Communications

The First Month in Family Practice Residency Training

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For the new resident the first month of the family practice residency affords an outstanding opportunity for a smooth transition into his/her new role. Described in this paper are the objectives and implementation of one multifaceted program, which is designed to make the resident and spouse comfortable group members, to help them develop relationships, and to assist them in becoming familiar with family practice.

The habits and approaches developed during the first six months after graduation from medical school will follow the physician throughout his or her life. It is essential that productive, empathic habits be actively formulated at the onset of a residency program and reinforced during this formative period. This is one of the reasons that many family practice residencies place the resident in the clinic setting for at least the first month of training.

The USAF Medical Center Scott Family Practice Residency Program has developed and activated a clinical model with objectives designed to nurture further productive, empathic attitudes.

From the Family Practice Residency Program at USAF Medical Center Scott, Scott AFB, Illinois. Requests for reprints should be addressed to Dr. John N. Dunn, USAF Medical Center Scott/SGHF, Scott AFB, IL 62225.

Objectives of the First Month

1. Make introduction into the residency structured and nonthreatening.
2. Assess the academic strengths and deficiencies of incoming residents so that their rotational programs can be patterned in response to their needs.
3. Recognize the personal feelings, conflicts, inadequacies, and emotional characteristics of the residents.
4. Teach techniques of emergency care of the potential life-threatening emergencies which the resident might encounter.
5. Integrate the residents into a helpful, cohesive team and social unit.
6. Recognize the limits, degree of responsibility, standards of practice, and the relationships of professional duties, and the personal and family needs of residents.
7. Accept the *family* as an entity affecting and influencing treatment.
8. Appreciate the importance of the treatment of behavioral needs as well as medical needs to the degree possible in the family practice setting.
9. Develop proper styles of patient interviewing using the behavioral-helping relationship model.
10. Become aware of influences and clues in body language and nonverbal communication.
11. Understand the preventive aspects of practice which are uniquely possible in the family

practice setting.

12. Become aware of the particular aspects of behavioral science applicable to family practice and start using this body of knowledge.

13. Enlarge the scope of treatment to include the utilization of the complete health-care team and all available resources.

14. Orient the residents to hospital and clinic plans, procedures, and modes of operation.

15. Experience the jobs and trials of subordinates working in the health-care team.

16. Explore effective new potentials available to increase understanding of the problems of the patient/family (home visits, etc).

17. Become functional in disaster situations.

18. Develop the skills of timeliness, specificity, completeness, and proper speed in performing duties.

19. Perform initial family visits, set up data bases, and develop short and long-term goals of treatment using the problem-oriented medical record.

Specific Approaches

Approaches used to meet these objectives (which are not necessarily original at this program) include the following:

1. First year residents are assigned 18 to 20 of their families during the first month of the family practice rotation. Most new families are seen for their initial family interview in special night clinics specifically set aside for this purpose. Examinations requiring chaperones are not performed, and follow-up visits can be arranged that night without tying up the appointment desk. Family instructions can be given easily and minimal help is required for the patient load. At least two initial interviews are video taped for later review with the behavioral scientist.

2. Four of the initial interviews are accomplished as home visits. The patients are preselected and contacted by the community health nurse, who accompanies the resident and orients him during the trips on how she conducts home visits. This has been accepted by patients without exception.

3. Each resident spends one half-day at the clinic desk where he/she answers all first contact questions. He cannot identify himself as a physician. This was intended as a means of sensitization to the problems encountered by the technicians, but turned out to be a very rapid education into operational procedures in the clinic.

4. Noon lectures and an afternoon devoted to disaster training prepared the residents for Emergency Room duty. The schedules for the first month and for noon conferences are available on request.

Comments

The Scott Family Practice Residency Program began with placement of residents in the unit for their first month. The program developed into the present model after the addition to the staff of a behavioral scientist and a community health nurse, and as staff experience increased concerning residents' needs. This model has many similarities and parallels to that of the Department of Family Practice, University of California at Davis as previously described.[1]

Family practice training is focused primarily on the first year residents during the month of July and no residents are taken off cycle. Spouses are included in as many activities as possible within the curriculum so they get an added sense of belonging and an increased understanding of their spouses' occupation. A social activity is included for husbands and wives early in the month so that they can meet the staff and other residents and their spouses.

It is our experience that the month in the family practice unit gives the faculty an opportunity to know the new residents, develop strong working relationships, and pinpoint areas where improvement may be required. It provides the resident with a thorough orientation to the area in which he will be spending 40 percent of his time, develops familiarity and interdependence between him and all the other residents, reveals faculty perception of family practice, decreases anxiety level attached to this momentous life transition, and brings the family into the family practice teaching program as integral members.

We have not developed an evaluation system because of the rapid change in our method of performing the first month's teaching. This will be completed and should include assessment after 6 months, 18 months, and 30 months, so that insights associated with growth can be included.

References

1. Burr BD: The first-year family practice resident—An identity crisis. J Fam Pract 2:111, 1975