Orienting New Residents to Family Medicine

Robert S. Meier, PhD, and Barbara L. Thompson, MD
Galveston, Texas

Residents entering residency training programs face many stresses. The beginning of the residency is the junction between limited responsibilities for patient care carried by a medical student and major responsibilities in the daily life of a resident. Beginning a new program also involves moving a household for most residents and their families. Changing jobs and homes and possibly acquiring a spouse (many residents are newly married at this time) are three major stresses, as indicated on the Holmes-Rahe Scale of Life Stresses.[1]

The residents also need to develop an identity as family medicine residents, as most of their first year is spent on other services in the hospital. Kantner and Vastyan[2] stated that it is important to foster a sense of esprit de corps among the new residents. Dunn[3] stressed that productive and empathetic habits must be developed at the onset of the residency program. An orientation month is a time when social support systems can be developed.

Residency programs in family medicine have different approaches to the orientation of new residents and spend different lengths of time at it. A few programs orient their residents in one to three days, and others occupy as long as two months at the task. For the past six years, the Family Medicine Residency Program at The University of Texas Medical Branch (UTMB) at Galveston has used one month for orienting new residents.

Many personal development and educational activities are scheduled during the orientation month in July. The activities for personal development are designed to help the entering residents identify with other residents, the staff, and the faculty in family medicine. The educational activities provide an introduction to the patient care methods in the family practice center and the university hospital. The experiences that proved helpful over the past six years have been repeated, and those that were not perceived as helpful have been dropped. All activities have been formally evaluated by both faculty and residents. The purpose of this communication is to describe the experiences that our residents have evaluated as useful for their adjustment to family medicine in a university setting; the following recommendations are based on these evaluations.

Personal Development

Social Gatherings

Several social gatherings should be planned: informal lunches in the family practice center, evening meals, and picnics. These activities are useful for developing informal lines of communication among family medicine residents. Including the residents' spouses and family members in these functions broadens the bonds that are formed.

Personnel Booklet

Our booklet, entitled "Who's Who in Family Medicine," containing names of family medicine personnel, their spouses, background information, addresses, telephone numbers, and interesting hobbies, has been helpful in orienting new residents and their families.

From the Department of Family Medicine, The University of Texas Medical Branch at Galveston, Galveston, Texas. Requests for reprints should be addressed to Dr. Robert S. Meier, Department of Family Medicine, The University of Texas Medical Branch at Galveston, Galveston, TX 77550.

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Orientation Follow-Up

Some mechanism is needed for follow-up of first year residents after the July orientation has ended. In our program, members of the departmental Behavioral Science Committee visit the new residents on their hospital rotations during the months of September, October, and November. These visits help to increase the feelings of identity with family medicine faculty and to reduce the "November slump" that occurs in many residency programs.

Educational Activities

Immediate Hospital Assignment

The first year residents should begin working in a limited way in the hospital within the first week, and should be on some form of call as soon as possible. In our program, all first year residents work eight hours in the emergency room of the hospital every three days during July. Most residents are eager to begin working in the hospital and would feel frustrated listening to a month-long series of lectures. In addition, this serves as an introduction to the hospital as a "system."

Limited Daily Quota of Lectures

A total of three lectures or conferences per day should be the maximum. Residents can absorb only a certain amount of new information in a day, and more than three lectures per day tends to result in low ratings from the majority of residents.

Focus on Acute Problems

Lectures should focus on management of acute problems. Beginning residents are most interested in functioning adequately in an emergency situation and topics related to their needs in emergency medicine are received well. During the first month, presentations about chronic problems are not received as enthusiastically.

Cardiopulmonary Resuscitation (CPR) Training

The July orientation month is a good time to provide basic and advanced CPR training for the new residents. Faculty and other residents can also update their CPR skills at this time. Residents are taught neonatal endotracheal intubation during this month using live anesthetized kittens.[4]

Standardized Tests

The orientation month is a convenient time to administer standardized tests of cognitive skills to the first year residents. In the past, we have used the Core Content Examination developed by the Ohio and Connecticut Academies of Family Physicians. A reliable index of the knowledge base for all residents in the program is helpful in planning the educational program. Second and third year residents take the in-training examination developed by the American Board of Family Practice during the month of November.

Chart Audit

Charts completed by all the first year residents should be audited, and feedback from the faculty should be given them within a short amount of time. In this way, the faculty has an additional basis for discussion of the first year residents' skills at problem management.

Evaluation

Each of the scheduled orientation activities should be evaluated. The evaluation should be very brief and the results should be used to plan the program for the following year. In this way, speakers and activities that are rated as helpful can be rescheduled.

In addition to the recommendations listed above, other activities that will continue to be scheduled during the July orientation include assignment of patient panels, group meetings with personnel in the family practice center, regular weekly conferences, patient home visits by residents, and distribution of keys, beepers, and mail boxes. We also plan to include a two-hour orientation session for the residents' spouses. Although much time and effort goes into the scheduling of an orientation month as described, it is very helpful in the adjustment of the new residents and their spouses to family medicine in a university setting.

References

1. Holmes TH, Rahe RH: The social readjustment rating scale. J Psychosom Res 11:213, 1967
2. Kanter TR, Vastyan EA: Coping with stress in family practice residency training. J Fam Pract 7:599, 1978
3. Dunn JN: The first month in family practice residency training. J Fam Pract 6:1105, 1978
4. Thompson BL, Richardson CJ: Use of kittens in teaching neonatal resuscitation to family medicine residents. J Fam Pract 9:128, 1979

Medical Student Values, Socialization, and Primary Care Career Choices

Mark S. Plovnick, PhD
Worcester, Massachusetts

Do students choosing primary care careers undergo different patterns of attitude and value change during medical school than their counterparts in the more traditional specialties? Much of the research concerning the socialization of medical student attitudes and values implies a certain student homogeneity. Eron,[1] for example, found that students' cynicism increased while their humanitarian concerns decreased during medical school. Several other studies of medical student socialization tend to support these findings.[2,3] These studies do not, however, distinguish between students choosing different specialties.

Reinhardt and Gray[4] reported that significant differences in the attitude and value orientations of students choosing different specialties develop *after* medical school as a result of the students' experiences in postgraduate work and in practice. In a medical school study, Canning et al[5] investigated the impact of a single family medicine course exposure on students. They found that student attitudes did not change. They concluded that the general medical school environment did not support the attitude and value changes encouraged by the course, and that an isolated course experience was not enough to cause significant changes in student attitude or value orientations. The Canning study, however, did not investigate the potential influence on attitude and value development of a wider range of influences within a specialty over a longer period of time during medical school. While Merton et al[6] did investigate the impact of a lengthier "comprehensive care" program on student attitudes in the 1950s, little current data are available on socialization within primary care programs. The analysis described in this paper was conducted to address this issue.

Methods

One class of medical students (1977) at a private, urban medical school in the Northeast was surveyed by questionnaire in the first and fourth years of medical school. Students were asked to indicate their specialty choice from a lengthy list including most of the standard medical specialties and subspecialties. Student values were determined by a question asking the student to rate the importance of each of 12 items (eg, income, status, helping people) in their choice of specialty.

Through factor-analysis the 12 items listed were reduced to a smaller set of 3 factors. Factor 1, composed of people oriented and service oriented variables, was labeled *Orientation to Patient Care*. Factor 2, consisting of variables related to the quality of work life (hours, practice location, pay, and supervision) was labeled *Orientation to Work Conditions*. Factor 3 combined concerns for status and intellectual stimulation and was labeled *Orientation to the Profession*.

Mean scores on each factor were computed for the freshman and senior year for each specialty group as well as for the overall sample. Students choosing family medicine and/or specifically indicating a primary care career were then compared with the rest of the sample which included students in surgery, internal medicine specialties, pathology, radiology, and obstetrics-gynecology.

Results*

Fifty-five percent of the population sampled responded to both surveys enabling a longitudinal comparison. Of these, 16 students indicated a primary care career choice in their senior year, while 36 chose non-primary care specialties. While the small sample size precludes meaningful statistical analysis, there were several important trends in the data.

Values and Career Choices

There were substantial differences in the value orientations of senior students choosing primary care careers as compared to those choosing other specialties. Those choosing primary care scored

From the Department of Management, Clark University, Worcester, Massachusetts. Requests for reprints should be addressed to Dr. Mark S. Plovnick, Department of Management, Clark University, 950 Main Street, Worcester, MA 01610.

*More detailed results available from the author on request

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Table 1. Freshman- and Senior-Year Value Orientations of Medical Students Choosing Primary Care Careers as Seniors as Compared to the General Student Population*

		Freshman				Senior			
		Primary Care N=16		Other N=36		Primary Care N=16		Other N=36	
		Mean	SD	Mean	SD	Mean	SD	Mean	SD
Factor 1:	Orientation to Patient Care	7.19	1.15	8.90	2.38	8.37	2.82	10.22	2.10
Factor 2:	Orientation to Working Conditions	12.50	3.09	12.60	2.91	12.19	3.43	11.86	2.49
Factor 3:	Orientation to the Profession	9.63	2.96	8.62	2.59	10.00	2.21	7.97	3.36

*Lower numbers indicate greater interest in factor. Factor scores range from 4 to 20
SD=standard deviation

higher on Orientation to Patient Care and lower on Orientation to the Profession than their counterparts in other fields.

These senior year differences between specialties are also evident in the freshman year. Freshmen who ultimately chose primary care careers had more of an Orientation to Patient Care and less of an Orientation to the Profession than freshmen who ultimately chose non-primary care careers.

Values and Socialization

The overall student population demonstrated a general increase in their Orientation to the Profession and Orientation to Working Conditions and a decrease in their Orientation to Patient Care. The general trends in student attitudes and values concerning patient care and working conditions were similar for the primary care group and the non-primary care group. For the factor Orientation to the Profession, however, students choosing non-primary care careers experienced substantial increases during medical school while the scores of those students choosing primary care careers decreased.

Comment

In the medical school studied, students who chose primary care careers were more concerned with people and less oriented towards the profession than students choosing non-primary care careers. Yet during medical school the primary care students experienced shifts in their attitudes and values away from a concern for patient care and towards a somewhat greater self-concern, similar to the changes found in students choosing medicine, surgery, and other specialties. This would indicate that the unique faculty and/or experiences encountered by students interested in primary care careers at the school studied were not sufficient to counteract the general socialization influence of medical school. While these results are derived from a small sample at a single medical school, they do support the conclusions of some medical educators that medical education for primary care physicians may need to be further differentiated from programs designed for secondary and tertiary care providers.[7]

References

1. Eron L: The effects of medical education on medical student attitudes: A follow-up study. J Med Educ 33:25, 1958
2. Becker H, Geer B: The fate of idealism in medical schools. Am Soc Rev 22:50, 1958
3. Gordon L, Mensh I: Values of medical students at different levels of training. J Educ Psychol 53:48, 1962
4. Reinhardt A, Gray R: A social psychological study of attitude change in physicians. J Med Educ 47:112, 1972
5. Canning C, Kane R, Gray R: Attitudes and electives: Predicting enrollment and measuring effects. J Med Educ 49:986, 1974
6. Merton R, Reader G, Kendall P: The Student Physician. Cambridge, Mass, Harvard University Press, 1957
7. Proger S: A career in ambulatory medicine. N Engl J Med 292:1318, 1975