



JOSEPH HARDISON

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THE HOUSE OFFICER'S CHANGING WORLD

We middle-aged and older physicians are smug about our house-staff days—the days when medical giants roamed the hospital halls day and night. We prepared and stained our own blood smears, performed white-cell counts and differentials, actually looked through a microscope at our patients' urine, gram-stained sputum smears, determined circulation times, and measured venous pressures. Invasive procedures consisted of lumbar punctures, paracenteses, thoracenteses, liver biopsies, pleural biopsies, sigmoidoscopies, and bone marrow aspirations. We worked in private hospitals and in gloomy non-air-conditioned city and Veterans Administration hospitals. Patients were crowded together on large, open wards, where the nurses could see and hear everyone and where blacks were often segregated from whites.

The fund of medical knowledge was manageable. We revered and feared our teachers. Occasional intimidation and embarrassment were accepted as effective methods of teaching. Professors had time to spend with us, to teach us and get to know us. Departments of medicine were smaller, and everyone knew everyone else. Conferences were well attended, well prepared, and in most instances, given by the faculty in residence. The drug-company lecture circuit had not yet begun. Conferences were rarely interrupted. Messages were briefly flashed on the screen, or interns and residents were summoned by a display of their call numbers. Beepers were a scourge for the future. It was possible, if we worked hard, listened well, learned from our mistakes, and read about our patients' conditions, to become, in three years, confident and competent to diagnose and treat most of the diseases we would encounter in internal medicine without ever having photocopied a single article.

We worked every other night or every third night. There were frequently three or four of us in one on-call room with one telephone. Our pay averaged about 25 cents an hour. Moonlighting, though prohibited, went on and consisted almost entirely of physical examinations of clients of insurance salesmen. In most instances, the client did not come to the doctor. I performed examinations in a liquor store and a bowling alley, and I once examined a movie projectionist in his booth while John Wayne was on the screen. Most of our wives worked (there were very few women in medicine), and most of us borrowed money at low interest rates. We didn't have large debts incurred in medical school. Entertainment was infrequent and simple and usually enjoyed in the company of other house officers. We were all able to go to the annual Christmas party because the faculty covered for us.

Many of the patients whom we (and private physicians) took care of could not afford to pay and were not expected to do so. There were charity wards in most private hospitals, and the big city hospitals were primarily for the indigent. There was no Medicare, Medicaid, or diagnosis-related groups (DRGs). Most patients were uninformed about medicine. They trusted and respected their physicians and did not question the diagnosis, prognosis, or treatment. They did not accept responsibility for their health. They went to the doctor when they got sick and expected the doctor to make them well. Physicians and their patients smoked.

Medicolegal and ethical matters were relatively uncomplicated. Malpractice premiums were low, and malpractice suits were uncommon; doctors usually won and, if they lost, the awards were reasonable. The courts, by and large, saw fit to leave medical decisions to physicians. There was no need for living wills or for distinguishing brain death from death. "No code" or "do not resuscitate" orders did not exist because there was no effective cardiopulmonary resuscitation. Often patients were not told that they had cancer or leukemia; they were given the opportunity to prolong the denial of their imminent death. After all, we thought, if they really wanted to know what the score was, they could tell from our actions and what we left unsaid. There was no patient's bill of rights.

Technology consisted of stethoscopes, ophthalmoscopes, tuning forks, reflex hammers, electrocardiographs, rigid sigmoidoscopes, bronchoscopes, and various and sundry biopsy needles. There were no medical intensive care units, no coronary care units, no respiratory care units, and no arterial lines, subclavian lines, Swan-Ganz catheters, pacemakers, Holter monitors, bedside monitors, or cardioverters. Imaging consisted of roentgenography and fluoroscopy. Ultrasound,

echocardiography, computerized axial tomographic scanning, and nuclear magnetic-resonance imaging were yet to come. There were no third-, or second-, or even first-generation cephalosporins, and nitrogen mustard was the only effective chemotherapy. We sterilized our needles in an autoclave and reused them; blood came in bottles. "End-stage" disease meant the end was near. There was no renal dialysis, and organs were not transplanted. We did very little to patients, and it was easier for them to die with dignity.

When we finished our training and were ready for practice or a career in academia, opportunities abounded. There weren't enough physicians to go around. There were no "docs in boxes" or preferred provider organizations, and there were very few prepaid health plans. Physicians did not advertise. We could be assured of working hard, earning a comfortable living, and being members of the most respected of professions.

Modern-day house officers find themselves in circumstances vastly different from those we experienced when we were house officers. Many of them have substantial debts from financing their medical school education. Although the salaries of the house staff are better now, many take outside ("moonlight") jobs because of their debts and a desire for a higher standard of living. Most work in emergency rooms, and few, if any, do physical examinations for life-insurance companies. Moonlighting is not the forbidden subject it used to be, and most program directors give tacit approval or simply turn the other way.

The days of working every other night are gone. Most house officers work every third or fourth night while they are on ward services. Because they work fewer nights, however, more patients are assigned to them when they do work. They become very adept at triage and at caring for many sick patients, but they have little time to read and even less to sleep. They are under enormous pressure to discharge patients, both because of pressures to contain costs from third-party payers and the DRG system, and because they have no control over the admission process.

Teaching hospitals are also moneymaking hospitals. The faculty has little time and often little inclination to teach. Attending rounds are made to ensure third-party payments. There are no monetary rewards for teaching, and teaching won't get faculty members promoted. Many big city hospitals, the former bastions of house-staff training, either have closed or are in difficult financial straits. Academic and clinical faculty members don't have time to give to these foundering behemoths. The house-staff members are given, and assume, more

and more responsibility. As a result of this increased responsibility and of the decrease in the faculty's time for and interest in teaching, the house staff has become more and more independent. The faculty and the house staff have become estranged. Everyone is busy taking care of patients or doing research. House officers have role models but few heroes.

There is now much more to do for and to patients. We expect house officers to learn all the procedures we learned and many more. We expect them to be equally competent in caring for ambulatory patients and critically ill patients in intensive care units. We keep stressing the history and physical examination as the source of the most important data we gather, but everyone, faculty and house staff alike, is relying more and more on tests and procedures. You need a gimmick to make it in private practice. Because of the pressure to get their work done, the house-staff members seldom, or only reluctantly, attend conferences. When they do attend, they bring their lunches, and the speaker strives to be heard over crackling cellophane, the crunch of potato chips, the rattle of ice cubes, and a cacophony of beepers. An hour spent in conference is an hour taken from time off. House officers today have many interests other than medicine. They want to enjoy these while they are still young.

It is impossible to keep up with medicine today. Knowledge is accumulating and changing so fast that you can't be sure that what is fact today will be true tomorrow. House officers, with little time to read, instead photocopy or tear out enormous numbers of articles from journals and, like squirrels hiding acorns, bury them in ingenious filing systems in the hope that the articles will still be pertinent when they finally get around to reading them some day.

House officers and practicing physicians are under attack from the public, the legal profession, and the government. Subspecialty programs are reducing the numbers of fellowship positions, and future funding is in question. Many will lose autonomy because, by choice or necessity, they accept salaried positions. Competition for patients will create tension among colleagues. Moral, ethical, and medicolegal issues that arise because of technology, greed, and public awareness consume enormous amounts of time, resources, and energy. There is evidence that emotional impairment is increasing in today's house staff. Sleep deprivation, the responsibilities of being a new physician, and rigorous training are cited as causes of the increased strain. These stresses, however, have been present for as long as there have been training programs. Another factor may be that the medicine that today's house officers dreamed about, which they

went to college and medical school and deep into debt for, no longer exists. Our young physicians are bemused and beleaguered, and they feel they have been betrayed.

I suppose it is natural for those of us who are nearer the end of a career than the beginning to extol the virtues of our house-staff training over the training of today. Each generation seems to believe it suffered more hardships and did things better than the next. House officers today have enough to worry about without hearing about how hard we worked and how dedicated we were. We accuse them of being the "me generation," of being incapable of delaying gratification. It is difficult, however, to enjoy life today when you are \$30,000 in debt and haven't yet begun to earn a living. Medicine has changed drastically since we were house officers. Comparing medicine then and now is like comparing horse-and-buggy days with interplanetary travel. It is impossible to know who worked harder and learned more, and it doesn't matter. There is, however, no question about who has more to learn and more to do. House officers are not responsible for what has happened to medicine, but we are responsible for what happens to our house officers. They are intelligent, diligent, responsible, and compassionate people, and they usually end up being well trained. They deserve our support, appreciation, and affection.