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 oner-
ous: 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 im-
prove 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 stan-
dards now mandate fewer house staff hours and far greater at-
tending 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 attend-
ings. We focus on the ward experience and thus on hospitalists—
who have taken over the bulk of ward attending responsibili-
ties at teaching hospitals—as well as the lion’s share of physi-
cian 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 of-
ten seen as the cause of the changing demographics of ward at-
tending physicians, it was actually a response to more complex
patients and therapies, imperatives to improve quality and ef-
ciciency, and other regulatory changes that have buffeted teach-
ing 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 differ-
ences in approach and philosophy. Older attendings tend
to be strongly influenced by the role models they encoun-
tered in their own training: they are more likely than young
attendings to round at the bedside, teach the physical ex-
adination, and focus on elements of clinical reasoning and
general approach rather than on the latest Cochrane re-
view 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 train-
ing failure to do so was sacrilegious and consequential.

Recalling their training days (when they enjoyed nearly un-
fetterd autonomy), older attendings are somewhat uncom-
fortable with the degree of oversight that today’s attendings
are expected to provide, worrying that house staff will not ma-
ture 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 con-
ferences,” mandatory resident days off, or the timing of morn-
ing 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 con-
ceding the advantages of the electronic chart, older attend-
ings 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 elec-
tronic 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 restric-
tions and an emphasis on collaborative care, they are less con-
+licted 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 pres-
ence is not seen as micromanaging but increasingly seen as the

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JAMA, September 12, 2012—Vol 308, No. 10 977
ward issues, brought a refreshing perspective to the team by attending physicians who, though not well versed in general staff and students. We both have vivid memories of having had scientists bring important knowledge and experience to the house wards has been a net positive for trainees, who now receive up-to-date teaching on the wide variety of problems encountered 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. 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. 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.

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. 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.

Conflict of Interest Disclosures: The authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Wachter reported serving as the chair of the American Board of Internal Medicine (for which he receives a stipend); receiving a grant to his institution from the Agency for Healthcare Research and Quality; receiving honoraria from more than 100 health care organizations for lectures on patient safety, health care quality, and hospitalists; receiving royalties from Lippincott Williams & Wilkins and McGraw-Hill; receiving fees for development of educational presentations from QuantraMD and IPC: The Hospitalist Company; serving on the scientific advisory boards of PatientSafe Solutions, EarlySense, and CRISI (for which he receives stock options); receiving compensation from John Wiley & Sons for blog writing; holding the Benioff endowed chair in hospital medicine from Marc and Lynne Benioff; and receiving funding for sabbatical at Imperial College from the US-UK Fulbright Commission. Dr Verghese reported serving on the speakers bureaus of and receiving royalties from Knopf and Random House and from foreign publishers for translations of his work; receiving honoraria from health care, universities, and literary societies for lectures related to his books and related to medicine; and that some of his work is funded by an unrestricted grant to his institution from Pfizer earmarked for continuing medical education tools for physicians.

Additional Contributions: We are grateful to Katie Hafner, MS, Linda Boxer, MD, PhD (Department of Medicine, Stanford University), Neera Ahuja, MD (Department of Medicine, Stanford University), Niraj Sehgal, MD, MPH (Department of Medicine, University of California, San Francisco [UCSF]), Brad Monash, MD (Departments of Medicine and Pediatrics, UCSF), Seth Cohen, MD (Department of Medicine, UCSF), Kara Bischoff, MD (Department of Medicine, UCSF), and Jerome Kassirer, MD (Tufts University), for their helpful suggestions on earlier versions of this manuscript.

REFERENCES


