BECOMING A PHYSICIAN

A Resitern's Reflections on Duty-Hours Reform

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Last winter, as a third-year resident, I hosted an informal Q&A session for applicants to my internal-medicine residency program. A group of crisply suited fourth-year medical students were gathered around asking typical applicant questions: What do you like about it? Are people nice? Is there parking? Then, one applicant asked me about the wards schedule, noting that ours was the only program in the area that still mandated overnight call for interns. I was so surprised to hear it that I burst out laughing. Quickly apologizing, I tried to explain: even since I was in your seat a few years ago, I told her, things have changed so much. She replied that she knew that working intermittent overnight shifts isn't healthy. I agreed with her. And the fact is that I do agree — although that system may actually be better for patients[1] — and yet I was flabbergasted at her expectations of her intern year and at her openness about revealing them.

Many of my predecessors viewed the 2003 duty-hour regulations as excessively restrictive and coddling. Similarly, the new cultural norms taking shape around the latest duty-hours overhaul have been difficult to internalize for those of us who completed our intern year under the most recent "old" system. My first year of residency, the majority of the workload still fell on interns, who worked more hours than almost anyone else in the hospital. Furthermore, interns had a substantial amount of responsibility as the primary caregivers for their patients and, as a result, were generally held responsible for just about anything that went wrong. As an intern, I, like so many of my colleagues and predecessors, struggled through a type of exhaustion and stress that is difficult to imagine unless you've experienced it. I fell asleep writing notes and possibly while walking, although thankfully never behind the wheel. I learned what it means to cry from the sheer overwhelming stress of it all — and what it means not to cry, and not to care, because there's nothing left.

Now, only a little over 2 years later, things have changed dramatically. The new interns still work hard, sometimes as many as 80 hours a week, but they also train for triathlons. They wear makeup to work. They feel entitled to circadian-rhythm health. They have more time than interns have ever had to look after themselves and their families.

As senior residents, my colleagues and I — who didn't have the same protections when we were interns — had to pick up the slack. We became "resiterns," working many more hours than the senior residents before us in order to make up for the substantial deficiency in intern staffing. And under other reforms emphasizing graduated duties, we were required to spend much more time overseeing interns' activities, in addition to completing many patient care tasks that interns were now unable to complete during their shift. The intern-as-workhorse paradigm had ended with us, and the workload was redistributed to . . . us!

I know, of course, that things were better for us than for previous generations. I've read *House of God*.[2] I've heard horror stories of pre–80-hour weeks from attendings. Of not being able to leave the hospital for 9 days, of falling asleep in the middle of a postcall clinic while with a patient. One of my older attendings compared his East Coast residency to jungle warfare in Vietnam.

The question, though, is not who had it worst, but which of the struggles of prior generations are actually beneficial to physician training. Is there value in sleep deprivation and long, painful shifts? What does this new cultural shift mean, and how does it relate to the ongoing discussion about medical errors and the attainment of clinical competency? Will we continue to put patients first if we don't learn the hard way to put ourselves last?

When, as a third-year medical student, I realized what I was headed for, it scared me to death. I wrote an essay for a "doctoring humanities" course discussing the narcissistic fallacy inherent in physicians' working like demons and trying to be superheroes. I cited a journal article about the moral rightness of duty-hours reform.[3] I believed that requiring residents to work 30-hour shifts was archaic, unsupported by empirical data, and a silly type of professional hazing.

I still support a more balanced approach to medical training. I have, like the medical students and interns I work with, felt entitled to enjoying personal time

and space and to being relatively pain-free at work. At the end of my training, I still feel somewhat entitled to those things. But not completely, and not all the time.

Now that the duty-hours reform I hoped for is here, I can't help but worry a little. Though I share others' concerns about delayed attainment of clinical competency, that's not what really gives me pause. What concerns me most is that I have seen in many new interns an almost frightening level of insistence on their new time and personal boundaries. I have seen them sign out unstable patients just because it's time for sign-out. I've seen them refuse to lend a hand to a fellow resident who is struggling with his or her workload because they want to get out "on time," and I've seen them make errors because they're rushing to be done. At times it's as if they're just going through the motions, like cogs in a machine. This new ethic strikes me as out of touch with our profession's historical emphasis on service.

In my view, the 2011 duty-hour reforms threaten, as a result of the associated "cultural transformation of our educational environment,"[4] to affect the process of physicians' professionalization. Paying careful attention to this aspect of physician development is essential to accomplishing the larger goal of improving the quality of the care provided by physicians-in-training. If trainees don't have a personal investment in patient care beyond the hours of their shift, it probably doesn't matter how well rested they are; without a sense of ownership, they may well be much more likely to make errors.

I doubt that sleep deprivation and grueling work hours are necessary for instilling professional values. But the fact is that in order to have the privilege of doing this job, we may have to miss dinner once in a while to take care of someone who got sick late in the day. An end to the boundaryless, whatever-it-takes attitude toward physician training should not imply that medicine is a factory job with factory specifications. It does call for a thoughtful and cautious new negotiation of the ethics of give and take.

The preamble to "Medical Professionalism in the New Millennium: A Physician Charter" states, "Professionalism . . . demands placing the interests of patients above those of the physician."[5] This is not an uncomplicated statement. As the impetus behind duty-hours reforms implies, no one can give unendingly and remain effective as a therapeutic instrument. One of the most important things I believe physicians have to learn is how to juggle the competing needs of many patients as well as our own needs.

If educators can guide physician trainees in negotiating their new professional boundaries while maintaining a primary focus on patients, they will help to prepare new physicians, in a supportive training environment, for the balancing act they'll have to perform for the rest of their careers.

I am still hopeful that our efforts as "resiterns" have been a worthwhile investment, both in the future of graduate medical education and in our patients. And to the old version of intern year, I still say "good riddance."

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Getting Through the Night

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I am from the bad old days. Not the very worst old days — when I was a medical student and a pediatric resident in the 1980s, attendings who'd trained during those even older, very worst old days let us know that we were soft, we had it easy, we'd never understand what it was like to learn and practice in the days of the giants. But still, in my bad old days, we took call ev-