EDITORIAL

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Toto, I Don't Think We're on the Adult Inpatient Unit Anymore

The March issue of the *Journal of Hospital Medicine* represents a landmark for pediatric hospital medicine (PHM), with 100% of the original research content devoted to pediatrics. Since the days of the National Association of Inpatient Physicians, pediatric hospitalists have consistently constituted 8% to 10% of the membership of the Society of Hospital Medicine (SHM). SHM has always welcomed pediatrics and pediatricians into the community of hospital medicine. A pediatrician has sat on the board since the founding of the National Association of Inpatient Physicians, and for the past 3 years, there has been a formal pediatric board seat. *The Hospitalist* has consistently included pediatric content with program descriptions and literature reviews. This past July, more than 325 pediatric hospitalists gathered in Denver for the largest PHM meeting ever, a 4-day event trisponsored by SHM, the American Academy of Pediatrics (AAP), and the Academic Pediatric Association (APA).

As pediatric hospitalists, we have prospered by following the successes of adult hospitalists. We have flattered/imitated our adult colleagues with pediatric voluntary referral policies, core competencies, salary surveys, fellowship programs, and quality improvement projects. In other areas, pediatrics has set trends for (adult) hospital medicine. Pediatrics developed the "medical home" concept. We zealously advocate for family-centered rounds. (Imagine actually rounding in the room with the patient, family, nurse, and physician. It certainly beats flipping cards in the conference room)! Pediatricians have developed global fee codes for evaluation and management services (albeit limited to neonatal and pediatric critical care). As evidenced by the trisponsored meeting mentioned previously and the Pediatric Research in Inpatient Settings Network, we have created collaborative relationships among the pediatric academic (APA), professional (AAP), and hospitalist organizations (SHM) that serve as models for other disciplines and their respective sandboxes.

Research and publications are where we most lag behind our adult colleagues and where the most work needs to be done for us to achieve legitimacy as practitioners and as a discipline. This issue of the *Journal of Hospital Medicine* is a harbinger of more pediatric content to come, with topics that run the gamut of PHM. Woolford et al.[1] highlight clinical, public health, and public policy issues with their analysis of the increased costs and morbidity associated with obesity and inpatient hospitalizations. Wilkes et al.[2] explore the logistic issues surrounding influenza testing. As is frequently true for hospitalists, our expertise is not purely clinical: Is oseltamvir effective and, if so, in what age groups? That question is probably best left to the infectious

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disease community. Rather, Wilkes et al. highlight both the provider and system issues involved in reliably and expeditiously obtaining, reporting, and communicating flu antigen test results so that clinicians and families have the opportunity to consider oseltamvir use within the first 48 hours of disease. Odetola et al.'s[3] analysis of a Michigan administrative data set suggests that morbidity, length of stay, and resource utilization are decreased for patients who ultimately require pediatric critical care when these patients are directly transferred from the emergency room to a facility with a pediatric intensive care unit (PICU) in comparison with the morbidity, length of stay, and resource utilization of patients who are initially admitted to the ward from the emergency room and then transferred to a facility with a PICU. This study lacks the rigor of prospectively collected physiological data and would probably never receive institutional review board approval for randomization, but it certainly raises key questions about appropriate transfer criteria for patients cared for in hospitals without a PICU. This is a key quality concern for pediatric hospitalists practicing in smaller, community hospital settings.

The 2 most controversial articles in this pediatric inpatient potpourri are the studies conducted by Freed and Kelly examining pediatric hospitalist training, practice, and career goals[4] and PHM fellowship programs.[5] These studies are part of a 6-perspective analysis of pediatric hospitalists/PHM requested by the American Board of Pediatrics (ABP) to provide background to the ABP as it begins to grapple with its role in certifying pediatricians whose primary practice is inpatient pediatrics. A previously published study analyzed the perspective of PHM group leaders.[6] The remaining studies assess the perspectives of residency program directors, department chairs, and hospital leaders.

Not surprisingly, these 3 articles[4–6] tend to be more critical of the PHM movement and its current state than are articles and commentaries written by those of us who are practicing hospitalists. As a hospitalist, my initial reaction was to focus on the studies' shortcomings. The methods seemed flawed, the criticisms seemed unwarranted, and the study limitations seemed underappreciated. Aside from the fellowship study, which surveyed the entire n = 8 universe of PHM fellowship programs, the group leader and hospitalist surveys suffer from a selection bias. Sampling for these studies was based on hospital size and type. Although this sampling strategy is appropriate for comparing programs across hospitals, it fails to account for programs of different sizes in different settings. It is not the best sampling strategy for a denominator of all pediatric hospitalists. For example, community hospital programs without residents are often much bigger than academic programs with residents. Community pediatric hospitalists are likely underrepresented in Freed's survey.[4] From a study design standpoint, it does not appear that specific a priori hypotheses were generated when subgroups were compared. Rather, one suspects that every possible comparison was analyzed. Thus, the percent differences from one group to another are best considered descriptive rather than rigorously statistically significant at a $p < 0.05$ level. Some criticisms addressed to hospitalists apply to all pediatricians. Given the current emphasis on quality assessment, wouldn't most office-based pediatricians (and particularly group leaders) believe that they need extra training in this field? When less than 50% of hospitals require practitioners in established subboarded specialties to be board-certified to maintain hospital privileges,[7] is it surprising to see that privileging standards vary for pediatric hospitalists?

However, nitpicking these studies is a defensive response that does a disservice both to the reports and more importantly to the PHM community as a whole and to the children, parents, and colleagues that we serve. There is no denying that we are a young, evolving field with significant inter-institutional and at times intra-institutional variability. All of us in the PHM community, leaders and lurkers, need to rise to the challenges offered by comprehensive analysis. Freed's sample of 431 hospitalists[4] is significantly larger than the sample of 265 hospitalist participants in the latest Pediatric Research in Inpatient Settings survey.[8] The perceptions of external observers are crucial; it would be a mistake to dismiss their findings or to ignore their interpretations and criticisms.

Certainly none would challenge the variability of practice revealed in Freed's analyses.[4–6] Remember, ''if you've seen one pediatric hospital medicine program, you've seen ONE pediatric hospital medicine program.'' Some may see this variability as a weakness; others may see it as a

strength. We must be equally receptive to other less-flattering observations, data, and conclusions included in these reports to the ABP. All programs target seamless communication with referring physicians, but hospitalists and referring physicians alike agree that we do not achieve it, as evidenced by the work of Harlan et al.[9] in this issue. SHM is taking the lead in developing performance standards for transitions of care and has created best discharge practices for the geriatric population.[10] Similarly, we in the PHM community would do well to ramp up our self-assessment and quality improvement activities. Our recusal from Centers for Medicare and Medicaid Services reporting requirements for (adult) inpatient quality metrics does not excuse us from pursuing voluntary, rigorous, transparent, public reporting on pediatric quality indicators. As Freed et al.[6] clearly implied, the public and payers expect this of us. No doubt, if we do not first propose and implement our own standards, external standards will be imposed upon us.

Aside from the question of mandatory fellowship training for hospitalists, does the vision implied in the studies commissioned by the ABP vary significantly from the challenges to PHM that Sandy Melzer[11] presented at his keynote address at the Denver meeting? Melzer used strategic planning principles to outline a future vision for PHM, including the following:

1. Harm is eliminated from the inpatient setting.
2. Inpatient care is evidence-based for all conditions treated.
3. Hospital care is highly coordinated, especially for children with chronic conditions.
4. A robust research agenda supports all aspects of inpatient care.

Is not the work done by the SHM and APA to develop core competencies for PHM an effort to define our field and identify (uniform) expectations? Do not the criteria for designation as a fellow of hospital medicine (5 years as a practicing hospitalist; 2 national meetings; and a minimum combination of leadership, teamwork, and quality improvement activities)[12] serve to recognize the commitment and accomplishments that distinguish a true hospitalist practicing systems-based hospital medicine from a physician who simply works in the hospital?

There is no need for pediatric hospitalists to respond defensively to the hospitalist studies commissioned by the ABP. In fact, Freed[4–6] has done us a favor by adding dimension and texture to the preliminary outlines of what it means for PHM to be ultimately successful. Both Freed and Melzer[11] are describing the same path. As hospitalists, we tend to take pride in how far we have already come along this adventure. External observers such as Freed remind of us of how far we still need to go. Either way, Dorothy Gale, MD, pediatric hospitalist, has a relatively well-identified yellow brick road to follow with specific challenges and charges to meet. What is unclear is whether formal acknowledgment will be awarded at the end of this journey and, if so, what form it will take. Options include (1) recognition of focused practice in hospital medicine with maintenance of certification, (2) SHM fellowship, (3) a traditionally boarded subspecialty, or (4) all of the above.

Any formal designation will be of secondary importance. Remember, the wizard did not change anything when he bestowed the diploma, the heart-shaped testimonial, and the medal of valor. Like the scarecrow, tin man, and lion, all the qualities that we need for success as pediatric hospitalists are already within us. No wizard's pronouncements will help us provide better care to our patients. Change will come from working together on shared goals with mutual support along our common path. Look to the *Journal of Hospital Medicine* for frequent updates on the journey. See you in the Emerald City.

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