I interviewed members of the Section on Hospital Medicine Executive Committee via email to find some answers to common questions residents ask about Pediatric Hospital Medicine. Below are their thoughts. Feedback can be emailed to clach79@gmail.com. Question #8 generated the most exclamation points!

D. Corey Lachman, MD, SOHM Resident and Young Careerist Subcommittee Chair

KEY:
EC: Erin Stucky, MD (San Diego, CA)
JD: Jennifer Daru, MD (San Francisco, CA)
MG: Matthew Garber (Columbia, SC)

1. To display the spectrum of pediatric hospital medicine career duties, could you briefly list a few activities you have done today (ie teach medical students, round, meet with hospital officials, work on peds policy, ED consults, research, etc).

EC: Sedations for other services; family meeting for chronic needs patient I cared for more than my colleagues; resident case conference; intern applicant intro (as Assoc PD, I meet with half and PD meets with half of all applicants); conference call with fellowship applicant; teaching meeting with neonatology division; billing and coding meeting with hospital re: respiratory APR-DRGS and SOI scoring; Vascular Access Team meeting with Director of Surgery, Director of Hemeonc and CMO; enrolled 1 patient for research study; UCSD review and appraisal committee (academic appointment committee)

JD: Teaching students and residents, rounding on patients, meeting with chief administrative officer, touching base with nursing leadership on H1N1, signing off on payroll, submitting my article to Pediatrics for review, reading AAP listserv®.

MG: I attended an information technology committee meeting for the hospital system (3 hospitals), attended and participated in the departmental "morning report/case conference," conducted "teaching rounds" with both hospital medicine teams and ancillary learners, conducted family-centered rounds with my team, worked with my division director and some subspecialists on inpatient consultation guidelines, reviewed the SOHM listserv® contributions and reviewed a document for the AAP SOHM executive committee, worked on a bronchiolitis protocol at my institution as part of a collaborative of 7 hospitals and associated with the VIP network, and took overnight call and aside from my calling to check in once - did not get any calls and slept soundly!

2. If I could tell you one thing to do as a resident to prepare for a hospital medicine career, it would be …

EC: 1) Be realistic: know it will take time after residency to become proficient in domains of hospital medicine, and 2) try to engage in at least one systems project over time (1 year or more) that exposes you to hospital staff, administration, finance, community, advocacy elements. "Doing" a project in residency is at times overwhelming, but participation is enlightening if done with enthusiasm and interest!

JD: Seek out opportunities for clinical and procedural expertise and develop your leadership skills.

3. How are community hospitalist experiences different from academics?

EC: More issues related to advocating for pediatric-specific services; different relationship with ED (consultant, seen as the expert diagnostician and one who will care for all needed for the patient); revenue generation (more clinical opportunities).

JD: At a community hospital you are the front line, the pediatric endocrinologist, nephrologist, neonatologist and the critical care doc. You won't do any of that every day, but when you need to do it - it is critical. You must be confident and a self-motivated learner. As well, you must really understand what community resources and barriers there are to care.

4. How can a membership to the SOHM help residents interested in pediatric hospital medicine?

EC: The listserv® is vibrant, and offers a window into the clinical world and variation in practice questions. The discussions resonate with the practicing hospitalist. In addition, opportunities for elective rotations and fellowships are posted.
JD: Membership creates opportunities to network, provides you with access to our library with its policy and procedures, etc as well you receive a new-journal with cutting edge info on the field, ways to get involved, challenges, etc. For me, the opportunity to connect with non-local mentors has been huge. Your membership also helps support the listserv® which is an amazing resource of great minds.

5. Are there electives you would recommend? What about procedures(extra time with sedation, line training, transport time, intubations in non-emergent settings)?

EC: A true hospital medicine rotation would be valuable if possible, as many identify with the clinical aspects of hospital medicine but are not aware of the other domains and opportunities. Regarding other electives, time spent in emergency medicine, PICU, transport, or level II NICU in a community setting are valuable clinical experiences. Other electives in administration and QI and formal leadership training can also be created or may be offered. Elective time spent participating in hospital based clinical research is also very helpful.

JD: Yes to part 2 of the question. Also, if you know where you want to go (e.g., you want to move to California) seek out programs there and find out what they do, get their procedure cards/credentialing requirements and build that in to your training. Certainly time on teams that are not represented at those hospitals (like Rheumatology) can be helpful in increasing your diagnostic acumen. Start to be aware of issues beyond clinical care- like bed flow, disaster planning, etc- see if there is room for a resident on a committee or ask to join your local program leader at a quality meeting.

6. Residents usually have limited if any exposure to the administrative and QI side of hospitalist life - do you have recommendations to help residents become more familiar with these fields?

EC: Aha! – see #5. This is very hard to do in the 3 (4 for med/ped) compressed residencies of the US, but a bit easier in the 4 yr in Canada. Involvement in QI is an ACGME mandate, but this still does not usually equate with adequate time to understand these aspects of medicine. A formal 1 month elective is a good way to be immersed, but most find carving out this time quite challenging, especially given the ACGME mandates for what qualifies as an elective. This is typically better taught in a post-residency fellowship or instead through mentorship/courses/local training once in a hospitalist position.

JD: See above on attending a meeting or joining a committee. Also perhaps joining in on a senior project that involves quality improvement would be fantastic. Attend PHM 2010 and go to the quality workshop instead of the lecture on cardiology.

7. Communication is a key trait for pediatric hospitalists. How can residents improve this trait?

EC: Role play training is the best method. There are many forms of communication of course, but all rest on the same tenants of understanding how messages are sent and more importantly, received. This is a skill all need to address continuously – consider this part of life-long learning, not a skill that is attained and somehow magically possessed from that point on.

JD: Seek feedback. Consider what it would be like to be the PCP or the patient if they got sick again that night and tried to get help. Also, call patients a week after discharge and find out how they are doing and what happened. You will be surprised at what they tell you.

8. Do you feel that the annual pediatric hospital medicine conference is helpful to residents (we will add link to recent resident articles)?

EC: YES!

JD: YES!!! Meeting people and mentorship; topics and exposure to the areas hospital medicine is about beyond clinical care that can be really hard to see as a resident.

9. Is a chief year helpful in starting a hospital medicine career?

EC: YES! Done correctly, with the proper mentor and clarified goals for the year.

JD: Maybe.
10. Do you feel strongly that all residents interested in pediatric hospital medicine should have research experience?

EC: No – this is not needed at all. Interest in it, yes. Experience, no. That comes in fellowship and then beyond, to the degree that meets the needs and goals of the individual hospitalist. Few will perform research as the core of their life's work; all should engage - to differing degrees - in research and active QI projects that benefit hospitalized children. The latter choices are often made by the individual as well as the venue of the hospitalists' practice.

JD: No, but I don't mind it.

11. Any comments on the role of fellowship?

EC: I am biased: I believe a 1 year fellowship offers the time and attention needed to address the core domains of hospital medicine – clinical, administrative, QI and patient safety, education, leadership, research, and advocacy. These can be addressed in other ways; however, the focused time and organized experiences and projects of a fellowship make this much easier to accomplish. A 2 or 3 year fellowship is best for those interested in careers in academic medicine, as more and more often these positions require an area of expertise and ongoing productivity in clinical plus one more domain.

JD: Great if you want to be a research academic type. I have interviewed two graduates who completed fellowship without the procedural knowledge they would need to do our job.

12. Other comments …

EC: It is not a job, but a wonderful career with many paths to success!

JD: Becoming a hospitalist was one of the best decisions I ever made for me. Choose a career that seems to fit you and enjoy every minute of it.