

## HANDOFFS

**Chief Resident Year as Stepping Stone to Attending  
Academic Hospitalist**

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Academic hospitalists have multiple duties including direct patient care, hospital management, teaching, and scholarly productivity. We are frequently pulled in divergent directions, while attending to these responsibilities. Without a framework to manage these assorted tasks, we are at risk of subpar performance and career dissatisfaction. Alternatively, we often thrive in our roles as utility players when armed with a developed skill set. Our profession could benefit greatly from encouraging future academic hospitalists to obtain further training prior to starting as an attending. Although hospital medicine fellowship training exists, there are still relatively few programs available. A well-crafted year spent as a chief medical resident (CMR) may be a viable alternative.

My year as CMR allowed me to develop the skills necessary for success as an academic hospitalist in a supportive setting, and has given me an advantage in accelerating my career. This experience provided me with important tools that my initial 3 years of internal medicine residency did not. Even during my final year of residency, I was focused mostly on obtaining medical knowledge, learning its clinical applications, and honing team leadership skills. My mind rarely trespassed into the broader concerns of quality improvement initiatives, educational enhancements, or hospital management issues. Although the American College of Graduate Medical Education (ACGME) core competencies are helping to better focus residents' attention to these more diverse aspects of healthcare, residents still spend the majority of their time providing direct patient care.<sup>1</sup> Now in my fourth year as an attending academic hospitalist, I continue to appreciate how my chief experience provided the foundation for much of the work I perform today.

My motivations for becoming a CMR included a desire to spend more time teaching and learning medi-

cine, and an interest in helping to improve the residency program itself. I did not appreciate how much of the job would be spent managing people, and evaluating systems of care within the hospital, while working closely with nurses and hospital administrators. However, the skills I learned while addressing those unexpected tasks are what continue to help me in my position as a multifaceted hospitalist today. CMRs have been described as middle managers, being "pushed and pulled by the demands and requirements of the groups above, below and around them."<sup>2</sup> Academic hospitalists who frequently wear administrative and educational hats are not dissimilar. Retrospectively, I realize how fortunate I was to be exposed to those aspects as a CMR, with many of the same responsibilities but without the full expectations of a more seasoned attending.

The most memorable interaction during my first day as junior ward attending was with a revered internist, himself a former CMR, who dryly commented, "So, you're pretending now." It took me a moment to catch his play on words until he clarified, "you are now a pre-attending." The true meaning of this was elucidated over the next several weeks as I was expected to perform many of the same duties of a seasoned attending, but often had the sense that I was only pretending to be an attending and still had much to learn.

CMR positions vary in terms of clinical, educational, and administrative responsibilities. Moreover, many institutions mix inpatient and outpatient roles. My position was focused almost entirely on inpatient duties at a single hospital, which gave me an in-depth and longitudinal view of how a hospital is managed. Like many other CMRs, much of my time was spent on educational activities, such as running morning report, preparing for chief of medicine rounds, coordinating noon teaching conferences, and spending time with the medical students. Administrative tasks included various institutional-based meetings for student grading, educational review committees, and program scheduling. In addition, I spent 1 month as junior attending on a ward team. Many other programs' CMRs spend more time as junior attending; however, by offloading some of this ward service requirement, I feel fortunate to have had that time to use for my own scholarly activity and teaching/administrative opportunities. Perhaps unique to my CMR position, I

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also was involved with the daily running of the hospital by working with administrators to evaluate patient transfer requests and addressing provider work flow issues. These additional tasks provided an invaluable learning experience.

Organizing morning report, running physical diagnosis rounds, and preparing cases and speakers for Chair's Rounds allowed me to hone and expand my teaching skills in ways that 3 years of residency did not. Moreover, it put me in direct contact with an energetic, inspiring group of learners that challenged me to solidify my own medical knowledge. (Try explaining the delta-delta equation to figure out if there are 2 metabolic processes going on, in front of a group of 20 residents, and you'll discover what I mean.) I quickly learned that the "one doing the talking is the one doing the learning" and changed my teaching style to better facilitate student learning. My bedside learning was further augmented by attending "Masters' Rounds" to which I owe my ongoing interests in physical diagnosis. Masters Rounds were given once a week by 2 master clinicians. It was only for chief residents and was directed at teaching us how to teach others the art of bedside physical diagnosis. The majority of physical exam teaching points I focus on today come from those sessions.

As chief, I felt like I had the pulse of the hospital at all times. Most of my mornings were spent on the wards floating between teams. I owe thanks to my predecessor who told me that the true sign of a good CMR was to never sit long enough in your chair to let it get warm. My office was located on the wards, between a team room and a double patient room. Aside from times when I was having confidential conversations with residents, the door was open. Nurses looking to vent, phlebotomists wanting to sit down, and attendings needing a break from their teams to get work done were common visitors. Administrative personnel were also frequent visitors, usually requesting me to disseminate new policies to the residents. Because of this, I learned to understand and better interact with the diverse group of people responsible for making a teaching hospital function. These are the same constituencies that I now sit down with on various committees to attempt to make my present hospital operate more smoothly.

Despite running morning report, attending rounds with teams, and developing plans for better patient flow, I had time for scholarly work and found easy mentorship. I was able to revive 2 projects I had started as a resident and bring them close to conclusion under the continued mentorship of my coinvestigators. Offers for career skill development were also abundant, and I benefited greatly from one associate director's tutorials on preparing effective PowerPoint presentations. Another attending mentored me in student feedback skills, which have allowed me to

become a much more effective educator. I was also able to model that mentorship and begin to build my own mentor relationships with my students. In fact, this mentorship has become one of the most fulfilling aspects of my job. I was fortunate to have that mentorship early on in my career, as similar mentorship becomes difficult to obtain once in an attending hospitalist position.<sup>3</sup>

In conclusion, although current internal medicine residency training provides intensive direct patient care experiences, it only allows glimpses into the other aspects of an academic hospitalist's job. Unfortunately, it does not adequately prepare one to begin this type of position with a full complement of skills. Only a minority of hospitalists pursue additional structured training directly after residency; the majority jump into hospitalist positions and opt for on-the-job training. While there is an early economic advantage to starting an attending position without delay, I believe that the skills learned during an additional year of dedicated training allow for a more meaningful work experience and, ultimately, a faster rise within the track of an academic hospitalist.

The tasks that residency programs and hospitals may give to CMRs provide fertile material for developing the skills necessary to become a productive academic hospitalist. I thrived on the multifaceted work of caring for a diverse group of patients, teaching different levels of learners, helping to manage various hospital systems, and better understanding the hospital as the sum of its parts. As noted above, this pre-attending league gave me the exposure to more fully develop my academic hospitalist game in a supportive environment. A CMR year may be beneficial for residents entering any career in internal medicine; however, I believe it is most aptly suited as a stepping stone for future academic hospitalists. I strongly recommend that current residents interested in academic hospital medicine consider a CMR position, and encourage program directors to consider molding their inpatient CMR experiences to facilitate this. Moreover, unless fellowship training in hospital medicine becomes the norm, I propose that current academic hospitalists do more to closely court and usher these "pretenders" into our ranks.

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