Welcome to a special issue of AAP’s Section on Hospital Medicine (SOHM) News devoted to medical students, residents, young physicians and other new careerists! The field of pediatric hospital medicine is growing rapidly. This newsletter offers information to new hospitalists and people considering hospitalist medicine about how to build hospitalist skills and how to secure a satisfying position in this exciting profession.

Pediatric hospitalists care for hospitalized children in many different settings—the inpatient ward, intensive care units (NICU and PICU), newborn nursery, the delivery room, and pediatric ED. They may provide consultation for surgical patients and offer sedation services. Hospitalists are employed by both academic medical centers and non-teaching community hospitals.

In this issue, you will find articles on whether or not to consider a pediatric hospitalist fellowship, how to find and choose a position with the job description that matches your skill sets, and then how to negotiate for what you need. You will see ways of getting involved by reading about the SOHM subcommittees (everybody’s welcome) and see that this involvement may lead you to exiting places both in the U.S. and abroad.

In addition, this month’s “Practice Profile” focuses on one of Kaiser’s pediatric hospitalist programs. It will give you a flavor of the day to day workings of a large hospitalist program. If you are interested in seeing more program examples, refer to other newsletters archived on the SOHM Web site: (http://www.aap.org/sections/hospicare/). There you’ll also find the “You are the Consultant” articles that outline interesting cases seen by hospitalists.

As a young physician or new careerist in hospitalist medicine, you will have the opportunity not only to help define your job but to help define the field. If, after reading this newsletter, you have questions or need support, contact our Chairperson, Dr. Laura Mirkinson at mirkil@holycrosshealth.org. We have hospitalist medicine leaders available in nearly every state ready to answer questions and serve as mentors as we build the field of pediatric hospitalist medicine together.

Jennifer Daru, MD, Editor and
Alison Holmes, MD, MS
Chair, SOHM Committee on Young Physicians and
New Careerists

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**HIGHLIGHTS IN THIS ISSUE**

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Making the Rounds
A Letter from the Chair

I am delighted to be writing this update for our newsletter as the new chair of the Section on Hospital Medicine. This year’s Executive Committee meeting was marked by a change in chairmanship and the delineation of new goals for the Section for the coming year. I think I speak for all the members of the Executive Committee and the Section when I express my appreciation to our past chair, Jack Percelay, for his tenacity and leadership in taking a national AAP hospitalist Section from an idea to reality.

Our Section sponsored our sixth successful Section meeting at the National Conference & Exhibition (NCE). The NCE is the most important continuing medical education (CME) activity of the AAP each year, and it is a time when members of a Section can interact at many levels. As the outgoing Program Chair, I was pleased by the number of people who attended our Section meeting and who contributed to the poster session. As always, it was a lively and interactive crowd!

A new and exciting development for the Section is the approval by the AAP’s Committee on Continuing Medical Education of the 2007 Pediatric Hospitalist Conference. For those of you who attended this summer’s Pediatric Hospitalist meeting in Denver, this is the next conference in that series. We are jointly sponsoring the conference with the Ambulatory Pediatric Association and the Society of Hospital Medicine. We are pleased to be the lead sponsoring group for the 2007 meeting, and the endorsement of the AAP will help us organize and fund the meeting. The 2005 meeting was an excellent conference, and I encourage all of our membership to look for details of the 2007 conference in the coming months.

Now that we are an established, strong and growing section, we are turning our sights to the complicated business of continuing our recruitment of new members, maintaining our membership, and developing new projects. The Executive Committee established specific goals for the coming year that will involve both short-term and long-term work. They include the formation of subcommittees of the Executive Committee that require the input and involvement of many members of our Section. As hospitalists we all interact with many different aspects of pediatric medicine. It was difficult to narrow our focus to just a few areas of concentration. If you have volunteered to be an active member of the Section in the past, we have your name, and you can expect to get a call from one of our executive committee members soon. In the future, we hope to expand our horizons again, but for the time being, these are the subcommittees that have been formed:

- Coding and Billing
  Contact: Yong Han @ yshan@texaschildrenshospital.org
- Community Hospitalists
  Contact: Karen Kingry @ Kkingry@suburbanhospital.org
- Palliative Care
  Contact: Maggie Hood @ Maggie.hood@multicare.org or Daniel Rauch @ Daniel.rauch@med.nyu.edu
- Terrorism and Disaster Preparedness
  Contact: Michael Ruhlen @ Michael.Ruhlen.md@promedica.org
- New Careerists and Pediatric Residents
  Contact: Alison Holmes @ alison_holmes@urmc.rochester.edu
- Medical Informatics and Technology
  Contact: Timothy Hartzog @ tim@hartzoghealth.com

This is the time for members of the Section to become more deeply involved. I encourage all of our members to become an active member of one of the subcommittees at some level. I believe very strongly that every member would find this work both personally and professionally satisfying. Over time, the Section will need new ideas, new goals, and new leadership. I am hopeful that we will be able to draw from our membership the expertise and excitement that will keep us a vibrant and active section of the AAP. Become involved with the Section on Hospital Medicine!

Look for information about the activities of the Section on our Web site (www.aap.org/sections/hospcare), and participate in our LISTSERV. I look forward to an interesting and challenging tenure as chair and hope to meet many members of the Section in the coming months.

Laura

Laura J. Mirkinson, MD
Chair, Section on Hospital Medicine
mirkil@holycrosshealth.org

Thanks to Dr. Jack Percelay (chair 2001–2005) for his years of service and tireless dedication to the AAP Section on Hospital Medicine. As one of the chief architects of the Section as well as its first chairperson, Jack has been instrumental in promoting pediatricians within the field of hospital medicine and providing a voice for pediatric hospitalists everywhere. He has seen SOHM grow from 60 to nearly 600 – and all within a five-year span. During his tenure, the Section developed and published a very important policy statement, “Guiding Principles for Pediatric Hospitalist Programs,” created an enhanced web site that offers a host of resources for pediatric hospitalists and pediatricians, and fostered the growth of our active and vital LISTSERV®.
Subcommittee on Community Hospitals

Providing consistent high quality pediatric hospital care in today’s medical marketplace is a challenge for community hospitals. How can the community hospital pediatric service provide quality care in a cost effective manner and not cause financial loss to the hospital? The number of children admitted to hospitals and the length of hospital stay has decreased dramatically in the last 20 years. For the most part the medical needs of children are met appropriately in the ambulatory setting. Therefore, the child who does require hospital-based services either in the form of emergent care or inpatient care is often more seriously ill than in the past and requires the special expertise of pediatric-trained physicians and nurses. In the face of shrinking revenue and patient volumes, many community hospitals have made the very difficult decision of closing the pediatric service or making less than optimal arrangements for hospital-based pediatric care.

In the past, community hospital pediatric departments and units have been modeled after academic centers, even if no residents are present to evaluate children. In the community hospital emergency room, children make up approximately 15% to 30% of total ED patient volume. Patients are seen by general emergency physicians with a pediatric consultation (usually over the phone) as needed. Once on the floor, pediatric patients may have their own unit but often share the floor and their nurses with adult patients. Physician staffing in this traditional model usually involves a local pediatrician or family practice doctor on-call for the emergency department and/or for inpatient admissions.

But now, with hospitalists, an in-house pediatric physician is available. However, it just isn’t cost-effective to have hospitalists staff a small community hospital pediatric ward without cross-coverage in other areas. Emergency pediatric volume varies considerably depending on time of day and time of year, making having a dedicated 24/7 pediatric care provider in this area a financial impossibility in many community hospitals as well.

It becomes a significant challenge when, in order to maximize efficiency and costs, the hospitalist pediatrician simultaneously covers delivery room emergencies, newborn nursery, inpatient unit, and the primary evaluation of pediatric emergency patients.

Pediatric hospitalist groups find they need to justify their existence regularly or attempt to exist without hospital subsidy. If hospitalists are employed by the hospital they are at times “held hostage” to unreasonable demands and expectations as hospitals try to squeeze costs into a tight budget. Whether a community hospital will continue a pediatric hospitalist program depends on many variables such as the value of offering full hospital services, meeting quality care standards, community expectations, or need for support of obstetric services. Other considerations include staffing demands and shortages, high costs of care, dropping patient revenues, and negative budget balances.

Most pediatric hospitalists are not trained or prepared to handle these non-clinical concerns and others that are relevant to a pediatric hospitalist practice in a smaller non-children’s hospital. These physicians are faced with issues, such as staffing and structuring the program, interacting with administration, organizing finances and budget, and marketing the group to ensure success. In addition, they need to keep support staff and their own skills current, while creating effective mechanisms of communication with community pediatricians, family practice physicians, other subspecialty physicians, and with tertiary partners. They may want or need to take on clinical research in the small volume setting, or tracking of quality measures.

This Section on Hospital Medicine Subcommittee will provide a specific forum for community hospitalists to identify, discuss, share information about, and advocate for their specific issues. It will also serve as a way to ensure representation of community hospitalists on agendas of national meetings and input into planning for hospitalist training programs. Already there has been great response to the Subcommittee and an untapped wealth of knowledge and experience identified. Please contact me if you wish to be involved with the committee.

Karen Kingry, MD
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About the Author
Karen is Head of the Subcommittee of Community Hospitalists and Medical Director of Pediatric Programs, Suburban Hospital, Bethesda, MD.

Join an SOHM Subcommittee:
• Coding and Billing
  Contact: Yong Han @ yshan@texaschildrenshospital.org
• Community Hospitalists
  Contact: Karen Kingry @ Kkingry@suburbanhospital.org
• Palliative Care
  Contact: Maggie Hood @ Maggie.hood@multicare.org
• Terrorism and Disaster Preparedness
  Contact: Michael Ruhlen @ Michael.Ruhlen.md@promedica.org
• New Careerists and Pediatric Residents
  Contact: Alison Holmes @ alison.holmes@urmc.rochester.edu
• Medical Informatics and Technology
  Contact: Timothy Hartzog @ tim@hartzoghealth.com
Subcommittee on Medical Informatics & Technology

Hospitalists have multifaceted jobs that require assimilating large amounts of information daily to provide excellent patient care. Labs and x-rays have to be reviewed, vital signs checked, orders written, and admit and discharge summaries sent to primary care physicians and consultants. Hospitalists are dealing with information on a large scale.

So what does this have to do with medical informatics? Medical informatics is just a fancy term to describe the use of computer technology to efficiently manage and distribute information and to provide clinical decision-making support. Paper is a wonderful tool in medicine. You can write using a cheap pen, store notes cheaply, and quickly retrieve information. Paper holds information regardless of formatting and spelling. Paper can be dropped on the floor, and work continues. Paper works well; it never needs rebooting, never gets a virus, doesn’t have hard drive failures and is always reliable. What are the problems with paper? Only one copy is actually current. Even if copies are made when a change is needed, all other paper copies are useless and outdated. Paper is expensive to store, gets heavy and is very hard to search. Distribution is expensive.

What is needed in medicine is a computer that is as reliable as paper, easy to use and cheap to operate. No such computer exists, but computers do offer many advantages: editing documents is efficient, documents and updates can be distributed easily, and searching for information can be done very fast. In fact, the entire Internet (well, almost the entire Internet) can be searched via a search engine such as Google in ten seconds. Computers hold potential, but hospitalists must guide the development and not be passive users.

The goals of the Subcommittee on Medical Informatics and Technology is to educate SOHM members on useful information technologies and ways of harnessing the tremendous power of computers in a quick and cost-effective manner. The goal is to build systems that will work for all of us. Not every hospitalist program needs to start projects from scratch; let’s share our knowledge via the Section on Hospital Medicine Web site.

We would like to collect protocols, lectures, and evidence-based reviews for hospitalists to access. We can convert any electronic data into PDF documents that can be distributed to or posted for members of the section. The SOHM Web site (http://www.aap.org/sections/hospcare/) currently has a tremendous amount of useful information, but let’s continue to expand it. As the committee begins to move forward, we would like to begin to distribute information on the use of computer/PDA material, build relationships with the Council on Clinical Information Technology, and work with David Stockwell, MD, editor of Pediatrics on Hand (http://www.pedsonhand.com/) to develop more hospitalist specific PDA reviews.

Other issues to explore and develop are electronic medical records, clinical decision support, and quality improvement tools. Hospitalists must be informed when hospital administration wants input into the purchasing of electronic medical records. Clinical decision-making support in the ever-growing field of medicine is critical as the human brain cannot possibly keep up with every facet of medicine. Computers can provide support to the clinician in complex or rare diagnoses.

Information technology can improve the care given to children, but only if it is the correct information technology. An informed hospitalist is a major asset to hospital administration when choosing information technology. Technology is going to invade our work environment so let’s harness the power and improve it. If you would like to volunteer, please email me at Tim@hartzoghealth.com.

Timothy H Hartzog, MD

About the Author
Tim is a member of the Section on Hospital Medicine Executive Committee and is one of the clinical faculty at the Carolinas Medical Center, Charlotte, NC

American Academy of Pediatrics
National Conference & Exhibition
Atlanta, GA October 7-10, 2006

Mark your calendars! Atlanta has first-class accommodations, outstanding restaurants and one-of-a-kind historic and cultural attractions. Members will enjoy more than 350 educational programs, 320 exhibitors and a career fair along with family-friendly tours and events. Look for registration and housing information in the June issue of AAP News.

SCHEDULE OF SECTION PROGRAM ACTIVITIES on p. 22
Family Life and Hospital Medicine

For decades the dream of many physicians that graduated medical residencies has been to join a successful primary care practice and pursue a career in outpatient medicine. Circumstances in medicine have changed dramatically since the midpoint of the 20th century. Huge increases in medical school debt, reduced reimbursement from payers, and demands of the consumer have changed the medical landscape forever. Pressure from the marketplace has driven physicians to increase their hours and patient load while correspondingly decreasing their income and personal time. Finding a suitable practice that fits personal, economic and professional goals has become a difficult challenge. Doctors are suffering significant career dissatisfaction on all levels of medicine. That is the point to which my career in medicine had taken me when I found hospitalist medicine.

After graduating from The Children’s Hospital of Buffalo pediatric program in 1998, I became engaged and joined a private multi-specialty group in Virginia. Office politics and internal disruption quickly drove me on to my next position in primary care. The birth of my first child and the tragic events of 9-11 caused us to move again. By 2004, I had experienced outpatient primary care across three states and as many practices.

Residency does not prepare a physician for the rigors of primary care. Longer hours and weekend work are now the norm in all areas of medicine. With two small children my wife and I found it extremely challenging to find family time. As a pediatrician I found it even more frustrating to have limited participation in my children’s growth and development. Early morning hospital rounds, late evening office work and frequent overnight call were hampering my ability to actively participate even when I was at home. To make matters worse, I pursued moonlighting opportunities to avert financial Armageddon. The promised “good life” appeared to be the proverbial carrot on the stick. I was at an impasse.

I was first introduced to Hospital Medicine as a moonlighter at a small community hospital. While I found the work interesting, I didn’t give it much thought as a career. Now I direct the Hospital Medicine Program at the State University of New York, The Women and Children’s Hospital of Buffalo. The last couple of years have been a rollercoaster ride, but my life has changed dramatically. Gone are many of the late nights, long hours and the arduous call schedule. I actually see my wife and children, participate in their lives, and actively seek new family adventures. Many of the previous stressors have disappeared, but nature abhors a void. The new stressors are varied as I face a previously foreign field that includes increased teaching responsibilities, administrative work, hospital politics, and pressures of research and academic career advancement.

One of the greatest advantages I have experienced as a hospitalist is the increased autonomy. Having clearly defined goals for patient care has allowed me to plan my workday around other necessary activities of life, a stark contrast to the rigid schedule of appointments in the outpatient setting. If a family activity materializes at the last minute, it is likely that I will be able to arrange my schedule to attend without the requisite three months’ notice I experienced in private practice. Additionally, working with a group of colleagues with similar family and professional needs has fostered an environment of support. We enable each other to take back our home lives while shouldering a significant workload.

The Hospital Medicine community encompasses a myriad of program models. Schedules vary from shift work with call from home to 24-7 in-house coverage. Each model can have a distinct impact on family life. A program that offers around-the-clock in-hospital coverage will involve evening work at the expense of family time. Fatigue and stress during overnight hours can build rapidly and result in both career burnout and increased family discord. Groups that take service call from home may have the unfortunate downside of requiring physicians to go into the hospital at night to care for a patient. Such calls are rarely convenient and predictably occur during family events or in the early hours of the morning. Furthermore, all groups have limitations. If a physician is removed from a schedule for a prolonged period of time, predictably or not, the remaining doctors may become indentured servants until the void is filled. However, there are few areas in medicine where workforce availability and call do not impact family life on some level.

It took me nearly a decade to discover an area of medicine that provided an acceptable balance between career and family. Since my tenure as a hospitalist I cannot easily imagine a scenario that would place me back into a traditional primary care setting. Physicians experiencing a similar crisis, I am certain, will find the field of Hospital Medicine equally provocative and replete with challenges and opportunity. I invite you to explore it.

John V. Pastore, MD

About the Author
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Clinical News

Hospitalist Fellowships

Pro: A Good Working Idea

The field of pediatric hospitalist medicine is still in its toddler stage, and fellowships are in their infancy. Currently there are five formal pediatric hospitalist fellowships available in the United States. These are not ACGME recognized, and there is no board offered in pediatric inpatient medicine. Also, with studies showing the benefit of having hospitalist programs, the demand for pediatric hospitalists is higher than ever. So an appropriate question to ask oneself right now is: Why should one spend two years of additional training to do a fellowship in pediatric inpatient medicine?

Frankly, the answer is multi-factorial and depends on one’s career path. A fellowship is intended to train pediatricians for careers in academia or leadership positions in the subspecialty. The goal is to foster contributions to the field of medicine beyond direct care of patients.

A fellowship allows one to develop skills needed to advance and pioneer the field of pediatric hospitalist medicine. Program initiation and expansion, fellowship development, medical education, clinical advancement, and research training are just a few areas where the field of pediatric hospitalist medicine needs development. Concentration on these domains will help advance the entire field of pediatric hospitalist medicine beyond simply filling a need to see inpatients. Many fellowships offer additional degrees such as master in public health, education or business administration in addition to specialization. Networking and mentorship are additional benefits gained from a pursuing a fellowship.

A two year commitment should be seen as an opportunity to develop and hone one’s skills...

Continued on p. 9

Con: Don’t Make Them Mandatory

According to the American Academy of Pediatrics, the goal of subspecialty fellowship training “is to advance the health of children by preparing graduates who are competent in clinical care, education, and research.” Surely many pediatric hospitalists require competence in these three areas. In addition, pediatric hospitalists overwhelmingly feel that they require further training. A mandatory pediatric hospitalist fellowship program therefore seems like a perfect solution to this problem, right? Wrong.

Several reasons—some theoretical, some practical—exist why most pediatric hospitalists do not, and should not, require the completion of a specific fellowship.

First, let us examine hospitalists’ training backgrounds. Nearly all pediatric hospitalists, regardless of how this is defined, were trained in general pediatrics residency programs. Much of this training involves inpatient care; in fact, the ACGME has attempted to limit this inpatient overemphasis by mandating that the percentage of a resident’s time spent in the inpatient setting be no more than 50 percent. Resident training is typically so inpatient-heavy that graduates are better prepared to be hospitalists than just about anything else.

Next, there is the diversity of jobs that fall under the ‘hospitalist’ category. Some hospitalists cover the delivery room; others cover the ED, NICU, and/or well-baby nursery; some teach residents and students; some do none of these. This diversity necessarily requires on-the-job training for which a one-size-fits-all fellowship may be woefully inadequate. Medicine inherently requires lifelong learning (there is always more to learn) and this learning continues well past any formal training one might complete.

The fact that many hospitalists feel under-trained may reflect several issues, few of which are addressed by the completion of a fellowship. First, many hospitalist positions are relatively new and therefore may suffer from somewhat unclear expectations from an organizational standpoint. Second, issues such as billing, clinical leadership, and organizational management may not lend themselves to formal teaching and are highly institution-specific. Primarily outpatient-based pediatricians, especially recent residency graduates, may feel similarly under-trained—especially in areas such as billing and leadership, as these topics are not well covered by many residency programs. Addressing these inadequacies in residency programs seems more prudent than requiring an additional fellowship.

The comparison between positions in pediatric emergency medicine and pediatric critical care to those involving hospitalists is a relatively poor one. General pediatrics residency graduates usually spend at most three blocks in the high-acuity PICU or ED; they typically spend far more time taking care of...

Continued on p. 9

Hospitalist Fellowship Programs

Children’s Specialists San Diego (affiliated with UCSD)
National Medical Center (Washington, DC)
Baylor College of Medicine (affiliated with Texas Children’s Hospital, Houston)
Children’s Hospital at Boston (affiliated with Harvard)
Available Pediatric Hospitalist Fellowships

Pediatric Hospitalist Fellowship - Baylor College of Medicine, Texas Children's Hospital
The Baylor College of Medicine Pediatric Hospitalist Fellowship Program is recruiting fellowship applicants for the 2006 academic year. We seek to train pediatric hospitalists for leadership roles in academic environments and generate new knowledge in the discipline.

This two-year program focuses on clinical experience, academic teaching, research and administrative skills. Clinical training takes place primarily at Texas Children's Hospital. It is a busy 715-bed tertiary care referral center. Texas Children's Hospital is the largest freestanding children's hospital in the U.S. Named in 2004 as one of the top four pediatric hospitals in the nation by U.S. News and World Report, Texas Children's Hospital has garnered a reputation for excellence in research and clinical care. Baylor College of Medicine is equally prominent, with over $300 million in research dollars, it is considered one of the nation's top medical schools. Clinical experience focuses on inpatient acute care as part of the inpatient hospitalist program that currently treats more than 3,000 patients per year. Additionally, we offer electives in transport Medicine, observation medicine, anesthesia, newborn nurseries, and intensive care. Electives also are offered in over 40 subspecialties, including child protection and advocacy.

Fellows will receive training in administration with a goal that s/he will be able to lead within, or independently develop an academic hospitalist program upon completion of this two-year training. It is expected that the trainee will develop a familiarity with patient safety and risk management, participate actively in 1-2 administrative committees, engage in community advocacy, and gain knowledge in billing and accreditation processes.

For further information, please contact:
Liza Zolayvar
lazolayv@texaschildrenshospital.org

Pediatric Hospitalist Fellowship—The Children’s National Medical Center, Washington, DC
Although pediatric resident graduates are well prepared to care for many ill children who require hospitalization, there are clinical, academic and administrative skills that are not a standard part of residency, but are necessary for long term academic success. The Children’s National Medical Center (CNMC) Hospitalist Fellowship program is structured over two to three years, depending on the applicant’s qualifications, and consists of a combination of clinical experience, formal course work, seminars, and mentored independent study. Fellows will work under the supervision of faculty in our 20 member Hospitalist Division, with inpatient pediatric services at five hospitals in Washington D.C. and suburban Maryland. A faculty appointment as a clinical instructor of The George Washington University (GWU) School of Medicine and Health Sciences allows the fellow to complete a Masters in Public Health. Committee membership and participation in quality improvement and epidemiologic projects will facilitate study of hospital administration and organization, performance improvement, and infection control.

Please contact:
Jennifer Maniscalco, MD
Director, Pediatric Hospitalist Fellowship Program
Children’s National Medical Center
Phone: 202-884-6123  E-mail: jmanisca@cnmc.org

Pediatric Hospitalist Fellowship - San Diego, CA
Well established pediatric hospitalist program at Children's Hospital San Diego (affiliated with the University of California San Diego) is accepting applications for pediatric hospitalist fellowship beginning July, 2006. Candidates must be BC/BE in pediatrics by the beginning of the fellowship. Excellent opportunity with diverse curriculum.


Please send CV and direct inquiries to:
Erin Stucky, MD
c/o Admin Asst Susan Stafford at sstafford@chsd.org
Phone: 858/966-5841
A Good Working Idea  Continued from p. 7

leadership, research, and advocacy skills, rather than a financial burden. The cost of professional investment and personal satisfaction cannot be valued enough. All fellowship programs focus on academic teaching, research, advocacy, administrative skills and clinical experience. These can be titrated based on individual goals. With residencies concentrating more and more on outpatient medicine, additional clinical training can only help alleviate the anxiety related to feeling under-trained. This is especially true in children's hospitals where a hospitalist group may be operating in parallel with other sections within an institution of subspecialty trained individuals.

Comparisons to the fields of pediatric emergency medicine and critical care medicine are inevitable since pediatric hospitalist medicine is following in their paths. It took ten to fifteen years after the introduction of pediatric emergency physicians for the field to be recognized as an independent specialty. We should study and reap the benefits from their path and their positive and negative experiences along the way. Current leaders in our field have done a great job initiating our specialty and have labored to have national organizations recognize us. Fellowship training programs can help unify curriculum agendas to help define a standard for expectations and skill sets in practicing hospitalists.

On the job learning is laudable and will inevitably still occur, as medicine inherently requires life-long learning. Fellowship training is the next step in developing pediatric hospitalist medicine as a recognized field, and more importantly, developing a stronger service line for inpatient care through the domains of research, advocacy, and medical education. The protected career development time, mentorship and personal development that fellowships offer make them indispensable for future leaders.

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About the Author
Rana Kronfol is the pediatric hospitalist fellowship co-director at Baylor College of Medicine, Texas Children's Hospital, a fellowship program started in 2005 with one fellow per year. The hospitalist service at Texas Children's Hospital sees and treats over 4,000 patients per year and includes over ten full-time faculty.

Don’t Make Them Mandatory  Cont from p. 7

general pediatric inpatients. Simply because pediatric emergency medicine and critical care represent new specialties does not require that pediatric hospitalists must blindly “follow their lead” in requiring fellowship training.

Finally, the expectation that applicants for hospitalist positions must complete a fellowship may create a significant financial hardship for those interested in the field. As we are all too aware, the cost of medical education is rising quickly; two or three more years of low pay (read loan deferment) in exchange for a generalist position that typically reimburses fairly poorly seems too high a price. This high price may discourage talented pediatricians from hospitalist positions just as the need is expanding, especially as hospitals have usually already forsaken the rewards of partnership in private practice.

In summary, while the spirit of a fellowship in pediatric hospitalist medicine is laudable, a fellowship should not be mandatory for hospitalist positions. The hospitalist movement has developed to address the need for quality, efficient inpatient care, not to address a new branch of knowledge in pediatrics or internal medicine. The fact that one can always learn more medicine does not inherently necessitate a fellowship. Alternatives such as a hospitalist track during residency, a chief resident year, or on-the-job learning represent superior approaches to further one’s development towards leadership and excellence in inpatient care.

David Rappaport, MD
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About the Author
David Rappaport is a hospitalist at AI duPont Hospital for Children in Wilmington, DE, which he joined after actively avoiding a pediatric hospitalist fellowship. The hospitalist program at AI duPont is rapidly expanding and includes active primary and consultation services.
Update from the Society of Hospital Medicine

The major pediatric activity in the Society of Hospital Medicine continues to be CME programs and the Pediatric Core Curriculum. The dramatic success of the Pediatric Hospital Medicine Meeting in Denver was highlighted with several articles in the October issue of The Hospitalist. The SHM will be serving as the primary sponsor for the meeting in 2008—time and location to be determined after the AAP selects the 2007 site.

The Pediatric Core Curriculum is nearly complete with target unveil in May, 2006. This curriculum is modeled after the adult core curriculum. It will serve as a framework for residency and fellowship directors, as well as a basis for the topics addressed at the Pediatric Hospital Medicine meetings. Thanks to Tim Cornell, Dan Rauch, and all the authors and editors who have contributed to this work.

The 2006 SHM Meeting is in Washington, DC, May 3-5. We are offering a full pediatric track as we have in prior years. Details are available online. Pre-courses include the ever-popular Practice Management course and a new Quality Improvement course. Meetings of both the Pediatric Committee and the Pediatric Forum will be held during the Annual Meeting. This year’s meeting immediately follows the PAS Meetings in San Francisco. Plan early so that at least one member of your program is able to attend the SHM Meeting. This meeting is particularly valuable to program leaders as there is much we can learn from our adult colleagues.

Adult activities in SHM are like white cells in a bad case of pyelo—TNICT. Highlights include the Compensation and Productivity Survey, which was completed in November 2005. Results will be presented at the May meeting and shortly thereafter will be available to SHM members on the Web site. The Career Satisfaction Task Force is establishing benchmarks by which adult programs can be measured. This includes an initial foray into what is a reasonable workload. On the sub-specialty issue, SHM has met with the American Board of Internal Medicine and is exploring a certification in hospital medicine (vs. “ambulatory medicine”) as part of the Internal Medicine re-certification process. This is a BIG topic; regular updates will be provided through “The Hospitalist” as well as the AAP SOHM Pediatric LISTSERV®. The first issue of the Journal of Hospital Medicine is slated for January, 2006. Pediatric submissions are welcome. The SHM Leadership Conferences continue to sell out regularly and have been well received by pediatric attendees. Next available slots are in September, 2006. The SHM is actively involved in public policy issues affecting hospitalists such as pay for performance and gain sharing.

So much for the tasting menu of SHM activities that directly relate to our work as pediatric hospitalists. The a la carte menu is available on the SHM Web site at www.hospitalmedicine.org. Hope to see you in Washington, DC, or electronically on the LISTSERV®.

For more information about SHM or the SHM Pediatric Committee, please contact co-chairs:

David Zipes at dgzipes@indy.rr.com or
Jack Percelay at JPerelayMD@yahoo.com

Need Volunteer Pediatrician to Serve One Year in Laos

Health Frontiers is recruiting for a pediatrician or medical pediatrician to coordinate its Pediatric Residency Program in Laos. Responsibilities of this volunteer position include providing clinical teaching for the Lao pediatric residents and administration of the residency program in collaboration with the Lao pediatricians and faculty of Medical Sciences. The training is also done in collaboration with a Thai medical school at Khon Kaen University. Cross-cultural sensitivity, flexibility and patience are essential in this work. No language ability is needed as all teaching is done in English. This volunteer position is particularly well-suited to hospitalists as most of the patient care occurs in a hospital setting and most of the teaching is done on the wards. Therefore, experience managing inpatients and doing bedside teaching are especially valuable.

We are seeking someone with at least one year and would be available to start in or around June, 2006. Health Frontiers provides travel, housing, use of a vehicle and a modest living stipend. Please note we are also recruiting for an internal medicine or medical pediatrician to coordinate the Internal Medicine Residency Program for the same time period.

Interested persons may submit an inquiry and resume by email to Melanie Rosenberg at melaniedenberg@yahoo.com. Please feel free to e-mail/write with questions.

Health Frontiers is a volunteer, non-profit organization (www.healthfrontiers.org) affiliated with the Rainbow Center for Global Child Health in Cleveland, Ohio. The primary projects in Laos are a Lao Pediatric Residency Program started in 1997 and a Lao internal medicine residency program which began in 2002.

Does volunteering overseas intrigue you? Check out Dr. Lance Chilton’s story of Sri Lanka on page 17.
Starting a Research Career

Pediatric hospitalists come from a variety of backgrounds and practice experiences, and with differing expectations and responsibilities. There are some things we have in common, however. One is the difficulty we have being financially self-supporting. Have you ever had to sit in a budgeting meeting or try to convince your administrative support that you really are worth it? Most pediatric hospitalists support themselves in part by doing other jobs in their hospital. We sit on committees, develop practice guidelines, run sedation services, help in emergency rooms, do consultations, act as medical directors; and we do research. The research may be informal, such as an outcomes study for a clinical practice guideline as part of a quality improvement project, or it may be formal research that will become a critical part of our retention and promotion process in an academic department.

If you are involved in any process improvement or patient safety study or need to become involved in formal research, here are some practical suggestions to improve your likelihood of success.

A Project
This is the easiest part of your research experience although that may not be immediately apparent. There is an unending list of clinical questions that need to be answered. Examine what you did this morning. Was there anything you did simply because that is what you learned to do? Did you make any decisions that had no basis in scientific evidence to support them? Did a question without an answer come up on rounds? Is there anything going on in your hospital that the administration would like to do better? Has there been an adverse outcome that you feel may be preventable? The project may address a clinical question, a process, a patient safety issue, baseline data for a clinical practice guideline you are developing, or outcomes data. Your research may be observational, epidemiologic, or try to answer a basic question in a prospective blinded randomized fashion. Your desired study design is important to consider. Some projects are straightforward and easier to undertake than others. Start with several possibilities and narrow the list as you look at the question and how to get the answer. Make the time you will spend on the project worthwhile. See if your hospital administration would also find this information valuable and perhaps fulfill some of your administrative responsibilities as well. Evaluate both the validity and value of what you have chosen to do. If you are new to research, and your support is limited, start with a project that you feel confident you can complete.

Mentor
Your initial experience in research will be easier with a mentor to help you in defining your research question or goal, designing the study, preparing the required IRB application, helping with securing funding if that is a necessary part of the project, and all the details you would rather not learn about through trial and error. The ideal mentor lives down the hall and is always available. An acceptable mentor lives across the nation and is reasonably available by phone and email. Your mentor should be familiar with clinical research, familiar with the resources available to you, and a friendly consultant for troubleshooting the inevitable problems and providing the needed criticisms. Many mentors will have certain expectations of you, and you should similarly have expectations of them. It is more helpful if you talk with them at the earlier meetings about these expectations and come to a meeting of the minds.

Administrative Support
Although your institution may not have the same interest in formal research that you have, they should. They are paying you for your expertise in committee work, improving patient safety, developing practice guidelines, and helping with process improvement. The ideal way to fulfill your responsibilities is to approach projects with the rigor of formal research, even if you never intend to publish your findings. In the interest of patient safety and medical ethics, following the research model is preferred. Hospital administration and clinical staff in your hospital are professionals who have had exposure to research during their educational experience. They will likely have an interest in participating with you (and having their name on the publication) to improve their own resumes if that possibility is made known. It is quite helpful, nearing the point of essential, to win their support. Be prepared to devote the time and effort needed for laying a foundation, negotiating a mutually beneficial project, and keeping them up to date on your progress if research support is not a normal part of their business practice. Also, make sure to have regularly scheduled meetings with your administrators to SHARE the data – this will be extremely important to continue to show them your worth.

Analyst
A critical research resource is a good statistician/analyst. Your mentor can be extremely helpful here. Find a good statistician with some time available, and start early with them. They do not work for free, you will need to either use an analyst associated with your hospital with their permission (this may be easier if you have certain administrative roles), or find funding to cover the cost. Analysts can be extremely helpful early in the process with defining your research question and study design to ensure your project will result in the appropriate data to answer the question.

IRB
Is the IRB your friend or foe? Although the IRB adds time and paperwork to your project, their function is essential to ensure project design will accomplish what you desire, you are complying with HIPAA regulations, and that you are planning an ethical intervention or modification of ‘usual and standard practices’. Get to know your IRB. They can be a very useful resource. The process of preparing an IRB application also forces you to examine your project carefully, and design it to be successful. For quality improvement projects with the intention of limited institution-only communication of the results, you may not need to

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Professional Opportunities

Inpatient Pediatrics and Neonatology, Philadelphia

The Children’s Hospital of Philadelphia has an outstanding opportunity for a board certified/eligible pediatrician to join four outstanding pediatricians in a beautiful short community. The CHOP Connection is a series of pediatric hospitalist programs in excellent community hospitals. The program includes a Pediatric Inpatient Unit, a Level II Intermediate Care Nursery, coverage of the Delivery Room, and consultation in the Emergency Department. Salary and benefits are highly competitive.

For consideration, forward curriculum vita to:
Mark Joffe, MD, Director, Community Pediatric Medicine
The Children’s Hospital of Philadelphia
34th and Civic Center Blvd
Philadelphia, PA 19104-4399
E-mail: joffe@email.chop.edu
www.chop.edu

An equal Opportunity employer M/F/D/V

The 2nd International Multidisciplinary Conference on Pediatric Procedural Sedation
May 31-June 1, 2006

Hilton Columbus Easton Towne Center Columbus, OH

This unique conference will explore the current state-of-the-art and science of Pediatric Procedural Sedation. Together, colleagues from multiple specialties including Anesthesiology, Emergency Medicine, Radiology, Nursing, Critical Care Medicine, Pharmacology, Dentistry and Medical Administration will discuss the most timely and controversial issues in the field.

Brochure to be mailed December, 2005
www.columbuschildrens.com/conferences

Pediatric Hospitalist- Canton, Ohio

Be a Big Fish in a Small (but Growing) Pond!

We are seeking well trained and confident applicants for our Pediatric Hospitalist group. Our service cares for over 1300 patients per year, with more than 3000 Patient Encounters. We have grown to care for over 95% of Medical Admissions to Pediatrics, and Consult on a growing number of Surgical Admissions as well. We offer Consultative services to our Office-Based Colleagues, as well as our Emergency Department. In addition, there are teaching opportunities with Family Practice Residency Program and Medical Students, as well as opportunities for Clinical Research in PRIS and EMNET.

Our 31 bed Pediatric Unit is part of Aultman Hospital’s 682 bed Health System. Aultman is located in a Very Affordable, Family-oriented Community with an Outstanding School system.

Our Group is a Private Physician Corporation of 4 Neonatologists and 3 Pediatricians. We have provided Pediatric Hospitalist Services since 1994, with Neonatology since 1983. You will receive an Excellent Salary and Benefits with an opportunity for early partnership. Average 1:4 Call, take Call from Home with Residents In-House overnight.

Please Contact:
Dr. Tim Kilkenny
2600 6th St, SW
Canton, OH 44710
330-363-5430
tkilkenny@aol.com

Pediatric Hospitalist, Philadelphia, PA

Join an energetic team of pediatric hospitalists that practices evidence-based pediatrics in a community hospital in suburban Philadelphia. Holy Redeemer Hospital plans to hire a full-time pediatric hospitalist to join our group. We are located just beyond northeast Philadelphia near Huntingdon Valley.

Clinical responsibilities include: management of all pediatric inpatient admissions (unit size is 10-14 beds), consultation for medical management of certain pediatric surgical patients, consultation for complicated pediatric patients in the emergency department, and evaluation of “private” patients in the emergency department when requested by a child’s primary care physician.

Excellent clinical skills, communication skills, and teamwork a must. Competitive salary and benefits. No delivery room or nursery responsibilities.

Please call or email and send CV to:
David Cooperberg, MD
Director, Holy Redeemer Inpatient Pediatrics
1648 Huntingdon Pike
Meadowbrook, PA 19046
Phone: 215/938-2748 Fax: 215/938-4610
dcooperberg@holyredeemer.com

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Professional Opportunities

Academic Pediatric Hospitalist, Ann Arbor, MI

The Department of Pediatrics at the University of Michigan is recruiting individuals with enthusiasm for patient care and teaching to join our 10-member Academic Pediatric Hospitalist Service at CS Mott Children’s Hospital in July, 2006. Ours was one of the country's first 24/7 programs staffed by clinician-educators. High quality graduates from pediatric and med-peds residencies, as well as chief residents and former chief residents are encouraged to apply. We anticipate openings for one entry level hospitalist, intended for recent graduates, and at least one for an experienced hospitalist or general pediatrician with teaching, academic or hospital experience. Our hospitalists are the attendings for general service patients at C.S. Mott Children’s Hospital and are the key teachers of inpatient general pediatrics to medical students and residents at the University of Michigan. We also are the attendings for the normal newborn service with 4000 deliveries per year. Evening and overnight hospital shifts are shared by all team members. Each team member is assigned to approximately 11 weeks per year of weekend/evening shifts without daytime duties. Duties include: supervision of ward admissions by house staff and students; consultations on surgical, psychiatric, and specialty patients; performance of and supervision of procedures; providing procedural sedation-anaesthesia, attending deliveries, and performing circumcisions. Opportunities and dedicated time are provided for advanced training in procedural medicine, palliative care, child protection, teaching skills, and clinical research throughout the year. Positions are on the clinical track. Salary and rank will depend on training and experience.

Interested physicians may forward a CV and contact info to:

Kenneth Pituch, MD, Dir, Pediatric Hospitalist Service
University of Michigan Medical Center
1500 E Medical Center Dr, Box 0243
Ann Arbor, MI 48100-0243
E-mail: kpituch@umich.edu
734-615-7845

Pediatric Hospitalist, Southern New Jersey/Philadelphia Suburbs

Full-time and part-time positions available due to program Expansion with Virtua Inpatient Pediatrics. Our activities include general pediatric ward, PICU, nursery and ER at two community hospitals. This is an outstanding opportunity for individuals interested in practicing across a wide range of hospital medicine activities with a focus on hands-on clinical activity.

If interested, submit CV to: Jack Percelay, Director Virtua Inpatient Pediatrics jperceleyMD@yahoo.com

BE/BC Pediatric Hospitalist, Spokane, WA

Sacred Heart Children’s Hospital is seeking an experienced BE/BC Pediatric Hospitalist. Join our Pediatric Hospitalist Program and a team of dedicated health professionals providing high-quality inpatient children’s services in a caring environment. Work closely with Pediatric Trauma Center, general pediatric unit, PICU, NICU (level III), and Pediatric Surgery.

Our new Children’s Hospital is the state-of-art 154 bed facility-serving children throughout a four state area. Children’s Hospital is located on the campus of Sacred Heart Medical Center (SHMC), the largest hospital (623 bed) in the region and serving 1.5 million people.

Located between the Rocky and Cascade mountain ranges Spokane offers a mild four-season climate. Spokane provides, excellent schools, (K-12) with numerous colleges and universities in the area, affordable housing and an abundance of outdoor recreation activities. A great place to raise a family.

For more information contact:
Kevin Malee, Providence Physician Services
Phone: 800/442-8536 or 509/232-1189
Fax: 509/232-1196 E-mail: maleek@psew.org

Board-Certified Pediatrician, Phoenix area

We are seeking a board-certified pediatrician to join our growing, private pediatric hospitalist practice. Our group provides pediatric hospitalist inpatient and newborn care coverage for almost 100 private pediatrician and family physicians at Banner Children’s Hospital and three community hospitals in the Mesa area, just East of Phoenix.

Our physicians work every other week, with 26 weeks off each year. Call is two nights during each work week, taken from home. There are no residents at these hospitals – this is a clinical, non-teaching position. You must be comfortable seeing healthy and special care newborns, as well as the ward patients. Deliveries are attended to by NNP’s and neonatologists; PICU care is provided by 24/7 intensivists. Competitive salary, benefits and CME.

Interested physicians forward CV to:
Steve Mousser, MD, FAAP
Desert Pediatric Hospitalists
Phone 480-220-9060
Fax 480-659-9333
smousser@cox.net
How to Get a Job As a Pediatric Hospitalist

So you have thought about becoming a hospitalist and are ready to take the plunge and look for a position. Here is a checklist for you as you make your way through the process:

**Step 1: Finding an opening**

While many pediatric hospitalist programs have existed for some time, new hospitalist programs are still starting up across the nation. Though nationally there may be more positions than there are hospitalists to staff them, identifying and contacting sites of interest may be your greatest challenge.

- Call or send a letter to hospitals of interest. Consider including large academic children’s hospitals as well as community hospitals based on your practice interest. If you send a letter we recommend making a follow-up call about a week later.
  - To determine whom to contact: ask for the director of the pediatric hospitalist team. Other team names may include the pediatric in-house doctor or the inpatient pediatric doctor.
  - If the operator is unsure if such a team exists, you may want to ask for the Chair of Pediatrics.
  - Another option is to talk to the nurse manager on the general pediatric ward. S/he will be able to let you know if hospitalists are involved in inpatient care at the institution, and will probably be able to give you some specific names for physician contacts so that you don’t need to cold call and can write a letter to a specific person.

- Check out ads in the back of *Pediatrics* or in the SHM publication *The Hospitalist*.
  - Don’t limit yourself to published ads, though. Most programs don’t advertise and fill through local searches and word-of-mouth. This is fine if you are a graduating resident looking to continue within the same institution or locality, but makes it a little harder to find a job when you are looking to move into a new area.

- Call/E-mail the AAP SOHM representative for the states you are looking in.
  - The list of state representatives is available through the AAP SOHM. Contact: Niccole Alexander at nal-exander@aap.org.

- Join the AAP SOHM
  - It costs $25 for residents to join the section; on the member’s center Web site you will find a growing list of program descriptions and directors.
  - At minimum join the SOHM LISTSERV® (IT’S FREE!). Lots of discussion occurs here re: pediatric hospitalist jobs and issues we face as hospitalists, and you can post that you are looking for a position. (Don’t post your CV on the LISTSERV. A simple notice with clear subject heading “PL-3 from Program X seeks hospitalist position in Region Y” with text stating CV and references available on request will usually suffice.)

- Consider joining other Hospitalist organizations
  - The Society for Hospital Medicine (SHM) focuses on adult hospitalist activities, but logistic issues overlap significantly with pediatric activities. There is an active Pediatric Committee. More information is available at www.hospitalmedicine.org.
  - The Ambulatory Pediatric Association has a Hospital Medicine Special Interest Group. This organization focuses on academic hospital medicine with an emphasis on research and resident education. More information is available at www.ambpeds.org.

**Step 2: Considering your options**

Pediatric Hospitalist programs are not all the same. You’ll want to ask about a number of the things in the list below and consider your skill sets as well as what you would like to do as a career and balance this with your lifestyle needs. Make sure to spend a fair amount of time interviewing with the people you will be working with and getting a sense of what the overall environment is like.

- Job description: Does the job include work in any of the following areas and what percentage of time is spent with this group of patients?
  - Pediatric Critical Care
  - Neonatal Critical Care
  - Pediatric Ward Service work
  - Emergency Room work (either as a primary ER physician or as a doc who assists in the ER on occasion)
  - Complex Medical Care (i.e., patients with chronic issues including neurologic, g-tube feedings, etc.)
  - Patient transport

- Professional Development
  - If a job requires advanced skills such as intubation, resuscitation, line placement, chest tube placement, how are skills maintained, and is special training required? Also, who is your back up in these scenarios if you need support and how quickly are they available?
  - Is there funding and time allotment for continuing medical education?
  - How will your work be evaluated? What criteria will be used, how frequently, and by whom?
  - Is research required or is the position clinical only?

- Shift Structure: This varies widely across programs.
  - How many shifts is in a contract year and how are you paid for them? (i.e., are you

*Continued on p. 20*
Negotiating with Your Department Chair

One of the best books I have ever read on negotiation is Getting To Yes: Negotiating Agreement Without Giving In by Fisher, Ury, and Patton. There are many other books and experts out there that claim to have all of the answers to effective negotiation, but I have not found anything better than Getting To Yes. The basic premise of the authors is that we negotiate every day, and to be most successful in these every-day negotiations is to focus not on the other person’s position, but on the merits of the desired outcome. “Attack” the underlying issue with an emphasis on seeing the negotiation as something that can be resolved by discovering a “creative solution” rather than a zero-sum game with a winner and a loser—a “win-win” solution.

Another thing I found useful in this book was the concept of BATNA—best alternative to a negotiated agreement. The way I think about this part is that there are five potential outcomes from any negotiation: (1) I win, you lose, (2) I lose, you win, (3) We both lose, (4) We both win (win-win), and (5) No deal. As you think about negotiating anything with your department chair, consider these five alternatives fully because one of the potential outcomes is “No Deal,” and you walk away from this situation with no resolution of the issue. If you are negotiating your salary or advancement, you may reach a point of “No Deal” and have to have a plan to find another job.

“Effective negotiation is 10% technique and 90% attitude.” (“Take It Or Leave It: The Only Guide to Negotiation You Will Ever Need”, Inc., August 2003). Really good negotiators are not those charismatic characters that just leave you in awe with their style; they are people who know themselves inside and out. They are completely aware of their strengths and weaknesses. They possess high self-esteem, think clearly under stress, are extremely good listeners (including having a superb understanding of body language and voice inflection), and possess stamina to persevere against all odds. Therefore, to be successful in negotiating with your department chair you’ll need to spend time in understanding yourself and studying exactly what you want from any negotiation. In my experience, physicians who are not successful in negotiating are not clear on who they are, how they react under stress, and do not have a clear sense of what they really want out of the negotiation.

Now to the advice section on how to make a negotiation work for you. First, be absolutely clear in your own mind what is acceptable and not acceptable as far as outcome, and stay focused on the issue being negotiated—know exactly what you want. Prepare, prepare, prepare and remember BATNA!

Second, become an effective communicator. Listen and observe what is going on in the room with everyone present including you. Ask questions, but give the other person ample time to talk, and use silence to your advantage—no one likes silence and will fill in the silence with conversation frequently revealing something that you can use to your advantage.

Third, be aware of your own emotions, and if there is a point in the negotiation where emotions are starting to surface, stop, and try to name the emotion in a non-threatening way (e.g., I sense that you are angry).

Fourth, “discover interests, probe positions” by clarifying what you are interested in achieving and by avoiding putting some offer on the table that can be either accepted or rejected. Also, try to determine what your division chair is interested in achieving from this negotiation, encouraging him/her to avoid some position. An explicit discussion of interests is a necessary prerequisite for developing a creative solution. When all the interests are finally on the table you have the building blocks for a stable, fair, mutually beneficial agreement.

Fifth, look for mutual gains. Your chair will seriously consider those proposals which advance his/her self interest. So any solution has to take this into account. In taking a position, you will reinforce the adversarial nature of negotiation. By looking for a mutually favorable outcome you will construct an outcome that appeals to the self-interest of your chairman. Now, this can feel dangerous, and your chair may wonder why you are so interested in his/her side. But you are looking for ways to draw him/her closer to your side by aligning your respective interests in the most efficient way.

Sixth, cite objective standards. Positional bargainers often see negotiation as an exercise in power. They search for leverage to coerce the other side into the terms they want. The overt or implied message is, “You need me, I don’t need you!” Pit two such bargainers together and you have a classic test of wills, each ready to show the other how tough and inflexible they can be. However, you want to be an interest-based bargainer who is attempting to shift the basis of decision-making from force to persuasion, from will power to external standards of fairness and equity. In essence you are asking the questions, “What would a judge rule? What are the standards for our profession? What precedents apply? What marketplace norms make sense in our situation?”

Experience has been a great teacher. I have used these techniques to successfully build a department and to avoid pending disasters that I inherited from a previous department chair. I have been teaching this to faculty for a number of years and the ones who have taken this advice seriously tell me that it does work. Thus, I am certain that it will work for you, and I wish you the best as you become proactive in managing your career.

Fred McCurdy, MD, PhD, MBA, CPE
fred.mccurdy@ttuhsc.edu

About the Author
Fred McCurdy is Professor & Regional Chairman of Pediatrics at Texas Tech University Health Sciences Center in Amarillo, Amarillo, Texas.
We created a dedicated Pediatric Hospitalist service at Kaiser Medical Center Santa Clara in July, 2001. The service was started because of both inpatient and outpatient service needs. Our practice is unique in that we are part of the largest HMO in California and have widely varied clinical and teaching responsibilities. Our goal is to provide outstanding patient care while preventing burnout and maintaining a balanced lifestyle.

History of the Service
Prior to July, 2001, pediatric inpatient coverage at Kaiser Santa Clara (KSCL) was provided by rotating attendings from the Department of Pediatrics. This included a mixed group of generalists and specialists with varied degrees of interest and expertise in inpatient medicine. Night coverage was shared between this group of staff physicians and Pediatric PL-2s from Lucille Packard Children’s Hospital at Stanford. This system had a number of weaknesses. For the Kaiser physicians, the more time they spent on the inpatient service the less available they were to their clinic patients. For a number of physicians, the combination of inpatient coverage, vacations, education, etc., amounted to about 40% of time out of clinic. For the inpatient service, every other night was covered by a PL-2 without in-house attending coverage. This led to erratic patient care in both venues.

In the months leading up to July 2001, a number of forces combined to make us re-evaluate our inpatient coverage. Kaiser Foundation Health Plans and The Permanente Medical Group decided as an institution to emphasize “panel management” in the clinics. This meant that outpatient providers had to be in clinic more consistently than our current system allowed. We also decided that a Kaiser patient admitted to the hospital deserved a face-to-face interaction with a Kaiser physician. As our inpatient population grew in numbers and complexity this required the 24/7 in-house presence of a staff physician. Some years earlier, our Internal Medicine department decided to follow suit and created the Pediatric HBS (PHBS). We also decided that a Kaiser patient admitted to the hospital deserved a face-to-face interaction with a Kaiser physician. As our inpatient population grew in numbers and complexity this required the 24/7 in-house presence of a staff physician. Some years earlier, our Internal Medicine department decided to follow suit and created the Pediatric HBS (PHBS).

Our team consists of six full-time pediatric hospitalists and one and one-half pediatric intensivists. With this core group and occasional moonlighters we cover a variety of clinical areas as outlined below. This variety of responsibilities avoids burnout, especially during the hectic inpatient winter season. Despite our busy night and weekend call schedules we each actively participate on hospital committees and other special projects specific to pediatric inpatient care.

Responsibilities
Pediatric Ward
Our core responsibility is the care of patients admitted to the pediatric ward and PICU. We have a 19-bed ward, with about 1,100 admissions per year and average daily census of 11. We are the primary service for all non-surgical pediatric patients including subspecialty admissions. This includes all diagnoses from common pediatric respiratory and infectious diseases up to complex chemotherapy regimens. Chemotherapy is our most common reason for admission with asthma and pneumonia second and third. We also consult on complex surgical cases and all surgical cases under two years of age. We have a great deal of subspecialty support as most pediatric and many surgical subspecialties are represented at KSCL.

We take a proactive multidisciplinary approach to rounds and patient care. On daily rounds, we have representation from Nursing, Pharmacy, Dietary, Social Services, Child Life, Child Psychiatry, Nutrition, and Patient Care Coordinators. We find three great advantages of this system. First, having everyone round together improves efficiency by reducing repetitive presentations and multiple discussions with various different team members throughout the day. Everyone hears the same story at the same time. Second, receiving input from every member of the team often gives us information that we would miss if the doctors rounded in isolation. We get a much broader view of the patient’s problems, progress and psychosocial issues. This benefits our patients and their families. Third, these open, multidisciplinary discussions make rounds more interesting and build collegiality among the various disciplines.

Pediatric ICU
Our six-bed PICU is adjacent to our ward and is covered by the same team that covers the ward. The PICU has about 375 admissions per year with an average daily census of four. The unit handles all cases except trauma and cardiac surgery. A pediatric intensivist rounds with the covering team each morning and is available for consultation and to come to the bedside at all times. About half of our PICU admissions arrive by our own pediatric critical care transport service. We cover a wide geographic area and often have patients from over 100 miles away. We care for patients with severe neurologic, respiratory and hemodynamic failure. We use up-to-date modalities including high frequency oscillatory ventilation and inhaled nitric oxide. As part of caring for these patients, members of the PHBS team learn to perform procedures such as oro-tracheal intubation, central venous catheter and chest tube insertion and basic bedside echocardiography. At KSCL, we also serve as the advice center for our sister pediatric wards at other Kaiser facilities. If needed, their patients are transferred to our PICU by our transport team.

Having pediatric hospitalists cover the PICU has been a great success here at KSCL. Working in the PICU is a wonderful source of professional satisfaction for the Hospitalists and it ensures a close and mutually beneficial working relationship with the intensivists and PICU staff. Patients benefit from having the same doctors care for their children during the transition from PICU to the ward.

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Hospitalists Abroad ~ A Hospitalist in Sri Lanka

I guess it’s been too long since I practiced inpatient medicine without such basic amenities as a laboratory. Despite being a sometime hospitalist in Albuquerque and Santa Fe, New Mexico, I was not ideally prepared for the situation in Kalmunai, Sri Lanka, when I became the de facto hospitalist there in September.

The non-governmental organization (NGO) that sponsored my trip had told me I would be working with the freshly-minted physicians at the hospital, but I assumed I was just there as an occasional consultant and teacher. However, I discovered I was the presiding doctor when I showed up at 8 am for rounds with the junior doctors at Kalmunai Base Hospital’s Ward 6, the pediatric ward, on my first Monday morning, still jet-lagged from a 26-hour journey from San Francisco to Colombo, and the subsequent grueling ten-hour drive across the country. My teaching in the Socratic manner was not expected; the junior doctors would look at me that morning and on many others for a disposition for the patients who had been admitted since my last visit rather than proposing a solution and asking for my assent.

Ward 6 has about thirty beds all in one large room, separated by about two feet, in three groupings. Mothers stay with their children, sleeping crammed up in the same four-foot cot as their child, regardless of age. There is one sink, one bar of soap, and one cloth towel per day. With such proximity and such sanitary facilities, it may not surprise you to learn that diarrhea spread rapidly among the closely-spaced patients.

Perhaps fortunately, a large proportion of the patients (I’d guess 60%) would never have been admitted to a hospital in the United States. They were children with ill-defined conditions: fever, abdominal pain, a prolonged cough, for example. Without a clear reason for admission, it was difficult to establish criteria for discharge!

About five percent were very sick – children with osteomyelitis, a child with thalassemia and septic arthritis, a child with severe dehydration. In the middle category were children with pneumonia or asthma or diarrhea.

The hospital has just a rudimentary lab where manual CBCs are done (but the doctors don’t trust them), and malaria smears, UFRs and SFRs (urine and stool full reports. U/as and stool microscopic exams and guaiacs) could be requested, and little else. X-rays can be obtained during the day. No chemistries or cultures are available. The closest option for these was 40 km (25 miles) north (but more than an hour on the very poor, very crowded roads of the war- and tsunami-torn east coast of Sri Lanka) in Batticaloa at a larger children’s hospital. My only other resource was a Nelson and a Red Book that a precious volunteer from Oregon had left; there were no other books and no Internet connection.

One morning I came in for rounds before my outpatient responsibilities and found a six-day old child admitted the night before with fever and ambiguous genitalia, which had been missed during the exam following birth. The infant appeared ill; I requested an IV and salt and hydrocortisone and a quick transfer to Batticaloa. The infant died in the ambulance. Salt-losing adrenal hyperplasia? I think so but will never know for sure.

On several occasions, it appeared as if a child might have a urinary tract infection, with more cells in the u/a than the usual six to ten, which were reported on nearly every child’s UFR. Unable to culture the urine, what should we do? Should we get an IVP and cystogram based on the suspicion of a UTI; should we send the child to Batticaloa just for a urine culture?

One night I was called in to the hospital by the surgeon, who had just admitted a child with a meningocoele, fortunately intact, which had also been missed during the neonatal period. The child had cellulitis of his arm that needed treatment, but he had to be transferred to Colombo for surgery on his back.

Perhaps the greatest surprise is that in this generally very poor country, the infant mortality is only 14/1000, just double what ours is, and that the life expectancy at birth is 73 years, not much less than our 77 years. All this in spite of the hospital situation and the fact that no one wears bike helmets as they ride four to a bike or motorbike on very crowded roads! Maybe the public health infrastructure is better than we have; maybe universal immunization makes a difference.

My conclusions from this fascinating and sometimes harrowing experience:

1) Clinical skills grow when you can’t rely on lab work and CT and ultrasound.
2) Despite this, a little laboratory goes a long way.
3) Pediatricians should take care of newborns so findings aren’t missed.
4) If a locality can’t afford to have lab tests available, it might be worth the investment to determine what is common in the area with selective lab work on a sample of children—screening for TB, finding common causes of bloody diarrhea, the prevalence of MRSA.
5) Good preventive care and public health measures may trump what we’d consider decent hospital care in keeping a population well.
6) Define your job expectations before you sign on for a job.
7) You (or at least I) can learn a lot from an out-of-body experience like Kalmunai, September, 2005.

Lance Chilton, MD

About the Author
Lance is a general pediatrician working at a University of New Mexico-associated clinic in Albuquerque. On about one weekend per month he serves as hospitalist on community hospital wards in Albuquerque or Santa Fe.

Need Volunteer Pediatrician (or Med Peds) to Serve One Year in Laos ~ See p. 10.
Triage of Patients Outside of KSCL
As we are the referral center for a large population and geographic area, we receive many calls that require triage to the appropriate facility. These calls come directly from other Kaiser facilities or from other offices when a Kaiser member is at a non-plan facility. The process of triaging these patients includes numerous factors including medical (Where is the best place for the patient to receive the required care?), geographic (Is there someplace closer than KSCL to the patient’s current location or home that is appropriate for referral?), functional (What is the best way to transport the patient?) and financial (Is the patient a Kaiser member?). During the day, there are other individuals to help with these decisions. At night, these decisions are usually made by PHBS physician in consultation with the transport nurse.

Transport
Once the decision is made to activate our Critical Care Transport Team, the PHBS physician and transport nurse discuss the appropriate team composition for the transport. If it is decided that a physician is needed, the transport physician is called in, accompanies the transport team and assumes care for the patient upon arriving at the referring facility. The transport physician is a member of the PHBS team and is available 24/7 (see Call Schedule). Transport is another of the unique and professionally satisfying aspects of our practice.

Emergency Department Consults and Clinic
We have a busy ED that has almost 6,000 pediatric visits per year. The vast majority of these visits are cared for by the ED staff. The PHBS physician is consulted on those cases that are more complex or may need admission. A recent additional challenge for us is that our clinics, that used to be on the same campus, have moved about one mile away. This means patients, who have had their medical screening exam in the ED and are triaged to clinic, can’t easily be seen at the clinic. So, these patients are now seen by the PHBS in an area adjacent to the ED. This system has been in place since spring 2005 and has led to three to four extra patient encounters per day during the summer. We anticipate this number will increase the other days of the week. The volume of this service is about three to five patients per week.

Skilled Nursing Facilities
The only two skilled nursing facilities (SNFs) in Northern California that accept children are both within five miles of KSCL. Thus, it falls upon our PHBS staff to care for a Kaiser member in these facilities regardless of the patient’s home location. These are generally medically complex, neurologically damaged children usually with tracheostomy and gastrostomy tubes. Our census at these facilities runs six to eight patients per day. We are required to see each child face-to-face at least once per week. In addition to this, we spend a significant amount of time caring for these patients by phone.

Clinic Follow-up
Our Department includes about 40 general and specialist pediatricians with clinics at four locations. The clinics close at 7:30 PM on weekdays and 5:30 PM on weekends. Follow up that must be provided at night after clinic hours is often signed out to the PHBS.

Advice Center Referrals
Kaiser Permanente has an advice center to take calls from members 24/7. The call center is staffed by nurses and physicians but they do not always have individuals with pediatric expertise available. When they deem it necessary for the member to speak to a pediatrician after clinic hours, the call is referred to the PHBS on-call.

Supervision of Trainees
We have an active teaching service. Our ward team includes pediatric PL-2s from Lucille Packard Children’s Hospital at Stanford (one to two per month), family practice interns from the San Jose-O’Connor Hospital Family Medicine Residency Program (one per month for six months of the year) and 3rd year students from Stanford School of Medicine doing their core pediatric rotation (two per month). Teaching is a highly rewarding part of our job. Rounds have a very academic feel with lots of open discussion about our cases and the respective roles of the medical literature and common sense. We give the trainees a more well-rounded view of community pediatrics than they would receive on a university service. Supervising trainees ensures that we stay up-to-date with our medical knowledge and care. This is an important, mutually beneficial part of our job.

Educational Conferences
We have taken it upon our selves to educate each other about pediatric hospital care issues. We meet twice a month for a combined educational and business meeting. One of us prepares a 20-30 minute presentation about an interesting clinical topic, case or recent journal article. We present evidence-based literature, discuss our approach and learn best practices from each other.
Starting a Research Career

Continued from p. 11

get IRB approval. Check with your institutional/local IRB for your specific requirements. We say the IRB is your friend.

Access to the Literature
It is very helpful to have access to the literature electronically, and the expertise of a good librarian, for background research. Pursue these resources through your hospital administration if they are not now readily available in your community. You can assure your administration that it is a very credible part of any hospital’s patient safety and quality improvement plans to add ready access to the medical literature, and this can be a great ‘gift’ to show appreciation for the medical staff at the same time. It can be cheaper and easier than maintaining a paper medical library for the staff also.

Assistance
There will be a commitment for time and human efforts collecting data, entering data in a database, and similar unglamorous necessities. Look to the professional staff you work with, particularly nursing, pharmacy, lab/pathology and radiology. House staff, medical students, and undergraduate students are also great potential resources. You will likely find people who are interested and able to give some time, particularly if your administration will appropriately protect some of their employees time for involvement in research. There may be funded undergraduate and graduate research assistance programs available at a university. In the ideal situation, you will have a formal funding process to pay for a dedicated research assistant; in the worst case, you will be doing most of the work yourself.

Computing Power
This one is usually pretty simple. One thing most hospitals will have is computing expertise. Software may be another issue. We recommend you speak with your statistician or analyst who will likely have some kind of statistical package they are both familiar and proficient with.

Publication Support
The payoff for all your hard work is sharing the results with others. A formal presentation to your hospital administration and staff if the project involved quality improvement and/or their support should be expected. You should seek opportunities to present your results at local, regional and national meetings. Appropriately cite institutional support you have received. Paper or electronic publishing assures the broadest dissemination of your contribution to evidence-based medicine. Find out what the specific guidelines or requirements are for the publication or meeting where your results will be shared. Make sure colleagues and your mentor review your presentations and writing to provide comprehensive criticisms before submitting the final copies. Give appropriate credit to all substantive contributors and take appropriate credit for your efforts as first author. It is great to see your name in print and this will make the next project seem much easier.

In summary, research can be an extremely rewarding process as long as you consider the necessary steps and resources that should be in place when you contemplate this step in your career path. As more hospitalists become involved in research and attaining these skills, the clinical questions faced on a daily basis will likely be answered by hospitalists, or hospitalists working closely with other researchers to improve the care of the inpatient population.

Bryan Stone, MD
Raj Srivastava, MD, MPH

About the Authors
Bryan Stone, MD and Raj Srivastava, MD, MPH are academic pediatric hospitalists in the Division of Inpatient Medicine at the University of Utah Health Sciences Center and Primary Children’s Medical Center, Intermountain Healthcare, Salt Lake City, UT. Dr. Stone is also the Medical Director on the Neuroscience Trauma Unit, Primary Children’s Medical Center, Intermountain Healthcare, Salt Lake City, UT. Dr. Srivastava is also with the Institute for Healthcare Delivery Research, Intermountain Healthcare.

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Practice Profile Continued from p. 18

Call Schedule
The features of our program that drive the number of physicians we need are the 24/7 coverage of the ward, PICU and transport needs and coverage of the Normal Newborn Nursery Monday through Friday during the day. This requires us to have three PHBS physicians on during the day and two PHBS physicians on at night. With vacations, educational leave, etc, this takes about seven FTEs. This is in addition to an intensivist who is in-house during the day and on-call from home at night. We currently have six FTEs and make up the rest of the shifts by having moonlighters and clinic staff assist with coverage.

We put a great deal of thought into designing our call rotations. We concentrated on providing continuity of care on the Ward/PICU while maintaining blocks of time off and not working too many weekends. The resulting system is complex but seems to strike this balance well. Here is our current schedule:

A1: covers Ward/PICU M-F 8:30-5:30 and 24 hr on Su
A2/T: helps round on Ward/PICU M-F 8:30-12:30, then covers Transport and SNF M-F PM/overnight and covers Ward/PICU 24 hr on Sa
B1: covers Ward/PICU M, W, F overnight
B2: covers Ward/PICU T, Th overnight
T: covers Transport F 5:30 – M 8:30 including 24 hours Sa/Su, comes in to help with rounds AM Sa/Su if needed
N: covers NNB M-F 8:30-5:30

We try to group the A and B rotations so the PHBS physician is familiar with the patients in the hospital, but does not work too many daytime weeks in a row. Because of all the night and weekend call, each PHBS physician gets a week without clinical responsibilities every 7 weeks. This does not count as vacation because he/she has already worked enough to fill a full-time schedule. Finally, we let members of the team personalize their responsibilities as much as possible. Some choose to do more night and weekend call, some choose to do more NNB.

Future Plans and Challenges
We have a number of challenges facing us now and in the coming years. We have been charged to automatically consult on all surgical patients. This will increase the number of patients we follow by about one per day. We also expect the patient volume in the ED referral clinic to increase during the winter. This combination may stress our staffing needs in the coming months.

In approximately two years, we will be moving into a new hospital with more pediatric beds. At that time, one or two of our sister facilities will close their Pediatric Wards and the patients will come to us. We expect this process to increase our current census by 50-75%. We will have to increase our staffing on the ward to handle this patient load.

On the positive side, Kaiser Permanente is transitioning to a fully electronic medical record (EMR). There are a lot of “growing pains” involved in this process. Members of our team are currently working on designing templates for the most common diagnoses, procedures etc. This takes an enormous amount of work but should pay off in the long run. Once the EMR is up and running, all orders, notes, requests for consults, labs, tests, discharge information will be electronic. This should help increase our efficiency, reduce errors and, we hope, be welcomed as advancement by our members.

Jonathan D. Feldman, MD, Director Pediatric ICU and Inpatient Care
Laurie Liang, MD, Team Leader Pediatric HBS

Get a Hospitalist Job
Continued from p. 14

paid based on how many hours you put in in a given payroll period, based on how many patients you see or based on a salary divided evenly across the year?)

- How many hours of the job are in-house versus on-call from home?
- Under what circumstances is a physician expected to come in from home and how often does this occur?
- If you come in from home is this factored in to your pay?
- If someone goes out on leave and the work distribution changes in the course of year, how is this handled financially and logistically
- How are night, holiday and weekend shifts handled?

Step 3: Making a Decision

Once you have identified a program it is time to negotiate salary, benefits (don’t forget malpractice coverage et al!) and any other points in the contract. We recommend that you have a lawyer review your contract (your residency programs should have recommendations on a local expert). You’ll also want to consider local and national standards for pay and benefits. This can be challenging. Some information on hospitalist salaries and benefits in general is available through the AAP SOHM salary survey as well as through the Society for Hospital Medicine productivity survey, but remember positions and requirements vary greatly and so may the salaries!

We hope you find hospital medicine as rewarding as we have. Our field is still young and growing so we welcome your input and encourage you to join other hospitalists at conferences or on the AAP LISTSERV®. There is also a SOHM newsletter available on the Web site and through the mail to members, which highlights cases, program outlines, billing issues and upcoming events. Good luck from all of us!
Don’t miss your chance to join over 700 clinicians, parents, government officials, health plan and public health administrators and clinical leaders, healthcare suppliers, and content experts attending NICHQ’s 5th Annual Forum for Improving Children’s Health Care on March 16-18, 2006. Enroll now by visiting www.nichq.org. Building on the theme of Forging Connections: Creating Seamless Health Care for Children and Their Families, the Forum includes:

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- NEW Scientific Session showcasing the best in quality improvement research.
- Storyboard presentations by peers and colleagues from around the world.
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Visit www.nichq.org for details on sessions and activities.

We promise you will walk away from the 5th Annual Forum energized and with a supply of new ideas to start applying in your organization that CAN and WILL make a difference in how care is delivered to children and their families. Please don’t miss out on the opportunity to join this crucial endeavor.

Enroll by January 13, 2006, and save $100 off the regular enrollment fee.
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If you have any questions please contact Bonnie Rains at rains@nichq.org.

We look forward to seeing you in Orlando!
National Conference & Exhibition

Atlanta, GA October 7-10, 2006

SECTION ON HOSPITAL MEDICINE
Schedule of Section Program Activities
Monday, October 9 (tentative)

Moderator: Daniel Rauch, MD, FAAP
Education and Program Chairperson

8:00 am Poster Session
9:45 am Break
10:00 am Session: “HIPAA in the Hospital”
11:15 am Break
11:30 am Section Business Meeting and Lunch
1:15 pm Session: “Inpatient Ethical Issues”
2:30 pm Break
2:45 pm Session: “Issues in Post-Operative Care”
4:00 pm Adjourn

The 2006 AAP National Conference and Exhibition Section and Council programs provide a forum for discussion of clinical matters or research related to a particular subspecialty or special interest area. The SOHM has a longstanding poster program. Submissions by AAP members and nonmembers are welcome from late January to April 14. Submit electronically at http://www.aap.org/profed/cfa.htm.
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