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."

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

From the Department of Internal Medicine, University of California at Davis, Sacramento.

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Getting Through the Night

Perri Klass, M.D.

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-

ery third or fourth night and did not necessarily (read: never) get real sleep and did not necessarily (read: hardly ever) go home the morning after call, no matter how intense the night had been.

Instead, we did other things. We asked people to check our calculations (particularly in the neonatal intensive care unit [NICU], where a decimal-place error in milligrams per kilogram or milliliters per hour could kill). We fell asleep during noon lectures. We wrote disorganized or perfunctory notes. We snapped and snarled at colleagues, nurses, friends, and family. And yes, we probably put our patients at risk. I definitely put the population at large at risk when I drove home postcall.

Of course we complained and boasted, often simultaneously. What a bad night I had. How many admissions I got. How the stable kids decompensated, the sick kids crumped.

But any sane person would know that it was bad. Looking back, I wonder whether everyone was a bit nuts, entrusting patient care to people who were predictably, by design, as tired as we were.

Yet — as proof that I'm becoming what is technically called an old fart — I sometimes feel an almost overwhelming nostalgia for that schedule and the feelings that it brought on. I think about those on-call nights and the days that followed them with very mixed emotions. I can't defend it from the perspective of patient care, and I wouldn't willingly put anyone else through it. And yet when I look back on certain aspects of that crazy, dangerous schedule, the memories have a certain sweetness.

There was that feeling of being the only one awake, the one in charge, steering the ward through the night. We were much less well supervised and much less adequately backed up than residents are nowadays, and I remember a proud and lonely conviction that as a pediatric resident, I had the most important job in the world, that I was close to the most sacred secrets at the center of the universe. I think that came from being there on those absurdly long shifts — *I've been here 18 hours, everyone else has gone home, I'm the one getting these children through the night.*

There was the level of involvement that came with admitting a patient and staying with the patient and the family through those first 24 — or 36 — hours. The scariest cases I ever saw were children who came in with bacterial meningitis and got worse fast. Some of them died, some of them made it (I spent my residency frantically watching out for *Haemophilus influenzae* type b and pneumococcus, both now largely eliminated by immunization), but those were 24 interesting hours. So were the first 24 hours of caring for a child in severe diabetic ketoacidosis, running the insulin drip, adjusting the fluids, checking all those blood draws. So were the first 24 hours of life in a tiny preemie.

I work with residents today, and I respect their commitment to their patients and the depth with which they come to understand them. The care they deliver is often better than the care I delivered — they're certainly better rested and supervised. But I've spent the occasional 24-hour stretch in the hospital as a patient (in labor with my first baby) or as the parent of a patient (a 4-year-old with a spiral femoral fracture and poorly controlled pain), and I think perhaps that accompanying me through that 24-hour stretch might teach a doctor something valuable about the rhythms and physiology of childbirth or about the management of trauma, pain, and pain relief. I'm sure there are other ways to learn those lessons, but keeping company around the clock certainly makes an impression.

There are stories that I still think of in 24-to-36-hour increments. I saw antibiotics start working — or fail to work quickly enough to overtake those virulent bacteria. I saw hyaline membrane disease or persistent fetal circulation (PFC, as we called it then) evolve and worsen and sometimes start to improve. I remember my senior resident, late one night in the NICU, looking down at our new preemie and saying, "I can just feel it, he's gonna PFC on you." And I knew I was going to spend the rest of the night hanging over that warming table, watching out for PFC — which we'd now probably call PPHTN (persistent pulmonary hypertension). Of course, I also learned how to manage the overnight aminophylline drips that we used for asthma exacerbations — and now haven't used in years — so you could argue that much of what I learned is now out of date in content as well as pedagogic form.

This is what old farts do: we look back at our valuable lessons and tsk-tsk over whether the new generation can possibly learn the same things, since they're learning them differently. We piously opine that, objectively speaking, whatever we did was the best possible way to do it.

But it's worse than that. Most of all, and most indefensibly, I sometimes feel nostalgic for the sheer crazy, slightly sick intensity

of it all — for the punch-drunk fatigue you felt when you hadn't slept, because you were doing the most important job in the world, awake while everyone else slept, you and the babies, getting through the night. For the kind of sleep-deprived connection you sometimes felt with particular patients all through that postcall day, going by to check on them, smiling proudly when the family members exclaimed that you were still there.

There was certainly a kind of macho stupidity involved at times — and real risk if you let yourself think you were actually in shape to make complex decisions or do procedures. But there was also a slightly addictive quality to the feeling that this extreme job in this extreme place had pushed you into an altered state.

There it is, then: I'm nostalgic for that altered state, for the way it felt toward morning when your mouth was dry, your eyelids grainy, your internal clock ticking hopefully toward the moment when help would arrive and you'd no longer be responsible, but your clipboard floated before your grainy eyes, displaying all those not-yet-filled-in boxes, reminding you that the pace would only pick up as the clock ticked on. And your beeper was poised to sound again and remind you that the beds were full and there were fevers spiking and IVs blowing and you were the one on call, the one to do whatever needed doing, and the night was not over.

So I'm becoming an old fart, like the attendings we used to mock for boasting of training in the days of the giants. Here I am, looking back fondly on a mental state that made me snappish with strangers, dangerous on the road, comatose or crabby with my nearest and dearest.

And yet. If we ignore the satisfactions and pleasures of that crazy schedule, I think we risk losing some aspects of what makes our jobs as good as they are, when they're good. That doesn't mean we should return to the bad old days, but I think we have to find ways to acknowledge and teach that doing this job properly sometimes feels painful or difficult or isolating. And sometimes being there for the patient is all and goes against all the other imperatives of your own best interests.

When I recall the joys and sorrows of my residency schedule, I am, of course, recalling the joys and sorrows of being young and the terror and excitement of becoming a physician. And probably I'm doing some selective forgetting and inventive remembering. But every so often, when I've managed my deadlines badly and find myself staying up much too late, I flash back to those on-call emotions. I'm the only one awake. I'm seeing it through. I feel the way you feel when you've been awake for 24 hours — fuzzy in some ways and focused in others. I think about watching the sun come up through the hospital windows long ago, and I must confess, I smile.

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From New York University, New York.

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Residency Training — A Decade of Duty-Hour Regulations

A video is available at NEJM.org

Changes in policy on residents' duty hours and supervision have generated ongoing debate. In a roundtable discussion moderated by Debra Weinstein, panelists Vineet Arora, Brian Drolet, and Eileen Reynolds consider the effects to date and approaches for future policy.