The First-year Family Practice Resident An Identity Crisis

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A definite identity crisis was recognized among first-year family practice residents prior to this year. A specific solution was found through a carefully planned one month family practice rotation that enabled the residents to become fully acquainted with the Family Practice Clinic operation while firmly establishing their identity as unique family practice residents. There is good evidence that this approach has been highly successful in dealing with the problem, and the alleviation of identity crises in first-year residents has, in addition, strengthened other areas of the residency program.

Several years of observing the assimilation of first-year residents into the Family Practice Residency Program revealed that even highly motivated first-year residents had difficulty in quickly developing a healthy identity as family practice residents. Like many programs, the University of California at Davis had incorporated a rotating internship as the basic structure for the first year of family practice residency training by adding one half-day per week in the Model Family Practice Unit to an already overburdened schedule. The residents felt a primary responsibility to hospital services because of the established tradition and heavy workload. Feelings of guilt resulted from placing the clinic experience low among their priorities, and this generated some resentment from the faculty and clinic staff.

The identity problem was heightened by the paucity of contact among first-year family practice residents, who were scattered among the multiple service rotations and were scheduled in the Family Practice Clinic at different times. Although there was an initial orientation day, it was clear that the residents felt isolated and unfamiliar with the Family Practice Clinic facilities, equipment, record system, and staff. This made their time in the Family Practice Clinic inefficient, frustrating, and less productive. Thus, clinic time was poor competition for those precious hospital hours. Furthermore, because family practice is a new specialty in the academic center, there is some reality to the belief that professional status is less secure than in other, long-established specialties. Thus, these residents more readily assumed identity as rotating interns rather than as unique first-year family practice residents. This article will examine this identity problem and describe changes made within the residency program in responding to it. The problem-oriented approach will be used; the "SOAP" format lends itself well to describing the events which took place.

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Problem — Identity Crisis

Subjective:

The first-year family practice residents were interviewed separately and as a group in an attempt to understand their attitudes towards the first six months of the residency program. Most of their feelings can be summarized as follows: (1) Feelings of letting fellow interns down by attending their Family Practice Clinic; (2) Frustration of having critically ill patients left for others to watch while at the clinic; (3) The Family Practice Clinic time meant they would be at the hospital even later that night working up new admissions and getting essential ward work done; (4) The clinic seemed inefficient, and as beginners they felt their own inefficiency to be further compounded by unfamiliarity with equipment, procedures, referral methods, recordkeeping, and appointments. Clinic preceptors slowed them down even further, occasionally resulting in their avoidance of the teaching staff; (5) Feelings of guilt for missing family practice conferences; (6) Feeling that the family practice faculty were well intentioned, but did not really understand the pressures of meeting the double obligations of hospital and clinic practice. Peer approval was based on relationships with other interns rather than with fellow family practice residents.

Objective:

Prior to this year, the first-year residents were slow in developing a sense of dedication to the function of the Family Practice Clinic. Inefficiency in patient management because of the residents' unfamiliarity with the clinic operation was reflected in tardiness and complaints when new patients were assigned. There was a distinct lack of interest in chart audits or attending team meetings.

The evaluation reports from other services revealed that the attending faculty occasionally did not know the evaluatees were family practice residents referring to them as rotating interns. Other objective data were the discussions and complaints voiced to the family practice faculty at oral evaluations and spontaneously to second and third-year family practice residents regarding hospital rotations and Family Practice Clinic experience. As

the year progressed, there was objective data to support the conclusion that the first-year residents' identity as bona fide family practice residents did develop, but at considerable expense to their emotional well-being. Every resident expressed negative feelings about the first six to eight months of the program, but emerged with a strong identity by the end of the first year.

Assessment:

After two first-year resident classes were observed and their performance in the hospital as well as the Family Practice Clinic was evaluated, it was concluded that there was a significant identity crisis experienced by our residents during the first six to eight months of the program. This incongruence was keenly felt because they were highly qualified, well-motivated residents who had been selected for their aspirations to accomplish the goals of the residency program.

Further assessment indicated that a method was needed to cement their identity as family practice residents and facilitate their being recognized by other housestaff as belonging to the Family Practice Residency Program. Peer relationships needed to be strengthened between first-year family practice residents and the rest of the family practice residents. A simple, but effective, idea was to give all family practice residents a silver lapel pin symbolizing the family practice movement. Explaining this interesting symbol resulted in the residents verbalizing the philosophy of family practice to other faculty and housestaff, gaining strength of conviction in the process.

Plan:

The aim was to design a first-month family practice rotation for the incoming residents that would help develop a strong identity as unique residents in the specialty of family practice.

This rotation was organized as follows: eight first-year residents were paired and assigned to four full-time positions in the Emergency Room; one of the two residents was always available for the Family Practice Clinic activities and was able to share with the other any information that the other missed. This gave the residents access to the hospital in an exciting and busy way and offered a dynamic hospital experience as a balance to the indepth experience in the Family Practice Clinic.

Because the Family Practice Residency Program has control of the content of the first year, it was possible to negotiate a schedule with the other services that would allow assignment of all first-year family practice residents to a mixed rotation of family practice and Emergency Room. Cooperation was obtained by explaining the goals of the rotation and the need for a hospital activity that did not require continuity of patient care. Each first-year resident received two full months of training in the Emergency Room. A total of four months was scheduled on a paired basis; this consisted of a combination of family practice rotation, an elective, and vacation (two two-week periods). Figure 1 shows a full year's schedule of first-year resident rotations incorporating these changes.

The family practice rotation was organized into five major categories:

1. Philosophy of the residency program and departmental organization.

The departmental chairman outlined the scope of the activities of the department, as well as its history, philosophy, and goals. The Family Nurse Practitioner Program, the undergraduate medical school courses, and the Family Practice Residency Network Program were described to demonstrate the overlapping circles of education and service required of comprehensive, team-oriented medical practice.

2. Orientation to facilities and resources.

a) The clinic personnel demonstrated each of the administrative functions dealing with making appointments, registering patients, answering telephones, and maintaining the clinic records. Various types of data collection were demonstrated and methods described for disease coding and data retrieval procedures. Operational problems were described to the new residents regarding chart management and coordination of clerical functions with the workload of the resident. The clerical personnel were afforded the opportunity to explain their side of the clinic operation.

b) The nursing personnel were responsible for demonstrating to the new residents all of the clinic equipment, the location of the various supplies and request forms needed for patient care, and the steps in initial patient management. To give the residents an appreciation of total clinic function, they were required to register as new patients at the front desk and to have a data base collected by the nursing personnel. This included a detailed history questionnaire, routine laboratory tests, skin tests, hearing and visual checks, EKG, and spirometry. A complete physical examination was then done by an experienced nurse practitioner and the entire data base was reviewed by one of the faculty members. This gave the new family practice resident a health record and data base at the Medical Center. It also identified several medical problems that needed immediate attention. The residents strongly endorsed this experience and other family practice residents have now requested it.

c) The Family Practice Chief Resident gave an informative talk and orientation to the hospital and support facilities. Favorite consultants, technicians, and nurses were identified, along with "pearls" about how to get things done quickly in the system. Peculiarities of the hospital operation were discussed and many questions answered. The Family Practice Clinic recordkeeping was carefully explained.

d) Each resident was assigned 12 new families from departing third-year residents. The medical record of each family member was audited by the new resident and a list of needed data base information made. The residents contacted the families by telephone, introduced themselves as their new physician and offered either to make a house call or have the family come in for a no-charge, get-acquainted visit. The residents were extremely pleased with this method of introduction to both the record and the new patients. Patient acceptance of no-charge visits and home visits by the residents was quite good, although the home visit was felt by the residents to be less productive than if it had been based on a clinical need. The residents also began to see new patients during assigned times in the clinic.

e) Each resident was assigned to a team and participated in the team meetings throughout the first month.

Figure 1. First-Year Family Practice Resident Rotations

EIGHT PAIRED FAMILY PRACTICE RESIDENTS

JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE
FP / ER	MED	MED	VAC / ER	MED	ER / ELECT	ORTHO	SURG	VAC / ER	OB	PED	PED
FP / ER	MED	MED	ER / VAC	MED	ELECT / ER	SURG	ORTHO	ER / VAC	PED	PED	OB
FP / ER	ER / ELECT	MED	MED	VAC / ER	MED	OB	PED	PED	ORTHO	VAC / ER	SURG
FP / ER	ELECT / ER	MED	MED	ER / VAC	MED	PED	PED	OB	SURG	ER / VAC	ORTHO
FP / ER	ORTHO	VAC / ER	OB	PED	PED	MED	MED	VAC / ER	MED	SURG	ELECT / ER
FP / ER	SURG	ER / VAC	PED	PED	OB	MED	MED	ER / VAC	MED	ORTHO	ER / ELECT
FP / ER	OB	PED	PED	ORTHO	VAC / ER	SURG	ELECT / ER	MED	VAC / ER	MED	MED
FP / ER	PED	PED	SURG	OB	ER / VAC	ORTHO	ER / ELECT	MED	ER / VAC	MED	MED

They were also introduced to the preceptors serving in the Family Practice Clinic for that month and went to their offices for a "get-acquainted" visit.

f) Representatives from a variety of ancillary health care agencies presented basic information about each agency to the family practice residents. Consultation requests and follow-up methods were detailed for the residents and early channels of communication established.

g) A variety of visits were arranged with community agencies and local clinical affiliations associated with the residency program. This afforded the residents a chance to get acquainted visually with a variety of agencies with whom they would be dealing and to meet key personnel. This also included a visit to the county jail, alcoholic detoxification center, and "free" clinics for drug abuse.

3. Special sessions.

a) The residents met with a senior psychiatry resident who was working in the Family Practice Clinic part time. A close relationship was established between the residents and the psychiatrist regarding many of their feelings about interview situations, interpersonal relationships, and the stresses encountered in the residency program. These group sessions resulted in a trust relationship. They elected to continue to meet once a month socially as a group to continue the interaction begun in these sessions.

b) The residents were given a variety of sessions from local speakers on the subjects of medical ethics, legal medicine, major medical health care financing, the local county medical society, and the state medical association. Team delivery of health care was stressed by the department faculty, emphasizing the integration of family nurse practitioner students in the residency program.

c) A clinical pharmacologist gave a short discussion of the ten most commonly used drugs in the clinic. This enabled the residents to immediately become aware of the side-effects and the need for patient education regarding the use of drugs. The management of drug overdose was thoroughly reviewed.

4. Skills, knowledge, and attitude testing.

a) All residents were given a two and one-half hour self-assessment examination during their first week of residency. This was followed by an attitudinal test. The residents were then given a confidential result of the self-assessment examination and a display of their attitudes compared with a control group of practicing physicians.

Each resident was video taped interviewing a simulated patient. The simulated patient was selected from drama students from the University of California, Davis, who were given clinical vignettes to enact filling in their own personal and family history to give the story validity. Following the video taping session, there was an immediate feedback critique of the session including the actor or actress, the resident, and the psychiatrist. This critiquing session was also video taped for evaluation. These interview sessions and immediate feedback critiques were highly rated by the residents.

5. Evaluation.

a) At least once a week during the first month rotation, an hour was set aside for the faculty to meet with all of the first-year residents. They were asked to evaluate their experiences encountered thus far in the new family practice rotation and to voice any suggestions that they may have had to improve the remainder of the month's activities. The group's cohesiveness was markedly increased as a result of the sessions with the psychiatrist and the open-ended discussions with the faculty members. As a result of the immediate feedback from the residents, several minor alterations were made in the remaining schedules. During the sessions, the residents were also introduced to the various faculty members involved peripherally with the residency program. Activities of the medical students were described, as well as the responsibilities of the residents for overall teaching of students and student nurse practitioners.

b) *Overall evaluation* – The faculty sessions with the residents held throughout the family practice rotation were extremely valuable in providing immediate feedback regarding their feelings about problem areas. It also gave the residents an opportunity to offer suggestions. One was to reduce the time given to the ancillary health care agency representatives during initial orientation and to obtain more of the information from site visits. The residents have felt strongly that the amount of time that they spent with each other during the psychiatric sessions, the pharmacology course, and the review sessions provided them an excellent opportunity to become well-acquainted. This obviously strengthened their identity as family practice residents and created an *esprit de corps* that had been lacking in prior first-year residency groups. The acquaintance with the other members of their team provided valuable support for early management of patients in the Family Practice Clinic.

There was evidence following the first month of family practice rotation that the residents felt much more comfortable in the hospital relating to other housestaff members than had prior residency classes. The first-year residents continued to meet socially every four weeks for a potluck dinner and continued the group sessions that had been started with the psychiatry resident. The attendance at family practice conferences and other teaching rounds was much better than in other years. A strong identity with the Family Practice Clinic gave the stimulus to the new residents to participate in all of the teaching activities available.

A secondary benefit was noticed among the second and third-year family practice residents. Many of them were able to sit in on the sessions provided for the first-year residents and obtain information that they themselves had previously missed. Furthermore, they felt much better acquainted with the first-year residents, and the high spirit and enthusiasm of the first-year group spilled over into the attitudes and behavior of the second and third-year residents.

Long-term evaluation of this family practice rotation will be done by interviewing each of the residents at six months and at the end of their first year. The information obtained from these interviews will be used to modify the family practice rotation for next year's first-year residents.

Our initial experience has demonstrated that what previously had been an identity crisis has become no more than the usual anxiety about starting a new life experience, and management of this anxiety has facilitated the development of a healthy identity as a family practice resident with strong peer support.