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Are Puppy Socials the Way to Save Our Residents?

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Introduction

I graduated medical school in 1985 and began my residency that same year. Like many of my peers, I endured every third (and sometimes every other) night on call for two full years, looking forward to the time when, as a third-year resident, I would only have to take call once a week. My daily schedule was long-twelve hours was the norm, and during my medicine year, I often worked well over 100 hours a week. I was always tired, constantly trying to find time to sleep wherever I could. I read medical journals when I got home, and days off were used to catch up on reading. But I don't remember being unhappy. I was living with my future wife, socializing with fellow residents and faculty, and I felt part of a community. We worked hard, but we also felt connected.

In 1989, New York State passed Code 405 after the death of a patient in a New York City hospital, setting new rules for resident duty hours. I was a senior resident at the time and served as a delegate for the Committee of Interns and Residents. I helped implement the changes in our hospital and saw no downside. It made no sense for people to work 110-hour weeks, be sleep-deprived, and possibly put patients at risk. I assumed that this would lead to happier, healthier residents.

Fast forward thirty years. We've cut back duty hours, we give residents meals, we protect their didactic time, and we offer puppy socials and ice cream socials-and still, they don't seem any happier. Depression, burnout, and even suicide remain disturbingly common. So, what's going on?

Yes, 80 hours is still a long week, and 24-hour shifts are still grueling. But most of us entered medicine knowing that we'd be working weekends, evenings, and holidays. That hasn't changed. What has changed is the nature of the work and the environment in which we do it.

When I started out, we used paper charts. I knew where to find lab results. I read the nurses' notes. The whole record was in one place. It was easier. I didn't know much about computers until the '90s. The field was smaller then. We knew less, but that also meant less pressure to keep up with a massive and growing body of knowledge. Back then, I could stay current by reading two journals. That's not possible anymore.

Over time, the field got more complex. We started talking about "best practices," "quality improvement," "manualized care," "population health," and "regulatory compliance." Neuroscience took center stage, and new medications kept coming. I tried to keep up, but it felt like being battered by waves. And it's not just the knowledge base. It's the bureaucracy. The chart became a computer screen, full of boxes and checklists. Notes are written for risk management and reimbursement, not for care.

Residents are now some of the most accomplished people I've ever worked with. But they are burdened. They stare at screens. They don't make eye contact at the nursing station. Patients are often seen as interruptions to the real task-documentation. Tasks pile up, forms need filling out, and there's always some new metric to meet.

And the didactics-there's so much content, so many slides, so many updates. But when you ask a resident what they've learned that they can use tomorrow, it's often a short list.

So how do we help? We start by telling the truth.

We stop sugarcoating residency. We tell applicants: this is hard work. There will be moments of joy and pride, but also exhaustion and frustration. Our job is to support you through it. We can't remove all the burdens, but we can promise to listen, to be honest, and not to threaten.

I often tell my residents that today's trainees are better than I was when I started. That's true. But they are navigating a very different system. When they get to their third year and start working in the outpatient clinic, they're surprised by how much "social work" they're expected to do. I show them the forms, and point out that they say "Physician Signature." This is physician work. Faxing forms, responding to pharmacy requests, handling regulatory demands-this is part of the job now.

When I started speaking plainly to residents about this, most handled it better than when I tried to protect them from the truth. They are smart. They can deal with reality. What they can't deal with is being treated like they're fragile or being misled.

Professionalism in this environment is tough. But it's essential. I still remember how proud I was to get my scrubs and beeper on July 1, 1985. I still feel proud to be a doctor. I still believe in our mission—to care for people in their most vulnerable moments.

That's what I try to pass on to residents. Not the bureaucracy, not the burnout, but the meaning behind the work. I want them to feel that being a physician is a privilege.

And we have to listen. Really listen. When a trainee says they're frustrated or overwhelmed, don't dismiss it. Don't retaliate. Don't act like its insubordination. They often see things we've become numb to. They may even have ideas that could help. And if nothing else, they need to feel heard and supported.

The goal isn't just to graduate residents. The goal is to help them become doctors we'd trust with our family and friends. That's what I tell them. That's the real mission.

No amount of puppy socials can replace that.