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Psychosocial Support Services for Family Medicine Resident Physicians

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Background and Objectives: *The stress of residency is well documented. Some residency programs recognize the importance of addressing resident stress and provide psychosocial support services. This study assesses the current state of support services offered to family medicine residents and documents historical trends of support. **Methods:** All US family medicine residency programs were surveyed about program characteristics and the presence or absence of 21 psychosocial support services. The prevalence of current services was compared to that of 10 and 20 years ago. **Results:** The percentage of family medicine programs offering 17 of 19 support services increased over the previous decades. However, percentages of some key services, especially those that address family life, are still quite low. **Discussion:** Increases in services may be due to programs' desire to offer more positive and supportive educational experiences. Offering supportive and reflective opportunities may lessen stress, increase flexibility and balance, create enthusiasm for learning, encourage compassion for patients, and promote future well-being. In times of decreasing interest in family medicine, the presence of effective psychosocial support services may be important for attracting and training the best possible family physicians.*

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Until recently, the stress of residency training has received minimal attention from regulatory agencies. In July of 2003, however, new duty hour requirements instituted by the Accreditation Council for Graduate Medical Education (ACGME) for resident physicians in all specialties took effect.¹ These requirements directly address overwork of residents. The ACGME requirements direct residency programs to attend to physician well-being and the prevention of impairment by supplying group support as well as training in balancing personal and professional responsibilities. It also states that "Training situations that consistently produce undesirable stress on residents must be evaluated and modified."² These requirements were designed to address issues of patient care, resident well-being, and the balance between education and service.³⁻⁷ The focus of this paper is family medicine's attention to the well-being of resident physicians as demonstrated by the presence of various psychosocial support services in residency programs.

The extreme stress of residency training is well documented.⁸⁻¹⁵ Residents must learn to cope with work and information overload, time pressures, sleep deprivation, and other difficult issues such as the uncertainty of medicine, ambiguity, autonomy, control and responsibility, difficult patient interactions, and the marked emotional swings of residency training.^{16,17} The attitudes, values, and behavior learned during residency become habits that often generalize beyond the training years.^{18,19} Some of these habits (eg, trying to get through patient encounters as quickly as possible, allowing one's personal and family life outside medicine to wither) can lead to poor patient care, decreased satisfaction (for physicians and patients), marital and family problems, isolation, depression, burnout, impairment, quitting, and even suicide.^{12,16,17,20-27}

Some residency programs have recognized the value and importance of attending to resident stress and provide many helpful support services. Others have not and provide minimal assistance. In 1979, a survey of support services offered to family medicine residents was conducted.²⁸ In 1988-1989, a follow-up survey was carried out to see whether the type or amount of support services offered to residents had changed.²⁹ Although there had been some positive changes, there were major areas in which residencies still offered inadequate support for residents.

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Now, two decades after the original survey, the results of the present survey will detail the current state of residency support services and compare these results with those from the previous two surveys. Like others, we believe that the more helpful and productive support services offered to residents, the less extreme their stress and perhaps subsequent burnout will be.^{19,23,27-43}

Methods

Design and Sample

This study used a cross-sectional design with cover letters and surveys sent to all 498 allopathic family medicine residency programs in the United States in 2000.⁴⁴ Residency programs that did not respond within 6 weeks were sent a second survey; a third was mailed at 12 weeks to groups still not responding. The cover letter included a request that the program director or his/her designee complete the form.

Instrument

The survey instrument in this study was adapted from one originally used by Berg and Garrard in 1980.²⁸ Items for the original survey were generated using an iterative process. First, a literature review on physician well-being was conducted. Potential items from the literature review were discussed with content experts working in family medicine residencies. From these discussions, an item pool demonstrating face validity and covering 20 support services was generated. Subsequent review of the relevant literature revealed that the major support services of the day were covered by these items.

For the current study, another comprehensive literature review on psychosocial support services was completed. We searched for potential items that might not have been part of the 1980 literature. In addition, data from the first two administrations of the survey^{28,29} were reviewed. Two additional questions were added in the 2000 version: the presence of resident advisors (written in on many of the 1989 surveys as supportive) and whether support services decreased based on a reduction in graduate medical education funding. Information also was requested in the 2000 survey about the number of residents in the program and several factors pertinent to first-year residents (number, length of paid vacation, average frequency of night call). The survey provided space for additional free-text comments of supportive services and requested the title of the person completing the survey (Appendix 1).

Statistical Methods/Data Analysis

Descriptive statistics included the frequency of each support service as well as means and standard deviations (SD) of continuous type data such as the number of residents.

Pearson's chi-square test was used to compare the current availability of support services with that of the

two previous surveys of 10 and 20 years ago. While it is likely that some of the same programs were surveyed in each of the three samples, it is not known which programs participated in the earliest survey, hence the three surveys were assumed to be independent for purposes of this analysis. All analyses were performed using SPSS version 9.0.[®]

Results

Respondents

The overall response rate was 85% (423/498). Most surveys were completed by a program director (76%). Others were completed by a behavioral scientist associated with the program (8%), a chief resident (5%), an assistant program director (5%), or some other designee (8%).

Based on the 423 residency programs responding to the survey, the mean (SD) number of first-year residents per program was 7.5 (3.0) while the mean (SD) total number of residents per program was 22.7 (9.4). First-year residents averaged 15.0 (3.7) paid days off per year. Their call averaged every 4.4 (1.0) nights over that year.

Support Services Offered

The percentages of programs that reported offering each support service are listed in decreasing order in Table 1, with seminars on emotionally charged issues and resident participation in decision making nearly universal among responding programs. Support groups for residents and significant others/spouses, part-time residency, support groups for significant others/spouses, and support decreased because of the Balanced Budget Amendment were reported in less than 20% of programs.

Write-in responses of other supportive services offered included membership in athletic clubs; maternity, paternity, and family leave; team-building activities; no in-house call; no post-call clinic; Friday off or Saturday call; short calls; flexible scheduling; and 24 hours off each week.

Comparison With Previous Surveys

As Table 2 shows, there has been a clear increase in the percentage of programs offering specific support services over the past 10 years. To facilitate comparison of results from the 1979–1980, 1988–1989, and 2000 surveys, the psychosocial support services were organized into areas of stress addressed by each support service. These five areas span issues of autonomy, doctor-patient relationship/physician socialization, economics, family, and work overload/sleep deprivation.

Two services have decreased in frequency: support groups for residents and their significant others and support groups for significant others. Part-time residencies and financial advisors, both measured as decreasing a decade ago, are now on the increase.⁴⁵ Also,

Table 1

Percentage of Programs Offering Psychosocial Support Services, 2000

	Percent of Programs (n=423)
• Seminars/speakers on emotionally charged medical issues	99
• Resident participation in decision making	98
• Formal gripe sessions	95
• Faculty advisors	94
• Residency orientation week or month	94
• Social activities planned by the residency	94
• Benefits supplied by the residency/hospital for counseling	94
• Seminars and/or speakers on stresses and conflicts of being a physician	90
• Support groups for residents	80
• Counselors available at a reduced or no fee	79
• Seminars on doctor-patient relationships (Balint type)	69
• Resident retreat, covered	69
• Financial advisor on staff	63
• Post-call time off duty	46
• Mental health days off duty	36
• Night float rotation	31
• Child care services	26
• Support groups for residents and significant others/spouses	18
• Part-time residency	18
• Support groups for significant others/spouses	16
• Support decreased because of Balanced Budget Amendment	12

average length of paid vacation for first-year residents has increased from 2.4 weeks in 1979–1980 to 2.6 weeks in 1988–1989 to 3.0 weeks in 2000. Average

length of time between call experiences for first-year residents has also increased from 3.6 days in 1979–1980 to 4.0 days in 1988–1989 to 4.4 days in 2000.

Twenty years ago, Berg and Garrard recommended that residencies provide more family support to residents.²⁸ It remains one of the ironies of family medicine training that the family life of residents is given short shrift during residency. It would seem that with today's increased necessity of both partners working, excellent child care and the possibility of a part-time residency would be priorities for residents and residency programs.²²

Overall, the percentages of family medicine residency programs offering support services have increased over the past 10 and 20 years. This increase in services may be attributable to several factors. First, residency programs may desire to offer a more positive and supportive educational experience so that residents will be better able to learn family medicine. Second, residents who believe they have been used as

inexpensive labor are pressing for greater attention to their education and well-being. Third, a better understanding of the adverse effects of resident fatigue on

Table 2

Percentage of Programs Offering Specific Psychosocial Support Services, 1979–1980, 1988–1989, and 2000, Organized by Areas of Stress That the Support Service Primarily Addresses

	1979–1980 (n=347)	1988–1989 (n=180)	2000 (n=423)	P Value*
Autonomy	%	%	%	
• Resident participation in decision making	—	95	98	.037
• Formal gripe sessions	85	94	95	<.001
Doctor-patient relationship/physician socialization				
• Seminars and/or speakers on emotionally charged medical issues	92	93	99	<.001
• Residency orientation week or month	—	86	94	.001
• Seminars and/or speakers on stresses and conflicts of being a physician	72	85	90	<.001
• Support groups for residents	61	72	80	<.001
• Resident retreat, covered	—	51	69	<.001
• Seminars on doctor-patient relationships (Balint type)	—	44	69	<.001
Economics				
• Benefits supplied by the residency/hospital for counseling	83	86	94	<.001
• Counselors available at a reduced or no fee	—	60	79	<.001
• Financial advisor on staff	48	43	63	<.001
Family				
• Social activities planned by the residency	90	94	94	.073
• Child care services	7	21	26	<.001
• Support groups for residents and significant others/spouses	22	28	18	.020
• Part-time residency	16	11	18	.112
• Support groups for significant others/spouses	—	27	16	.001
Work overload/sleep deprivation				
• Post-call time off duty	—	15	46	<.001
• Mental health days off duty	—	26	36	.020
• Night float rotation	—	5	31	<.001

* P value for Pearson's chi-square, comparing percentages across years

patient care may have resulted in an increase in psychosocial services. In any case, this is an encouraging trend and one that bodes well for the well-rounded reflective education of the family physician.

At the same time, some of the comments we received indicate a type of ominous pessimism about the entire area of support services. Quite a few responses contained comments referring to “imminent” or “anticipated cutbacks” in services, faculty who were increasingly stressed to the point of being unable to support residents, supportive and idealistic faculty who had left, and programs that were resistant to changes.

Given the economic changes in medicine and medical training, it is not at all clear that the positive trend found in the current survey will continue. As of the writing of this paper, the governor of California has just called for massive cuts in the state budget, including another 10% reduction in MediCal reimbursement rates. Hospitals that house residency programs will need to make further budget cuts. As money allocated to residency training grows more scarce and compensation decreases, support services may decrease or be eliminated.

As of the writing of this manuscript, approximately 26 residency programs in family medicine have closed since 2000.^{46,47} Many other programs have taken on business partners to supply needed financial resources. Some of these partners have brought with them a corporate mentality and corporate practices that are only gradually being applied to residency training. As budget cuts continue to occur, we would not be surprised to see decreases in many support services in the next decade’s survey. This is ironic in that given the shift to a more corporate structure of health care and medical education, increased psychosocial support services may be even more important to resident physicians.

In the face of such shrinking resources, why bother with research studies such as described in this article? The number of applicants to US medical schools has declined over the last few years.⁴⁹ The same is true for family medicine residency programs.⁵⁰⁻⁵⁴ Family medicine can not afford to lose more bright, caring, concerned, and idealistic physicians. Residency programs that offer better support services and have a more humane working environment may attract more and better medical school graduates. Programs can compare their own offerings with the results of this survey. They can also look toward adding those psychosocial support services not currently offered.

To determine whether increasing the quality or quantity of support services actually results in less stress and burnout, better education, or better patient care, much more research is needed. In-depth questioning and observation of residency programs might elicit a more complete picture of the value of support services. More research is needed to determine which support services are effective in reducing stress, promoting well-

being, increasing patient and physician satisfaction, encouraging empathy for patients,⁵⁵ and improving health care.⁵⁶ To this end, an in-depth retrospective study of the support services practicing family physicians received as residents would be helpful.

Limitations

In any survey such as this one, there is always the possibility that the individual who responds to the survey has a biased perspective. Some respondents may have better knowledge than others of the services actually offered. It is also possible that some respondents may have indicated the presence of a support service that is not offered, while others may have indicated the absence of a support service that is present.

We were unable to assess the level or quality of support indicated by a positive response. For example, a program that reports offering an ongoing Balint group does not differentiate between a group that meets weekly, biweekly, or monthly or between a group that residents are required or not required to attend. In fact, what someone may label a Balint group may actually be more of a support or personal and professional development group.⁴⁸ Such inevitable interpretive uncertainties do not translate well into a yes/no survey format.

Although we chose those items we thought were central to resident stress, we did not include all items that might be considered supportive (as evidenced by additional items that were written in). Further, there is no guarantee that increasing the number or frequency of support services actually increases the overall feeling of support. Programs with few support services may be experienced by residents as quite supportive, whereas programs with many support services may not. The global perception of a supportive atmosphere for education and professional growth may not be reflected adequately on any quantitative evaluation. A qualitative follow-up study is indicated to investigate the relationship between support services offered and such variables as stress and burnout, openness to education, and better patient care.

Conclusions

The habits and patterns learned during residency often extend well beyond training. The overwhelming atmosphere of residency training can crush the idealism, compassion, and hunger for learning in youthful, energetic residents. As residents receive support services, they may become more open to learning, more empathic toward their patients (and themselves), and more curious about the doctor-patient relationship. Offering residents supportive and reflective opportunities during the training years can lay down positive and productive patterns for balancing post-residency stress, maintaining enthusiasm for learning, providing better patient care, and staving off burnout. Our results show that support services are being offered more frequently

than in the past, but the level of support is still less than optimal. And, with decreased financial support for residency training, continued funding for support services may be jeopardized.

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Appendix 1

Support Services for Residents

Instructions: Please circle YES or NO to indicate whether your residency program currently makes the following items available to residents.

Confidential professional counseling:

- 1. Counselors are available within the residency at a reduced or no fee YES NO
- 2. Benefits are supplied by the residency or hospital for counseling YES NO

Ongoing support groups for:

- 3. Residents YES NO
- 4. Significant others/spouses YES NO
- 5. Residents and significant others YES NO

Balint seminars

- 6. Ongoing problem patient seminars focused on the doctor-patient relationship YES NO

Alternative residency scheduling involving time off without lengthening the duration of residency

- 7. A night float system YES NO
- 8. Post-call time off YES NO
- 9. Other (please explain): _____ YES NO

Other issues

- 10. Seminars/speakers dealing with emotionally charged medical issues, e.g, the dying patient YES NO
- 11. Seminars/speakers dealing with the stresses and conflicts of being a physician, e.g, physician drug abuse YES NO
- 12. Financial advisors to help residents deal with financial concerns YES NO
- 13. Formal "discussion sessions"—an avenue for voicing complaints and requests for program change YES NO
- 14. Resident participation in decision making—participating on hospital committees, with residency curriculum, etc YES NO
- 15. Part-time residency—decreasing the ongoing time commitment while lengthening the duration of residency, e.g, shared residency positions YES NO
- 16. Residency-sponsored mental health days that allow residents half or whole days away from work YES NO
- 17. Social activities planned and sponsored by the residency, e.g, parties, sporting events YES NO
- 18. Residency retreat—opportunities for all residents to get away from the program together, with coverage provided by the program YES NO
- 19. Orientation—a week- or month-long program for new residents with limited patient care responsibilities YES NO
- 20. Child care services—daycare or baby-sitting services sponsored by the residency program or hospital and available on an ongoing basis to residents who are parents YES NO
- 21. Assistance for resident spouses/significant others to obtain employment YES NO
- 22. Housing provided for residents YES NO
- 23. Assistance for finding housing provided for residents YES NO
- 24. Faculty advisor—matching a resident with a faculty member who assists the resident with his/her professional development or other needs YES NO
- 25. Have your support services had to decrease as a result of funding cuts caused by reduced GME funding (Balanced Budget Act)? YES NO
- 26. Have any residents "dropped out" of your program within the last 12 months? YES NO
- 27. Type of program
 Community based Community based and university affiliated
 University based Community based and university administered Military program
- 28. Number of residents: Total in the program: AMG _____ IMG _____; first year of the program: AMG _____ IMG _____
- 29. Paid vacation (excluding conference and sick time) for the first-year residents? _____ days OR _____ weeks
- 30. What is the average frequency of night call for the first-year residents? Every _____ night
- 31. Individual completing questionnaire: _____ Program director Assistant program director Chief resident
 Other (please specify) _____

Please add comments to the back of this form.