Waiting for Godot: The Quest to Promote Scholarship in Hospital Medicine

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Twenty years into the hospitalist movement, the proven formula for developing high-quality scholarly output in a hospital medicine group remains elusive. In this issue of the *Journal of Hospital Medicine*, McKinney et al. describe a new model in which an academic research coach—a PhD-trained researcher with 50% protected time to assist with hospitalist scholarly activities—is utilized to support scholarship.[1] Built on the premise that most hospitalist faculty do not have research training and many are embarking on their first academic project, the research coach was available to engage hospitalists at any stage of scholarship from conceptualizing an idea, to submitting one's first IRB, to data analysis, and grant and manuscript submission. This innovation (and the financial investment required) provides an opportunity to consider how to facilitate scholarship and measure its value in hospital medicine groups.

Academic institutions are built on the premise that scholarship—and research in particular—is of equal value to clinical care and teaching; a perspective that is commonly enshrined in promotion criteria that require scholarship for career advancement. While hospitalists are competent to begin clinical practice and transfer their knowledge to others at the conclusion of their residency, most are not prepared to lead research programs or create academic products from their clinical innovations, quality improvement, or medical education work. Yet, particularly for hospitalists who choose to practice in an academic setting, the leadership of their Section, Division, or Department may naturally expect scholarship to occur, similar to other clinical disciplines. In our experience as the directors of research and faculty development in our hospital medicine group, meeting this expectation requires recognizing that faculty development and scholarship development are intertwined and there must be an investment in both.

We believe that faculty development is required—but not sufficient—for the development of high-quality scholarship. In order for hospitalists to generate new knowledge in clinical, educational, quality improvement, and research domains, they must acquire a new skill set after residency training. These skills can be gained in different formats and time frames such as dedicated hospital medicine fellowships, internal faculty development programs, external programs (eg, Academic Hospitalist Academy), and/or individual mentorship. Descriptions of internal faculty development programs have unfortunately been limited to a single institutions with uncertain generalizability.[2,3] One could argue that faculty development may even be *more* important in hospital medicine than in clinical subspecialties given the relative youth of the field and the experience level of the entry-level faculty. Pediatric hospital medicine may be farthest along in faculty development and scholarship development after becoming a distinct subspecialty recognized by the American Board of Pediatrics and American Board of Medical Specialties; pediatric hospitalists must now complete fellowship training after residency before independent practice.[4] Importantly, completion of a scholarly product that advances the field is a required component of the pediatric hospital medicine fellowship curricular framework.[5] Regardless of what infrastructure a hospital medicine group chooses to build, there is a growing realization that faculty development must be firmly in place in order for scholarship to flourish.

In addition to junior faculty development, there is also a need for scholarship development to translate new skills into products of scholarship. For example, a well-published senior faculty member still may need statistical assistance and a midcareer hospitalist who leads quality improvement may struggle to write an effective manuscript to disseminate their findings. McKinney et al.'s innovation seems intended to meet this need, and the just-in-time and menu-style nature of the academic research coach resource is unique and novel. One can imagine how this approach to increasing scholarship productivity could be effective and utilized by busy junior, midcareer, and senior hospitalists alike. As the authors point out, this model attempts to mitigate the drawbacks that other models for enhancing hospitalist scholarship have faced, such as relying on physician scientists as mentors, holding works-in-progress or research seminars, or funding a consulting statistician. A well-trained scientist who meets hospitalists "where they are" is appealing when placed in the context of an effective faculty development program that enables faculty to take advantage of this resource. We hope that future evaluations of this promising innovation will include a comparison group to measure the effect of the academic research coach and demonstrate a return on the financial investment supporting the academic research coach.

Measuring return on investment requires defining the value of scholarship in hospital medicine. Some things that are easy to measure and have valence for traditional academic produc-

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tivity are captured in the McKinney manuscript: the number of abstracts, papers, and grants. Indirect costs from extramural funding may be particularly important for the financial "bottom line" of many hospitalist groups, which tend to be clinical cost centers in most academic institutions. However, other outcomes that are more challenging to measure may be equally or more important. Does investment in a model to support scholarly productivity lead to less burnout, higher retention, and greater professional satisfaction for academic hospitalists? Does this investment change group culture from "week on, week off" or "on service, off service" to one that has more balance in clinical and nonclinical pursuits?[6] How does investment in research development translate into national reputation, the ability to recruit outstanding candidates, or the number of hospitalist faculty who become interested in research careers? Measuring the impact of an academic research coach or other intervention on these factors might offer useful insights to drive further investment in hospitalist scholarship.

Measuring the value of scholarship in hospital medicine touches very near to the core of the value proposition of hospital medicine overall as a specialty. Without high-quality scholarship that demonstrates the influence of hospitalists in improving systems, leading change, educating learners, and advocating for the needs of our patients, why continue to invest in this model? We are struck every year at the Society of Hospital Medicine national conference about how much innovation hospitalists are leading – and how little is systematically evaluated or disseminated. In Beckett's "Waiting for Godot," Vladimir and Estragon talk about life and wait for Godot who, of course, never arrives. Instead of patiently waiting for more scholarship to arrive, we suggest that hospital medicine leaders follow the lead of McKinney et al. and take action by investing in it.

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