Resident Development in Family Practice Training: A Personal Counseling Program

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A family physician's personal development and professional functioning are strongly meshed. Family practice residencies need to implement programs which promote personal development and support the integration of the resident's personal and professional development. This paper describes and evaluates the personal counseling program in the Department of Family Medicine, Medical University of South Carolina, from 1973 through 1978. The evolution of goals and their implementation are outlined. Providing resident counseling as part of a family medicine curriculum presents problems which are generic to primary care. These problems and their solutions, within the model of resident development, are defined and addressed.

Personal and professional functioning are strongly meshed for the family physician. On the one hand, the family physician's diagnostic and therapeutic skills are enhanced to the extent that he or she can use personal skills in an informed and competent manner in patient encounters.[1,2] On the other hand, fulfilling the professional role of family physician may stress the individual physician and impair both his personal and professional functioning.

Training programs in family medicine need to assume more responsibility for monitoring and supporting family physicians' personal development along with their professional development. Incorporating programs for personal development into professional training has several effects. It validates the importance of the physician's use of self as a clinical tool in family medicine.[3] It helps the family physician better distinguish and integrate these two aspects of self. It provides a resident with immediate support, along with alternate models of personal and professional functioning, at a time when the stresses of training[4,5] make him most motivated to adopt new styles of functioning.

This paper describes the development of a resident counseling program at the Medical University of South Carolina. Resident counseling was initiated as a supplemental educational experience within the behavioral science curriculum. The residents' need for support and the counselors' desire to integrate the program within the overall educational context forced the counseling program to develop a more continuing and comprehensive format. Having developed a model that shares a philosophy and format of providing care with family medicine, the personal counselors also share the generic problems faced by the family physicians. These will be discussed, along with the ethical, clinical, and educational issues involved when a training program provides counseling for its residents.

Evaluation of Personal Counseling Program

Philosophy and Purpose

A major and continual goal for the Medical University of South Carolina's behavioral science curriculum is to "enable the future family physician to grow in awareness of his ongoing involvement in a social context and to incorporate this sensitivity to self [and] to others."[6] In the spring of 1973, behavioral science faculty initiated two self-appraisal programs—one personal and one professional—to help the resident learn to use self-awareness as a barometer of his professional functioning. The purposes of the programs were:

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1. to enhance the family physician's professional and personal relations with his patients
2. to increase the probability of his living an emotionally satisfying and complete life
3. to establish early the habit of seeking help and of sharing one's personal problems, frustrations, delights, and ambitions

Client-centered counseling was chosen as the model for the personal self-appraisal program, for several reasons. It stresses and facilitates self-awareness.[7,8] If the family physician can explore and stretch his personal boundaries in such a relationship, then he can better define and extend these boundaries in the context of patient care. Client-centered counseling makes the acceptance of one's own diverse feelings and perceptions more possible and acceptable. To the extent that the resident can accept these in himself, he can recognize, empathize with, and accept them when expressed by patients. In this model, the client is helped to take the major responsibility for defining problems and for determining their solutions.[9]

The client-centered model of counseling is different from the resident's traditional models of psychotherapeutic intervention. It focuses more on a client's personal style and growth potential rather than on his specific problem. The role of the counselor is to facilitate the client's understanding, awareness, and acceptance rather than to provide insight or solutions. In summary, it introduces the resident to a nonpathological, non-crisis oriented model of personal and professional functioning that makes self-awareness, self-acceptance, and intimacy crucial to continued development and not simply behavior necessary for managing transient, stressful episodes.

Implementation

Nonmedical clinicians implement the "Appraisal of Self: Personal" program, and family physicians implement the "Appraisal of Self: Professional" program. A nonmedical counselor, freed by his lack of identity with the resident's professional role and experiences, can maintain the focus on the resident's personal development. A physician, because of his similar experiences, can focus the resident on his developing professional style, performance, and aspirations.

After three years of experience with both programs (in 1976), the names of these two programs were changed to "Personal Counseling" and "Professional Advising." One reason to differentiate between "counseling" and "advising" was to help the two different providers of care better define their limits of responsibility and unique focus. The second reason for the change to "personal *counseling*" was to make more explicit what aspects of support and education this relationship could offer to the resident. With experience, the counselors realized that offering support to the resident in crisis did not necessarily undermine the educational aspects of the self-appraisal relationship.

The educational component of this relationship was so highly valued that it determined the counseling program's early implementation (1973-1975). The program was structured to expose as many residents as possible to counseling in the context of personal development rather than personal support. Residents were therefore assigned to counselors at periods of lowered stress. First year residents, who typically face heavy clinical responsibilities and stress, were not assigned to personal counselors. Second and third year residents were assigned to counselors for a specific two-month period, which was selected to coincide with hospital or preceptor rotations that were relatively "light" in patient care demands.

Residents were told that they could terminate the counseling relationship only after two sessions with their counselor and after a thorough discussion of their reasons for termination. This requirement was made by the counselors because they anticipated resident resistance to "seeking help," and they recognized that a relationship needs to be established and nurtured before work on the self can begin. Since the purpose of the program was the resident's exploration of the limits of his personal self, and since "the personal self" changes with each context and relationship,[10] residents were assigned to a new counselor each year.

Beginning in 1975, when residents requested more personal responsibility and flexibility from the counseling program, they were allowed to rank their top three choices for counselor before assignments were made. With this freedom to choose a counselor, residents soon requested the right to retain a counselor. Flexibility, but not outright permission, was added. Requests are now individually evaluated for their therapeutic and educational efficacy. Residents also complained of

the limited and arbitrary access to counselors. They wanted to see their counselors at a time when they were motivated to seek personal support or development.

This resident need was accommodated by two changes in implementation, made in 1976. Second and third year residents' assignments to a counselor were no longer restricted by time period. Instead, residents were asked to enter counseling at a time when they could initiate intensive work. Counselors were asked to monitor whether the residents were making appointments and to periodically extend an invitation to the residents assigned to them. First year residents were included in the personal counseling program. They are assigned to a temporary counselor during their first two months of training, and then they choose a counselor for the remainder of the year. Monthly meetings with a counselor are recommended to first year residents.

Inclusion of Evaluation Data

Initially, reports about a resident's professional performance were kept from his personal counselor. This policy followed naturally from the philosophy of a counseling relationship. Traditionally, the client's self-evaluation is the one "that counts." Without data about the resident's professional functioning, the counselor can better focus on his personal functioning. The counselor finds it easier to remain nonjudgmental and to allow the resident to explore whatever aspect of self he wishes.

In 1976, however, the personal counselors petitioned for and, after some resistance, won the right to automatically receive evaluations of residents assigned to them. Residents occasionally object to this policy, and their evaluations may be withheld. The counselors had several reasons for wanting to see comprehensive and objective evaluation data. First, as clinical teachers, they already had access to some information, often subjective, about a resident's professional functioning. Secondly, they recognized that restricting themselves to a traditional implementation of a counseling relationship diminished their potency both as counselors and as teachers.

With objective data, the counselor can know what dissonance exists between a resident's self-evaluation and objective evaluation. The opportunity to explore that dissonance is rich with possibilities for awareness and change. With objective data about the resident's functioning in various professional contexts, the counselor/teacher can initiate more topics for self-exploration and can better help the resident integrate understanding about himself as a person with understanding of his diverse professional functioning.

Revised Goals and Objectives

Implementation of the personal counseling program had to change to reflect the counselors' new objectives and to keep the program accessible to residents. By 1977, the personal counselors realized that optimal care for residents means *continuing and comprehensive care to the whole person of a physician in an educational context.* Continuing care means crisis intervention (support) as well as preventive intervention (personal development). Comprehensive care, focus on the whole physician, and providing care within an educational context demand coordination with other aspects of the resident's professional training. With this definition of care, the greatest problems for the counselor are maintaining his own role effectiveness and the resident's confidentiality.

These problems were addressed by making the counselors' goals more explicit and by providing more detailed guidelines for the counselors' behavior. Currently, each resident receives a copy of the following description of the revised personal counseling program.

Goal 1

To promote the personal growth of the resident and to provide assistance to him/her (when needed) in adapting to the stresses of resident training.

To achieve this goal, the personal counselor should:

A. provide a trusting atmosphere in which personal support and growth can occur

1. by clearly informing the resident of the limits on their relationship with regard to:
   a. confidentiality,
   b. the introduction of performance data and information from outside sources, and
   c. that particular counselor's interpersonal style, especially as it relates to and is different from his/her functioning as a teacher and consultant;

2. by encouraging the resident to seek another counselor, perhaps outside of the Department of Family Practice, if the resident is uncomfortable with the limits on the current relationship;

B. provide structure to the relationship so that the resident can explore some aspects of his/her personal self in a manner which suits his/her needs and styles;

C. encourage the resident to pursue a counseling relationship on a regular basis.

Goal 2

To help the resident integrate his/her personal self with his/her professional role and functioning. To achieve this goal, the personal counselor should:

A. help the resident discriminate attitudes, feelings, and values which may affect or detract from his/her desired personal and professional functioning;

B. delineate personal needs which the resident may be inappropriately gratifying through patient care and discuss how those needs might be gratified in other ways;

C. identify interpersonal behaviors, observed within the counseling relationship or in patient care and learning situations, which interfere with the resident's personal and professional functioning and use the counseling relationship, if appropriate, to experiment with different behaviors:

if the counseling process would be impeded by such work, the counselor should encourage the resident to explore new interpersonal skills, within the process of medical education, and the counselor should enlist the help of the appropriate teaching faculty;

D. identify interpersonal behaviors, observed within the counseling relationship or in patient care and learning situations, which enhance the resident's personal and professional functioning, and use the counseling relationship to help the resident value and reinforce those behaviors;

E. discuss those areas of personal and professional functioning which cause the resident personal discomfort and help the resident work through these feelings.

Goal 3

To help the resident establish norms for his/her own personal and professional functioning and to feel comfortable in seeking future counsel if he/she experiences a loss in personal satisfaction and effectiveness.

Evaluation by Residents

At the end of each academic year, residents are asked to evaluate their counseling experiences using a structured form. Generally, the resident is asked to comment on: (1) the ability of the personal counselor to establish a trusting and accepting relationship, (2) the effectiveness of the counseling relationship in helping the resident achieve awareness and enhanced personal and professional functioning, and (3) structural aspects of the program.

Table 1 summarizes the residents' evaluations for each of five years (1974 through 1978), and then presents the cumulative average of the residents' ratings. The first three columns show that the counselors were consistently able to provide the kind of close, involved, and accepting relationship that is necessary for self-exploration and personal growth.[7-9] These positive ratings by residents show that it is the behavior of the counselor, and not the context in which counseling occurs, that engenders trust and acceptance.

The next five columns address structure and the residents' overall satisfaction with their personal counseling relationship. Despite the changes in implementation over the five years, residents consistently gave neutral ratings about the formal structure of counseling. The residents report that the experience was both moderately personal and satisfying (ie, complete). This perception of having finished a piece of work is significant, since most of the residents met only three to five times with their counselor each year. In scheduling their days, residents gave time for the personal counseling relationship relatively low priority, despite their overall feelings that the experience was quite worthwhile.

The next five columns of data address the issues of enhanced self-awareness and personal development and the integration of the resident's personal self with his professional role. The first two columns present moderately strong ratings of the residents' increased self-understanding and their desire to continue self-exploration. The latter rating implies that residents may have greater comfort with seeking a counseling relationship in the future. These evaluations provide good sup-

Table 1. Ratings by Residents of the Relationship with a Personal Counselor over a Five-Year Period (1=most negative, 4=neutral, 7=most positive)

			I. I felt that my counselor was:			II. For me, the experience itself was:					III. This experience has led me to:							
			Distant/Close	Non-Accepting/ Accepting	Detached/Involved	Not/Most Worthwhile	Low/High Priority	Informal/Formal	Frustrating/ Satisfying	Pastiming/Personal	No Increased/Greater Self-Understanding	Discontinue/Continue Self-Exploration	Less/Greater Self-Acceptance	Less/Greater Self-Confidence	Less/More Spouse Closeness	Less/More Concern for Others' Feelings	Less/More Confidence as Family Doctor	Believe My Feelings Affect Professional Judgment: None/Much
Academic Year	**Resident Class**																	
1973-1974	(II,III)																	
(Residents:	22)	$\bar{x}$	5.7	6.3	6.2	6.1	5.3	3.8	5.3	5.5	5.9	5.8	5.8	5.2	5.4	5.5	5.5	6.1
(Returns:	21)	sd	1.35	.66	.89	1.09	1.31	.75	1.06	1.21	1.11	1.18	.98	.98	1.02	1.12	.37	.92
1974-1975	(II,III)																	
(Residents:	24)	$\bar{x}$	6.3	6.4	6.4	6.6	6.1	4.2	5.6	5.9	6.1	5.6	6.0	5.6	5.2	5.5	5.5	6.3
(Returns:	14)	sd	.83	1.34	.76	.63	1.07	.89	1.22	.83	.86	1.34	.88	1.02	.93	.88	.85	.91
1975-1976	(I-III)																	
(Residents:	41)	$\bar{x}$	6.0	6.4	6.2	5.9	4.8	4.0	5.3	5.4	5.4	5.8	5.1	5.1	5.0	5.4	4.9	5.9
(Returns:	32)	sd	1.12	.87	1.04	.96	1.37	.74	1.09	1.03	.81	1.10	1.11	1.13	1.43	.96	.95	1.53
1976-1977	(I-III)																	
(Residents:	43)	$\bar{x}$	5.6	6.5	6.3	5.9	4.1	3.8	4.9	5.2	5.2	5.6	5.4	4.8	4.4	5.3	4.9	6.2
(Returns:	19)	sd	1.21	.96	.81	.99	1.97	.37	1.33	1.27	1.31	1.02	.96	.83	1.33	1.15	.88	.98
1977-1978	(I-III)																	
(Residents:	43)	$\bar{x}$	5.9	6.6	6.4	6.0	4.7	3.7	5.3	5.6	5.2	5.4	5.1	4.9	5.0	4.9	4.9	5.7
(Returns:	30)	sd	.82	.61	.60	1.03	1.60	.52	.94	1.12	1.30	1.03	1.11	.94	1.13	1.05	.97	1.05
Cumulative Average																		
(Residents:	172)	$\bar{x}$	5.9	6.5	6.3	6.1	4.9	3.9	5.3	5.5	5.5	5.6	5.4	5.1	5.0	5.3	5.1	6.0
(Returns:	117)	sd	1.09	.86	.83	.99	1.58	.67	1.11	1.11	1.14	1.12	1.08	1.00	1.21	1.05	.95	1.00

port for two of the personal counseling program's basic objectives.

The next four columns address specific personal development issues. A client-centered counseling relationship should lead to greater self-acceptance, greater self-confidence, and better interpersonal relationships. The residents gained more confidence as people and as family physicians because of their relationship with a personal counselor. Self-acceptance and empathy increased moderately, and their feelings of closeness with spouse increased mildly.

When asked whether the personal counseling experience led them to believe that their personal feelings affect their professional judgment, the residents' answer is a very strong "yes." Before a family physician can effectively integrate his personal self with his professional functioning, he must first recognize that the boundaries between personal and professional self are not automatically distinct. The personal counseling relationship seems to be highly effective in facilitating this recognition and also in helping the resident clarify the boundaries of his personal self.

The reader will notice only slight differences in resident ratings of effectiveness among the various

academic years reported. It could be assumed, therefore, that changes in implementing the personal counseling program did not alter its effectiveness. Differences among the years does occur in rate of evaluation forms returned. The larger proportion of non-responders are residents who did not establish a relationship with their personal counselor. If a program is successful when implemented, as personal counseling apparently is, then its failure occurs when residents do not take advantage of it. The changes in implementation in 1976 and 1977 were apparently successful in getting more residents to seek counseling, since the evaluation return rate increased dramatically the following year.

Discussion

The problems of providing comprehensive programs of care are the same, regardless of whether the consumer of such care is a patient or a resident. Delivering good care means that the provider of care needs to understand and use the resources of the educational context, yet safeguard the resident's confidentiality and enhance the resident's involvement in his own care. The revised objectives detailed earlier address this problem and present some checks and balances. A greater source of problems for the provider of comprehensive care is in defining and implementing his own role. These problems include defining the effective limits of that role, delegating portions of care to other providers, and finding support for the role.

It was difficult to gain credibility for the educational components of the counselor role. Residents believed that the proper role for a counselor is to provide support and that personal development is an individual, not a curricular, issue. Residents also challenged counseling as a required method to implement personal development. In time they learned that counseling is not just another caring relationship or learning experience, but is a unique way to learn about self and others.

It was more difficult to resolve the seeming conflict between the traditional models of "counselor" and "educator." Essential counselor behaviors are accepting the client, encouraging client initiative, allowing the client to make his own decisions,[9] and preserving the client's confidentiality. A teacher employs evaluations, develops objectives, and tries to initiate work on those objectives. The Charleston personal counselors resolved the conflict in several ways. They agreed that a counselor does not have to be nondirective[9] in order to encourage resident responsibility. Educator behaviors like setting goals and teaching skills have therapeutic value and can be part of counseling[11] so long as the counselor is explicit and ethical in his objectives and methods.[12] Publishing the revised goals and objectives resolved the conflict.

The greatest difficulty for the counselors was, and continues to be, defining the limits of their responsibility and effectiveness. When counseling is part of an educational curriculum, it can become the proposed solution for problems that are better handled administratively or by other educational methods. One example is being asked to divulge whether the resident is "impaired" so that an administrative decision can be made. It has been the counselors' position that the administration should not know that a resident is stressed unless his professional performance is affected. If that is the case, however, this information should come from the clinic or hospital. Instead, the counselor's role is to work with the administration to develop a plan that serves both the residency's educational objectives and the resident's therapeutic needs.

Having counseling available to residents may preclude the development of other support systems that may be more effective for the resident. One example is the limited effectiveness of a one-to-one relationship in helping the first year resident deal with his sense of incompetence and isolation. The counselors have tried to initiate a peer support group to meet this need. A more cogent example is the counselor being asked to ease a resident's personal distress so that his professional functioning will return to normal or improve. Instead, the counselor may be more helpful as a consultant to the resident's health care team, to help them remediate his dysfunctional behavior. The resident can learn to accept feedback and support from co-workers. Team members can learn how to give constructive criticism and to reorganize health care delivery to support both the physician and his patients.

Despite four years of experience in implementing the Charleston personal counseling program, the insights about the dual role of the counselor/educator and the need for a comprehensive focus of care were not clear until the counselors

began to meet regularly as a group. Active discussion helped the counselors to define the limits of their role and to innovate the role of systems consultant. Ongoing discussion helps the counselors better integrate and coordinate their relationship with a resident with the support and education he receives from the rest of the training program. In isolation, the personal counselors had coped with the issues presented by overly restricting or extending their role and sometimes by "losing interest" in the role. Regular group meetings challenge and revitalize individual provider's notions about professional role and function. The rationale for having a personal counselor support group is, then, strikingly similar to that for implementing a personal counseling program in a family medicine training program. The more that one can explore the boundaries of his personal and professional self in a protected relationship, the more one can extend those boundaries effectively when functioning in a professional role.

Conclusions

Whether self-awareness is valued because it is necessary for personal stability, or for monitoring professional functioning, or for the use of self as a diagnostic and therapeutic tool, or for all three, it is an essential part of any curriculum in family medicine. Evaluations by Charleston residents show that a personal counseling program can be highly effective in increasing self-awareness. It highlights the interplay of personal feelings and professional judgment, and increases residents' recognition that ongoing self-exploration is important for continued personal and professional development. Certain aspects of a resident's personality, most notably self-acceptance and greater concern with others' feelings, are directly enhanced by personal counseling. In sum, the Charleston experience shows that a counseling program which focuses on the "person" of the resident has great impact on the overall development of the emerging family physician.

Adaptations in the implementation of a personal counseling program should incorporate the combination of elements which makes the Charleston program effective: (1) a strong focus on the resident's personal self, (2) by people who understand the context of the resident's professional self, (3) and who then try to integrate the resident's personal and professional selves (4) by a combination of supportive and educational interventions. Family physicians can serve as personal counselors, but they should restrict their focus to the resident as a person. Counselors from outside the educational setting can be used, but they should have good understanding of the educational setting and ways to influence it. Variations in who implements the counselor role will produce only variations in specific role-problems encountered. The generic problems will remain. The continuing experience of developing a personal counseling program in Charleston highlights the importance of peer review and support in maintaining the effectiveness of such a program and its providers.

Finally, each family medicine training program should give great thought to how to use the resident's peers, teachers, and health care team to support the resident, to facilitate his/her personal development, and to help the resident use his personal self better in patient care. Such interactions can form the basis for more constructive relationships later in the resident's life when he works as a clinician or as a teacher. This support and feedback, while not equivalent to an intensive relationship with a counselor, can contribute to a resident's personal development and can supplement a personal counseling program.

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