Comparing the Care of Pediatric Hospitalists With That of General Pediatricians
Is It a Question With Waning Relevance?

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Early in the transition of inpatient pediatric care from general pediatricians to hospitalists, demonstrating the value of a focus on inpatient practice was important to establish the legitimacy of the future specialty and demonstrate why hospitals might wish to adopt a hospitalist model. The movement toward hospitalist care of children receiving inpatient treatment has been gradual but steady during the past 2 decades, but broader market, societal, and practice demographic forces may now have taken over as the primary reasons why general pediatricians have continued to cede inpatient care to hospitalists.¹,²

Atkinson et al³ compared outcomes among 1423 hospitalizations from January 1, 2009, to August 31, 2015, at 1 academic medical center. The patients were cared for by either a pediatric hospitalist or a general pediatric attending physician, but all physicians were faculty at the institution. Assignment to type of attending physician was based on a triage decision made by an admitting officer of the day and nursing leadership, according to bed availability, but was not random. Regardless of the type of attending physician, patients were cared for by similar resident-staffed teams and the same unit nurses. Atkinson et al³ compared patient-level outcomes for 57 diagnoses representing a range of conditions, purposefully excluding some common diagnoses, such as bronchiolitis, in an effort to oversample conditions that might exhibit greater differences in care between the 2 types of physicians. The hospitalists (n = 39) provided only inpatient care, while the generalists (n = 56) primarily saw patients in the outpatient setting, with limited inpatient service each year. The generalists had been in practice for longer than hospitalists (mean, 16.0 vs 7.9 years). Outcomes included quality (readmissions and adverse events), use of health care resources (length of stay), and cost measures. Adverse events were compared in total as well as by 3 subgroups: drug events, infections, and device-related adverse events. Patient variables included age, sex, type of insurance, month of hospitalization, and a measure of patient complexity. Adjusted analyses that included both patient and physician characteristics did not demonstrate a difference in 30-day readmissions, length of stay, or total costs. All-cause adverse events were less common among patients receiving care from general pediatricians (adjusted odds ratio, 0.48; 95% CI, 0.23-0.97), and device-related adverse events were lower among pediatricians who completed training at a hospital other than the study hospital.

What are some of the strengths of the study? The study includes recent data, examines a large number of admissions, and accounts for physician characteristics from a relatively large population of hospitalists and generalist pediatricians.³ The outcome measures have face validity, but the authors appropriately note that the measures are not comprehensive of all outcomes of interest, such as patient satisfaction. Additional strengths include accounting for the years of physician practice experience and the clinical complexity of patients. Limitations that cannot be overcome include that the general pediatricians were still medical school faculty and the nonrandom assignment to hospitalist or generalist care. Although the authors have attempted to account for unmeasured bias in the assignment of patients by adjusting for patient characteristics, unmeasured bias in assignment to type of attending physician was almost certainly still present.
How will the pediatric medical community interpret this study? Ardent supporters of pediatric hospitalist subspecialization will appropriately raise concerns with the measures (too few measures, not the "right" measures, and the elimination of common conditions) and that this study represents findings at a single institution, while readers wary of the hospital pediatric subspecialty designation may overinterpret the results to say that there is no difference between the 2 types of physicians and that the hospital pediatric subspecialty designation is not needed. I would posit that the separation of pediatric care during the past 2 decades has rendered the research question one of waning importance. Pediatric hospitalist programs were instituted largely as voluntary services, with general pediatricians admitting patients to them electively or not. However, as hospitals, ambulatory practitioners, and even patients became more accustomed to the hospitalist model, each constituency found additional value in the separation of labor. Hospitals realized that a cadre of inpatient-focused pediatricians could provide needed attention to hospital quality outcomes and efficiency and provide hospital clinical leadership in ways that community pediatricians might not. The increasing complexity of child inpatient admissions required different practice knowledge. Outpatient pediatricians realized the added value of spending less time commuting to hospitals to see a dwindling number of hospitalized patients, and an increasing focus on mental and behavioral health demanded new outpatient practice arrangements and skills. Although large children's hospitals have more easily made the transition to hospitalist care, hospitals with smaller pediatric volumes may find it challenging to balance the cost of pediatric hospitalists with a decreasing number of newborns and inpatient children. Patients continue to be the constituency least studied in this arrangement, and their opinions on the separation should be studied more.

In what scenarios might the question of differences in care provided by pediatric hospitalists vs general pediatricians still be relevant? First, comparing outcomes of patients cared for by pediatric hospitalists vs nonfaculty community pediatricians may still be of interest. Second, examining the research question in nonacademic settings or community hospitals where pediatric residents and pediatric-specific nurses are not present to provide a buffer might demonstrate differences in care provided by attending physicians that were obscured in the present study. Third, as stated previously, the pediatric community owes it to patients to further explore their considerations of this dichotomy of practice, including how it might affect patient satisfaction, adherence to care after hospitalization, and potential errors introduced during the transfer of care from hospitalists back to community pediatricians.

In the end, even if differences in care are not found, there are many factors contributing to the evolution of pediatric inpatient care to the hospitalist model. An increasing proportion of young physicians are willing to be employed by hospitals or health care systems, making entry into hospitalist careers more acceptable. More community physicians of all types are pulling back from inpatient services not paid for by hospitals, including emergency coverage for deliveries. Hospitals find value in employing dedicated hospitalist pediatricians for many reasons, and the practice separation will continue for reasons far beyond questions of care differences between pediatric hospitalists and their ambulatory colleagues.

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REFERENCES


