

PRACTICE VERSUS THEORY IN
ACADEMIC MEDICINE:
THE CONFLICT BETWEEN HOUSE
OFFICERS AND ATTENDING
PHYSICIANS*

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THERE is a small scandal in the land. Wherever attending physicians—not surgeons—gather, the conversation often turns to the conflict between medical house staff and attending physicians. While the discussion among ourselves will surely continue, the underlying issues are important enough to be aired in public and to require attempts at a solution. This essay grew out of an effort to understand my own distressing conflict with house officers over the past several years.

Two features suggest that the reasons for the tensions might not simply be my cranky personality. The first is that this difficulty has come into bloom in the last eight to 10 years, although I have been interacting with house staff as an attending physician for 22 years. The second reason is that I have no problem with these same physicians when they are students. It is difficult to understand how it is that they might love me on June 30th and hate me on July first! They should either hate me or love me: the date should make no difference. Something happens on July first, however, which changes the situation.

Medical attending physicians are not the only troubled group. A new complaint is heard from interns: "I hate it," "It's the worst year of my life," "I'm just trying to get through the year." In my Third Division

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days at Bellevue, just as now, an internship was hard work. However, although the year was tough, it was an exciting and challenging time whose good memories far outlived the bad. It was not discussed, as a rule, in the stark terms of hate. Widespread talk of *hating* one's internship is a new phenomenon. Further, both the intensity of the attending physicians' unhappiness with medical house officers and the dissatisfaction of medical interns suggest that this is not just the same old intergenerational conflict. Indeed, I believe it is something new.

Often such problems are explained in social terms: the house staff is a close knit bunch with such strong group identification that it is difficult for them to act out their anxieties and tensions against one another. It is, after all politically unwise to get angry at one's resident, so, instead, the attending physician becomes the butt of tension. Some attendings are considered good guys (male or female) at whom one does not sound off and others are considered bad guys (male or female) to whom one can do whatever one can get away with. Unfortunately for simple answers, the current problem cannot be discounted in this manner. While there may always be merit in explaining things on a social level, that "always" undercuts the explanation. The explanation is old; this problem is new.

I believe, instead, that there is a truly *new* structural—systemic—issue at the present time that is more fundamental than any interpretation based on social factors. This issue can explain the current conflict between house officer and attending physician, as well as the unhappy malaise of house officers. For at least two generations, academic medicine, as practiced on the medical wards of many teaching hospitals, has been ahead of—setting the example for—good medical practice by even the best of practitioners outside of the hospital, the part-time attendings. Medicine was said to be "academic" to indicate that it was "good medicine." An important aspect of the current problem is that academic medicine has fallen *behind* the practice of good medical care. Between the shift of technology to *outside* of the hospital and the sophisticated demands and requirements of modern patients, the world of good patient care has changed drastically during the past 10 years, and academic departments of medicine have failed to keep in step with the change.

Academic medicine is lagging, as I see it, because of three internal conflicts—all conflicts between medicine as it is taught in medical schools (theory) and medicine as it is practiced in the teaching (academic) hospital. I shall enlarge on each of these later, but let me introduce them now. First, the student of the present era enters medical school with an

internalized *ideal* of the doctor as someone who takes care of patients and who is driven by a personalized humane feeling for the sick. This idealized belief about what medical care is supposed to be and what doctors are supposed to do is actively encouraged during medical school only to come into conflict, during internship and residency, with the technology-intensive and technology-exclusive medicine most often practiced in academic wards. The second problem is that the fundamentally important training in pathophysiological thinking that the student receives during medical school deteriorates on the floors of many academic medical centers into pattern recognition of disease and "recipe thinking" about treatment characteristic of current academic hospital medicine. Third and finally, a method of training that originated in the early years of this century from a desire to rid medicine of the authoritarianism of the German schools of the 19th century has resulted in training programs that provide experience in a setting which *denigrates* experience!

THE "EGO IDEAL" VERSUS PERFORMANCE

Let us turn to problem one. An internalized ideal of "the doctor" exists in each student. When an ideal is internalized, no matter whether cynicism overlies it—all the more so when cynicism overlies it—the ideal continues to provide the image against which reality and the individual's performance is measured. For physicians of my generation, "scientific medicine" might be such an ideal against which we measured our performance. When an internalized ideal has failed, people tend to blame themselves and not the external reasons why failure was inevitable.

Nowadays the "ideal physician" that medical students internalize and that is emphasized by the world around them is a technically competent doctor who cares about the patient as a person. Doctors on television are this way—of course, they are more fortunate than most of us because they see only about two patients a day and therefore they can spend their entire time on these two patients, their families, the community, and what else. This view of physicians, however, comes not only from television or the perspective on the ideal physician provided by other media, it is also the image that inspires the increasingly popular and visible family practice model in the United States.

There is a cluster of beliefs about these ideal doctors. For one thing, they care about feelings. Nobody asks what you *think* about something any more, they inquire "how do you feel about it?" Also part of the

