An observable trend in pediatrics, during my tenure practicing in New York City, was the consistent truncating of pediatric divisions and services. One by one pediatric floors in hospitals closed, then pediatric emergency rooms until those specifically pediatric trained were staffing remaining facilities over less and less hours. Urgent care centers proliferated, and more and more they and adult emergency rooms stretched employees beyond the scope of their training to cover children and infants -- despite their discomfort with the proposition.

Errors in dosing and wrong diagnoses were consistently picked up when I would assess patients in follow-up. Don’t get me started on the unnecessary CT scan exposures, excessive antibiotic use or low quality care, in general.

The consolidation of pediatric-dedicated emergency and hospital services moved uptown. NYU Langone and Mt. Sinai-Beth Israel Medical Centers started to become the only game in town for lower to midtown Manhattan. Interhospital transfer to these and the remaining uptown facilities capable of servicing this population were becoming the norm.

These uptown institutions saw the opportunity to purchase or partner with the downtown struggling facilities as a feeder for their patient volumes. Sadly, now many have swallowed up independent practitioners, from pediatricians to pediatric specialists, making the prospect of remaining so even more challenging and a number of pediatric practices present in communities for years have closed.

Study shows confirmation of this trend

New research [2] published in the journal *Pediatrics* confirms this trend can be extrapolated beyond this unique urban center. (1) Recognizing that pediatric care was concentrating significantly in
Massachusetts, investigators from Boston Children’s Hospital and Harvard Medical School chose to see if this was a multi-state pattern. They reviewed inpatient and emergency department data sets from California, Florida, Massachusetts and New York “to measure transfer frequency and identify the site of care completion for >252 million hospital encounters from 2006 through 2013.” (This time frame reflects a substantial period of my experience in practice in NYC).

They found (paraphrased from study [2]):

- Availability of hospital care was significantly more limited for children than adults in all 4 states (such that the two systems must be considered separately)
- Interhospital transfer for pediatrics increased by 24.6%
- The number of hospitals caring for children declined in all 4 states
- Largest change in transfer rate was in kids with common conditions, like abdominal pain and asthma
- Conclusion: “We confirm that definitive pediatric care has concentrated such that even common pediatric conditions are now highly regionalized. Definitive pediatric hospital care is less available than adult care and is increasingly dependent on referral centers.”

**Why is this happening?**

Because pediatrics has typically been a financial loss for hospitals. This population can be quite labor intensive, for example, requiring multiple personnel to accomplish even basic procedures. As a result, less patients can be seen. Reimbursements are way less than the adult sphere. Equipment has to be available in many gradations given the changing structure and physicality of the developing child, in the adult world it is often one-size-fits-all. Neonates to toddlers to teens require different sized blood pressure cuffs, dosages, and specifically trained specialists and staff to treat congenital disorders to cookie cutter conditions. There are uniform adult dosages in the medical world, not so for pediatrics as medications are traditionally based in mg/kg per dose.

Pediatric admissions decreased by 9.3% from 2006-2011, which is not a surprise. Fortunately, there are many things pediatricians can do today in the outpatient setting to stave off an admission and there have been a number of advancements in the field. As a result, many hospitals might not do enough cases of a particular etiology to maintain a pediatric surgeon’s or pediatric cardiologist’s livelihood and clinical skills. So, it is quite common for specialists to go between several facilities to be able to achieve a sufficient caseload.

**The Good**

Interhospital transfer can be lifesaving if complex services are not provided at the originating hospital and with specific conditions.

Under some situations, this regionalization can provide cost-savings.
See Top 10 List Is Out! But Are Children’s Hospitals Worth It Anyway? \[3\] where I go in-depth about the benefits of children’s hospitals and answer the question of whether academic, community and other more general facilities are good enough for pediatrics.

**The Bad**

Interhospital transfer can be life-ending or complicating if it delays care to a profound degree given certain conditions.

Under many circumstances, regionalization can be costly and add on extraneous expenses. That’s not simply on the healthcare delivery side, but consider family travel and lodging alone as an additional burden should their child be admitted or transferred far from home.

It used to be that even if a community, academic or general hospital couldn’t provide critical care services, they had appropriate ancillary staff to stabilize for transfer. With less and less exposure to complicated patients and now with even less exposure to the very bread and butter pediatric conditions like appendicitis, gastroenteritis and leg fracture, capacity to provide safe and informed care will continue to decline. Access to hospital care is crucial to remaining current or up-to-date and such a lack is detrimental to disaster preparedness success, public health efforts and an adequate network of providers.

This report \[2\] affirms that a growing number of hospitals with varying capabilities and size are adjusting services - up or down - based on the fewer available referral partners. Those whose bottom line can’t survive the consolidation are closing. It also acknowledges all states showed high capability for adult care in most acute-care hospitals while it failed to demonstrate the same for pediatrics.

Again in all four states, the scope of conditions treated showed decline with few acute-care hospitals able to deliver a high capability for pediatric care. Regionalization of all pediatric hospital care increased in all states studied, so dependence on them increased as well.

**The Ugly**

Common conditions being treated at regionalized centers intended to handle complexity will become overburdened. Many already are. Quality will be impacted. Rural, community and even more populated locations not geographically in close proximity to a regionalized center will lose more and more access to experienced, well-trained staff.

Maintaining competency is of vital importance and this trend does not benefit that. It is important for pediatricians to have hospital relationships for continued learning, an ability to treat their admitted patients directly for greater continuity of care (which leads to improved outcomes), testing services as well as specialists etc.

A loss of this capacity now encourages a more ambiguous future.

Regionalized hospital and academic centers will even further erode the ability for physicians to be independent. Furthermore, many of these behemoths have designed their employee structure to emphasize perverse incentives which likely will contribute to greater dissatisfaction. These algorithms and management systems rarely value high quality care. Given the current and
expected continued doctor shortage with nearly 1 in 50 expecting to leave the field entirely in the next 2 years to focus on a different career, another avenue to devalue them doesn’t seem particularly wise or prudent (see here [4]).

Source:

(1) Trends in Regionalization of Hospital Care for Common Pediatric Conditions [2]

Urbano L. França, Michael L. McManus

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