It Is What It Is…. For Now.

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This issue of the *Journal of Hospital Medicine* addresses an emerging trend in internal medicine graduate medical education: the hospitalist rotation.

In the article, Training Residents in Hospital Medicine: The Hospitalist Elective National Survey (HENS). by Ludwin et al., the authors present a descriptive overview of the composition of hospital medicine rotations, as described by program directors from some of the largest training programs. [1] It can be said for sure that hospital medicine rotations exist: half of the 82 programs that replied to the survey noted that a hospital medicine rotation was already in place. That is where the certainty ends. Although there are common themes across these rotations, there is no one clear definition of such a rotation. Like all good contributions to the medical literature, this study inspires more questions than it answers.

The Mark Twain-inspired cynic would be quick to make an interpretation of the hospital medicine rotation: Is this not just a clever way to coax residents into using their elective time to cover the service needs left over from Accreditation Council for Graduate Medical Education (ACGME)-mandated shift limits and admission caps? Seventy-one percent of these rotations were involved in "admitting new patients." And since forty-six percent were tasked with taking hold-over admissions, it is reasonable to surmise that these rotations are playing a role in covering patient care duties left over from traditional ward services.

But is there anything wrong with that? Within the confines of reasonable intensity, caring for more patients usually benefits a resident's education. And if the resident is learning knowledge, skills and attitudes that are unique from those that are acquired on a traditional ward service, painting the fence for free might not be that bad. The question is: "Does the hospitalist rotation help in the acquisition of those unique knowledge, skills and attitudes?" Although this study alludes to such unique components via its qualitative analysis (i.e., more autonomy, co-management of non-medicine services, etc.), it does not fully answer that question. It does, however, inspire the next study: How do residents perceive the unique and additional value (if any) of the hospital medicine rotation?

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For the sake of argument, let's say that residents' perception of the hospital medicine rotation is one of meaning and value. Does that matter? It is great if they do, but equally important is the question of whether or not hospital medicine rotations are effective in preparing resident graduates for a career in hospital medicine. This study suggests that those who have designed these rotations have tried to anticipate and address this need. Components such as quality, patient safety, co-management, and billing and compliance are all clearly a part of a hospitalist's practice, and all are elements that have not been traditionally emphasized in residency training. The question is: "Are these elements the knowledge, skills and attitudes that are most lacking in the residency graduate as he/she enters the practice of hospital medicine?" The unfortunate answer is that we do not know for sure, and this uncertainty has been the Achilles heel of our current residency-training infrastructure. Not unique to hospital medicine, there is simply not a well-defined feedback loop between practice requirements and residency training requirements. A structured and regular gap analysis comparing the residents' areas of competence at the end of training to what they need in practice, would go a long way in answering questions such as this one, and would most certainly inform the components of a hospital medicine elective going forward.

Even if the components of a hospital medicine rotation are valuable, and even if they do align with what the practice needs, there is still the question of whether a month-long hospital medicine rotation can even come close to closing the gap of what is needed versus what is delivered. One can surmise that the answer to that question is what has extended the "hospital medicine rotation" to the "hospital medicine track," comprised of a multiple of such rotations. Like all discussions on time-constrained medical education curricula, what will be discarded to make room for these rotations? In thirty-six months of training, there is opportunity cost: every month spent on a hospital medicine elective is a month that could have been spent on something else (rheumatology, nephrology, etc.). Again, this is not unique to hospital medicine; the same could be said of the resident who does too many cardiology electives at the exclusion of learning about endocrinology. It would be overly dramatic to say that devoting a month to a hospital medicine rotation, or any elective for that matter, meaningfully compromises the resident's overall competence as an internist. It is, instead, a question of degree: an excessive number of these electives would likely compromise the resident's overall competence. The likelihood of this happening is proportional to the size of the gap between what is required to effectively enter hospital medicine practice and what can be delivered in a month-long hospital medicine rotation. We return, then, to the question: How much

hospital medicine training in residency would be required to fully prepare a resident for the current practice of a hospitalist?

Whatever the answer might be, that question takes us to a difficult dilemma that has lurked in the background of residency training for some time now; one that is not at all unique to hospital medicine. Should residency training be "voc-tech" or "liberal arts"? A purist would argue that an understanding and appreciation of all things not hospital medicine is what truly makes for the great hospitalist. An understanding of primary care, for example, would seem to optimize a hospitalist's performance with respect to transitions of care. Adding to the gravity of such an argument is that residency might be the last time to acquire such "nonhospital-medicine" experiences.

Noting that the practice of hospital medicine being so dynamic and heterogeneous, the realist might pile on by saying that it is simply impossible to fully prepare a resident for the actual practice of hospital medicine. Further, many of these skills might be impossible to fully master outside of being fully immersed in the practice of hospital medicine (i.e., billing and coding). The best that can be done is to set a solid foundation that would enable them to learn further as they practice; there will be opportunities to learn the specific components of the field later on.

On the other hand, it is hard to justify residency training if the graduate is unprepared to practice, and without the fundamental knowledge, skills and attitudes specific to their career as they practice. For example, it is reasonable to suspect that a new hospitalist who has had no prior training in quality improvement will, because of the inertia that comes with engaging in any new and foreign skill, find it much harder to engage in quality improvement as a part of her career. It is also worth considering the role that mastery, autonomy and purpose have upon the overall residency experience. Engaging in electives that have a palpable purpose for the resident's eventual career, and engender an opportunity to begin developing a sense of mastery in that field, could be an effective antidote in mitigating the burn-out that is far too common in residency training today.

For residents engaged in a future practice of hospital medicine, the hospital medicine rotation seems like a promising way out of this dilemma. An effectively designed elective approach could enable maintaining a core foundational education, while getting an early start on the specific components necessary for a promising career in hospital medicine. The operative words, of course, are "effectively designed." What exactly does that entail? That is why this study is so important; even if we do not fully know what it should look like, we now have our first glimpse of what it is.

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References:

1. Ludwin S, Harrison J, Ranji S, et al. Training Residents in Hospital Medicine: The Hospitalist Elective National Survey (HENS). *J Hosp Med*. 2018;13(9):623-625. doi: 10.12788/jhm.2952