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From the Editor

General Medicine Attending In 1995 : Observations and Reflections

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From the Editor

General Medicine Attending In 1995: Observations and Reflections

Each year at Thomas Jefferson University Hospital, hundreds of busy clinicians devote thousands of hours to the bedside teaching of trainees at all levels of experience. Traditionally called "Teaching Attending Rounds," these near daily gatherings are supplemented by Grand Rounds, Morbidity and Mortality conferences and the like. How have attending rounds, the central focus of in-hospital medical education, changed in the last decade?

To answer this question, I'd like to acknowledge my tenth year of inpatient attending with some musings and reflections on the role of the attending from circa 1985 to 1995. Let me illustrate some of the challenges that many attendings face using several patient vignettes. These cases are real, but I have changed the names and clinical presentations to protect patient privacy.

For seriously ill patients who come to Jefferson, lacking a primary care physician but suffering from a medically related problem, most will find their way on to the Jefferson Medical Group (JMG) inpatient service. The JMG service, as it is often referred to, is staffed year round by members of the Jefferson Division of General Internal Medicine within the Department of Medicine. This group of hard working primary care general internists covers four inpatient services every month at Jefferson, as well as a consultation service at Wills Eye Hospital. Each team consists of an attending, two residents, two interns, and several medical students.

On my two months of attending in the past year, our JMG service cared for a broad spectrum of severely-ill patients. For example, Jeffrey had been in the hospital nearly seven months when, on our rotating system, I suddenly became his primary doctor this past March. Upon entering his room for the first time, I was faced with a morbidly obese male who had suffered multiple severe complications from what would have been routine surgery for a slimmer person. Now, because of these complications, he was on a medical service with little chance of making a full recovery, at least according to the expert consultants. Jumping into a complex case like this is all too often a part of our routine attending responsibilities. In Jeffrey's case, a confused family member insisted on my speaking to his parole officer in order to clarify some of the complex medical issues involved in Jeffrey's care. The parole officer served as a surrogate elder spokesperson of sorts for this sadly dysfunctional extended family. While certainly not a formal part of anyone's medical education, extensive dealings with an angry and defensive family was very stressful.

Ryan, another patient on our JMG service, was a homeless young black male, ravaged by intravenous drug use who undoubtedly got infected with the virus that causes the Acquired Immunodeficiency Syndrome from sharing dirty needles with his fellow addicts. Ryan is as much a challenge to the hard working professionals in the Department of Social Services, as he is for the young interns and residents caring for him. While the details of his care are not relevant to our story here, Ryan's long-range outlook was bleak at best. Frankly, I found myself in the unenviable position of

fending off the many well-meaning specialists as they sought to bring all of the technological expertise to bear on Ryan's undoubtedly hopeless situation. This is an ongoing dilemma for the primary care attending, balancing the advice of consultant experts with the overall clinical picture.

Connie, a patient with severe bacterial pneumonia, was transferred from the medical respiratory intensive care unit to the JMG service on our regular rotating schedule. Connie had recently been successfully taken off a ventilator (breathing machine) in the ICU despite severe end-stage chronic obstructive pulmonary disease from a life time of smoking four packs of cigarettes per day. Her short-term outlook was as bleak as Ryan's but for obviously different medical reasons. What could we offer Connie at this point? Her family could not care for her daily complex medical needs, and her life expectancy was measurable in weeks, not months. She had been bouncing from physician to physician in the community, and no one in particular was taking final responsibility for her care, except our service. I can't help but think that in certain institutions she probably would never have been a candidate for life saving therapy in an intensive care unit. I am very ambivalent about Connie's care, torn between the futility of her situation and a lifetime of medical teaching that compels us to bring all of the forces to bear for her benefit.

Juanita was a young Hispanic woman with end-stage liver failure due to alcohol abuse. Her skin was as yellow as the page you are currently reading, and her large extended family spent hours in a bedside vigil in her room. The house officers, well meaning and very well trained, pressured me to consult with the liver transplantation team in desperate hopes of saving Juanita's life. Her family, poorly educated, and from a lower socioeconomic strata than all of her caregivers, looked to the team for succor and strength. Once again, a sickening wave of ambivalence engulfed me (with physical manifestations of heart burn and insomnia). Would the liver transplantation team take her even in her debilitated and near terminal state? Was this the appropriate use of a precious limited resource like donated livers? Would I have felt differently caring for Mickey Mantle? In the end, Juanita went to a hospice where two weeks later I found out she had died.

Are there any lessons that can be learned from the four aforementioned real cases on the JMG service in the past few months? Certainly, while four cases hardly constitute a broad cross section of the patients at Jefferson, they do, I believe, illustrate some of the major challenges for the role of the teaching attending in medicine in 1995.

Teaching hospitals have become the final common pathway for many of society's ills including drug abuse, homelessness, AIDS, alcohol abuse, and cigarette smoking. Many researchers have argued1 that the real costs of medicine are reflected in caring for these ills.

In 1985, we were just learning the nuances of the Prospective Payment System (PPS) and Diagnosis Related Groups (DRGs). Managed care was a foreign concept to most practitioners, and capitation, with tight utilization criteria, was practically non-existent in our marketplace. Residency programs, fueled by direct funds from the federal government, were growing rapidly.

Now, in an era characterized by market reform and the hegemony of managed care, how will we continue to be able to care for these kinds of cases? What will happen

when proposed cuts in the Medicare budget drain hospital resources even further? If cuts in Graduate Medical Education (GME) are enacted, will we still care for Ryan and Juanita?

While the answers to these difficult questions are played out on the stage of national health policy making, the hard working health care teams will continue their non-stop performance. As usual, I am interested in your views on this issue.

-David B. Nash

Reference

1. McGinnis JM, Foege WH. Actual causes of death in the United States. JAMA 1993; 270:2207-2212.