Psychosocial Support of Residents in Family Practice Programs

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Family practice residency programs (N=347) were surveyed to examine the frequency of 11 kinds of psychosocial support available to residents through their programs. Family practice programs offer a considerable number of support elements to residents, with programs showing much homogeneity in the kinds of support offered. The size of a program does influence the kinds of support available, with small programs less likely than medium or large programs to offer the formal kinds of support examined in this study.

Four patterns of support emerge from the data, each reflecting a specific orientation: (1) the psychological orientation, (2) the "bare bones" of support, (3) the support group orientation, and (4) the family orientation. In general, the kinds of support that address the residents' family needs are least likely to be available.

Because time away from work helps to relieve the pressures of residency training, length of vacation and frequency of night call were also examined. On the average, first year residents cover night call every 3.64 nights and have 2.4 weeks of vacation.

Residency training, because of its intensive time and energy demands, affects many aspects of residents' lives. A survey of house staff at Stanford University School of Medicine reveals that residency training frequently has negative consequences for residents and their families. A large portion of the residents surveyed resent training demands on their families (94 percent), worry about relationships ending due to training (49 percent), and report that they have inadequate physical exercise (68 percent), no time for personal reflection (59 percent), and worsening sex lives (49 percent). Furthermore, many feel powerless to influence their training experience (87 percent), reporting that faculty are not available to give support (53 percent) or to serve as advocates (49 percent).[1] Nelson and Henry's survey to assess the problems of family practice residents reinforces the above findings: residency training frequently conflicts with residents' personal needs for leisure and socializing and with their responsibilities to spouse, children, and household.[2]

There is increasing interest in addressing problems of residents and their families, as indicated by the existence of groups such as the Humanistic

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Medicine Task Force (American Medical Student Association)[3] and the Committee on the Well-being of Medical Students and House Officers (Stanford University School of Medicine).[1] These groups advocate development of support systems for residents.

Support systems are being developed by residency programs, with examples of psychosocial support for residents described in the medical literature. Residencies in family practice utilize several methods to help residents cope with the stresses of residency training, including support groups,[4] second-year "reorientation" programs,[5] peer review committees,[6] and encounter groups.[7] In addition, residencies in specialties other than family practice report the use of retreats,[8] part-time residencies,[9] and support groups for spouses.[10]

The authors' earlier study of residency programs in six clinical specialties indicates that programs in family practice and psychiatry are more likely to offer psychosocial support to their residents than programs in internal medicine, pediatrics, surgery, or obstetrics/gynecology.[11] In order to investigate in more depth the use of psychosocial support in family practice residencies, the above study was expanded to include a larger sample of family practice programs. This paper, which reports the results of the expanded study, has four purposes: (1) to further document the availability of 11 kinds of psychosocial support in family practice training programs, (2) to ascertain whether program characteristics (geographic region, type of program, size of residency) influence the availability of these kinds of support, (3) to explore the different patterns of support, and (4) to examine the range of variation in frequency of night call and length of vacation.

Methods

Instrument

From a survey of the literature and informal discussions with residents and residency program directors, the authors identified 11 kinds of psychosocial support that might be available to residents in residency training programs. The 11 kinds of support and operational definitions of each follow:

- Support groups—groups of residents who meet together at a scheduled time with or without a leader to discuss problems, share feelings, and give support
- Family support groups—support groups composed of residents and their families together
- Part-time residencies—shortening the number of residency hours per day and days per week and lengthening the duration of residency training
- Professional counselors—psychologists, psychiatrists, or social workers available within the program to help residents with personal or family problems
- Child care services—day care or babysitting services sponsored by the residency program or hospital and available to residents who are parents
- Formal "gripe sessions"—scheduled time when residents can bring complaints about the residency program before the staff
- Seminars and/or speakers dealing with emotionally charged medical issues—for example, the dying patient, euthanasia
- Seminars and/or speakers dealing with the stresses and conflicts of being a physician—for example, physician drug abuse, balancing of professional and private life
- Paid sick leave
- Social activities planned and sponsored by the residency program—for example, parties, sports events
- Financial advisors—people to deal with income tax concerns, investments, setting up future practice

These 11 kinds of support, together with their definitions, were included on a one-page questionnaire, and respondents were asked to indicate the kinds of support available in their programs. In addition, data pertaining to frequency of night call, vacation length, and program characteristics were gathered.

Subjects

The questionnaire was mailed in 1979 with a cover letter to the directors of all family practice

residency programs, as listed in the *Guide to Family Practice Residency Programs*.[12] Two follow-up mailings were used to maximize response rate. Of the 362 family practice residency programs surveyed, 96 percent (N=347) returned completed questionnaires.

In spite of the favorable response rate, the authors wished to assess any possible differences between responding and non-responding programs. A statistical analysis (using chi-square or one-way analysis of variance, as appropriate) of three characteristics of the residency program shows that responding programs (N=347) do not differ significantly from non-respondents (N=15) in terms of geographic region, size, or type of program. On this basis, one can assume that the responses are representative of all family practice residency programs and that the results are generalizable to the population as a whole.

Data Analysis

The data resulting from the survey were analyzed using different statistical methods, depending on the research question being examined. The different kinds of data and the data analysis used for each kind are described below.

Support Variables: The 11 kinds of psychosocial support (previously defined) were examined across each of three major program variables: geographic region, size, and type of program. Chi-square analysis was used.

Patterns of Support: In order to explore the statistical relationships between and among the various kinds of psychosocial support, the data for all programs (N=347) were combined. On the basis of an 11 × 11 intercorrelational matrix, the data were examined by means of factor analysis, using the normal varimax method of rotation.[13]

Night Call and Vacation: In addition to the 11 kinds of psychosocial support surveyed, two additional variables, frequency of night call and length of vacation, were each examined separately, using a three-way analysis of variance. In each of these two analyses, the three independent variables were geographic region, size, and type of program.

Results

Support Variables

Four geographic regions, Northeast, South, Midwest, and West (as defined in the *NIRMP Directory*[14]) are used for purposes of this study. Only 1 of the 11 kinds of psychosocial support—financial advisors—shows statistically significant differences across geographic regions. Financial advisors are less likely to be available in family practice residencies in the West (24 percent) than in the other three regions (52 percent to 55 percent).

A second variable, size of residency program, is defined on the basis of number of first-year residency positions available. Three categories emerge: small (two to four first-year positions), medium (five to eight first-year positions), and large (nine or more first-year positions). (The authors defined size categories based on the frequency distribution of residency programs.) Six kinds of psychosocial support show statistically significant differences across size of program. For each of these six kinds of support—support groups, family support groups, part-time residencies, professional counselors, personal/professional seminars, and social activities—small programs are less likely to offer the support than medium or large programs.

The third program variable, type of program, utilizes definitions of program structure set forth by the American Academy of Family Physicians.[15] Five program types are described:

Type 1: Community Based—program is based in a community hospital and is not affiliated with a university or medical school

Type 2: Community Based and University Affiliated—program is based in a community hospital, has a written contractual affiliation agreement with a university or medical school, but is administered by the hospital or other sponsoring institutions

Type 3: Community Based and University Administered—program is based in a community hospital, has a written contractual agreement with, and is administered by, a university or medical school

Type 4: University Based—program is based at, and administered by, a university or medical school

Type 5: Military Program

Table 1. Percentage, by Type of Program, of Residency Programs Providing Different Kinds of Psychosocial Support

Kind of Psychosocial Support	Percent by Type of Program				
	Community Based (N=49)	Univ-Affil Community Based (N=173)	Univ-Admin Community Based (N=52)	University Based (N=57)	Military Program (N=16)
Support Groups	55	60	56	68	69
Family Support Groups*	20	19	13	35	31
Part-Time Residencies†	20	12	15	30	0
Professional Counselors	88	82	79	88	81
Child Care Services	4	7	6	7	25
Formal Gripe Sessions*	92	88	75	77	100
Seminars—Medical Issues	92	91	90	95	94
Seminars—Personal and Professional Issues	74	69	67	77	94
Paid Sick Leave	92	89	90	93	94
Social Activities	92	88	88	96	100
Financial Advisors	47	51	48	46	25

*$P<.05$
†$P<.01$

Of the 11 kinds of psychosocial support, three show statistically significant differences across type of program (Table 1). Whereas both military (31 percent) and university based (35 percent) programs are more likely to offer family support groups than the other three types of programs (13 percent to 20 percent), it is university based programs that lead in percentage of programs offering part-time residencies (30 percent) and military programs that lead in percentage of programs offering formal gripe sessions (100 percent).

Patterns of Support

In addition to examining the availability of each of the 11 kinds of support, the authors were also interested in examining patterns of support; that is, which kinds of support seem to occur together. A factor analysis based on the 11 kinds of support included in this study results in a solution with four factors. The first factor, which reflects a psychological orientation, accounts for 60 percent of the variance. This first factor shows that three kinds of support—(1) seminars and/or speakers dealing with emotionally charged medical issues, (2) seminars and/or speakers dealing with stresses and conflicts of being a physician, and (3) professional counselors available in the program to help residents with personal or family problems—tend to be found together when the data are examined across all of the residency programs.

The second factor suggests a "bare bones" kind of support which consists of (1) sick leave, (2) social activities, and (3) gripe sessions. Twenty percent of the variance is accounted for by this factor. Although these three kinds of support appear to be vital to any program, this combination suggests a minimum level of support that is probably least taxing of the faculty's time and personal investment in the resident as a person.

The third factor, reflecting a support group orientation, accounts for ten percent of the vari-

Table 2. Frequency of First-Year Night Call in Family Practice Residency Programs

Night Call Interval Every (no.) Night	Number and Percent of Residency Programs	
	Number	Percent
2-2.9	2	<1
3-3.9	179	52
4-4.9	138	40
5-5.9	19	5
6-6.9	3	1
7-7.9	3	1
No night call	2	<1

Table 3. Length of First-Year Paid Vacation in Family Practice Residency Programs

Number of Vacation Weeks	Number and Percent of Residency Programs	
	Number	Percent
1	3	1
2	234	68
3	74	21
4	35	10

ance and consists of two items: (1) support groups for residents, and (2) family support groups.

The final factor indicates a family orientation and consists of three items: (1) financial advisors, (2) child care, and (3) part-time residencies. This factor also accounts for ten percent of the variance. As the results in the preceding section indicate, few residency programs offer child care or part-time residencies, but in those programs in which these are options, they tend to be found together and with the additional availability of a financial advisor.

Night Call and Vacation

Because vacation and evenings away from work help to relieve the time pressures of residency training, length of vacation and frequency of night call (both for first year residents) are assessed, as shown in Tables 2 and 3. On the average, first year residents cover night call every 3.64 nights. Across each of the three program variables—geographic region, size, and type of program—frequency of night call does not vary significantly when the remaining two variables are held constant. On the other hand, length of paid vacation does show statistically significant differences by geographic region and by type of program. Controlling for the remaining two variables, one finds that on the average, residency programs in the Northeast and West offer longer vacations (2.62 weeks and 2.71 weeks) than do Southern (2.21 weeks) or Midwestern (2.25 weeks) programs ($P<.001$). In the same fashion, controlling for geographic region and size of program, one sees that

university based programs offer longer vacations (2.61 weeks) than do the other four types of programs (2.25 to 2.41 weeks). This latter difference is statistically significant at the $P<.05$ level.

Discussion

On a national basis, there is considerable similarity among family practice residency programs in terms of the kinds of psychosocial support offered to residents. This homogeneity may be related to the fact that family practice is relatively new as a specialty and that most family practice residency programs have developed over a short time span under well-defined guidelines.

Size of residency program, however, is a factor in the amount of formal support offered to residents. It is not surprising that small programs are generally less likely than larger programs to offer the kinds of support surveyed. It may not be cost effective to provide numerous formal kinds of support to a small group of residents. More importantly, in small programs there is likely to be closer interaction between and among residents and faculty, thus providing valuable informal support systems and reducing the need for the more structured kinds of support examined in this survey.

In general, family practice residency programs offer considerable psychosocial support to their residents. Family practice as a specialty emphasizes preventive, holistic health care. It is possible that this orientation has been incorporated into the structure of family practice residency programs, with residency programs showing concern for the resident as a "total person."

On the other hand, of the 11 kinds of support surveyed, those which are most supportive of the resident's family needs—family support groups, part-time residencies, and child care services—are least likely to be offered. Although residency programs as a whole rarely offer child care services, family practice programs lag behind programs in other specialties (obstetrics/gynecology, pediatrics, psychiatry, and internal medicine) in the frequency with which part-time residencies are available.[11] Since family responsibilities are frequently a major source of conflict for the resident, family practice residencies should consider incorporating into their programs more support options related to family needs in addition to the support already available that addresses the residents' individual needs. By providing support for both individual and family needs of residents, family practice residency programs will exemplify the field's commitment to the whole person within the context of environment, community, and family.[16]

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