Communications

Building Identity in a Family Practice Residency Program

Merrill N. Werblun, MD, Jenina Deshler, MSW, and L. Robert Martin, MD
Los Angeles, California

When the first class of residents entered the Family Practice Residency Training Program at the University of California, Los Angeles (UCLA) in June 1975, the residents spent their first year essentially as rotating interns on various inpatient services. During the course of the year it became evident that the residents lacked identification with each other, with family practice, and with the Family Practice Center. In 1974, Burr[1] diagnosed a similar "identity crisis" among the residents in the residency training program at the University of California, Davis, and reported the success of a combined, first-month family practice and Emergency Room rotation in establishing an immediate identification with family practice. The rotation he described was modified and expanded to suit the particular needs of the UCLA program.

From the Division of Family Practice, University of California, Los Angeles, School of Medicine, Los Angeles, California. Requests for reprints should be addressed to Dr. Merrill Werblun, Department of Family Medicine RF 30, School of Medicine, University of Washington, Seattle, WA 98195.

Problems

The residents entered their training program with a high level of commitment to the concepts of family medicine but were given little opportunity to experience these concepts before being integrated into the traditional, hospital-based, inpatient training. Their schedules included one half-day per week to attend patients in the Family Practice Center, but the overwhelming workload on the wards made this requirement a frustration and a burden. The half-days in the Center were viewed as "extra" work hours appended to an already overfilled schedule.

Assigned individually to other specialty services, family practice residents never developed the group cohesiveness which would have allowed them to address their common problems. Without formal commitment of curriculum time to specific functions of family practice residents, the residents identified temporarily with the specialty of their rotation; they "became" medical or pediatric interns and lacked an ongoing sense of family practice identity in their training and relationships. Family practice made little impact on residents or faculty in other specialties, and the residents received almost no recognition of their unique family practice status.

Under these circumstances, the residents would be unlikely to view the Family Practice Center as the nucleus of their education. They did not develop a working knowledge of the administrative operation of the Family Practice Center and relationships with Center staff and faculty were superficial and unrewarding. Although they were nominally members of a health-care team including faculty physicians, a nurse practitioner, a nutritionist, a clinical pharmacist, a social worker, etc, the residents did not have the opportunity to integrate these other health-care professionals into their delivery of patient care.

In evaluating the first year of training, the faculty recognized the dissatisfactions and frustrations of the resident group. The faculty also recognized that the first goal of the training program should be to establish a foundation of family practice identity in its residents. This led to the institution of a first-month rotation in the Family Practice Center for all residents, with the following goals:

1. To orient the resident to the Family Practice Center as the nucleus of his/her education

2. To develop group identity
3. To introduce family practice concepts of ambulatory care
4. To develop a common educational base in behavioral science.

The First-Month Family Practice Center Rotation

The first three mornings of the rotation served as an extended group orientation to the administrative structure of the Family Practice Center: personnel, fee schedules, appointment schedules, the problem-oriented medical record, coding systems, third-party intermediaries, and cost of medical care. At the end of the first week, the residents received the records on their new cohort of patients and began the process of contacting these families personally in order to establish good doctor-patient relationships.

During the second week, the residents initiated their practices at the Center, gradually enlarging their cohort of patients through the third and fourth weeks. They also met individually with each staff member of the Family Practice Center to understand each position and develop working relationships.

During the initial afternoon sessions residents and other members of the health-care team discussed cases that introduced and illustrated the roles and functions of health-care team members in the delivery of such care.

The remaining afternoon sessions were spent in the didactic and experiential teaching of the behavioral science curriculum. Lectures were given by the clinical social worker and by family practice faculty.

The development of a common educational base in behavioral science systematically progressed from the individual occupying protected personal space (body language, etc) to a person within a family system[2] (systems boundaries, subsystems, etc), to the family as the primary context of psychosocial definition and expression (communication rules, affective states, etc), and, finally, to the family in process as a developmental and historical unit (life stages of a family).

The concommitant experiential learning exercises were designed to be similarly progressive from low-stress, non-intimate group interaction ("space" games, non-verbal "charades"); to video-tape analysis of a fictional family, "known" but impersonal, to role-playing with one another in "family" groups of five where the learner interacted personally but within the anonymity of the "role," and, finally, to a high-stress intimate task using the formal structural models taught to describe to a group of one's peers one's own personal life/family, at an historically critical juncture.

This last experiential exercise was optional. If a resident elected to participate, the individual presented his/her family of origin at the point when he/she last lived "at home" according to the developmental schema and structural family systems theories discussed. The group's cohesiveness and mutual trust were demonstrated in that eight out of the ten residents elected to take this risk within his/her newly formed peer group.

The behavioral science curriculum during the first month provided an educational base, an attitudinal approach toward the specialty of family practice and a sense of shared process within the group facilitating the development of satisfying interpersonal relationships.

Consistent with Burr's observations,[1] the new graduates were eager to assume patient care responsibilities and become oriented to their unfamiliar hospital environment. A rotation in the Medical Emergency Room at the Center for Health Sciences was designed to satisfy these concerns. Functioning in pairs,[3] the residents rotated through the Emergency Room for one four-hour shift every fourth night and one 12-hour shift every second weekend.

Early-morning rounds, with faculty, on family practice patients further acquainted the residents with the hospital complex and increased their visibility among peer groups in other specialties. Emergency Room experiences of the previous night were discussed as part of these rounds, enhancing the growing sense of group identity.

Summary

At the conclusion of the first-month rotation, the faculty found a cohesive, identifiable peer group of residents able to synthesize the delivery of health care in the Family Practice Center. The residents had integrated the other members of the health-care team into the delivery of care and had begun to use interviewing skills and family dynamics in their day-to-day practice of medicine. When they left this rotation for their various ward services as paired residents,[3] they regarded the Family Practice Center as their educational "home base" and were eager to return for their patient care times. The Family Practice Center rotation has, to date, solved a major problem encountered at this University in the first year of the residency training program.

References

1. Burr BD: The first-year family practice resident: An identity crisis. J Fam Pract 2:111, 1975
2. Minuchin S: Families and Family Therapy. Cambridge, Mass, Harvard University Press, 1974
3. Lincoln JA: The three-year paired residency program: A solution to a teaching dilemma. J Fam Pract 1(2):31, 1974