The Attending Physician on the Wards
Finding a New Homeostasis

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TWENTY-FIVE YEARS AGO MANY WARD ATTENDINGS WERE senior specialists. It was considered both an honor and a duty to attend on the teaching service, which typically involved serving for a 4-week stretch at least once a year. Being a specialist with an arcane research interest was not a disqualification. Even though such attendings might have had relatively narrow comfort zones, residents often learned both about medicine and the nature of an academic and research career from them.

These senior specialists and researchers found attending work to be pleasant, intellectually satisfying, and not too onerous: billing and documentation requirements were minimal, the educational watchwords were "house staff autonomy," and the system was under little outside pressure to produce high-quality, efficient care. An attending might spend an hour or two a day teaching, and it was unusual for an attending to stay late at night; indeed, doing so might have been viewed with annoyance by the house staff. The vintage of ward attendings closely matched that of the department's overall faculty.

Beginning about 15 years ago, conditions began changing, and change has recently accelerated. The attending cadre is now far younger and much more clinically engaged. Pressures to improve quality and safety, greater documentation requirements, and increasingly complex logistics of the clinical environment have upped the ante for an attending's involvement. Moreover, Accreditation Council for Graduate Medical Education standards now mandate fewer house staff hours and far greater attending oversight. The job of attending can no longer be handled in relatively brief visits by itinerant subspecialists.

In this Viewpoint, we describe the reasons for this marked shift in attending physician demographics, consider its effects on education and clinical care, and suggest interventions that may help improve the experience of trainees as well as attendings. We focus on the ward experience and thus on hospitalists—who have taken over the bulk of ward attending responsibilities at teaching hospitals—as well as the lion's share of physician staffing on nonresident medical services.[1]

Because the hospitalist field is relatively new, many academic hospitalists are fresh out of training and are overseeing house staff who until recently constituted their peer group. Although the unprecedented increase in the number of hospitalists is often seen as the cause of the changing demographics of ward attending physicians, it was actually a response to more complex patients and therapies, imperatives to improve quality and efficiency, and other regulatory changes that have buffeted teaching hospitals. In comparison with the vigorous discussions over changing house staff roles and schedules, little thought has been given to the role of the academic attending in a vastly altered educational and clinical environment.

The Shift From Older to Younger Attendings

Observations of older and younger attendings reveal differences in approach and philosophy. Older attendings tend to be strongly influenced by the role models they encountered in their own training: they are more likely than young attendings to round at the bedside, teach the physical examination, and focus on elements of clinical reasoning and general approach rather than on the latest Cochrane review or the cutoff value for a normal troponin level. They are also more likely to "go down to radiology to look at the films" and review other specimens, because in their training failure to do so was sacrilegious and consequential.

Recalling their training days (when they enjoyed nearly unfettered autonomy), older attendings are somewhat uncomfortable with the degree of oversight that today's attendings are expected to provide, worrying that house staff will not mature into autonomous clinicians if they do not get to think and act independently. Moreover, they chafe at the disruption of the "sanctity" of attending rounds by "discharge planning conferences," mandatory resident days off, or the timing of morning report. Whereas old-style attendings often left thoughtful written notes, today's attendings (both old and young) hit a hot key that generates a billing-friendly sentence. While conceding the advantages of the electronic chart, older attendings lament that notes today are so routinely populated (via a keystroke) with medication information, problem lists, and laboratory and radiology reports that it is difficult for anyone to discern what has actually changed from the previous day.

Younger hospitalist attendings seem more comfortable with systems thinking, and they embrace quality and safety as core competencies. They are "digitally native" and facile with electronic tools, although perhaps less comfortable with, and with less faith in, the bedside examination (we have recently noted a resurgence in interest in the bedside examination that feels like a new generation trying to preserve a lost art). Because younger attendings came of age in the era of duty-hours restrictions and an emphasis on collaborative care, they are less conflicted about rolling up their sleeves to help expedite the work. They worry less about the erosion of house staff autonomy and are comfortable hanging out in the residents' room; their presence is not seen as micromanaging but increasingly seen as the

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norm. When patients decompensate, these young attendings are often there and making decisions with, and sometimes for, the house staff.

With such variation in styles among attendings of different generations and such profound changes in the attending-trainee relationship, opportunities for misunderstanding abound. Given time constraints, should the team sit in a conference room, discussing the virtual construct of the patient in the computer—"the iPatient"[2]—or should they be rounding and seeing patients together? If the senior resident prioritizes "getting the work done" over attending teaching rounds, is that an acceptable tradeoff? All of these questions have made clear how fragile the old attending-trainee ecosystem was and how much of the daily work (and harmony) rested on a bedrock of unspoken assumptions and powerful traditions. The magnitude and rapidity of today's changes have left all the species groping for a new and more stable habitat.

What Can Systems Do?

The phenomenon of younger ward attendings will evolve, because it stems in part from a widespread replacement of the historical attending cohort with a cohort of younger hospitalists. Over time, the hospitalist age distribution is likely to approach that of other fields that have weekend and overnight coverage expectations, such as emergency medicine and critical care. Even so, the attending cadre will probably remain younger and relatively inexperienced for the foreseeable future.

Training programs will have to address the issues raised by the changing demographics and altered roles on the wards. First, there should be stronger expectations regarding the importance of teaching time and content, and a consensus should be reached on the necessary balance between teaching and patient care. Absent such a consensus, conflicts and tension—often unspoken—are sure to arise, and there is a risk that teaching will be shuffled to the bottom of the deck in the name of efficiency, particularly with the house staff duty-hours clock always ticking. Even as such standards are developed, it will be vital to provide flexibility so that each team in its particular environment can determine the best way to balance "card flipping" conference-room discussions with bedside rounding and teaching. New hospitalists need to take part in robust faculty development activities designed to enhance teaching, team management, leadership, and quality improvement skills.[3,4] All attendings need to become expert in the use of electronic information systems, although this is likely to be more difficult for senior physicians.

Replacement of specialists with generalist-hospitalists on the wards has been a net positive for trainees, who now receive up-to-date teaching on the wide variety of problems encountered on a general medicine service.[5] Yet subspecialists and physician-scientists bring important knowledge and experience to the house staff and students. We both have vivid memories of having had attending physicians who, though not well versed in general ward issues, brought a refreshing perspective to the team by virtue of their research interests, their specialty interests, and their life experience. Although we neither expect nor favor having such individuals serve as full-fledged ward attendings, finding ways to reintegrate them into the environment on the wards—perhaps through teaching conferences or even short bursts of co-attending—should be a high priority.

In a world of instant point-of-care information systems and computerized decision support, attendings need not be the fonts of all knowledge—information has become democratic. Yet applying that knowledge prudently, and in the context of life experience, remains vital. The function of the teaching attending must transcend meeting regulatory requirements, guaranteeing high quality and safe care, and promoting efficiency. There is an additional function, akin to parenting, that transcends knowledge alone: helping to shape resourceful, caring, and interesting human beings who are also competent physicians.[6]

Although some challenges will be more easily addressed by junior attendings and others by senior ones, the goals are the same. All attendings will need encouragement and wisdom to take a step back, keeping a measured distance that allows house staff to achieve and demonstrate competency while still ensuring patient safety.[5] It is time that programs, trainees, and attendings take vigorous action to balance all these competing imperatives and establish a "new normal." After all, we are not getting any younger.

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