



## Commentaries

### The Way Things Were, or, In the Days of the “Giants”

A recent issue of *JAMA* discussed the impact of restricting resident hours per week. I suspect that the restriction is probably good for patient care, keeping sleep-deprived, stressed-out housestaff away from patients, but maybe not so good, unfortunately, for medical education. I have been struck by the requirement that restricts house-officers from spending more than 24 hours in the hospital so that they are forbidden from attending conferences after their tour of duty. Of course, if they weren't forbidden, many residency directors would simply shift work schedules to put the conferences at the end of a shift to get more work out of the resident. But, regardless of these limitations, it reminded me of my own training.

When I was in medical school, the older attendings would occasionally comment on their training. In their days the interns lived in the hospital, got free food, free laundry service, and paid no rent. They did not get paid, or if they did it was a token, not a living wage. It sounded fairly brutal, although I could certainly see a benefit to sleeping in the hospital and saving the 30-45 minute commute I had every morning and evening (when I was able to go home at night).

When I was an intern I was on call every third day, which meant working through the night and next day until the work was done, usually a bit under 36 hours straight, with a couple of hours to sleep on most nights. In the winter I got in before the sun came up and left after it went down. I do not look back fondly on those days, and aside from the number of hours worked, it appears that the stresses now are pretty much as they had been, except there are lots more things to know about these days, making it less possible than ever to feel comfortable in one's knowledge.

My residency, in neurology, was different, and I do have great feelings of nostalgia for that time, but also look back in amazement at how the educational system worked then, and shudder at how many patients paid

for my and my colleagues' education. A true anecdote I often ponder speaks to the heart of the problem back then of our medical imperiousness, a belief that doctors somehow became special when they received their degree. At our daily intake rounds with the department chair, an avuncular, well-deserved famous man, we would give the names of each person admitted the day before, with the diagnosis. If the chief was interested in hearing more, he'd ask. Otherwise it was, "Mr. Jones, stroke. Mrs. Smith, seizure. Mr. Doe, dementia." So I listed my names and diagnoses and got to a 19 year-old young woman, "Ms. X, myasthenic crisis." So the chief, a myasthenia world expert, asked me to describe her, which I did. Because he was a famous world expert, we saw lots of cases of myasthenia, including the occasional case in crisis. To me it was a bit out of the ordinary, but not worth discussing with my colleagues as a particularly interesting or unusual case. What happened next, however, is the true story here. The chief asked me, "Who did you call?"

"Excuse me?"

"Who did you call?"

"I don't know what you mean. Who would I call?" I was the senior resident and senior residents didn't call anyone, at least so far as I was aware.

"Which attending did you call?"

"I don't understand what you mean. Which attending would I call?" "Which attending was on call last night?" "I didn't know anyone was on call. Why was someone on call? I really don't know what you're asking about."

It turned out that for three years neither I nor my colleagues knew that there were attendings on call and that we were supposed to call them about difficult cases. Perhaps we were supposed to call them about all the cases. I don't know. I had never known that. I never called anyone during my three years. And you can bet that those attendings who were on call never complained about not being called.

I never asked any to determine if any of them even knew there was a call schedule.

The consult service at our very large New York City hospital was very busy. The service consisted of two residents and students on elective. Each case was seen by one of the residents, including the student cases. We would begin rounds with the attending in the early afternoon with student cases seen first, then the interesting or challenging cases, and if it got too late, we'd break for the day with the remaining cases not seen by the attending. Some of these cases were never seen by the attending. The resident could request the attending to see a difficult case, but that choice was the resident's. Many a patient, including sick ones, would be seen by a neurology resident but not an attending.

When I moved to RI in 1982 I marveled at the practice of having an attending physician in the emergency department. That was not the standard of care at the famous hospitals in New York (I don't know about Boston). It would be considered a sign of weakness of the housestaff, rather than judiciousness, to involve attendings in decision-making, and power was never ceded without a battle. Patient care quality became a secondary consideration.

Like my colleagues, I have mixed views on the increasing limitations on the "good old days." Certainly sleep-deprived doctors make more errors and learn less than rested ones, and while we certainly need "fodder" to hone our skills, patient well-being must always be our touchstone. I shudder when I think of my past delusions of grandeur, making life and death decisions as a house officer, without a perceived "need" for experienced counsel. While it would be nice to allow some flexibility in the hour restrictions, we know that certain prestigious programs, given that option a few years ago, immediately reversed all their restrictions until their programs looked just like they used to look. Those programs were suspended, despite their prestige. We are our own worst enemy.

— JOSEPH H. FRIEDMAN, MD

#### Disclosure of Financial Interests

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