

The Three-Year Paired Residency Program: A Solution to a Teaching Dilemma

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Concurrent responsibilities of residents to both inpatient clinical services and the model family practice unit represent an organizational and teaching problem within most family practice residency programs. This problem can be effectively approached through a pairing system involving two residents at the same level of

training throughout their three-year residency program. Such a pairing system is described which has been in operation in the family practice residency program at the University of Washington since July 1972, together with an evaluation of the first full year's experience with this approach.

A basic premise of a family practice residency program requires continuing ambulatory training in a Model Family Practice Unit as well as hospital experience. This dual requirement often leads to a teaching problem, i.e., how can family practice residents be assigned real responsibility for inpatients and at the same time be periodically relieved of these assignments so that they can care for their patients in

a continuing practice? This article will describe the approach to this problem currently being used in the Family Practice Residency Program at the University of Washington School of Medicine, together with our experience during the plan's first year of operation.

Introduction

Until recently, residency programs in most specialties have been conducted almost exclusively in hospital settings. When the Department of Family Medicine was established at the University of Washington in 1971 as one of the

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16 clinical departments offering residency programs within our University Hospital, we attempted to balance the training so as to establish a better division between inpatient and outpatient experience. Beginning in July 1972, we therefore arranged for all of our residents to spend part of each week (ranging from 20 to 75 percent of their working time) with outpatients in the practice of the Family Medical Center.

Departments of Medicine, Surgery, Pediatrics, and Obstetrics-Gynecology in particular readily accepted the responsibility for providing in-hospital training for family practice residents, even though this sometimes appeared to dilute the work of their own trainees. It was understood that family practice residents would accept the same responsibility as other residents when assigned to an inpatient service. Thus family practice residents now actually fill the positions usually held by house officers assigned to Medicine, Pediatrics, Obstetrics-Gynecology and Surgery services.

Our announced emphasis on offering residents continuous experience from the beginning of training with ambulatory patients posed some difficulties, however, since it seemed to conflict with residents' obligations to in-hospital training and responsibility. In other programs, it often happened that when a resident was seeing outpatients in his practice, he would suddenly be called for on the ward; if he was unable to come, the ward staff would be required to get another house officer to take care of the patient. Such situations caused not only irritation among the ward personnel but frustration on the part of the residents, and even lent credibility to criticism from other clinical departments that residents in other specialties provided better care for inpatients than did family practice residents.

Kindig in 1970 suggested that a pairing system might permit simultaneous ward and ambulatory responsibility for house staff.¹ Phillips and Holler² in 1971 described a similar system which they introduced into the second year of the Family Practice Residency Program at the University of Rochester. Other programs also have tried this approach, but no one else has tried using it for all three years of the residency program.

How the System Works

The members composing each pair are from the same year of training, i.e., two first year residents are bracketed together and for practical purposes can be looked upon as one person. An inpatient service is asked to provide a position for one house officer. We assign a pair of family practice residents to fill the position.

The pair meets the other residents and the attending staff on the ward each morning. They make rounds together and attend the teaching activities and conferences together. After lunch they separate. One remains on the ward to see new patients, perform procedures, and do ward tasks while the other goes to the Family Medical Center to see outpatients. The next day the two residents reverse roles. In this way, the ward patients are always covered while one of the pair is available each afternoon in the model practice where they are each assigned to the same multidisciplinary team. Each team includes a pair of residents from each of the three years of the program, two faculty physicians, a nurse and a secretary. A medical social worker functions with three teams.

Our Experience

Since clear, open and frequent communication between the members of each pair is vital, we initially gave considerable thought to various possible methods of selecting the pairs; finally, however, we decided to rely upon an arbitrary, alphabetical order. This principle seems to have worked well with all pairs except one, wherein so much incompatibility gradually developed that one of the pair withdrew from the program entirely. From this incident we have learned, and wish to emphasize strongly, that whenever problems occur between residents which threaten to affect the operation of the program, prompt intervention becomes the urgent responsibility of the program director.

Within each pair, there are several styles of functioning. In one, according to the residents themselves, there is complete sharing of patients: the pair talk over the patient's history and findings as they jointly plan treatment. In most of the other pairs, there is a somewhat more proprietary attitude of "my" patient and "your" patient, with the alternate member of the pair seeing his partner's patient only in an emergency. It is interesting to note that there is more of a sense of sharing of inpatients than of outpatients.

An essential element in continuing this kind of paired residency training is the complete understanding by staff members of other departments of what is being attempted. In our program we found that nurses, residents, attending physicians, and secretaries all were puzzled at first by seeing two names in place of one on charts and in the on-call schedules. It was frequently necessary, therefore, to remind everyone concerned how the system worked, i.e., that they were to treat the two names as one person and not expect the two to do more than one resident's job. Family practice residents have sometimes been looked upon as not pulling

their weight in relation to the common service obligation to the hospital. At such times we have had to remind other services of the considerable obligation of our residents to ambulatory care. Now, just after the end of the first year, we can say that most of the people from other services who have contact with our residents have finally become accustomed to the system.

Since the paired resident system has now been in operation for over a year, we can begin to evaluate it. In our day-to-day experience with it and in comparison with other programs with which we have been associated, we consider that the pairing system meets our objectives.

There are, of course, some problems still to be worked out, and there are also some drawbacks which are more apparent than real. One of the latter is that, in the paired residency system, a given resident has a chance to do initial workups of only half as many patients as he would otherwise do. This situation might seem detrimental to a resident's education until one stops to think that these physicians are not at the stage where they need to do a large number of histories and physical examinations. They have already done many of these in medical school; it is sufficient now if the pair share the findings of each other's workups. What they need now is to see how various diseases present, how they progress, what can be done for them, and how the physiological processes can be altered.

In order to validate and supplement our own perception that the system is on the whole working well, we asked for and received input from the ten residents currently paired who have been in the project for more than one year. We sent each of the ten a two-page open-ended questionnaire which all ten returned signed.

A few real, though minor, problems presented themselves through responses to these questionnaires: five residents reported that they had, though rarely, experienced difficulties in leaving inpatients to see outpatients; four had had this problem "occasionally." Five experienced "rarely," and one "occasionally" a difficulty in leaving outpatients in order to care for inpatients. Two residents commented on "the inability of traditional institutions, i.e., hospital, nurses, faculty, house staff — to catch on to" the pairing system. There were also scattered comments on the following points: one resident didn't "always feel entirely comfortable with patients he hadn't evaluated completely"; two felt some (slight) loss of continuity in the care of inpatients; and one mentioned "problems of logistics" — having to travel several miles across Seattle from the Family Medical Center, where he sees outpatients, to the Veterans' Administration Hospital to see his inpatients.

Pondering these not unjustified comments, we feel that

none of these problems are insurmountable. The following predominantly favorable responses from the same ten residents give us incentive to try to solve whatever problem areas are reported. To the question, "In general, how has the pairing system worked for you and your partner?" all ten responses were favorable, ranging from "beautifully" (one), "superbly" (one), "very well" (six) to "well" (two). All ten residents stated that the pairing system made the educational process better. Two of them also felt that it made patient care better while seven felt that it left it the same; only one respondent suggested that, while it left inpatient care the same, it made outpatient care slightly worse.

Various advantages were cited for the paired system. The point made most often (six respondents) was that pairing facilitated cooperation and provided a model for working with other physicians in one's own practice. Others (three) stressed that "we have been learning to communicate with one another." Two other residents pointed out that "we learn from one another," and another two that pairing offered "intellectual stimulation." Still other comments brought out the fact that the system has given them a chance to spend a reasonable amount of time with outpatients, that it made it possible to take time for conferences, that it allowed them wider clinical experience than they would otherwise have had (with both inpatients and outpatients) and that it has provided patterning of important behavior. Finally, two residents pinpointed what we had really hoped for when we first inaugurated the paired residency system: it has given them a chance to fulfill multiple commitments — "to do two things at once — literally."

Among suggestions made by the residents themselves on the questionnaires was one that we attempt to rotate the pairing several times during the three years so that each resident could experience working with different partners. Other alterations, too, might be considered. On the whole, however, we believe that this system maximizes a resident's learning opportunities through wide exposure to a variety of patients and their illnesses during each resident's three-year stay in our program. Looking ahead, we see that pairing of residents at the same stage of training, with parallel responsibilities may be a useful concept to extend further to other professional situations outside the walls of our Family Medical Center.

References

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