 1–114. [PubMed: 20440783]
2. PRIS. Pediatric research in inpatient settings. [June 30, 2012] Available at: www.prisnetwork.org/
3. Value in Inpatient Pediatrics Network. [June 30, 2012] Available at: www.vipnetwork.webs.com/

4. Academic Pediatric Association. [June 30, 2012] Pediatric Hospital Medicine 2012. Available at: www.ambpeds.org/PHM2012/hospitalmed.cfm
5. Freed GL, Brzoznowski K, Neighbors K, Lakhani I. American Board of Pediatrics, Research Advisory Committee. Characteristics of the pediatric hospitalist work-force: its roles and work environment. *Pediatrics*. 2007; 120(1):33–39. [PubMed: 17606559]
6. Freed GL, Dunham KM. Research Advisory Committee of the American Board of Pediatrics. Pediatric hospitalists: training, current practice, and career goals. *J Hosp Med*. 2009; 4(3):179–186. [PubMed: 19301370]
7. American Academy of Pediatrics. [June 30, 2012] Section on Hospital Medicine: professional opportunities. Available at: <http://www2.aap.org/sections/hospcare/hospcareprof.htm>
8. Epstein D, Brill JE. A history of pediatric critical care medicine. *Pediatr Res*. 2005; 58(5):987–996. [PubMed: 16183804]
9. Shulman ST. The history of pediatric infectious diseases. *Pediatr Res*. 2004; 55(1):163–176. [PubMed: 14605240]
10. Alderman EM, Rieder J, Cohen MI. The history of adolescent medicine. *Pediatr Res*. 2003; 54(1):137–147. [PubMed: 12672903]
11. Barkin RM, Rosen P. An evolving new expertise: pediatric emergency medicine. *J Emerg Med*. 1988; 6(6):545. [PubMed: 3221071]
12. Rauch DA, Lye PS, Carlson D, et al. Pediatric hospital medicine: a strategic planning roundtable to chart the future. *J Hosp Med*. 2012; 7(4):329–334. [PubMed: 21994159]
13. Srivastava R, Stone BL, Murphy NA. Hospitalist care of the medically complex child. *Pediatr Clin North Am*. 2005; 52(4):1165–1187. x. [PubMed: 16009262]
14. Landrigan CP, Conway PH, Edwards S, Srivastava R. Pediatric hospitalists: a systematic review of the literature. *Pediatrics*. 2006; 117(5):1736–1744. [PubMed: 16651332]

TABLE 1**STP Committee Themes Identified and Specific Training and/or Certification Options Considered**

Original Themes Identified	Specific Training and/or Certification Options Considered
Traditional subspecialty certification	3-y fellowship under ABP guidelines
Extra training	Alternate route to subspecialty certification
	2-y fellowship under ABP guidelines
	Hospital medicine residency track plus 1-y fellowship
	Fast track model (2-y residency plus 2–3 y fellowship)
	1-y fellowship under ABP guidelines
Residency track	Hospital medicine track during general pediatrics residency
No change	Status quo with option for specialized training
	Mandatory mentorship program
	Recognition of Focused Practice (equivalent to American Board of Internal Medicine option)

ABP, American Board of Pediatrics.