**BECOMING A FAMILY PHYSICIAN – EXPLORING THE EXPERIENCES OF RESIDENTS DURING THE FIRST SIX MONTHS OF POSTGRADUATE TRAINING**

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
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**Abstract**

*Becoming a Family Physician – Exploring the Experiences of Residents During the First Six Months of Postgraduate Training* describes the early training experience of residents from their perspective as they begin a postgraduate program in Family Medicine. A case study approach using focus groups and individual interviews was used to gain insight into the resident-participant's experiences of the first six months of training. Resident-participants were asked to describe their concerns, changes that occurred and the influences they attributed to those changes as a way to explore their early training experiences from their perspective.

This study found resident-trainees do not begin a Family Medicine postgraduate training program knowing what it means to be a Family Physician, but must learn what it means to fulfill this role. From the participants' perspective, this process involves adjusting to significant shifts in responsibility in the areas of Knowledge, Practice Management and Relationships that occur when they make the transition from being medical students in undergraduate training to doctors responsible for the outcome of care during postgraduate training.

As the participants began postgraduate training they were eager to accept the responsibility of being the doctor, but were uncertain they had the necessary medical

experience and expertise for someone calling themselves the doctor. The experience of practice, which included developing relationships with different patients over time (continuity of care) was particularly influential in helping the participants gain confidence in fulfilling the role of doctor and learning that the role of Family Physician is complex, multifaceted and not limited to their initial concept of doctoring. As the participants adjusted to their new responsibilities, they gained confidence in their new role as doctor, which subsequently led to a more comprehensive understanding of what it meant to be a Family Physician.

This study was able to contribute to what little is know about the transition into a postgraduate Family Medicine program by illuminating from the resident-participant's perspective how the transition is experienced. In doing so, medical educators have a better understanding of the early training experience of resident-trainees and how these experiences contribute to consolidating their new professional identity.

## Acknowledgements

They say it takes a village …

My village included: my husband (Jeffrey), my children (Alexandra, Charlotte and Samantha), my mother and father (Kathleen and Alister), my extended family (Joan and Julie), my committee (Dennis, Louise, Bart and Sue), my friends (Laura … many, many people who through their words or actions helped push me forward).

Although I have written and rewritten the text for this page many times in my dreams when the time has finally arrived, no words seem powerful or descriptive enough to capture what is in my heart.

I thank everyone for their encouragement, cheering, pushing, pulling, support and most of all patience during this endeavour.  If it hadn't been for you … I would have finished, but not necessarily in this decade!

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Chapter 1

The Journey Begins… Seeking a Deeper Understanding

The purpose of this study is to develop a deeper understanding of how newly graduated doctors experience the first six months of a postgraduate Family Medicine program. In particular, after completing the undergraduate requirements necessary to be called doctor, how do physicians-in-training to become Family Physicians (hereafter called resident-trainees) describe their experience during the first six months of training? About what are resident-trainees concerned? What changes to practice and within themselves do resident-trainees describe during this beginning training period and what influences do they describe as shaping this experience? A case study approach was used to answer these questions using focus groups and individual interviews with resident-trainees in a Family Medicine postgraduate program. More specifically, five resident-trainees individually reflected about their training experiences during in-depth monthly interviews during the first six months of training while Family Medicine trainees at various stages of their training were asked to reflect in focus groups about their early experience of transition into the Family Medicine program.

This opening chapter is about providing a contextual backdrop for readers. Locating the study begins by retracing the educational steps of a typical medical student leading up to admission into a Family Medicine program in Canada and finishes with an overview of the context in which this study took place, a Family Medicine training program. The chapter then focuses on the rationale for this study and concludes by defining relevant terms and concepts.

*The Context of Medical Education Defined*

To understand the viewpoints of the resident-trainees who took part in this study, it is helpful to understand the different contexts of medical training experiences. I start with a more general description about the structure of medical education in Canada and then move to a more specific discussion about the context of Family Medicine.

*The Structure of Medical Education in Canada*

This study took place in Canada at one of the 17 university-based medical schools. In Canada, undergraduate and postgraduate medical education is the responsibility of the medical school (Gray, 1998). Students can complete their undergraduate degree to become a medical doctor and then go on to complete their postgraduate training to specialize at the same school. However, it is common for graduating doctors to apply to another medical school to complete their postgraduate training, depending on their interests and the positions available. Entrance requirements for medical school vary somewhat from school to school; however, most schools require applicants to complete an undergraduate university degree and the Medical College Admissions Test (MCAT). An applicant's ability to complete a rigorous scientific education is often the basis for admission. Therefore, required characteristics often include high intelligence, prior academic success, and high motivation; less attention is placed on humanitarian abilities (Pfeiffer, 1983).

*Undergraduate medical training.*

Although all medical schools provide a similar undergraduate curriculum in Canada based on shared accreditation standards the timing of clinical experiences can

vary. Differentiation of the core medical training experience does not occur until after the medical student has completed the requirements to be called doctor. Most Canadian undergraduate medical programs are four years in length (although two programs are only three years in length) and provide both didactic and clinical experiences. During clinical training, medical students rotate through different specialties both in the hospital and in ambulatory clinics where the emphasis is on collecting comprehensive patient histories and practicing technical skills. Although medical students receive graduated responsibility for patient care, clinical decision-making remains the responsibility of the supervising residents (postgraduate resident-trainees) and attending physicians.

In most medical schools, formative and summative evaluation is ongoing throughout the four undergraduate years. Medical students receive feedback about their progress and performance primarily through completion of Multiple Choice Examinations (MCQs), Objective Structured Clinical Examinations (OSCEs), and supervisor feedback. At the end of undergraduate training, medical students earn a Medical Doctorate (MD) or equivalent and the right to specialize their knowledge in the medical discipline into which they are accepted, which is known as postgraduate or residency training.

*Postgraduate training.*

All Canadian medical schools provide postgraduate training but not all offer training in each of the 31 primary-entry specialties that may be directly entered following medical school (there are also about 40 additional "sub-specialty" programs, but these are entered after completing the applicable primary-entry specialties). Depending on the specialty chosen, postgraduate training can last from two to six years. Medical students

are required to identify in which specialties they are interested by their next to last undergraduate year so they can choose appropriate electives and obtain relevant reference letters for their residency applications, which are completed and submitted early in their final year.

All doctors graduating from the Canadian medical education system have had similar training experiences and exposure to the specialties during training (Conrad, 1988; Knight, 1981). Students must decide which area of medicine they will choose as their vocation based on those sometimes limited experiences and their own personal values and beliefs. When deciding whether to pursue a career in Family Medicine, factors cited by medical students include length of training, scope of practice, diversity, lifestyle, relationships with patients, and current debt load (Jordan, 2003). Family Medicine tends to attract physicians who are interested in seeing patients (McWhinney, 1997) across the lifespan with a broad range of problems.

*Family Medicine postgraduate training.*

At the University where this study took place, there were several teaching sites affiliated with hospitals offering Family Medicine training programs. Postgraduate training in Family Medicine begins in July and lasts for 24 months. Although the incoming trainees experience Family Medicine residency from their own perspective; there is a set of standardized expectations across all of the teaching sites of each Canadian medical school. Family Medicine resident-trainees must successfully meet these expectations to complete their training and be qualified to write their final examinations for certification to practice as Family Physicians (The College of Family Physicians of Canada, 1998, 2004, 2006).

Each resident-trainee completes four one-month rotations in Family Medicine per year. First year Family Medicine rotations are in the Family Practice Unit located either within the hospital setting or in an associated community-based family practice. During first year, resident-trainees complete rotations in obstetrics, general surgery, paediatrics, psychiatry, emergency, selective, and medicine (two rotations).

All resident-trainees are involved with prenatal patients and take part in the delivery of babies. During Family Medicine rotations, resident-trainees are expected to be on-call for one in every four to five nights. Being on-call means carrying a pager to accept calls from patients of the Family Practice Unit who feel they need medical advice or attention outside of normal hours. The resident-trainee is responsible for assessing the situation over the phone, consulting with the supervising physician on-call, and making a treatment or management decision. On-call may involve providing advice over the telephone or asking the patient to come in for further assessment. On-call may also include attending to patients who are in palliative care at home, delivering babies, and having to "pronounce" and complete the death certificate for patients who have died.

Similar to many large teaching practices, resident-trainees on Family Medicine rotations provide service to patients attending an Urgent Care Clinic. The Urgent Care Clinic is similar to that of a walk-in clinic where the focus is often on diagnosing and managing acute problems of patients who are unable to see their regular physician.

Each resident-trainee attends the following (a) academic seminars held weekly for three to four hours, (b) core seminar days held monthly that include didactic lectures and skills workshops presented by physicians and other health professionals on different medical and social issues, (c) rounds that are held monthly (obstetrics, ethics, and Family

Medicine), and (d) a weekly three hour behavioural science program, which is a series of three-hour workshops addressing the doctor-patient relationship with an emphasis on both process and content.

It is expected trainees will receive close supervision at the beginning of their Family Medicine experience, and will be able to function independently by the end of two years. Preceptors provide both formal and informal feedback to resident-trainees. Formal evaluations are based on resident-trainee's clinical work, patient encounters, rounds presentations, simulated office orals, and academic projects. At the end of two years, if they are successful, the Family Medicine program director at the teaching site recommends that trainees are ready for their College of Family Physicians of Canada certification (CCFP), the successful completion of which is mandatory to obtain an independent medical license in Family Medicine (The College of Family Physicians of Canada, 1998, 2004, 2006).

*How Family Medicine differs from other specialties – the four principles.*

All postgraduate (residency) programs have an overarching goal to graduate competent physician specialists. The aims and objectives of training differ depending on the specialty and, as a result, the experience provided in each of the medical specialties varies. This study is about postgraduate training to become a Family Physician, which has been described as a different way of doctoring than that of other medical specialties (Carmichael, 1985).

Four principles guide the practice of Family Medicine in Canada:

1. The Family Physician is a skilled clinician.

2. Family Medicine is a community-based discipline.

3. The Family Physician is a resource to a defined practice population.

4. The patient-physician relationship is central to the role of the Family

   Physician (College of Family Physicians of Canada (2004).

A comprehensive description of the four principles is included in Appendix A**.** Through accreditation standards, the College of Family Physicians of Canada (2007) requires that the four principles form the basis of any Family Medicine postgraduate experience.

 Ian R. McWhinney (1997) in his book, "A Textbook of Family Medicine", discusses how these four principles, when taken together, represent a distinctive worldview from other medical disciplines.  While all medical students may have completed a rotation in Family Medicine during their undergraduate clinical clerkship, their experience in this context is time-limited; therefore, it is important for the reader to have a comprehensive understanding of the worldview into which postgraduates are being immersed.  McWhinney describes the worldview of Family Physicians in relation to the following beliefs or dispositions:

1. The Family Physician is committed to the person (including his/her family) rather than to a particular body of knowledge, group of diseases or special techniques.

2. The Family Physician is available to manage any health problem in a person of either sex and of any age.  There is no defined end-point to commitment, meaning, it is not terminated by cure of an illness, the end of a course of treatment, or the incurability of an illness.

3. Unlike other specialties, most doctor-patient relationships in Family Medicine begin when the patient is healthy.

4. Family Physicians may see patients in their homes, at the office or in the hospital.

5. Family Medicine involves addressing undifferentiated problems in the context of a continuing personal relationship with individuals and families.

6. Family Physicians are often the entry point for most people into the health care system; therefore, the Family Physician must make the first diagnosis of an often-disorganized presentation of symptoms and complaints.

7. There is an underlying assumption that the Family Physician will coordinate all necessary treatment regarding the presenting illness and continuity to provide care for any future illness.

8. The Family Physician provides continuing and comprehensive care to the patient; therefore, he/she is responsible for prevention and early detection of any disease process.

9. The Family Physician is responsible for deployment of community and health-care system resources for the benefit of patients. As a generalist and first contact person, the Family Physician is able, within limits, to control admission to hospital, use of investigations, prescription of treatment and referral to specialists.

Phillips & Haynes (2001) provide a succinct definition of what it means to be a Family Physician, "A Family Physician is the physician generalist who takes professional responsibility for the comprehensive care of unselected patients with undifferentiated

problems committed to the person regardless of age, gender illness, organ system affected, or methods used" (p. 273).

*The medical encounter – approach to care in Family Medicine.*

In Family Medicine, the resident-trainee's experience of practice predominantly takes place in the focused clinical encounter, which can occur in the office, emergency department childbirth center, or extended-care facility (Phillips & Haynes, 2001). Undergraduate training predominantly teaches an approach to medical care in the clinical encounter that is both evidenced-based medicine and patient-centered medicine (Bensing, 2000). Regardless of medical specialty, these approaches are valued, considered highly relevant, and recognized as something to strive for in order to be a competent physician (Ong, De Haes, Hoos, Lammes, 1995).

Evidence-based medicine is a positivistic, biomedical perspective where a disease context anchors the patient's problem (Mischler, 1984) and where decision-making regarding treatment for patients is described as a cognitive-rational exercise (Ebrahim & Smith, 1997). While the evidence-based model of care focuses on what specialized knowledge is used to provide care in the doctor-patient relationship, patient-centered medicine is more concerned with how this knowledge is used in the context of the doctor-patient relationship.

Elements of patient-centered care have been described since antiquity (Epstein, 2000); however, the approach has been criticized for being too vague (Bensing, 2000) because the aims, objectives and intentions may mean something different to everyone. For this study, the patient-centered model (Roter, 2000; Stewart, et al., 2003) is defined as a conceptual framework based on six interconnected components: exploring both

disease and the illness experience, understanding the whole person, finding common ground regarding management, incorporating prevention and health promotion, enhancing the doctor-patient relationship, and being realistic given limited resources and time constraints (Stewart et al., 2003, p.5).  Unlike evidence-based medicine, patient-centered care puts a strong focus on patient participation in clinical decision making by taking into account the patient's perspective and preferences, alongside the physician's recommendations.

All doctors beginning postgraduate training have been exposed to the patient-centered model in varying degrees during their undergraduate training.  In the training of Family Physicians, learning how to use a patient-centered approach in the clinical encounter is heavily emphasized (Carmichael, 1985; Kurtz, Silverman & Draper, 2005; Phillips & Haynes, 2001; Steele & Marvel, 2002; Taylor & Bogden, 1984).  Family Physicians view the doctor-patient relationship that evolves over time in the clinical setting, and the communication on which it is based, as their most important diagnostic and therapeutic tool (Phillips & Haynes, 2001; Simpson et al., 1991).

In summary, at the end of four years of medical training, doctors are no longer medical students, but they are not yet certified physicians in their specialty of choice.  As newly graduated doctors, they are beginning a new and challenging phase in their training (Bligh, 2002).  The transition from undergraduate to postgraduate training is transformative because the values, attitudes, and behaviours of the nascent doctor continue to be shaped during this journey (Johnson, 2000; Mezirow, 1991; Mezirow, 2002).

In the second half of this chapter, I focus on the development of the research question and a review of the relevant concepts and terms used throughout the study.

*Locating Myself*

My own professional and personal history has given me access to medical culture either formally or informally almost all of my life.   I have been involved with the health care system as a patient and family member and interacted in a hospital environment as a nursing student, housekeeper, social work intern, social worker and medical educator. Each of these lenses has contributed to and shaped my own conceptualization of medical culture and the training of medical students.  Although my perspective on the medical profession is multifaceted and informed by a range of experiences, it is from the vantage point of a medical educator that I approach this study.

*My Interest Leading to the Question*

My specific interest in how resident-trainees understand their experience arose from my work as the behavioural science coordinator for a Family Medicine teaching site affiliated with the University of Toronto.  For almost fifteen years, I have been using the context of behavioural science to teach first- and second-year Family Medicine resident-trainees about the knowledge, skills, and attitudes necessary to develop therapeutic doctor-patient relationships.  Learning about behavioural science is meant to extend resident-trainees' focus beyond the patient's disease process to include the patient's unique illness experience associated with the disease.  During my teaching experience, I noticed that resident-trainees' interest in skills and issues related to behavioural science varied considerably depending on where they were in their training experience.  I also

noticed in conversations with Family Medicine resident-trainees that first- and second-year learners seemed to talk about their role as doctors and their relationship with patients differently. For example, second-year Family Medicine resident-trainees seemed far more interested and engaged in discussions about their role with patients in the clinical encounter than first-year resident-trainees. This variance motivated my interest to explore the experience of incoming Family Medicine resident-trainees from their perspective.

In scanning the literature, I noted that my experience was not unique. Behavioural science at the graduate level has not been well received or taken seriously by other medical trainees (Benbassat, Baumal, Heyman & Brezis, 2005; Frederickson & Bull, 1992). In fact, postgraduate medical trainees are sceptical of the merit of behavioural science (Metcalfe, 1983) and often fail to perceive its relevance to clinical practice (Benbassat et al., 2005) If postgraduate Family Medicine resident-trainees are not interested in learning about issues related to behavioural science, as a medical educator, I was curious about what concerned them.

*Broadening my Focus*

Although my own interest in better understanding the resident-participants' thoughts and feelings toward behavioural science motivated this research, the lens of this study is not focused on this issue. Behavioural science is only one aspect of experience amongst many others that occur during Family Medicine postgraduate training. I realized if the study focused only on exploring the resident-trainees' thoughts and feelings about behavioural science, it would provide an inaccurate, or at least an incomplete, understanding of their experience of postgraduate Family Medicine training. It was

necessary to first get a sense of the whole puzzle before seeing where, and how, the behavioural science piece might fit. So I took a large step back, broadened my lens and parked my curiosity about behavioural science for another day.

Although Family Medicine training is a two-year program, I decided to focus my study on the first six months. While learning to become a doctor begins during undergraduate medical school, the experience of acting, thinking, and approaching medicine as a medical doctor is continually being shaped throughout training and on into practice (Dall'Alba, 1993; Dall'Alba & Sandberg, 1996). The transition from undergraduate to practice in any profession is enormous as graduates learn how to use what they know in a different context (Eraut, 1994), and medicine is no different in this regard. New graduates are moving from being in a highly dependent learner role to a role where they have been delegated responsibility for the outcome of the patient's care (Prince, Boshuizen, Van Der Vleuten & Scherpbier, 2005).

The literature suggests that the critical moment in the socialization process for better understanding the development of doctors is at the beginning of postgraduate training when graduating medical students first meet the reality of practice and where they take on responsibility for the outcome of patient care (Becker, Geer, Straus & Hughes, 1961; Bligh, 2002; Cribb & Bignold, 1999; Haas & Shaffir, 1987; Sinclair, 1997). It is during postgraduate training that the newly graduated physicians' identity about who they are as a doctor and their role in relation to patients is accelerated.

Taking up the role of doctor involves many challenges, but in addition to the real and very practical organizational tasks to be faced, there is also the anxiety inherent in trying to establish and feel at ease with one's new professional identity (Wilkie &

Raffaelli, 2005).   I knew from my own teaching experiences that resident-trainees'

perspectives and viewpoints about their work and themselves in the role of doctor seemed

to change over the course of their training and I was curious about what those changes

were about from the outset of their experience.  If I wanted a deeper understanding of

what their postgraduate experience of training was like from their perspective, I had to

make contact with them at the beginning of their journey.

*Development of my Research Question*

Inui (2003) suggests that there are good descriptions in the literature about the

ideal attributes of medical practice, but there are not good descriptions of what actually

happens in practice.  I discovered first-hand, when I began exploring the literature, that

there are very few studies exploring the experiences of postgraduate medical trainees

from their perspective and even fewer studies that focus exclusively on Family Medicine

training.  Although quantitative methods have been used to explore aspects of the

postgraduate training experience, they have been criticized for failing to take into account

the way in which the resident-trainees experience the learning context, which is critical to

learning (Dall'Alba, 1993; Eraut, 1994; Marton, 1986; Ramsden, 1988; Saljo, 1991).

Many studies looking at the development of medical students concentrated on the

undergraduate years at a collective level (Becker et al., 1961; Haas and Shaffir, 1987;

Mumford, 1970).  While most recent studies have either not specifically looked at Family

Medicine or have focused on predetermined aspects of the resident-trainees' experience,

such as their educational preparedness (Hesketh, Allan, Harden & MacPherson, 2003;

Jones, McArdle & O'Neill, 2002; Lempp, Seabrook, Chockrane & Rees, 2005) or clinical

skills (Goodfellow & Claydon, 2001; Moercke & Eika, 2002; Smith & Poplett, 2002).

One way of developing an understanding of what is meaningful to resident-trainees during the first six months of training is to use a qualitative approach that allows trainees to talk about and explore their experience of training while they are living the experience.  Good (1994) describes the field of medicine as a particular way of constructing reality where resident-trainees understand and experience medical practice in different ways.  As much as possible, I wanted to leave the agenda open so I could hear the different ways the trainees made sense of their personal experience without pointing them in one direction or another.  Dahl (1995) suggests that an individual's voice is as distinctive as an individual fingerprint.  I deliberately let the resident-trainee take the lead, while I followed.

*Research Questions*

By exploring the following questions, this study provided an opportunity to gain insight into the resident-participants' thoughts and feelings about their experience of the first six months of a Family Medicine training program.

The following question guided this study:

1.  How do resident-trainees in a Family Medicine residency program describe their experience during the first six months of training?

This question was explored more in-depth through three sub-questions:

a)  What concerns do resident-trainees describe during the first six months of a Family Medicine training program?

b)  What changes do resident-trainees describe in the first six months of Family Medicine training program?

c)  What influences do resident-trainees describe that affect the changes that they

will identify in the first six months of Family Medicine training program?

The knowledge gained through answering these questions would be useful to not

only behavioural science educators, but also to medical educators, program developers,

and others interested in the study of the early experience of Family Medicine resident-

trainees.

*Constructs and Concepts*

While a subsequent chapter discusses the methods and methodology used to delve

into the resident-trainees' experiences, some of the key constructs used to explore the

research questions, beginning with the research resident-participants are laid out in the

following section.

*The Resident-participants - Resident-trainees*

Training to become a physician involves many different stages and most phases of

training are accompanied by a title to distinguish one phase of learning from another.

During undergraduate training, medical trainees' titles include medical students,

undergraduate medical trainees and clinical clerks.  On June 30th of their final year of

medical school, medical trainees are undergraduates and on July 1[st,] they are

postgraduates.

Residents, postgraduate trainees, resident-trainees, medical graduates, postgrads,

or postgraduate year 1,2,3,4 or 5's (PGY1 etc.) are the titles given to newly graduated

doctors entering postgraduate training.

In this study, the research resident-participants are referred to as resident-trainees. Throughout the study, the resident-participants frequently refer to their experiences during undergraduate medical training and describe themselves during this training period as medical students. During the latter chapters where the study discusses the findings and implications more broadly, the term resident-trainee refers to trainees at the postgraduate level, unless otherwise stated.

*Concerns, Changes, and Influences*

I am interested in exploring what the experience of training is like for resident-trainees beginning a postgraduate program in Family Medicine. Any transition involves a fundamental re-examination of who and what we are, even if this process is occurring at a largely unconscious level (Wilkie & Raeffili, 2005). To better understand how the first six months were experienced, the resident-participants (resident-trainees) reflect on and describe their experiences during this period. By asking the resident-participants to recount and explore their thoughts and feelings about events and activities they found to be meaningful, it is possible to construct an understanding of their experience.

*Concerns, Changes, and Influences* were sensitizing concepts used in this study to provide a general sense of reference and direction along which to look (Blumer, 1969). These concepts were chosen because the answers to these questions could help to better conceptualize a multi-dimensional picture of the resident-participant's experience.

As previously mentioned, the resident-participants are moving from a learning context where they were highly dependent with limited responsibility to a context where they are more independent with greater and growing responsibility. Subsequently, they are faced with a new set of challenges and circumstances. It is a period of significant

change in their lives and all periods of significant change are accompanied by a period of

unease, enhanced vulnerability and a degree of identity confusion (Wilkie & Raffaelli,

2005). Resident-participants were asked to identify, describe in detail, and reflect upon

what they considered to be the important challenges, events, circumstances, and activities

during the first few months. There is an underlying assumption that the stories the

resident-participants chose to tell were their most pressing concerns at that moment in

their training and that the stories the resident-participants chose have significance and

meaning to them. In this way, the resident-participants' stories help verbalize and

uncover what the experience is like for them from their perspective, subsequently

providing outsiders with a richer understanding of that experience. As the researcher, by

carefully listening, clarifying, and encouraging the resident-participants to elaborate and

to provide nuanced stories, I tried to leave little room for later conjecture on my part

during the analysis.

As the study progressed, I listened for how and in what way these stories changed.

I was interested in the factors, causes, conditions, and circumstances, past or present, that

the resident-participants attribute to the changes they experience. I was interested in how

and if their attitudes, feelings, and approach to practice, the doctor-patient relationship,

and the role of doctor changed. What do their stories tell us of how they see events

influencing who they are and what they do? The changes that the resident-participants

described helped build a deeper understanding of what their experience was like. Not all

of the resident-participants' concerns, changes, and attributed influences came neatly

labelled, but as they described their experiences, a picture of a transformational journey

began to enfold.

*The Importance of Understanding the Resident-trainees' Experience of Training*

At the end of undergraduate medical training, doctors are no longer medical students, but they are not yet certified physicians in their speciality of choice.  As newly graduated doctors, they are beginning a new and challenging phase in their training (Bligh, 2002). The experience of training is believed to shape the values, attitudes, and behaviours of medical students and resident-trainees (Allport, 1935; Bensing, 1991; Eron, 1955; Lynch, Newton, Grayson & Whitely, 1998; Kurtz et al., 2005).  If medical educators want an improved understanding of what the experience of postgraduate training is like so they can improve the training experience, it is critical to develop an understanding of the resident-trainees' experiences from their viewpoint in the context of practice (Mann, 1994).

There is a growing body of evidence suggesting that the more educators know about adult learners (the changes they go through and how these changes motivate and interact with learning), the better educators can structure learning experiences that both respond to and stimulate development (Combs, 1972; Huppatz, 1996; Roche, Sanson-Fisher & Cockburn, 1997); therefore, a rich understanding of how doctors experience their postgraduate training would be of value to medical educators.  The knowledge gained from developing an understanding of the training physician's perspectives can directly improve educational practice by making teaching more relevant to the students' voiced needs and by identifying learning gaps, which would help produce more competent practitioners (Clark, Lipkin, Graman & Shorey, 1999; Cook-Sather, 2002; Corbett & Wilson, 1995; Dall'Alba, 1993; Dall'Alba, 1996; Good, 1994; Roche et al., 1997).

The study of learners' needs over time in the context of practice is crucial if educators wish to influence teaching and learning (Eraut, 1994). The medical education literature agrees that a better understanding of the medical student's perspective on training is of critical importance to focus teaching and learning efforts, and has identified the need for research in this area (Cantillion & Jones, 1999; Mann, 1994; Wolf, Balson, Facuett & Randall, 1989).

*Summary – Chapter 1*

Postgraduate Family Medicine training presents a window of opportunity to influence the continuing development of doctors in their journey to becoming Family Physicians, but little is known about the postgraduate training years for medical educators to optimally support and guide this process (Merriam, 1988). One way of addressing this is to understand the doctors' lived experience of this transformative journey. This study specifically explores the experience of the first six months of a postgraduate Family Medicine training program from the viewpoint of the resident-trainees undergoing this transformative journey.

*Outline of Thesis Content*

In the following chapters, the map I used to make sense of the resident-participants' stories is unfolded. I begin by reviewing some of the relevant literature to the questions I have raised and later introduce the methodology I used to explore the answers to these questions. In later chapters, I deal with different iterations of the data itself before moving to a discussion of the findings.

To help the reader see and hear how I made sense of the resident-participants' experiences, I use different methods to present the findings to give the residents' voices a rich platform. A journal representing a composite of the stories heard in the study provides the reader a window into the resident-participants' journey during the first six months. A weekly journal was one way of capturing the often-subtle nuances of the resident-participants' adjustment to their new responsibilities and the changes they experienced as they began the Family Medicine residency programme.

In a chapter six, the voiced concerns of the resident-participants are used to reconstruct a chronological account of their experiences. Quotes from the data, mixed with interpretation, depict the resident-participants' stories beginning with graduation from medical school to the end of the first six months of postgraduate training in Family Medicine. Sample quotes are used liberally to give voice to important concerns and key changes, drawing links, and showing relationships.

The lens narrows again and two fictional interviews reconstruct the resident-participants' experiences during their first six months in the clinical encounter at two different time points, the first and the last weeks. In providing two similar interviews, but at different points in time, I was able to depict the dramatic change that enfolded as the resident-participants struggled with their new responsibilities. I chose a clinical encounter or interview to describe the resident-participants' experiences because it is in this context that the resident-participants learn to use their knowledge in the doctor-patient relationship.

The clinical encounter continues to act as a backdrop in chapter eight to highlight the main influences resident-participants attribute to helping them make changes. Once

again, the resident-participants' voices through direct quotes are used to make sense of their experiences. The resident-participants' stories paint a picture of their transition into and through the first six months of a postgraduate Family Medicine program, allowing a conceptualization of what this experience is like from their perspective in chapter nine.

Finally, the lens widens to provide a proposed framework for conceptualizing how resident-trainees learn what it means to be a Family Physician. Almost every chapter begins or ends with a chart synthesizing the findings to provide a visual interpretation of the resident-participants' experiences.

**Chapter 2**

Literature Review: Learning to be a Doctor

The impetus for this study has been presented, and the discussion now moves to an examination of the relevant literature. In this chapter I selectively review the literature to provide further context for understanding where this study fits in with prior knowledge, and to act as a guide for better understanding the findings. The literature will be presented in two parts - undergraduate medical education and postgraduate (i.e., residency) training - to provide the reader with context for understanding what is known about from where resident-trainees have come, where they are, and where they are going.

The research questions will act as a guide to navigate and organize the review of the literature. First, the medical students' and resident-trainees' concerns during medical school and the beginning of residency training, respectively, will be explored. What are the trainees describing as challenges and hurdles for them during these two periods? From their perspective, how do they view their educational and training experiences? What concerns have medical educator-researchers identified and what methodology have they used to explore medical students' and resident-trainees' concerns?

The literature will then be explored to identify what changes have been described during these two periods. What changes to practice and approaches to patient care do resident-trainees and medical educators describe? Do resident-trainees begin seeing their roles and responsibilities differently than they did as medical students? What methods, if any, have medical educator-researchers used to explore these changes? Finally, the influences resident-trainees and medical educators have attributed to possibly causing

these changes will be described.  It should be noted that sometimes the terrain is dense, where many medical educator have stopped to gather and explore what is going on, whereas at other points along the way, the terrain is sparse and speculation may be our only guide.

The literature review begins with a look at what has been reported during the undergraduate years because the views and knowledge to which the training doctor has been exposed during their beginning years of training are internalized and reflected in the postgraduate years (Coulehan & Williams, 2003; Langdale et al., 2003).  As Louis (1980) noted, to understand what individuals are changing to, it is critical to know what they are changing from.  The undergraduate experience will conclude with a look at how medical students view their role at the end of undergraduate training as they are about to commence postgraduate training.  This discussion will act as a bridge to help the reader make the transition from the world of the undergraduate medical student to the world of the postgraduate resident-trainee.

The changes and challenges experienced during medical training have been viewed and reported from a variety of perspectives including sociological (Becker et al., 1961; Bloom, 1963; Coombs, 1978; Haas & Shaffir, 1987; Reilly, 1987;  Pratt, Rockman & Koffman, 2006; Shuval, 1975), developmental (Brent, 1981; Erikson, 1980; Grose, Goodrich & Czyerski, 1983; Levinson, Darrow, Klein, Levinson & McKee, 1978; Mumford, 1970; Olmsted & Paget, 1969; Perry, 1970, 1981; Pfeiffer, 1983; Robart, Nelson, Krantz & Doughty., 1985; Zabarenko & Zabarenko, 1978), and educational (Conrad, 1988; Eraut, 1994; Little, 1989; Merton et al., 1957).  The experiences of medical trainees have also been described using a variety of formats such as biographical

(Doctor X, 1965; Konner, 1987; Martin, 1986), anecdotal (Klass, 1987; Klitzman, 1989; Lam, 2005; Pories, Jane & Harper, 2006; Shapiro, 1987), and scientific (Adler, Werener & Korsch, 1980; Blackwell, Gutmann & Jewell, 1984; Beagan, 2000).  Regardless of the different perspectives and approaches to sharing the findings and stories, all describe the process of becoming a practicing doctor as stressful.  For example, the authors write about the stress of having to deal with information overload, dissection, long hours, endless paperwork, death, and the demands of family and friends.  Many of the stressors reported begin from the outset of undergraduate medical education.

*Undergraduate Medical Education*

Much of what is known about the effects of medical school on the professional development of the medical student has emanated from sociological and anthropological studies.  The research on medical socialization examines the learning of attitudes, norms, self-images, values, beliefs, and behaviour patterns that are associated with becoming a doctor (MacLeod, 2000).  The most frequently cited studies in the field that have become classics are "The Student-Physician" edited by Robert K. Merton (1957), "Boys in White" by Howard Becker and his colleagues (1961), "Interns: From Students to Physicians" by Emily Mumford (1970), "Becoming Doctors:  The Adoption of a Cloak of Competence" by J. Haas and W. Shaffir (1987), and "The Doctor and His Patient: A Sociological Interpretation" by Samuel Bloom (1963).  Although some of these commentaries and studies occurred over fifty years ago and primarily focused on the collective undergraduate medical education and training experience, our understanding of how students learn to be doctors has not significantly changed (Beagan, 2001).  Consequently, these studies provide a helpful benchmark for appreciating how medical

students view themselves in the process of becoming a doctor prior to beginning postgraduate (i.e., residency) training.

*Concerns*

There is an assumption that, on the first day of medical school, new trainees have many concerns about what lays ahead. As medical students begin the journey to become medical doctors they view themselves as medical students responsible for learning the knowledge necessary to earn the right to be called doctor. Knight (1981) suggests that a career in medicine begins the first day of medical school and is characterized by and anchored in the responsibility of someone calling himself or herself doctor.

The most predominant concern found in studies looking at the socialization and development of undergraduate medical students was the pressure and anxiety associated with needing to acquire a huge volume of knowledge (Bensing, 2000; Coburn, 1975; Firth, 1986; Guthrie et al., 1998; Lee, 2001; Radcliffe, 2003; Rosal et al., 1997; Roter, 2000). The breadth and depth of knowledge that needs to be grasped in a relatively short period of time often overwhelms medical students. Coombs and Boyle (1971) report that the most persistent anxiety voiced by incoming medical freshman students during the interviews they conducted was the fear that they would not learn the specific piece of information that they may need later on to diagnose, perhaps even save, a patient's life. Almost all studies implicate information overload and the need for rapid acquisition of information as sources of stress (Boyle & Coombs, 1971; Conrad, 1988; Fox, 1957; Knight, 1981; Lloyd & Gartrell, 1983; MacLeod, 2000; Rosenberg, 1984; Zocolillo, Murphy & Wetzel, 1986).

Fox (1957) described the pressure and anxiety associated with needing to know so much as medical uncertainty. Three main types of uncertainty were identified: (a) the inability to learn everything; (b) the realization that medical knowledge itself is incomplete, limited, and filled with gaps; and, (c) difficulties distinguishing between personal lack of knowledge and the limitations of medical knowledge and technology. Haas and Shaffir (1987) felt issues related to dealing with medical uncertainty were so central to the socialization of the medical student that they titled their book, "Becoming Doctors: The Adoption of a Cloak of Competence". Other concerns for training medical students included the pressures of an increasingly sophisticated health care system, an exponential increase in medical knowledge, rapid technical advances, and society's conception and expectation of physicians (Bensing, 2000; Roter, 2000). Finally, the time and energy necessary to study also impinges on recreational, social, and personal compounding stress.

*Changes*

One of the most obvious effects of learning is change, and medical school is no exception. When sociologists write about medical socialization they refer to the change that occurs in attitudes, norms, self-images, values, beliefs, and behaviour patterns that are associated with becoming a doctor (MacLeod, 2000). While, learning the vast amount of knowledge necessary to become a doctor was voiced as the biggest concern for medical students, medical educators report that the medical students' efforts to learn how to use that knowledge under conditions of uncertainty results in some of the biggest changes in medical students during undergraduate training. For example, Fox (1957) felt medical students went through a series of specific experiences that changed and prepared

them to learn how to make decisions and to act despite the inherent medical uncertainty. The literature looking at the socialization and development highlights two primary strategies used by medical students to deal with the anxiety and pressure associated with medical uncertainty: detached concern and impression management. The literature also highlights a change in attitude toward patients as a consequence of managing the anxiety of medical uncertainty.

*Detached concern.*

During undergraduate training, medical students learn that they need to control their emotions if they are going to learn how to handle the responsibility of caring for patients. Detached concern means that students need to be detached enough in their attitude toward patients to exercise sound judgment, yet they must maintain sufficient concern for the patient to provide sensitive care. Fox (1957) believes that medical students undergo a series of emotionally-loaded training experiences, such as dissecting cadavers, observing autopsies, and witnessing pain and suffering, that graduate in intensity and lead to the necessary development of detached concern. Haas and Shaffir (1987) describe how, as students progress through medical training, they learn that their sense of idealism is noble, but the patient needs to be objectified if the students are to provide objective, yet compassionate care. This sense of distancing and depersonalization occurs in two steps.

First, students recognize that if they are to become competent doctors, they need to acquire a substantial base of medical knowledge. To do this, they must maintain focus on the patient's pathology, otherwise they may become overwhelmed by emotion or distracted by the patient's social needs, which might interfere with learning. Becker and

colleagues (1961) concluded that students' initial idealism was quickly replaced by cynicism as a means for surviving the intellectual demands and expectations of the curriculum.

Second, developing competence requires the students to absorb a vast amount of information in a short time period. The productive use of their time becomes a priority, which means funnelling energy away from anything that will distract from making the most efficient use of learning opportunities. The students' anxieties about death or suffering are either repressed or quickly suppressed. Fears about competence to handle the responsibilities of medical practice are quickly channelled into efforts to learn the subject matter well (Knight, 1981). As medical education and training progresses, and these same students realize it is impossible to learn all they need to know, they focus their limited time on what they collectively thought would be on exams and evaluations (Coombs & Boyle, 1971). Medical students rationalize that their treating of patients as objects now will lead to physicians that are more competent later. More recent studies echo earlier findings that the priority for medical students is absorbing the knowledge necessary to be called doctor during undergraduate training (Apker & Eggly, 2004; Baker, Williams & Clair, 1998; Bonsteel, 1997; Conrad, 1988).

*Impression management.*

Impression management is the term given to the efforts medical students make to project an image of competence in any evaluative situation. For example, if the student acts confidently, faculty and others (health care professionals and patients) will assume the student is competent and respond accordingly. Whereas, if the student projects an image of uncertainty, others will assume the student does not know what he or she is

doing. Medical students are concerned about the impression they are giving to their supervisors and other health care professionals. Medical students are more interested in their credibility in front of their teachers than with patients (Becker et al., 1961; Good, 1995; Haas & Shaffir, 1987).

Haas and Shaffir (1987) write at length about the accommodations medical students make to both manage the impressions they give others about their abilities to perform and to get through undergraduate training. For example, medical students begin to realize that their interests are best served by conforming to the demands of faculty members. It is the faculty, not patients, who will be evaluating and determining their progress; therefore, students focus on understanding the expectations of their various clinical teachers. Providing supervisors with comprehensive histories, demonstrating technical skills, and achieving high marks on examinations become the gold standards for approval.

*Approach to the clinical encounter.*

Despite efforts to teach a patient-centered approach to the doctor-patient relationship during the undergraduate training years, the evidence suggests that this approach to the medical encounter is lost or no longer viewed as important beyond the second year (Barbee & Feldman, 1970; Dornbush, Singer, Brownstein & Freedman; 1985; Haidet et al., 2002; Helfer & Ealy, 1972; Pfeiffer, 1983; Preven, Kachur, Kupfer & Waters, 1986; Rezler, 1974; Rezler & Ten, 1984; Tsimisiou et al., 2007; Wolf et al., 1989; Woloschuk, Harasym & Temple, 2004). Researchers have shown that as students progress through medical school expressions of humanitarian feelings decrease and expressions of cynical attitudes toward patients and the practice of medicine increase

(Eron, 1955; Haidet et al., 2002; Wolf et al., 1989; Woloschuk et al., 2004). Hafferty and Franks (1994), Kurtz et al (2005), and Weston and Brown (1995) found that medical education actually erodes the physicians' ability to develop effective social relationships with patients.

At the completion of four years of medical school, graduating doctors feel patient-centered communication takes too much time and is not practical or relevant in a busy office setting (Stewart & Roter, 1989). Studies of doctor-patient communication show that the perspectives of patients are devalued in many ways (Stoeckle, 1987). For example, medical students interrupt patients' descriptions of their medical problems (Beckman & Frankel, 1984), neglect to ask about the psychosocial aspects of the illness experience (Donnelly, 1986), fail to give patients information about either their illness or their treatment (Waitzkin, 1984), and fail to involve patients in major clinical decisions (Lidz et al., 1984; Wu & Pearlman, 1988). Hafferty (1998) suggests that medical students' attitudes toward the doctor-patient relationship and approach to the clinical encounter are overshadowed by the powerful experiences of the undergraduate clinical years.

*Influences*

   *Experience.*

   While change may be an outcome of learning, change does not occur in a vacuum. Different factors and forces interact to create change. An outcome of change is an increase in confidence in one's ability to fulfill a role or to perform a task. Smith and Irby (1997) suggest that gaining experience in using new knowledge in relevant situations is a prerequisite to gaining confidence in one's ability. As confidence grows, feelings of

insecurity diminish. Concepts such as confidence and experience are crucial in socialization theory, but they remain difficult to articulate. Some medical studies equate resident-trainees' level of comfort and confidence in dealing with medical uncertainty with the amount of training they have experienced (Fox 1957; Haas & Shaffir, 1987; Merton, Reader, & Kendall 1957). Timmersman and Angell (2001) contend that resident-participants develop clinical judgment (knowing how to doctor) through the experience of managing and using an uncertain knowledge base. As medical trainees have the experience of using their knowledge in the context of practice, they gain confidence in their ability to use their knowledge.

During undergraduate training, medical students eagerly seek out clinical experiences with patients and strive for opportunities to perform clinical procedures whenever they can. However, gaining relevant experience is an ongoing challenge when the experience being sought is to perform an invasive procedure on a potentially unwell patient. As well, opportunities to perform procedures may be scarce, creating a competitive atmosphere to gain these experiences. The medical student is at the bottom of the ladder, outranked in responsibility and access to patients, by a hierarchy of other medical health professional learners, such as residents and fellows who are seeking similar experiences.

*Interactions with faculty and health care professionals.*

Shuval (1975) notes that supervisors and healthcare professionals have a strong impact on the socialization of trainees. Medical students work closely with physicians and health care professionals throughout their training years observing medical skills,

personal habits, roles, interprofessional interactions, approaches to care, and communication styles.

Shuval (1975) conducted extensive studies in Israel exploring how faculty, other healthcare professionals, and patients play a role in socializing medical students by either encouraging or discouraging the students from undertaking the professional role of doctor. Other healthcare professionals occupy an ambiguous status in relation to medical students because they are generally more highly skilled, but occupy a lower status position than the future status position of the students. As a result, other healthcare professionals often emphasize students' present learner role rather than their future professional role, thus avoiding problems of deference to young unqualified people, while at the same time maintaining their own status. Patients also often emphasize the trainees' student role rather than their future professional role, while the senior physician often sets the tone for emphasizing the difference in professional roles, sometimes demonstrating a more informal collegial relationship, while at other times, reinforcing the medical students' learner status.

The relationship between medical students and physician supervisors during undergraduate training is particularly influential because supervising faculty are seen as role models and are in an evaluative role (Duncan, 1996; Hafferty, 1991; Peschel & Peschel, 1986; Pitkala & Mantyranta, 2003). According to Apker and Eggly (2004), supervising faculty control the topics and focus of conversation, which reinforces principles of medical ideology and explicitly establishes how medical students should and should not behave as doctors. For many students, faculty physicians embody the values and norms of medicine (Hafferty, 1991) and are role models of medical mastery

and clinical expertise (Duncan, 1996).  Apker and Eggly (2004) argue that identity of a doctor as an objective, emotionally distant, scientific authority is strengthened and perpetuated in medical school.  For example, medical students learn that doctors should, through implicit or explicit communication behaviours, convey messages representative of scientific medicine when interacting with individuals not from the medical community.

*The medical curriculum.*

The general aim of most medical schools is the education of a basic doctor who needs further postgraduate training (Whitcomb, 2005).  Most medical students are exposed to the preclinical and clinical sciences and to all of the major clinical specialties. Although undergraduate medical education and training may include exposure to Family Medicine, primary care experiences do not usually play a central role in the education of medical students (Noack, 1980).  Specialty medicine and primary care (Family Medicine and/or general practice) are different ways of doctoring (Carmichael, 1985). Specialty medicine focuses on a well-defined area of medical knowledge and patient contact is often time limited and focused on a specific population, whereas, in Family Medicine there is no limitation to the problems seen and relationships are ongoing and cross the lifespan.  During undergraduate medical education and training, most teaching occurs by specialists and emphasizes less common medical problems where the disease or problem has already been identified for the medical student (Bucher & Stelling, 1977; Hendrie & Lloyd, 1990).  Specialists and Family Physicians often approach the problem and the relationship differently because of their different training and focus of care, which has implications at the postgraduate level on the resident-trainee's developing identity (Pratt et al., 2006).

*Professional identity at the end of undergraduate medical training.*

Researchers in the medical socialization literature take the perspective that as students undergo training they learn about the work of a doctor, which leads to changes in their identity shaping the concept of what it means to be a doctor  (Becker et al., 1961; Haas & Shaffir, 1987; Marion, 1991).  Understanding the significance of students' medical experiences on their identity formation is important to this study because it is the starting point for the next phase of their medical training and subsequent development of their professional identity.

An important goal of medical educators is for medical students to identify with the role of doctor by the end of undergraduate medical education and training (Gude et al., 2005).  However, there is considerable debate as to whether the graduating doctor's identity is more aligned with that of a student or that of a doctor by the end of undergraduate medical education and training.  Some researchers feel that medical school concentrates on teaching facts but leaves the students to deal with their professional development on their own (Conrad, 1988; Pilpel et al., 1998; Weston & Lipkin, 1990).  Learners' roles as students are reinforced by the constant need to acquire medical information to pass examinations and evaluations, their limited patient responsibilities, and their low position in the medical hierarchy (Bloom, 1963; Coombs, 1978; Mumford, 1970; Doctor X, 1965).  Hafferty (1991) suggests that students' preoccupation with the academic rigors of medical education and training directs their attention away from the altruistic morals and values of being a physician.  Becker's (1961) exploration of medical students' experiences led him to believe that medical students do not take on the professional role of doctor while they are students.

Other researchers observe that the enculturation process of medical school aligns students more with that of doctor, or at least that of healer (Becker et al., 1961; Knight, 1981). Mumford (1970) declares that medical students need to feel responsible for patient care if they are to feel like the doctor. Becker (1961) reports that medical students need to have responsibility for patients if they are to identify with the role of doctor. Haas & Shaffir (1987) suggest that as medical students progress through their education and training, their interest and focus shift depending on what they perceive to be their role. The students' shift in focus seems to relate both to their idealized perceptions of medicine and to their anticipation of the responsibilities they will soon be expected to meet.

Caplovitz (1980) conducted a study seeking to find out what components of the physician's role were emphasized during medical school. In other words, does the student receive a professional education in medical school, which directly represents the standards and realities of the future professional role? Or is the school mainly just a step, limited in function, to establishing groundwork of knowledge and skill? Caplovitz (1980) concluded that the acquisition of technical knowledge and skills are given far more emphasis than the acquisition of medical values.

Recent literature agrees with what Caplovitz (1980) wrote forty years ago: that the undergraduate medical education and training years continue to emphasize the accumulation of information and the demonstration of technical skills (Pipel et al., 1998; Weston & Lipkin, 1990). In summary, little appears to have changed over the years regarding the overall structure of medical education and experience of undergraduate

training, which suggests that although some of the literature dates back almost sixty years, it is still applicable today.

*The Undergraduate Years - Summary*

Professional socialization in medicine is seen as a life-long developmental process, which begins in medical school. The influence of undergraduate medical education and training on the professional and personal development of medical students learning to be a doctor is often underestimated (MacLeod, 2000). During each phase of doctors' training, they are exposed to a particular social environment, and within that environment, to a set of specific learning and work situations. During medical school, students interact with patients, health care professionals, and physicians in specific ways, and unconsciously and consciously assess the expectations of individuals and situations, and react accordingly. These situations and interactions determine formal and informal learning, roles, self-image, and identity (Noack, 1980).

Medical students are active agents in their developmental process (Weston & Lipkin, 1990). During undergraduate training, medical students are most concerned about acquiring the knowledge necessary to become a doctor. Physician-teachers are seen as evaluators and as role models. Although medical students are highly motivated to care for patients, it is other physicians' expectations that are most important and influential.

Opportunities to gain desired clinical experience are often limited and the curriculum is predominantly delivered from a specialist's, and not a generalist's (e.g., Family Medicine), perspective. As a result, medical education and training occurs in a context where acute medical problems and rare disease presentations are overrepresented,

while in Family Medicine the focus is more on the presentation of common medical problems.

During medical school most learners view themselves as medical students in training, not as doctors. At the end of undergraduate medical education students, soon to become newly graduated doctors, possess certain knowledge and skills, share certain attitudes and values, and are ready to learn how to practice medicine (Whitcomb, 2005).

The discussion in the remainder of this Chapter provides a more focused look at the postgraduate (i.e., residency) years of training. As previously noted, the literature on the postgraduate experience from the resident-trainees' perspective, specifically in the context of a Family Medicine program, is small, making it difficult at times to comment directly on training experiences that occur in a Family Medicine setting. This is significant because studies specifically looking at the professionalization of doctors during residency training have noted that doctors in different specialties have a markedly different set of experiences (Broadhead, 1983; Bucher & Stelling, 1977; Hendrie & Lloyd, 1990), potentially leading to a different sense of professional identity. That said, the studies that take place in a context other than Family Medicine often provide rich insight into some of the challenges experienced as resident-trainees make the transition into and through a postgraduate (i.e., residency) program

The second half of this chapter will follow a similar pattern as the undergraduate medical education and training discussion by reviewing the literature using the research questions as guideposts. I first explore the studies that speak to postgraduate concerns, then I shift to the changes experienced by resident-trainees, and conclude with a look at the influences attributed to those changes.

*The Postgraduate (Residency) Training Years*

*Introduction to the Postgraduate Training Years*

Researchers specifically looking at medical training during the postgraduate training period report that this is a particularly critical time in the development of the doctor (Radcliffe, 2003).  The transition between undergraduate medical education and postgraduate training has been consistently described as the most stressful because resident-trainees are now viewed as doctors with more active responsibility for patient care (Blackwell et al., 1984; Bloom, 1963; Dean, 2003; Grover & Puczynski, 1999; Little & Midtling, 1989; Paice, Rutter, Wetherell, Winder & McManus 2002; Wilkie & Raffaelli, 2005).  Although very few studies specifically use the term 'concerns' to explore what is most pressing for newly graduated doctors, medical educator-researchers do explore the stressors associated with making the transition from undergraduate to postgraduate medical education and training; while other researchers look at how prepared newly graduated doctors feel to begin practice and train at the postgraduate level.  One study used the Clance Imposter Scale to explore a cohort of Family Medicine residents' concerns about their ability to become competent physicians (Oriel, Plane & Mundt, 2004), while another study used a qualitative approach to explore the concerns of junior Internal Medicine trainees (Luthy, Perrier, Perrin, Christine & Allaz, 2004).  While each of these authors use different lenses to draw their conclusions, both studies concluded that new graduates are concerned about their ability to fulfill the role of doctor.

Although the postgraduate years are viewed as one of the most stressful periods in a physician's professional development, the literature describing the changes that occur in

the first few months of postgraduate training is less well developed. Most studies focus on specific aspects of training and, if a qualitative lens is used to explore resident-trainees' perspectives, it is limited to predefined areas of exploration. For example, some researchers use a developmental lens (Brent, 1981) to look at the different cognitive changes that occur, while others (Schmidt & Boshuizen (1993) explore how new graduates change in how they use their knowledge in practice. Again, because the transition into postgraduate training is viewed as stressful, several researchers (Berridge, Fret, Sharpe & Roberts, 2007; Cruess, Cruess & Steinhart, 2008) have looked at different strategies and interventions to influence or ease the transition of new graduates during the first few months of postgraduate training. While some interventions emerged because of previous research (McCue, 1985), very few studies have specifically set out to explore the factors and forces that contribute to change.

*Concerns*

Beginning a residency training program should be cause for celebration. New graduates have recently been conferred the title of Medical Doctor and are about to embark on the next phase of their journey that will allow them to practice medicine more independently and continue to shape who they are in the role of doctor. Yet, it is clear that the transition into a postgraduate program is not easy. This study is interested in better understanding, from the trainee's perspective, what events, experiences and moments during the first few months of the transition into a postgraduate residency program create concern for them.

*Stress.*

As previously, mentioned, postgraduate training has been characterized in the literature as a period of great personal and professional stress and adjustment (Grover & Puczynski, 1999).  Recent studies show that the incidence of psychological morbidity among resident-trainees remains high (Birch, Ashton & Kamali, 1998; Bogg, Gibbs & Bundred, 2001; Peterlini et al., 2002). Concerns mentioned in the literature include long working hours, large workload, fears of making mistakes, lack of time for friends and family, caring for terminally ill patients, fatigue, lack of support, insufficient knowledge, responsibility for patients, dealing with uncertainty, and inadequate supervision (Bates & Hinton, 1973; Calman & Donaldson, 1991; Edwards & Zimet, 1976; Eron, 1955; Firth-Cozens, 1987; Liu & Wissow, 2008; Mawardi, 1979; Showalter, 1970).  Most studies looking at stress were conducted using questionnaires, small samples, and focused on a specific specialty or training program.

One notable exception to using a quantitative approach was Calman and Donaldson's (1991) study, which used critical incident reports from two hundred house officers (first-year postgraduate resident-trainees) to look at the causes of stresses during the transition into practice.  They found concerns aggregated into eight broad categories: personal aspects, clinical skills, communication and relationships, problem-related, organization skills, education, dying patients, and administration.

Pacie et al.'s (2002) study represents a similar approach to exploring the causes of stress in a group of newly graduated doctors.  A questionnaire was mailed to almost 2,500 new doctors in their first year of general training following medical school, with a resultant response rate of 58.4%. The purpose of the study was to explore how stressed

the new graduates were at the time of the study, what aspects of their jobs they found stressful, and how they coped with stressful events. The researchers' aim was to gain a deeper understanding of stress in recently-graduated doctors so ideas could be generated about interventions that might make the year less stressful. An open question was included asking all respondents to describe stressors of their first year. The incidents were categorized into five major groups: responsibility, interpersonal, overwork, death and disease, and self. Responsibility was most frequently cited as it related to professional responsibility beyond the trainee's competence or expertise, while the second most frequently cited category was interpersonal, which referred to interpersonal relationships, conflict, or communication problems with patients, health care providers or supervisor-teachers. The researchers found that those respondents who wrote about incidents related to responsibility and self were more stressed than those that described incidents related to death and disease.

The researchers concluded the results painted a depressingly familiar picture of young doctors trying to struggle with the excessive demands of work and not having the time to utilize normal support routes such as talking with friends and family. However, the researchers point out that they were unable to probe the meaning of the reported incidents, which limited their ability to speculate further on their significance. As well, respondents typically described only one incident, which lead the researchers to wonder whether the reported incident is simply a random anecdote or whether they are indicators of a more general situation.

The shift from relatively protected medical student to responsible practising resident-doctor has a clear effect on junior doctors clinically, physically, and

psychologically.  While the studies on stress were useful in eliciting information about perceived experiences that cause stress, the results are limiting because the researchers in most cases were unable to probe respondents for deeper meaning and the studies provide only a snapshot of a specific time or day in the life of a postgraduate medical trainee.

*Preparedness for work.*

First-year resident-doctors have often expressed the idea that they have been 'thrown into the deep end' with little experience from their undergraduate medical education and training to know what to expect in the postgraduate medical education environment (Bligh, 2002).  Not feeling prepared to start work in the role of a resident-doctor is a common theme in the literature and often the lens used to explore first-year residents' concerns (Clack, 1994; Evans & Roberts, 2006; Eyal & Cohen, 2006; Goldacre, Stear & Lambert, 1997; Goodfellow & Claydon, 2001; Hesketh et al., 2003; Hill, Rolfe, Pearson & Heathcote, 1998; Lambert & Goldacre, 2006; Prince et al., 2005; Roche et al., 1997; Wall, Bolshaw & Carolan, 2006).

The few studies that describe the issue of first-year resident-doctors preparedness found, from both the resident-trainees' and their program directors' perspective, that first-year residents feel least well prepared in decision making, prescribing, clinical problem solving, physical exam skills, communication, practice management skills, and organization of knowledge (Clark et al., 1999; Evans & Roberts, 2006; Eyal & Cohen, 2006; Fox et al., 2000; Goldacre et al., 1997; Goldacre et al., 1997; Hastings, McKinley & Fraser, 2006; Jones et al., 2002; Langdale et al., 2003; Lempp et al., 2005; O'Neill, Jones, Willis &  McArdle, 2003; Prince et al., 2004; Prince et al., 2005; Wall et al., 2006).   The concerns about first-year residents' lack of preparedness for postgraduate

training are the impetus for the development of different types of orientation programs to minimize stress and to ease the transition for recent medical school graduates making the leap into a postgraduate program (Burch et al., 2005; Evans, Woods & Roberts, 2004; Evans & Roberts, 2006; Goodfellow & Claydon, 2001; Moercke & Eika, 2002; Smith & Poplett, 2002).  Again, most applicable studies have used questionnaires to explore both the trainees' and program directors' perceptions and none specifically examined Family Medicine.

One study did use focus groups to look at first-year postgraduate trainees' experience in supervised practice before choosing further training in general practice or specialty practice (Prince et al., 2004).  Seventeen recent medical school graduates took part in one, two-hour focus group (three groups in total).  Fourteen of the resident-participants were women; the average postgraduate work (i.e., residency) experience was 4.8 months; and work settings varied (emergency department, psychiatry, cardiology, internal medicine, surgery, gynaecology, intensive care, public health, and transplant team).  The moderators asked the resident-participants to comment on what had gone well, what problems they had encountered, and how they had dealt with these problems. The main themes that emerge from the focus groups are changes in responsibility, workload and work content, relationships with patients and health care workers, preparation by undergraduate medical education and training, problems related to practical procedures, feelings of uncertainty, and formal learning.  The authors felt the most salient change from clerkship was the sudden and significant increase in responsibility.  For example, the resident-trainees were expected to make decisions about treatment, whereas as medical students they had never been expected to make decisions

about management.  Although a qualitative study, resident-participants were only

interviewed once, often further along in their training, and their experiences were in a

variety of specialty areas.

   *Adjusting to the role of resident.*

   Only one study could be located that used a qualitative approach and used the

term concerns to directly inquire about new doctors' training experiences.  Twenty-four

first-year residents in Internal Medicine were asked to "Please identify two to three major

difficulties or concerns related to your practice of medicine in the hospital" (Luthy et al.,

2004, p. 613).  Nine categories of concerns were identified: communication, problems at

the workplace, feelings of not being respected, constraints of collaborative work,

experiencing the gap between medical school and clinical care, work overload,

responsibility towards an emotional investment in patients, worries about career plans,

and lack of theoretical knowledge.  The resident-participants in this study express major

difficulties communicating with seniors and peers in particular, and with hospital staff in

general.  They also voice problems in coping with emotions, either their own or those of

their patients.  The researchers conclude that the trainees' responses stress the complexity

of blending the requirements of the doctor's role when instrumental or cognitive

knowledge is not sufficient to deal with problems requiring personal and relational

dimensions.

   This study is one of the few qualitative studies about concerns of new trainees

using a qualitative approach.  Although the resident-participants in this study were

Internal Medicine resident-trainees, dealing with patients' suffering and expectations is

an emotional experience that is universal for all trainees learning to become practising

doctors. According to the researchers, the theme of responsibility was expressed consistently throughout the study but, unfortunately, opportunities to further probe or explore what trainees meant by responsibility were not possible as the data were collected through written responses. The researchers recommend using a more open-ended approach to exploring the perspectives of new trainees. Responsibility has been identified in other studies as contributing to stress in the early stages of postgraduate medical training, but again opportunities to develop a deeper understanding of what is meant by responsibility have been limited due to the research methodologies used (Hesketh et al., 2003; Paice et al., 2002).

*Impostor phenomenon.*

Literature looking more generically at the transition experience of individuals moving into a professional workplace setting for the first time found that these individuals describe feeling like they were phoney (Noack, 1980) and impostors (Clance & Imes, 1978). Clance and Imes (1978) first describe the Impostor Phenomenon in high achieving women who believe they are less intelligent and less competent than others perceive them to be. In subsequent studies, researchers have documented that the Impostor Phenomenon occurs in both men and women (Clance & O'Toole, 1988; Holmes, 1993). Individuals with the Impostor Phenomenon believe they have achieved success by fooling others into believing they are intelligent and capable. The Impostor Phenomenon has been linked to personality traits such as perfectionism and anxiety (Henning & Shaw, 1998). Harvey and Katz (1985) view the Impostor Phenomenon as a transient developmental experience associated with changes in responsibilities, but do not elaborate on what is meant by responsibility.

Oriel et al., (2004) used the Clance Impostor Scale to measure impostor traits in Family Medicine resident-trainees in a three-year program and found about one third of the resident-participants (41% of women and 24% of men) were concerned they were less intelligent and less competent than others perceived them to be. These same resident-participants scored high on anxiety and depression scales. It is interesting to note that the prevalence of impostor symptoms do not vary with year of residency. There were as many exhibiting impostor symptoms in their final year nearing completion of their program, as there were among those just starting out.

*Reality shock.*

Flynn & Hekelman, (1993) set out to analyze what they term an atypical experience with an incoming group of resident-trainees in Family Medicine. In doing so, the researchers provide a case report illustrating some of the concerns and challenges experienced by new trainees. The researchers used a model of professional socialization called reality shock (Kramer & Schmalenberg, 1979) to make sense of the resident-trainees' experience.

Reality shock is defined as the conflict resulting from movement from the familiar subculture of school to the unfamiliar subculture of work. Reality shock involves a role transformation process that requires the reconciliation of the differing values and behaviours of the school and work worlds. The process consists of four phases: honeymoon, shock, recovery, and resolution. According to Flynn & Hekelman (1993), in the honeymoon phase the world is seen through rose-coloured glasses as residents feel they are finally a "real" doctor. The residents are concerned with mastering work

routines and acquiring practical clinical skills.  The researchers report that this phase in the residents' program ends very quickly, but do not stipulate a timeframe.

The shock phase takes over when new residents realize that the values and behaviours expected of a resident are different from those learned in medical school. Flynn and Hekelman indicate that it is not until the six-month point in training that residents enter the recovery phase where they are able to put the training experience more in perspective.

Finally, residents enter the resolution phase where personal growth and the ability to make a positive contribution to the program occur.  Flynn and Hekelman conclude that, while the model does not fully explain all aspects of residents' experience, it is useful in helping staff become more empathetic towards a group of residents who are experiencing (from the supervisors' perspective) an unusually difficult time adjusting to the residency program.

While the model provides a useful framework for conceptualizing the experiences of new resident-trainees, the case study used is an unusual example of what the researchers would normally expect residents to experience as they make the transition into a Family Medicine program.  Unfortunately, the researchers did not provide a description of what they would expect a normal or typical transition experience would be like nor did they describe in detail how this cohort of resident-trainee experiences may have differed from those of residents in other years. As well, the results are based on only two focus groups, each with six residents, conducted later in the residents' training experience.

*Summary - Concerns*

Postgraduate training is clearly recognized as a stressful time in a resident-trainees' development, with the first year being especially stressful. While the body of literature devoted to better understanding the resident-trainee experience is not as robust as the literature examining the experiences of medical students, medical educator-researchers have certainly spent time and energy trying to better understand the different forces that contribute to improving the resident-trainees' experience. Commonly cited factors for resident-trainees' emotional distress continue to be heavy workloads, sleep deprivation, insufficient knowledge, and working environments (Luthy et al, 2004). Although most stressors experienced by resident-trainees seem to be universal (Biaggi, 2003; Butterfield, 1988), the studies have generally focussed on specialty areas other than Family Medicine. In Ontario, the resident-trainees' union (the Professional Association of Interns and Residents of Ontario) actively advocates on behalf of postgraduate medical trainees to ensure that working conditions such as on-call time are considered reasonable as a way of managing some of the stress experienced by the resident-trainees. It is not known if the resident-participants in the present study will also identify these issues as concerns. If article titles and terms are a reflection of the type of experience resident-trainees associate with making the transition into a postgraduate program, Reality Shock and Impostor Phenomenon signify that the transition is not as seamless as medical educators had hoped.

The stress associated with taking on the responsibility for caring for patients seems to be the concern most consistently identified by resident-trainees, whether they are entering a program in Family Medicine or whether they are entering a program in

another medical specialty. However, the studies that have identified this theme have not explored responsibility in-depth or over time from the trainees' perspective.

The resident-trainees' levels of preparedness to use medical knowledge and clinical skills in the context of practice are concerns often explored by medical educator-researchers and, not surprisingly, resident-trainees consistently agree that they do not feel as prepared to commence practice, as they would like. The resident-trainees' approach to practice and ability to establish relationships with patients has not been at the forefront of research agendas and this may account for the lack of comment by resident-trainees in this area. As we move to look at the literature on changes that occur upon entry into postgraduate (i.e., residency) training, it is interesting to note that many of the themes such as knowledge acquisition continue to be the focus.

*Changes*

MacLeod (2000) comments that one of the reasons that medical students go to school is to be changed and, further, highlights how sociologists have been impressed by the powerful effect of the medical world in changing or altering attitudes, beliefs, and values. Change is inevitable during any transition and on many different levels. Although there is much literature looking at how medical students change during undergraduate training, the literature about how postgraduate trainees change is less robust, especially from the Family Physician trainee's perspective.

Only two studies could be located about changes that occur in postgraduate training from the trainees' perspective. One study looks at changes in a cohort of Family Medicine trainees' in perceived sense of competence in knowledge, clinical skills, and consultation skills over a three-year period (Kramer et al., 2007). A questionnaire was

given to incoming trainees and to outgoing third-year trainees. Results show that outgoing trainees feel more confident and competent, but as the researchers conclude, they do not know how to explain the improvement.

Marel et al. (2000) used questionnaires to look at the levels of confidence and experience with a broad range of clinical skills with postgraduate trainees in years one, two, and three. No specific specialty is reported. Again, the results show that after three years of training, the trainees' perception of their skill level and confidence increased. Further, this study reported that the greatest change occurred in the first year of training, although the researchers did not describe how or why.

Although no studies were found that examined training from the perspective of Family Medicine trainees in general, there are studies that look more closely at specific changes that occur in the areas of knowledge acquisition, cognitive development, and the doctor-patient relationship that are worthy of comment.

*Knowledge acquisition and use at the postgraduate level of training.*

The transition from theory to practice is more difficult than often assumed by medical educators (Boshuizen, 1996). It is a difficult time for postgraduate trainees as they move from a learning context where they were active in their learning efforts, but were heavily reliant on senior and supervising physicians to guide this process. At the postgraduate level of training, learning is expected to be more self-directed, which creates additional anxiety.

It is well documented that how resident-trainees use their knowledge in practice shifts and changes, in comparison to experienced doctors. Eraut (2000) explains that the process by which codified knowledge is acquired during undergraduate programs is

affected by the learning context, so that subsequent use of that knowledge in a different

context (in this study, a Family Medicine setting) requires further learning. Experts and

novices, regardless of discipline, differ in their encoding of information, the organization

of information in memory, and the use of this information in reasoning or problem

solving. Experts store knowledge in abstract, problem-relevant categories that are

connected by underlying conceptual principles relevant to problem solution (Chi, Glaser

& Farr, 1988). In contrast, novices organize knowledge into categories based on

superficial, irrelevant and often inefficient cues that may not be pertinent to generating a

problem solution (Etringer & Hillerbrand, 1995).

Schimidt & Boshuizen (1993) describe expertise development as a progression

through a series of consecutive phases, each of which is characterized by functionally

different knowledge structures underlying performance (Schmidt, Norman, Boshuizen,

1990). Experts use different clinical reasoning and problem solving strategies than

medical students to clinically diagnose medical problems (Eva, 2004). For example,

Anderson (1983) has suggested that pattern recognition is developed through repeated

presentations of examples with varying degrees of similarity. The novice medical student

does not have this experience. Experts engage in forward reasoning, meaning they

recognize problem features to draw diagnostic and conceptual conclusions (Glick, 2001;

Larkin, McDermott, Simon & Simon, 1980), whereas novices learn to think in reverse,

from diagnosis to identifying features that support the diagnosis (Prince et al., 2004).

Novices are less certain about the relationship of problem features to end-goals, so they

tend to reason backwards (Glick, 2001). This process takes considerable time and

cognitive resources (Anzai, 1991). Novices are not good problem solvers when

compared to experts. Novices lack the experience to have built up knowledge structures; therefore, unlike experts, novices cannot discern relevant problem information, solution paths and solutions goals (Frederickson & Bull, 1992).

Finally, because novices do not have the experience with problems that experts have built up over time, they have difficulty processing ill-structured problems (Voss, Greene, Post, & Penner, 1983). Learning how to deal with ill-structured problems is particularly challenging for residents training in Family Medicine because many patients present with undifferentiated (undiagnosed) and ill-defined problems. Family Physicians are generalists and, unlike specialists, have no body of knowledge they can call their own (McWhinney, 1997). Family Physicians are responsible for knowing a little about a lot. Only by specializing, can one attain depth of knowledge necessary to reduce uncertainty (Stephens, 1975).

Studies have shown that as resident-trainees begin using their knowledge base in practice they initially encounter problems knowing how to use this knowledge (Boshuizen, 1996; Boshuizen & Schmidt, 1992; Prince et al., 2000). Although there are several theories suggesting reasons for this difficulty, all conclude that there are differences between novices (those just learning the knowledge base) and experts (those with many years of experience) in how they use, develop, and store knowledge (Benner, 1982, 1984; Chi et al., 1988; Daley, 1999; Dreyfus & Dreyfus, 1985; Etringer & Hillerbrand, 1995; Schmidt & Boshuizen, 1993; Schmidt, Norman, & Boshuizen, 1990). When they begin using their knowledge base as a resident-trainee, the differences between how resident-doctors and experienced doctors use and store knowledge leads to challenges for the resident-trainees in diagnostic reasoning (Anzai, 1991; Daley, 1999;

Eva, 2004; Frederickson & Bull, 1992; Glick, 2001; O'Neill et al., 2003; Prince et al., 2004), processing ill-structured problems (Voss et al., 1983), history-taking (Benbassat et al., 2005; Bordage, 1999; Elstein & Schwartz, 1992; Gale & Marsden, 1983), and developing treatment and management plans (Radcliffe, 2003; Thistlewaite, 2002).

*Knowledge organization.*

Undergraduate medical education tends to promote and focus on the quantity of knowledge rather than its organization (Kriel, 1986); however, the amount of knowledge stored in memory is deemed less important than the manner in which it is organized and understood (Mandin, Jones, Woloschuk & Haraym, 1997). Inability to recall information stored in memory is due to lack of organization and understanding (Bordage & Zacks, 1984; Glaser, 1984). Unlike the knowledge of novices, the knowledge of experts is organized into schemes useful for both information storage and retrieval, thus facilitating an organized approach to problem solving (Glick, 2001). In other words, diagnostic reasoning is markedly enhanced when medical knowledge becomes elaborated, or linked to clinical findings with the experience of practice (Bordage & Zacks, 1984).

According to Bordage and Lemieux (1991) the reduced or absent knowledge of novices emanates from lack of experience and naturally interferes with solving medical problems; equally ineffective is a large body of knowledge that has been stored as lists through rote memorization. Slotnick (2001) contends that experience in clinical practice is necessary before doctors can incorporate what they have learned in medical school. Dall'Alba (2002) also concluded that trainees acquired specific medical knowledge and skills, but did not have the understanding needed to successfully incorporate this knowledge in a medically meaningful and effective way.

*History taking.*

Resident-trainees use of their knowledge to collect medical history changes at the postgraduate level. For example, medical students are traditionally taught an approach to clinical examination that emphasizes an orderly collection and recording of patient data along the sequence of history taking, complete system review, and routine physical exam (Benbassat et al., 2005). They are taught to delay forming their differential diagnosis until all patient data have been collected and evaluated. How students are taught to interview and to clinically reason does not reflect strategies used in real practice (Benbassat et al., 2005; Boshuizen, Schmidt, Custers, Van De Weil, 1995; Kassirer, 1983) nor does it reflect practicing physicians' thinking. In practice, experienced physicians generate working diagnoses soon after a patient interview begins and modify these with additional findings (Crombie, 1963; Eva, 2004; Lutz, Schiltz & Litton, 1986). For example, collecting data, diagnostic reasoning, and clinical decision-making are not separated (Arocha, Patel & Patel, 1993; Elstein & Schwartz, 2002; Kassirer, 1983; Mandin et al., 1997; Norman et al., 1992). As a result, resident-trainees struggle to develop a plan and have difficulty moving beyond data collection in order to consider different possibilities (Bordage, 1999; Elstein & Schwartz 2002; Gale & Marsden, 1983). As well, how medical students are taught to gather data creates difficulties in generating a diagnosis at the postgraduate level of training (Prince et al., 2005) and in developing treatment and management plans that involve the patient's viewpoint (Thistlewaite, 2002). Not only are medical students unsure of how to use their knowledge, they are unsure how to include the patient in the process because the focus of the medical interview emphasizes data collection (Dall'Alba, 1998).

*Interactions with patients.*

It is well documented in the literature that medical students' attitudes and approaches to patients change from the first day of medical school to the end of undergraduate training (Barbee & Feldman, 1970; Dornbush et al., 1985; Eisenthal, Stoeckle & Erlich, 1994; Haidet et al., 2002; Helfer & Ealy, 1972; Noguiera-Martins et al., 2006; Pfeiffer, 1983; Preven et al., 1986; Rezler, 1974; Rezler & Ten, 1984; Tsimisiou et al., 2007; Wolf et al., 1989; Woloschuk et al., 2004). Most studies looking at the attitudes and approaches of undergraduate medical students in patient interactions acknowledge that students have more of a spectator's role, suggesting opportunities to get involved are limited. Whereas at the postgraduate level, resident-trainees view themselves as responsible for the patient's care and so feel they need to be more actively involved.

One group of researchers provided undergraduate medical students with responsibility for the outcome of the patients' care and found that the students tended to care about their relationship with patients and began to develop patient-centered relationships. Developing patient-centered relationships in this study meant focusing beyond the patient's disease and finding out more about the patient as a person (Savenius, Schmidt & Klazinga, 2006). Savenius et al., (2006) claims that the critical moment in the socialization of medical students' attitudes toward patient care is the stage at which the students' idealism meets the reality of practice, and that, unless medical students have a certain level of responsibility for care, they continue to narrowly focus on the patient's pathology. Providing trainees with responsibility would suggest that postgraduate

trainees' earlier cynical attitudes and approach to care might change once they feel responsible for the patient's outcomes of care.

In a study that more closely mirrors the present study, Williams, Cantillon, and Cochrane (2001) used a qualitative approach (semi-structured interviews) to explore how 24 newly qualified doctors describe ways in which doctor-patient relationships differ from their undergraduate medical education experience. Twelve of the resident-participants were in Family Medicine, while the other 12 were in Medicine and Surgery. All resident-participants were interviewed individually for an hour within four to six weeks of starting their training, four resident-participants were interviewed twice. There were a variety of ways in which the resident-trainees described their relationships with patients as different when compared with their relationships with patients during medical school.

First, the resident-trainees felt there was more of a power balance between themselves and the patient, although they felt forced to take control of their relationships with patients because of time and expectations. Second, as residents, their new role brings with it a certain amount of authority, which means that patients are much more likely to implicitly accept procedures and treatment being carried out, whereas in the role of medical student during undergraduate training, they and the patients feel uncomfortable with a non-doctor carrying out procedures. Third, the resident-trainees' ideas about what it means to be a good doctor change. For example, they are more concerned about caring as a medical student, whereas in the doctor role they are more concerned about providing the right treatment. Fourth, trainees feel they are disconnecting emotionally from patients as they become increasingly more responsible

for difficult situations such as providing care to dying patients. Fifth, for the first time resident-trainees recognize that being tired interferes with their relationships with patients.

Another theme that emerges is how factors within the medical profession affect relationships with patients. For example, doctors who are more senior often have a harder attitude toward patients and treat medicine more as a business, which is difficult for new trainees to accept. As well, senior physicians do not always appreciate incorporating a patient-centered approach, which means trainees need to adjust their approach in terms of being less interested in how disease is affecting the patient. A final theme is the difference between Family Practice and Surgical trainees' perspective on the role of communication in the doctor-patient relationship. Family Practice trainees recognize the importance of communication skills to providing care, whereas the surgical residents report feeling their appreciation for communication skills in the relationship decline as they become busier. The researchers conclude by recommending that the effects of the transition from undergraduate to postgraduate training on the new doctors' communication skills and approach to the doctor-patient relationship need to be explored further.

Kramer et al. (2004) explored the impact of providing communication skills training to a cohort of Family Medicine trainees in a three-year program because evidence suggests that providing communication training over a longer period of time in a rich clinical context is effective in changing communication skills. Using a longitudinal design the communication skills of a randomly selected sample of 25 trainees were assessed at the start and at the end of training. Eight videotaped real life consultations

were rated per trainee using a standardized and validated communication checklist.  The results indicated that communication skills do not improve in a three-year postgraduate training comprising both a rich clinical context and a longitudinal training of communication skills; and that an unsatisfactory level still existed at the end of training.  Although the present study did not specifically explore the communication skills of beginning postgraduate trainees, the results of Kramer's study would suggest that no changes would be reported.  One area where change seems to occur during postgraduate training is in the postgraduate trainee's professional development and identity.

   *Personal and professional development.*

   The personal, cognitive, and professional development that occurs while learning to be a doctor involves a change in identity (Stewart & Brown, 1989), meaning how medical students and resident-trainees see themselves in relation to their families, patients, and the world at large.  These changes also influence how they see their tasks, roles, and responsibilities in the doctor-patient relationship and how they structure their knowledge.  Haas and Shaffir (1982) suggest that professionalization involves the moral and symbolic transformation of a layperson into an individual who can take on the special role and status claimed by the professional.  The postgraduate training years represent the initial formation of a more permanent, differentiated professional identity from that of medical student (Conrad, 1988; Knight, 1981; Pratt et al., 2006).  Five developmental theories and studies looking at physician development will be reviewed to highlight what is known at the postgraduate level of training.

   1.   Adult Development

Erickson's theory of adult development has been used as a backdrop by several researchers to discuss the challenges encountered by medical students during training (Grose et al., 1983; Pfeiffer, 1983). According to Erickson's (1980) theory of adult development, identity formation and establishing personal independence are major developmental tasks of adolescence and early adulthood. Yet the demands, challenges, and time commitment of medical school usually restrict students' capacity to undergo the experiences necessary to completely move through these stages. Many medical students simply postpone or delay these important developmental tasks. Olmsted and Paget (1969) referred to medical school as an extension of childhood socialization because of its polarized power structure, which emphasizes the low status and high dependency of its subjects. This form of structure lends considerable power to the physician-teacher/supervisors especially in view of the high motivation of students to get through the system. The authoritarian tradition of teaching and hospital structures also reinforces the child-like status of medical students and does not generally encourage their early assumption of professional role patterns.

2. Cognitive Development

Several studies have looked at the cognitive development of physicians. For example, Perry (1970, 1981) describes a series of stages that reflect the cognitive growth in thinking from undergraduate medical education and training through residency to independent physician including (a) dualism, (b) multiplicity, (c) relativism, and (d) commitment. Each stage of growth involves a qualitatively different frame of reference for perceiving and responding to experience.

Dualistic and multiplistic thinking primarily take place during the undergraduate years. During the postgraduate years students develop their critical thinking skills and begin to recognize there is a diversity of opinions including their own. This means patients' ideas about treatment are relevant and that the resident-trainees begin to develop opinions beyond their teacher-supervisors'. Relativism leads into the final stage of commitment where in the place of uncertainty resident-participants begin taking the risk of making their own choices and decisions. These stages suggest that resident-participants may be more tentative in their decision-making at the beginning of residency training and more secure towards the end of it.

3. Developmental Tasks

Brent (1981) identifies five core developmental tasks in postgraduate (i.e., residency) training. The first is coping with the conflict between vulnerability and invulnerability. This developmental task requires that postgraduate trainees are able to accept vulnerability in themselves and others while still maintaining a self-image as a competent healer. In the second task, active versus passive, the postgraduate trainees need to learn how to balance the desire to care versus the desire to cure. Related to this is the need to recognize the limitations of medicine and to learn effective approaches to providing support to a patient rather than ordering further interventions (e.g., tests, procedures, medications, etc.). The third task, helplessness versus problem solving, refers to the need to find an effective approach to dealing with the complexities of the broader social environment. In other words, medical knowledge in and of itself cannot cure

poverty or lessen waiting times for surgery.  Brent considered the fourth task of

boundary maintenance as one of the most important developmental tasks to be

negotiated at the postgraduate level.  Levinson et al., (1978) describes this issue as

the polarities of closeness and separateness.  Brent's fourth task involves deciding

how close to get to patients, learning how to say no, and when to ask for help.

Brent indicates the final and fifth task as the consolidation of a professional

identity.  A core sense of identity begins to emerge that is preserved regardless of

the locale.  In other words, a doctor's sense of identity as a Family Physician

solidifies despite continual rotations to different services within and outside the

community/hospital setting.

    Although Brent (1981) did not conduct any formal research, he drew on his

experience first as a resident in paediatrics and then as a resident in psychiatry.

Brent relied heavily on the work of Levinson et al. (1978), and Zabarenko and

Zabarenko (1978).  Levinson describes certain developmental tasks involved in

occupational selection, attainment, and achievement and demonstrated their

invariance in four different occupational fields.  Zabarenko and Zabarenko (1978)

in "The Doctor Tree", describe five developmental lines for physicians, which

emphasize the need for attitudinal changes in addition to acquisition of skills and

knowledge.  It should be noted that Zabarenko and Zabarenko's (1978) work was

primarily at the undergraduate level.  These three studies provide a context and

important reference point for understanding the doctor's cognitive development

during medical training. It was Brent's opinion that postgraduate training is more

than the acquisition of new skills and knowledge. It also involves the

development of attitudes and the modification of self-representations.

4. Professional Development

   Other studies specifically looking at the professionalization of doctors during

training (Broadhead, 1983; Bucher & Stelling, 1977; Hendrie & Lloyd, 1990)

support the notion that doctors in different specialties have a markedly different

set of experiences and so develop a markedly different sense of professional

identity and commitment. In other words, the training experiences of a surgical

doctor are not the same training experiences to which Family Medicine doctors

are exposed. These same studies found that even students within the same

specialty actively and selectively sought out different experiences from their peers

depending on what they felt they needed in order to enhance their sense of

competency at different points in training.

5. Identity Construction in Family Medicine

   Pratt et al (2006) describe the changes to professional identity new resident-

trainees in a Family Medicine program undergo as they commence training.

These researchers performed a six-year longitudinal, primarily qualitative study

that tracked resident-trainees through their entire residency programs in Family

Practice, Radiology, and Surgery. The purpose of the study was to build theory in

the area of professional identity construction. These researchers found that

systematic changes occurred in the resident-trainees' professional identities, that

work itself changed throughout residency, and that changes in identity were intertwined with changes in work. More specifically, they found that professional identity changes occurred when the trainees' ideas about whom they are as professionals do not match with the work they do.

Relevant to this study were the findings relating to changes in how Family Medicine trainees conceptualized their role. Primary care resident-participants experienced relatively minor variations in their work identity, meaning that most work assignments matched or mirrored what they anticipated a Family Medicine trainee would be doing. Although they struggled initially with the breadth of knowledge they needed to know, they saw themselves from the outset as coordinators of care for patients over the patients' lifespan. The trainees did experience what the researchers termed minor violations to their work-identity integrity as they came to recognize the scope of responsibility they had for patients. The resident-trainees in the Family Medicine program knew they had responsibility for patients, but underestimated the breath and scope of this responsibility as Family Physicians. This identity violation (not knowing the extent of their responsibility) deepened their understanding of what it meant to be a Family Physician. At the end of three years of training, the trainees describe having a more holistic or broader view of their identity as Family Physicians in training that grew out of their experiences with patients.

Pratt et al., (2006) also found that the trainees' concept of what it initially means to be a doctor emanates from their experience during undergraduate training. The Family Physician trainees noted that the work they were doing was

similar to the doctoring they either observed or participated in during undergraduate training, whereas, the Surgical and Radiology trainees found much of the work new and expectations different.   In the beginning, when work and professional identity were not aligned, it was common for all trainees to look back at prior socialization in medical school as a reference point to make sense of their current experience.  When there was a discrepancy between how things were done during undergraduate training and the expectations of postgraduate training, the trainees broadened their understanding of their new role and moved forward.

   Pratt et al. (2006) also looked at how the trainees validate their identities.  All were influenced by the feedback given by senior physicians and peers; their overriding sentiment being, "No news is good news" (p. 250).  If the trainees do not receive feedback (positive or negative), this means they are doing well.  All trainees reported receiving little instruction on how to perform their work.  Finally, the researchers note that as trainees began identifying more closely with their work over time, their perceptions of their own competence improved.  In the beginning, when the trainees are unsure of what their responsibilities as care providers entailed, they feel incompetent.  These researchers determined that feelings of competence occur when one's identity beliefs are relatively stable.  In Pratt et al.'s study the Family Medicine trainees who experienced the fewest work-identity violations, reported feelings of mastery and competence at the end of their first year, while the trainees who experienced more integrity violations identified with their role at a later point.

*Summary - Changes*

Change is inevitable with any transition and the move to a postgraduate context for resident-trainees is no exception. How resident-trainees use their knowledge in the context of practice is an area that predominates the literature about changes that occur at the postgraduate level of training. According to Eraut (1994), all learners experience changes in how they use knowledge in practice because the context has changed. In medicine, the struggles with knowing how to use knowledge are compounded by working in a context that is known for its uncertainty. Part of the challenge for new resident-trainees is not only to learn how to use their knowledge in medical encounters, but how to do so competently. Learning how to care competently involves changes to how the resident-trainees see their role as the doctor in relation to themselves and to patients (Brent, 1981; Perry, 1970, 1981; Zabaranko & Zabaranko, 1978). Many of the changes involve learning how to set limits both for themselves and for patients. In the process of learning what their role as doctors is and what that means in the context of a Family Medicine setting, changes to professional identity occur. While the literature is sparse about how the identity of a resident-trainee in a Family Medicine program evolves, Pratt et al. (2006) suggest that the professional identity changes that occur reflect the interactions that occur in the specific training program.

Two final comments before moving to explore the influences identified as affecting change during the postgraduate years. First, given the consensus by medical educators that the medical students' approach and attitudes to providing care in the context of the medical encounter change during undergraduate training, there is little literature looking at how these attitudes manifest themselves or change at the

postgraduate level (Jolly & MacDonald, 1989; Rolfe & Sanson-Fisher, 2002). Second, most of the studies (and there are not many) looking at how the resident-trainees experience changes at the postgraduate level do not do so from the resident-trainees' perspective, and certainly not in a context where resident-trainees reflect on their experiences. The lack of literature on changes that occur during practice from the resident-trainees' perspective naturally impacts the amount of literature about what influences have been attributed to those changes by resident-trainees.

*Influences*

This study is focused on better understanding what influences, identified by resident-trainees, affect changes, both positively and negatively, during their training experiences. The aim is to build a better understanding of their training experience, and to use that knowledge to create a better learning experience. The literature on medical education and adult learning provides broad ideas and suggestions for influencing the teaching and learning of postgraduate medical trainees; however, many suggestions are a result of teacher experience and not a result of resident-trainees' views. Some researchers based strategies that might be of benefit at the postgraduate level on concerns identified at the undergraduate program level. For example, some of the more common reasons cited in the literature for trainees having difficulty adopting a patient-centered approach and knowing how to use knowledge in practice are skills not being taught in the context of practice, lack of practical experience, and a lack of coordination between the undergraduate and postgraduate training experience (Clark et al., 1999; Fisher, 2002; Jolly & MacDonald, 1989; Relman; 1990; Rolfe & Sanson-Mandel et al., 1988). Subsequently, providing patient responsibility at the undergraduate level and developing

a more seamless transition between undergraduate and postgraduate training are recommended. Studies about the postgraduate training experience describe program innovations such as orientations to the specific work environment at the beginning of training to ease the transition of new resident-trainees (Berridge et al., 2007; Cruess et al., 2008; Epstein, 1994; Grover & Puczinsky, 1999).

Very few studies directly explore the influences that resident-trainees attribute to changes that occur during their training experience. One way of trying to develop a better understanding of what researchers and trainees might consider as potential influences (that would affect training experiences) is to look at the various recommendations that researchers have made following studies that looked at trainees' concerns.

*Satisfaction.*

Wolosin (1993) interviewed 23 Family Medicine resident-trainees about their professional satisfaction and dissatisfaction with their training and practice in Family Medicine . Satisfaction relates to the interpersonal aspects of patient care (e.g., establishing relationships, receiving positive patient feedback), the intellectual aspects of medicine (e.g., problem-solving, using knowledge), the process of delivering care on a day-to-day basis, and instances of intervention in critical situations. Dissatisfaction reflects concerns about the bureaucratic climate in which medicine is currently practiced (paperwork), time demands of a medical career, frustrations with patient behaviour, and negative feelings about the professional situation of the Family Practice residents. These findings are similar to other studies looking at satisfaction in Family Medicine, which also note that Family Physicians derive satisfaction from the diversity of and interactions

with the people and problems encountered in practice (McCranie, Hornsby & Calvert, 1982; McWhinney, 1997; Pisacano, 1990).

*Experiences with patients.*

Patient contact and feedback have been cited as contributing to trainee satisfaction and motivation (Greco, Brownlea & McGovern, 2001; McCranie et al., 1982; Pitkala & Mantyranta, 2003; Wolosin, 1993). Brady and Branch (2002) conducted a study to explore, from trainees' perspectives, important moments that influence development as a doctor. The researchers instructed Primary Care residents in a three-year training program to spend thirty minutes writing about any event in their lives that they view as important and that has some influence on their development as physicians. Twice in the first year, and then once in each of the next two years, they were also asked to write narratives about events that influenced them. In early training, the common underlying theme is the trainees' search for professional identity and core values. Most trainees wrote about experiences they had with patients. The researchers found positive role modeling reinforced the trainee's ideals. By the end of the first year, most narratives reflect feelings of disillusionment, but no specific influences as to why they feel disillusioned are mentioned. In year two, all trainees expressed a sense of despair, disillusionment, and detachment and attributed these feelings to interactions with colleagues and faculty. In the final narrative in year three, the theme was hope and reconciliation. Half of the trainees' stories center around positive experiences with patients, while the other half of the trainees reflects on their overall training experience. Clearly, the resident-trainees' viewpoints about themselves as doctors changed during

training, but the researchers were unable to probe the responses to the trainees' written

narratives to explore what prompted these changes.

*Support of senior physicians.*

The support, feedback, and guidance of more senior physicians has also been

reported as a positive influence in helping new trainees make the transition into a

postgraduate program. Brown, Chapman & Graham, (2007) conducted a study with

trainees and their supervisors, using both qualitative and quantitative methods, to explore

why some new doctors view their training as a valuable period in their professional

development, whereas others see it as a year to be endured and survived. Based on the

results of questionnaires and focus groups, the researchers recommend several strategies

for making the transition into postgraduate training less anxiety provoking. For example,

most trainees find that shadowing practitioners that are more experienced is a valuable

element of their preparation, while meeting with their supervisor early to establish a

learning plan is also helpful. Receiving ongoing support and feedback from supervisors

is also highlighted as an important influence in easing the trainees' transition. The

authors comment that assumptions by senior and supervising physicians that new doctors

know what they should be doing are common, and recommend that further efforts to

explore resident-trainees' views on how best to support their transition into postgraduate

training should be made.

In a study exploring influences on the development of general medicine residents

to provide psychosocial support, Eisenthal et al., (1994) found that the setting and the

attitudes of the supervising physicians influence the resident-trainees' approach to care

with patients. Supervising physicians are seen as more supportive of a psychosocial

approach in an ambulatory care setting than in a hospital setting where patients are often less well. It was interesting to note that the further resident-trainees were in their training, the less influence supervisors had on the resident-trainees' development. This suggests that supervisors' opinions and influence have a greater impact early in training as resident-trainees are beginning their specialty training.

*Coping strategies.*

Another way influences have been described in the literature is through coping strategies that resident-trainees have identified as being helpful. Paice et al., (2002) sent out a questionnaire to almost 2,500 first-year postgraduate resident-trainees asking them to describe a stressful incident and then to complete a fourteen-item Coping Checklist and a twelve-item checklist measuring Stress. The largest group of described stressful incidents related to having professional responsibility beyond their competence or experience. Many of the reported incidents of stress relate to events that had occurred in the first few days and weeks at the beginning of residency training, despite the fact the questionnaires were administered toward the end of the first year. The responses suggest several interventions to reduce stress: better supervision in the first few weeks in training, at night, and for medical problems on surgical wards; more attention to avoiding sleep deprivation; more time for discussion with colleagues at work; and more personal time with friends and family. Learning to take professional responsibility is an inevitable process in becoming a doctor, but many of the incident reports show that the resident-trainees do not have access to senior physicians and this adds to their anxiety. Although the results were helpful in suggesting possible interventions that could decrease or influence the resident-trainees' stress level, the suggested strategies are speculative

because the trainees were forced to choose among questionnaire items and there was no opportunity to probe their answers.

*Training experiences*

Based on the literature, McCue (1985) wrote an excellent review of some of the challenges that influence postgraduate trainees' experience during training and set forth a series of interventions that might improve the trainees' experience. While this overview has not been constructed through formal assessment of trainees' needs from their perspective, it does look at the literature and helps to synthesize and summarize medical educator-researchers' perceptions on training experiences that influence or contribute to the resident-trainees' experience.

Time pressure and intense professional commitment have been found to adversely affect the ability of resident-trainees to learn and to respond to problems (Asken and Raham, 1983; Cousins, 1981). The quality of a resident-trainee's education is believed to be related to the number of patients for whom they care and are responsible. Often patient care is replaced by the demands of test ordering and paperwork. The shock of responsibility often contributes to the stress, which was identified as a common experience of resident-trainees earlier. The resident-trainees have focused on vocational development and often have poorly formed support networks (Erikson, 1980; Pfeiffer, 1983). The resident's job is more stressful now because of fear of malpractice, increased numbers of patients with chronic illnesses, pressures to discharge patients, informed consumers, increased technology, and health care shortages. Several researchers comment on the nature of medical education and the extent to which it is likely to produce medical graduates who are equipped to deal with their changing role in the

twenty-first century (Calman, 1992; Sanson-Fisher, 1991; Weatherall, 1994). Close contact between individual faculty and trainees has diminished as programs have grown in response to doctor shortages.

Feedback and faculty involvement, which were cited earlier, are suggestions set forth that could positively influence the training experience of postgraduate medical trainees. McCue (1985) also suggests that working conditions such as training hours and salaries could be improved. Formal supports such as seminars on personal issues, financial advisors, support groups, and childcare are also suggested. Interestingly, Family Medicine programs are noted for offering the greatest number of supports, while surgical programs offer the fewest (Berg & Garrard, 1980). Finally, attention to providing a collegial and friendly work environment that deemphasizes competition and emphasizes cooperation and the enjoyment of taking care of patients are final recommendations. Although many of the ideas set forth by McCue occurred in the mid-1980s, most of these concerns and suggestions persist in the literature today (Evans & Roberts, 2006; Evans et al., 2004; Hesketh et al., 2003).

*Summary - Influences*

Roche et al., (1997) recommends that a better understanding of residents' education and training experiences would assist in identifying gaps in the educational process, which is intended to produce competent, independent medical practitioners. One way of providing a deeper understanding is to explore, from the resident-trainees' perspective, what they feel positively or negatively influenced changes that occurred during their postgraduate training experience; however, there is little reported in this area.

What literature does exist, consistently points to the same key messages. The role of the supervisor in providing feedback and role modelling seems to be pivotal in shaping how resident-trainees both view themselves as doctors and how they adjust in their new professional roles. As well, resident-trainees consistently feel they lack support and accessibility to more senior physicians (Brown et al., 2007; Busari, 2005; Paice et al., 2002).

Some researchers hint that the role of the learning climate influences the resident-trainees' identity and their development as doctors, suggesting that the context of where training takes place matters (Pratt et al., 2006). The stress of making the transition into postgraduate training was often attributed to not knowing what to expect and needing to acclimatize to new responsibilities (McCue, 1985). Subsequently, many of the studies focused on evaluating orientations that would ease the transition of new resident-trainees into postgraduate training. It is interesting to note that one researcher pointed out that the orientation goals of program directors and the reported orientation needs of residents often differed (Grover & Puczynski, 1999). Most directors want non-clinical areas such as group cohesion to be goals of orientation, while resident-trainees value clinically-related information such as on-call responsibilities. These discrepancies suggest that developing a better understanding of resident-trainees' perspectives on what is helpful is needed.

A final theme that emerges from the literature is the influence of patient interactions on resident-trainees' satisfaction with practice and with gaining a better understanding of their interpersonal skills. Greco et al. (2001) point out that the most significant gains made in changes to interpersonal skills were in the early stages of

general practice training and occurred because of patient feedback. Unfortunately, the gains made tended to deteriorate as training progressed, a finding also supported by Kramer's (2004) study. While patient feedback is seen as a positive influence, the researchers could not account for the later decline in communication skills.

The literature is sparse about what influences resident-trainees' experience and mostly focuses on the role of the supervisor and the role of the learning climate (e.g., large workload). Many researchers focus on the evaluation of strategies that resulted from concerns identified by earlier studies. No studies could be found that directly identified a research agenda to explore what influences resident-trainees themselves attributed to changes that occur use their knowledge in practice shifts and changes during training.

## *Summary – Chapter 2*

Learning to take professional responsibility is an inevitable process in the making of a doctor, but few studies have explored the process from the resident-trainees' perspective. The studies that have used a qualitative approach begin to highlight themes of adjusting to responsibility and to learning how to use knowledge in practice as concerns, but there are too few studies to begin drawing any conclusions or to speculate about how these concerns may be linked or interrelated to other changes or influences.

At the end of medical school graduates have a similar medical professional identity because of their reasonably similar undergraduate medical education and training (Conrad, 1988; Knight, 1981). Most studies indicate that the identity of newly graduated medical doctors is formed by their experience of undergraduate training. Undergraduate medical students are most concerned about their ability to absorb and manage the level of

knowledge they need to learn.  The anxiety and pressure associated with the medical

uncertainty they feel leads to changes in how they study, manage relationships, and

interact with patients.  The experience of undergraduate training influences and shapes

their initial concept of what it means to be a doctor, but there is little known about how

that concept manifests itself at the postgraduate level of training.

Many of the studies and books written about the experiences of medical students

are widely known as "The Student-Physician" edited by Robert K. Merton (1957), "Boys

in White" by Howard Becker and his colleagues (1961), "Interns: From Students to

Physicians" by Emily Mumford (1970), and "Becoming Doctors:  The Adoption of a

Cloak of Competence" by J. Haas and W. Shaffir (1987).  It is difficult to identify the

same familiarity with the literature at the postgraduate level.

The number of studies about the voiced experiences of resident-trainees as they

make the transition from undergraduate into postgraduate programs has been few and

even less have been written specifically about the experiences of Family Medicine

residents.  Studies about Family Medicine training tend to focus on communication skills

and use quantitative methods to evaluate different teaching and learning methods (Ong et

al., 1995; Stewart, 1995; Stewart et al., 2000).  Most researchers seem to focus on the

medical student's technical preparedness from the postgraduate residency program

director's perspective (Jones et al., 2002; Langdale et al., 2003) or on the specific work

stressors from the postgraduate trainee's perspective (Butterfield, 1988; Levey, 2001;

Michels, Probst, Godenick & Palesch, 2003).

Researchers have used surveys and questionnaires extensively to gain insight into

resident-trainees' thoughts and feelings during their postgraduate experience, but the

results are often limited or speculative as there is no opportunity has been taken to probe

the trainee's answers. The results of most studies, regardless of whether they were

qualitative or quantitative, provide only a snapshot picture of what was happening at a

given moment in time. Very few studies followed resident-trainees over time. The few

researchers that have taken a qualitative approach to explore the transition of medical

students into postgraduate education have identified responsibility as a variable

contributing to change (Calman & Donaldson, 1991; Hesketh et al., 2003; Luthy et al.,

2004; Prince et al., 2004), but have not explored what the change in responsibility means

to the resident-trainee. While some researchers have used qualitative methods to explore

the experiences of graduating doctors, they have asked focused questions or

predominantly examined specific skills sets (Goldacre et al., 1997; Jones et al., 2002;

Wall et al., 2006). Perhaps most importantly, few studies have used focus groups and

individual interviews to explore, more generally, how newly graduated doctors describe

their experience during the first six months of a Family Medicine training program.

More recently, there has been interest in better understanding the transition of

medical students into postgraduate programs because efforts have been made to adjust the

training experience of medical students to better prepare them for this shift. (Kramer et al,

2007; Lempp et al, 2005; Prince et al., 2004; 'Tomorrow's Doctors,' 1993). Grant (1998)

reports that in the first year of postgraduate training, doctors are redefining themselves in

a transitional context from their role as medical students to the professional role of a

resident-trainee and suggests this is an area for exploration, but does not offer any

specific recommendations. A better understanding of the experience of training in a

Family Medicine program will be developed by exploring the resident-trainees' concerns,

the changes that occur during the first few months of practice, and the influences the resident-trainees attribute to creating those changes.  If a deeper understanding of the resident-trainees' perspectives on their training experience is going to be constructed, dialogue with the trainees needs to occur over time and in a setting where they can reflect about what their experiences mean to them.  As Dahl (1995) so aptly suggests, by listening to the learner's voice, the deeper meanings and perspectives of individuals can be heard, reflecting the learner's personal reality.  Only then can we be confident that we have begun to build the deeper understanding that we are seeking.

Ruestam & Newton (1992) comment that the reader should conclude at the end of a literature review, "Yes, of course, this is the exact study that needs to be done at this time to move knowledge in this field a little further along" (p. 47).  Given what little literature exists on the viewpoints of resident-trainees during the beginning of a postgraduate program in Family Medicine, it is an area worthy of further exploration.  Marshall & Rossman's (2006) recommendation that literature reviews should go on simultaneously with fieldwork, permitting a creative interplay among the processes of data collection, literature review, and researcher introspection certainly fit the needs of this study.  The literature is used extensively in later chapters to make sense of the findings.

This study's lens focuses on better understanding the transitional experience of resident-trainees into a postgraduate Family Medicine residency training program.  The literature does suggest that the formation of a more permanent, differentiated professional identity does take place during the postgraduate training years (Blackwell et al., 1984; Johnson, 2000), but there has been little exploration and examination from the resident-

trainees' perspectives of how the experience of training contributes to this process. While the next chapter outlines how this study methodologically explored the questions it has set out to answer, given the lack of research in this area, the literature will again be revisited in a subsequent chapter to further locate the findings.

**Chapter 3**

Methodology and Design: Decisions and Choices

The focus of this chapter is on the processes used to explore the experiences of postgraduate training in a Family Medicine resident-trainee program and the next chapter focuses on data analysis and presentation. I begin this chapter with a more general discussion of the initial decisions made regarding the research strategies and design and then progressively narrow to a more focused discussion about the study itself. Information from the literature is interwoven throughout the text to outline the rationale for the choices made.

*Methodology*

Research design is a matter of choosing methods that match the research questions in a manner that is consistent with the aims and values of the researcher (Miles & Huberman, 1994). The purpose of this research is to better understand the experiences of residents in a postgraduate Family Medicine program during the first six months of training. I used qualitative methods to explore three research questions related to residents' experiences during this period:

1. How do residents describe their experience?

2. What changes to practice do the residents describe?

3. What experiences do the residents attribute these changes?

*The Paradigm*

*Paradigm* refers to the set of beliefs and practices that serve as the foundation and guide for the study, and which determine the criteria by which one may judge that inquiry

(Kuze1, 986).  Research paradigms determine not only the approach or research methods

used, but also the purpose of the research and the roles of the researcher (Firestone,

1987).  I was interested in better understanding the experiences of the Family Medicine

residents from their perspective; therefore, a naturalistic paradigm was chosen because it

best fit those needs.  The subsequent epistemology, method, and methodology choices

were made to reflect this paradigm. The questions I explored were from an interpretist or

phenomenological perspective using a case study approach.  I conducted focus groups

and individual interviews to explore the problem.  Researchers carrying out studies using

a naturalistic paradigm do not use the traditional notions of validity and reliability, but

instead use criteria that are meant to demonstrate the credibility and trustworthiness of

their findings and methods (Kuzel, 1986).  One way of doing this is through providing

clear links between the research questions, methodological choices, data collection,

analysis, interpretation and conclusions.  Yin (2003) refers to this as a chain of evidence.

The chain of evidence begins this methodological chapter, in which I will document the

research process and decisions made in the study.

*The paradigm choice.*

I used a qualitative approach for this study because I was interested in the views

of the Family Medicine residents at the beginning of their postgraduate training program,

their perceptions, meanings and interpretations of what was happening in the first six

months of training.  A qualitative approach allowed for a depth of exploration of the

resident-participant's experience that a quantitative approach would not.  An interpretist

epistemology rejects the notion of an external reality that can be discovered through

objective means (Gall, Gall & Borg, 2005).  Qualitative approaches allow researchers to

see the situation through the eyes of the study participants, as opposed to using a

quantitative method that focuses on isolated variables and uses numerical analysis

(Cohen, Manion & Morrison, 2005).  Quantitative methods were not commensurate with

either the study's research purpose or question.  Quantitative methods could not elucidate

the subtle nuances associated with uncovering a person's lived experiences, whereas, a

qualitative approach naturally lent itself to better understanding and exploring the

resident-participants' experiences (Strauss & Corbin 1998).

This study was based on a naturalistic, interpretive paradigm because I was

interested in better understanding the subjective world of the resident-participant's

experience from the inside, as opposed to the outside (Cohen et al, 2005; Glesne &

Peshkin, 1992).  This study is based on the assumption that there are multiple, socially

constructed realities and, in order to make interpretations or deepen the researcher's

understanding of the participants' experience, access must be gained to the resident-

participants' perspectives.  The interpretive paradigm for this study will be further

described within a postpositivist paradigm of naturalism inquiry, meaning reality is

assumed to exist, but to be only imperfectly apprehendable, while the epistemology

asserts dualism is largely abandoned, objectivity remains an ideal (Guba & Lincoln,

1994).  A realist orientation will be taken, meaning it is impossible to capture the

absolute truth of the resident-participants' experience, but we can improve our

understanding of what is going on.  Finally, the role of the researcher is ideally to be that

of an objective and neutral observer, as opposed to co-creating findings with the resident-

participants (Beck, 1979; Guba & Lincoln, 1994; Willig, 2001).

*Methodology Choice*

Different types of methodological approaches were explored to find the best fit for this study. For example, ethnography has been described as the quintessential qualitative research method because it is concerned with experience as it is lived, felt, or undergone (Glaser & Strauss, 1967). Although I was interested in understanding resident-participants' lived experiences during training, resident-participant observation is the base method for ethnography and this method was not commensurable with this study (Banister, Begman, Parker, Taylor & Tindall, 1994). Resident-participant observation means the researcher takes part in the very activities they set out to understand and in this study many of those experiences took place in the clinical encounter with patients. It was not possible to sit in on office visits with the resident-participants as it would be intrusive and issues of doctor-patient confidentiality needed to be strictly upheld. A grounded theory approach was also considered, but rejected. Although this study, like grounded theory, is focussed on the progressive identification and integration of data for comparison purposes, the primary goal is not theory generation (Holloway & Wheeler, 2002) but to develop a deeper understanding of a phenomenon.

This study is most closely aligned with the principles of interpretative phenomenology because the focus is on better understanding the experiences and the meanings resident-participants attribute to the experiences. Phenomenological research is concerned with how the world presents itself to people as they engage with it in particular contexts and with particular intentions (Giorgi, 1986; Marton, 1986). Its aim is to capture an experience and to unravel its meaning(s) through interviews (Van Manen, 1990).

Where this study primarily departs from phenomenological research is in the focus of interest, which had implications for both how the data were collected and analyzed. For example, the focus of the study was not in creating textural or structural descriptions of the resident-participants' experiences in order to capture the essence of this phenomenon (Moustakas, 1994). This research was primarily exploratory in nature and needed a method that allowed for greater flexibility. The goal was to gain a deeper understanding of the resident-participants' experience during the first few months of training. It was not known ahead of time what experiences would be important to the resident-participants or what stories they would voice; therefore, it was imperative to choose a method that allowed the design to vary and emerge as new information was gained and new insights formed (Guba, 1994). A case study method provided this necessary flexibility.

*Case Study Method*

Case studies aim to improve our understanding of what is going on in a particular situation and allow for the discovery of new insights and interpretations. This method not only provided a means for accessing subjective factors such as the thoughts and feelings of the resident-participants, but it also allowed for a wide net into which to gather evidence (Bromley, 1986). A case study is an approach that allows the researcher to look at changes or developments that take place over time (Willig, 2001). Being able to look at changes that occur over time was important to this study because the objective was to gain insight into the resident-participants' perspective on their experience and the changes that occurred over the initial six months of residency training.

Case studies can be used to explore, understand, and describe the case within its context. The case can be the situation, individual, group, organization, or whatever it is that the researcher is interested (Robston, 1993). Clearly, case study research can take different forms and, if an audit trail is to be clearly laid, then it is important to delineate what is meant by case study in this research. One way of doing this is by defining the boundaries of the case. In other words, the researcher needs to be explicit about what is of interest in the case study. To establish the boundaries of the case study, the researcher needs to clearly identify its terms of reference. Boundaries can be defined with reference to the characteristics of the individual and groups involved, and can be defined by the resident-participants' roles and functions in the case.

Hamel, Dufour & Fortin (1993) differentiates between the *object of study* and the *case*. The object of study constitutes the phenomenon of interest to the researcher. By concentrating on a single phenomenon this approach aims to uncover the interaction of significant factors characteristic of the phenomenon (Merriam, 1988). In this instance, the phenomenon of interest is the resident-trainees' voiced experience of the first six months of a Family Medicine residency program. More specifically, this study was interested in understanding what concerns the resident-participants experienced in the Family Medicine clinical context, what changes occurred from the resident-participant's perspective during the first six months in the Family Medicine program, and what influences resident-participants attributed to those changes. The case is the concrete manifestation of the object of study and should be selected to better understand the phenomenon under investigation (Hamel et al. 1993). The cases for this study are postgraduate trainees in a postgraduate Family Medicine residency program.

*Type of case study.*

Case studies can further be defined by the design choices. Case studies can be exploratory, descriptive, or evaluative (Yin, 2003). This study is exploratory in that the focus is on developing a better understanding of the phenomenon by describing the experience and by looking for patterns and relationships. This type of case study is particularly useful in studies where theory is either lacking or does not describe the phenomenon adequately (Merriam, 1988; Yin, 2003). This was also an instrumental case study, meaning the cases or doctors were chosen because they were exemplars of the phenomenon and they provided insight into an issue; in contrast to an intrinsic case study where the object of interest is the case in its own right (such as a rare disease). The phenomenon of interest in this study is the experience of postgraduate trainees during the first six months of a Family Medicine residency program. Individuals who are experiencing the phenomenon of interest (Family Medicine resident-participants who are either in or have experienced the first six months of training) constitute suitable cases for analysis (Stake, 1994).

In this study multiple cases of the phenomenon were explored in order to formulate hypotheses and explanations of the experience by comparing responses. A multiple case study allows the researcher to consider a series of cases in relation to one another in order to develop a conceptual framework that best accounts for them (Willig, 2001). Residents' beliefs change with the experience of training (Lynch et al., 1998); therefore findings from these cases were compared and contrasted looking for both similarities and differences in how the resident-participants described their experiences during the first six months. More specifically, the resident-participants in this study

included those who were (a) just beginning their postgraduate training, (b) at the end of first year, and (c) at the end of their second year.

<center>*Delimitations and Limitations*</center>

Another way in which to give definition to a study is by laying out the delimitations and limitations. Delimitations refer to the scope of the study, what the study will and will not address, while limitations identify potential weaknesses in the study (Cresswell, 2002).

*Number of Resident-participants*

Every study is fraught with decisions about its focus. There are no perfect research designs and decisions have to be made based on time, resources, and the limits of human ability to competently grasp the complex nature of social reality (Patton, 1990). Sometimes decisions have to be made between breadth and depth of focus. While quantitative methods often allow for breadth (large numbers) of resident-participants, qualitative studies lend themselves more to depth and detail about a much smaller number of people and cases. Erikson (1980) notes that in qualitative studies the researcher can extract a universal from a particular. In-depth interviews and focus groups were used in this study to better understand the experiences of a small number of resident-trainees. Although the entire two-year training experience of postgraduate trainees is important, the focus of this study was limited to the first six months in hopes of generating a deeper understanding of this initial period of residency training.

*The Program Type*

This study focused on one University of Toronto teaching site and that may have been limiting for two reasons. First, as previously mentioned in Chapter 1, there are two types of Family Medicine residency programs offered: a horizontal program and a more traditional block or longitudinal program. These program structures differ in that a horizontal program is one in which resident-participants are based in the Family Practice clinic for a concentrated period of time every week throughout their two years of training, whereas in a block program resident-participants are on specialty-specific block rotations. Naturally, the horizontal program offers resident-participants more opportunity to experience relationships based on continuity of care. The resident-participants in this study were in a horizontal program and described this type of program as advantageous because it more accurately reflected the practice of Family Medicine in which they could follow patients more closely by offering regular, ongoing appointments.

In the more traditional program, which is offered at other University of Toronto Family Medicine teaching sites, the residents are largely able to see Family Medicine patients when they are on their months of Family Medicine block. This means they are not able to necessarily offer patients weekly follow up appointments when they are not on block, but they are able to closely follow patients during their four-month rotation.

Although studies suggest that there are no differences between the experiences of continuity of care in a horizontal program versus a more traditional block (longitudinal) program (Merenstein et al., 2001; Weiss & Blastein 1996), the results of this study were based on only one program structure. It is difficult to say whether the results would have been similar had the case study used more than one program type. It is worthy of

mention because some of the findings suggest that continuity of care is a powerful contributor to the developing Family Medicine physician-trainees' approach to the doctor-patient relationship and understanding of their role in the clinical encounter. Not including more than one type of program structure makes the generalizeability of the findings more speculative. If additional cases, reflecting the different program types had been included the methodological framework of the study would be strengthened.

*Collective Voice*

As this study was about better understanding the training experiences of resident-participants in a postgraduate Family Medicine program, it focused on the resident-participants' collective voices of that experience. This study did not look at individual factors such as gender, status, race, or age of resident-participants in a Family Medicine program. Current experiences outside of the Family Medicine setting such as family and social life were also not explored. Although these factors are important, there is evidence to suggest that these individual variables might be minimized through the intensive socialization process that students undergo during professional education (Becker et al., 1961; Coombs, 1978; Haas & Shaffir, 1987; Konner, 1987; Shapiro, 1987). In other words, gender issues are neutralized and students become more similar in their outlooks than they were before beginning this intense training process (Beagan, 2000). This study also did not focus on the resident-participants' social history or past educational experience. Resident-participants could refer to these contexts, but the researcher did not deliberately invite, lead or direct the  resident-participants to talk about these areas.

*Stage of Training*

The researcher was interested in hearing the voices of resident-participants who were either in the first six months of a Family Medicine program or those in a later stage of Family Medicine training who were specifically reflecting back on their experience of the first six months. The concept of training experience was not defined ahead of time for the resident-participants. Training experience in this study could refer to encounters with patients, the patients' families, supervisors, and other health care professionals. Training experiences with patients could take place in the patient's home, hospital, or office setting. Training experiences might also include grand rounds, educational seminars, and inpatient and ambulatory clinical rotations, although direct inquiries were not specifically made about these latter experiences.

*One Person's Interpretation*

Miles and Huberman (1994) note that each qualitative researcher tends to act as a one-person research machine: defining the problem, doing the sampling, designing the instruments, collecting the information, reducing the information, analyzing it, interpreting it, and writing it up. One researcher raises concerns with the reliability and validity of the study, although Kvale (1996) suggests reliability can also become an issue when there are as many different interpretations of the data as there are researchers. Although I was the primary researcher, I was surrounded by a committee who acted as a resource, providing a built in set of checks and balances during every stage of the study. Trustworthiness or confidence in the research findings (Denzin & Lincoln, 1994) was built into the study in other ways. I used seven approaches to ensure confidence in the research findings:

1.  Validation of the data was sought from study resident-participants by offering them the opportunity to review and comment on the data after each stage of analysis.  Patton (1990) suggests that one way to test the credibility of qualitative findings is to get the perspective of the people who are going to use the information; therefore, the invitation to review the data analysis and provide feedback was extended to Family Medicine resident-participants at a similar stage of training and preceptors at another Family Medicine teaching site.

2.  Although drafts were shared for review and comments with all of my thesis committee members throughout the study, it was the committee members who possessed qualitative research expertise who worked most closely with the researcher.  Meetings were held at regular intervals and drafts at each stage of the research process were submitted for review and feedback.

3.  More than one method of data collection (i.e., focus groups and in-depth interviews) was used over a six-month time frame.

4.  The study involved eighteen resident-participants at different stages of Family Medicine training, which helped triangulate the findings.

5.  The possibility of interpreter bias was reduced by transcribing the interviews verbatim and analyzing the text immediately after an interview was completed.

6.  The literature was used iteratively to locate and anchor the findings of the study.

7. In writing up the study, efforts were made to leave an audit trail of each step of the process so that the study was as transparent to the reader as possible.

This final approach (#7) is worth further elaboration. It was not the intention of the researcher to leave the reader trying to evaluate the influence of the researcher's perspective on the outcome of the analysis. It was for this reason that multiple analysis of the data was done. In other words, the "cards" were put on the table for inspection (Giorgi, 1986). In this study, by analyzing and presenting the data in increasingly more rigorous ways, a chain of evidence was created (Yin, 1994). For example, in Chapter 5 the purpose of the initial data presentation was to achieve verisimilitude (Adler et al., 1980), so the reader could begin by entering the resident-participants' and researcher's world as closely as possible. The data were used to create a journal that depicted as closely as possible the researcher's insiders' perspective of the experience. In Chapter 6, the data were further analyzed and quotes from the interviews were liberally used to portray the resident-participants' concerns chronologically as they experienced the transition from undergraduate to postgraduate training. In Chapter 7, the changes and influences that shaped these changes were highlighted using the medical encounter. In Chapter 8, the specific influences that are believed to lead to change were presented, setting the stage for Chapter 9 where a link was made between changes and identity formation. Finally, in Chapter 10 the reader was presented with an in-depth analysis of the findings that was anchored in the literature.

*The Method*

This study used individual and focus group interviews to collect data. Triangulation of data is the term given when the researcher uses multiple forms of data

collection to ensure that the phenomenon under study is viewed from as many perspectives as possible to do justice to the complexity of the situation (Miles & Huberman, 1994). As it was, individual interviews often had to be rescheduled or cut short because of the conflicting demands of residency training. It was not unusual for resident-participants to be paged during interviews, which sometimes interrupted the flow of conversation or prematurely ended the discussion. As well, it was not possible to ask resident-participants to turn off their pagers as they were often "on-call" meaning there were other legitimate competing responsibilities during the interview times. As previously mentioned, as each data chapter was finalized, including the discussion section, the findings were forwarded to resident-participants for their input and feedback. This was one way of checking the validity of the reconstruction of the resident-participants' perspective. Not all resident-participants replied, but comments received were duly reviewed and additions and changes were made as necessary.

*Data Collection*

Researchers who use case studies tend to use certain data collection methods, such as, interview, observation, narrative accounts, and documentation (Cohen et al., 2005). For this study I used focus groups and semi-structured in-depth individual interviews.

*Focus groups.*

Focus groups were chosen because they are ideal for exploring how knowledge and, more importantly, ideas develop and operate within a given cultural context (Kitzinger, 1995). Focus groups provide resident-participants with an opportunity to

generate ideas and debate about a focused topic, which was congruent with the needs of this study, as information generated would be used as a tool for developing insights and further questions. In the past, focus groups have been predominantly used as a way of testing or generating possible questions for future surveys or questionnaires.

Medical educators recognize the need to include the student's voice when considering curricular change or evaluation. Focus groups have proven to be a valuable way to do this (Lam, 2005; O'Neill et al., 2003). Focus groups are particularly appropriate for exploring topics that are poorly understood or ill defined (Britten, 1995) and have proven their worth in providing insights into those aspects of the medical curriculum that are not amenable to study using more conventional quantitative methods (Barbour, 2005).

Focus groups can facilitate resident-participants' expression of ideas and experiences, which might be left underdeveloped in an interview, and to illuminate the resident-participants' perspectives through the debate within the group. This was the experience in this study; after a short period of time group resident-participants would be engaged in a lively discussion about either their current experiences or reflections about the time of interest. Focus groups offer resident-participants a relatively safe place to share such experiences. This is important because statements made by resident-participants tend to be challenged, extended, developed, and qualified in ways that generate rich data for the researcher (Willig, 2001). It has been suggested that when the focus of inquiry is a homogenous group (as it was in this study) the power imbalance between researcher and study resident-participants is diluted because of the naturally occurring peer group (Barbour, 2005).

Focus groups serve two main purposes in this study. First, they allowed resident-participants in the later stages of the Family Medicine program to reflect on their experience during the first six months of training. These findings informed development of subsequent questions with incoming first year residents and, because resident-participant groups were essentially homogenous, allowed for later comparison and contrast (Kitzinger, 1995). Second, focus groups were used at the beginning of the study to explore incoming resident-participants' experience as it unfolded in the first weeks of residency. This was important because the researcher was particularly interested in gaining insight into the resident-participants' experience as it occurred. In summary, focus groups were used to develop themes, help articulate more focused areas for exploration, and later triangulate information with other data.

*Individual interviews.*

Focus groups were not used as a substitute for one-to-one interviews (Crabtree & Miller, 1999). Interviews with individuals differ from focus groups in that they are a focused way to explore individual ideas rather than stimulating ideas based on shared perceptions of the world (Robinson, 1999). Although the focus groups played an important role in this study, it was perhaps even more important to provide opportunities to deeply explore resident-participants' views on their experience of training as it occurred. Interviews are used when we want to find out things we cannot directly observe and in this study it was not possible to observe the resident-participants in the clinical setting.

Interviews should be used when there is an interest in understanding someone else's perspective. In the past, researchers have used interviews productively to explore

residents' thoughts and feelings about the doctor-patient relationship (Becker et al., 1961; Mumford, 1970). At the root of in-depth interviewing is an interest to better understand the experience of other people and the meaning they make of that experience (Seidman, 1998). Interviewing provides access to the context of people's behaviour, providing the researcher a way to better understand the meaning of a particular experience. As this study was about understanding the resident-participants' experience of the first six months of Family Medicine residency training, individual interviews seemed to be an ideal method to explore these viewpoints in depth.

There are primarily three different approaches to interviewing (a) structured, (b) semi-structured, and (c) unstructured (Robston, 1993). Structured interviews are usually used when a study is designed to test an a priori hypothesis. A researcher may also use structured interviews to minimize variation in the responses and seek specific information. This study used a mix of semi-structured and unstructured interviews, which according to Merriam (1988) are valid methods of collecting data because they allow for clarification and elaboration. An interview guide (see Appendix B), based on the research questions was used in the initial focus groups and individual interviews, which is similar to a semi-structured approach. However, the iterative nature of the preliminary data analysis meant questions for subsequent interviews emerged from previous interviews. The focus of these findings was woven into subsequent conversations and the interview approach became less and less structured as interviewees led, while I followed.

*The Researcher*

In qualitative research, the researcher is the data collection instrument; therefore, the skill of the interviewer is critical to the success of the interview. This is important because the quality of the data retrieved depends almost exclusively on the interviewer. A good interviewer is sensitive to the verbal and non-verbal messages conveyed, is a good reflective listener, and is non-judgmental (Whyte, 1982). Kvale (1996) outlined several qualifications for a good interviewer such as knowledge of the subject matter, sensitivity, good recall, and ability to guide the interview process. In this study I was the only person responsible for interviewing.

Becoming a skilled interviewer takes practice. For the past twenty years I have been either interviewing or teaching interviewing skills. This life experience made many of the skills necessary to be a good interviewer second nature to me, which meant I could fully concentrate on listening to the resident-participants' stories. One of the philosophical assumptions underlying naturalistic interpretive inquiry is that reality is not an objective entity; rather, there are multiple interpretations of reality (Merriam, 1988). Given my past work experience in the area, the challenge for me was not interviewing, but ensuring that I was aware of, and did not allow my bias, preconceived ideas, or attitudes influence the interviewing process. One way I did this was by being very cognizant of when I was talking because that meant the interviewee was not. In other words, while I may have been the expert at asking the questions, the interviewee was the expert at answering them (Denzin & Lincoln, 1994).

*Sampling*

Systematic, non-probabilistic sampling was used because the purpose of this study was not to establish a random or representative sample drawn from a broader population but rather, to identify specific groups of people (newly graduated doctors) who either possess characteristics or live in circumstances relevant to the social phenomenon being studied (residency training in Family Medicine) (Mays & Pope, 1995).  Purposive sampling, a type of non-probability sampling, was used to select resident-participants for this study.  Purposive sampling means the study resident-participants were hand-picked by the researcher because they represent typicality in the researcher's judgment (Cohen et al., 2005).

The power of purposeful sampling lies in recruiting information-rich resident-participants (Patton, 1990).  Information-rich in this study meant inviting doctors in a postgraduate Family Medicine program to participate.  They are considered homogenous to the extent that they share the same experience of taking part in Family Medicine residency training.  This point is important because the purpose of this study was to better understand the phenomenon or experience of Family Medicine residency training by resident-participants at a particular time in their training as opposed to focusing on specific characteristics that might affect training experiences such as gender or culture.  As well, a homogenous sample allowed for cross comparison of cases.

Selection of resident-participants within the Family Medicine residency program itself involved convenience sampling because the residents were invited to participate based on their accessibility (Cohen et al., 2005).  Choosing residents who were available was important.  Resident-trainees have complicated and demanding schedules making

reliable accessibility a challenge, which was the case in this study. Interviews could not be scheduled until the resident-participants had their schedule for the month. Sometimes interviews had to be scheduled three or four different times based on unforeseen schedule conflicts, patient responsibilities and heavy on-call experiences. A few individual interviews had to occur by telephone because it was just not possible to synchronize schedules within a realistic time frame.

*Setting*

The Family Medicine residency program at the University of Toronto was established in 1970. At the time of this study it was offered at nine teaching hospitals affiliated with the University and is believed to be the largest Family Medicine residency program in North America. Each teaching site is the same in that it offers a comprehensive 24-month educational and training program designed to prepare Family Physicians for the challenges of community practice for a multicultural population and in a changing health care system. All sites provide patient-centered care, which is taught through adult learning principles. Each site also offers a myriad of teaching strategies such as videotaping, chart review, and small group discussions. In addition, the overall program is accredited by the College of Family Physicians of Canada (CFPC) and received full Approval during the most recent 2001 and 2007 CFPC Accreditation Survey.

In the first year of the program each resident is expected to complete four months of block time in a Family Medicine practice, meaning they work in a Family Medicine practice for several days a week during a concentrated period. In addition, the residents are expected to return to their home base hospital for at least one clinical half day per

week throughout the two years to develop a roster of Family Medicine patients for whom they will provide continuing comprehensive care under the supervision of the multi-disciplinary Family Medicine teaching staff.  While the program at each of the nine hospital sites is structured somewhat differently, the programs are more similar than they are different.  The curriculum is competency based and is guided by a set of standardized goals and objectives.

*Recruitment*

There were 12 residents in each of three annual cohorts taking part in the Family Medicine residency program at the University of Toronto site when and where this study was conducted.  In other words, 36 residents were invited to take part in the study, although there were no more than 24 residents in the program itself at any one time.  That is not to say that all 36 residents took part in the study, but all residents enrolled in the program at the time were invited to participate.  The study commenced in May of 2004, which meant there was an opportunity to meet with the residents at the end of second year before they graduated from the program.  The new or incoming residents began on July 1, 2004; each year twelve doctors graduate from the program and twelve enter it. This meant two recruitment meetings were required, one prior to June 30, 2004 and the other after July, 2004.

After securing ethical approval and permission of the Program and Site Directors, I had to decide which would be my best way to make initial contact with the potential resident-participants (Glesne & Peshkin, 1992).  The program administrator, with whom I consulted, recommended making a brief announcement about the research project during the core teaching day at which all potential resident-participants were expected to attend.

Recruitment had to take place at two different time periods to engage the participation of

both the outgoing second year residents (end of June) and the incoming first year

residents (beginning of July). Initially an announcement, introducing myself and

outlining the purpose of the research was made following a seminar on the core

educational day. Potential resident-participants were offered two different lunchtimes to

attend a further information meeting. To maximize recruitment potential, the dates

chosen for the informational lunch sessions were scheduled to follow the last seminar on

core education days. A signup sheet was passed around at the initial meeting offering the

two meeting choices. A pizza lunch was provided to encourage attendance. Potential

resident-participants were contacted by telephone prior to the day to remind them about

the recruitment meeting. Since recruitment took place at two different time periods, the

process was repeated twice.

During the information session, I presented information about the purpose and

design of the study and encouraged questions. A sample of how the study was introduced

and discussed is presented in Appendix C. Potential resident-participants were given the

opportunity to commit or decline publicly during the meeting, privately through e-mail,

or by telephone at a later time. Issues related to recruitment are also discussed in the

following section about ethics. There was no budget for this research and resident-

participants in the study were not offered any monetary compensation for their time;

however, lunch was provided during every focus group or individual interview.

The descriptions in this chapter about the research process itself belie the reality

that the research process was emergent and that the design strategies were modified to

meet the evolving inquiry topic and to respond to resident-participant needs (Strauss &

Corbin, 1998).  For example**,** during the recruitment phase of the study, resident-participants who agreed to be part of the individual interview process were also asked to complete a minimum of two critical incident reports during a six month time period, which were to be explored during individual interviews.

A critical incident report is the written documentation of events in which resident-participants have taken part that they perceived as particularly significant (McClure, 1989).  Critical incidents were chosen because the information could be used to typify or illuminate a particular event or circumstance.  Information on how to complete a critical incident report was provided during the recruitment phase luncheon meeting (see Appendix D).  Critical incident reports were chosen rather than diaries because they are less time-consuming and intrusive, but still have the advantage of collecting data as the selected incidents occurred or unfolded.  It became clear with the resident-participants agreeing to take part in individual interviews that they would consent to interviews, but not to completing critical incident reports.  There was consensus among the resident-participants, even after reassurance that it did not need to be a lengthy report that the reports would potentially take too much time and effort to complete.  Subsequently, the design of this study was modified to include only the focus group and individual interviews, although the resident-participants did agree to verbally discuss events or circumstances they felt typified their experiences. As a result, the consent form for individual interviews still includes an invitation to complete Critical Incident reports even though these did not happen.

*Ethical Considerations*

The ethical review protocol necessary to complete research at a medical institution (University Health Network Research Ethics Board) and as part of a university degree (OISE/UT Education Ethics Review Committee – Human Research) were submitted and approved.  Samples of ethics approval forms are presented in Appendix E, F and G.

Case studies are concerned with the details of resident-participant's lives; therefore the researcher needs to be particularly sensitive to issues related to confidentiality and anonymity.  For example, it is possible to make alterations in such a way that the particular case is rendered unrecognizable, while preserving the case study form and content (Bromley, 1986).  All study  resident-participants were assured that their contributions would be kept confidential and efforts would be made, such as coding names, to ensure anonymity.  Potential resident-participants were also informed of who would have access to the data.  Reassurance was given to resident-participants that only material revealed in the focus groups and interviews would be used as data.

Participation in this study was voluntary and residents were reassured, both orally and through the consent form, that their decision to take part or not take part would in no way influence any aspect of their residency program. As well, there would be no repercussions should a resident-participant decide to withdraw from the study at any time.  Knowing that they could withdraw from the study at any time without repercussions was particularly important to the resident-participants just beginning training because they were unsure of their future time and work load commitments.

The residents were also informed that the findings from the study may be used in future academic journals and presentations. Residents were asked to sign consent forms after they had been fully informed about the study and had opportunities to ask questions. The consent forms disclosed the full purpose of the study and made reference to issues of anonymity, evaluation, and confidentiality. They also provided more formal information about the study and ensured that all residents were given the same information. There was one consent form for the focus groups and another consent form for the individual interviews. The original consents were already prepared and on hospital letterhead so were not changed. Samples of these consent forms can be found in Appendix H and I. Residents who were unsure about their desire to participate were encouraged to take their time in thinking about this decision and were offered the opportunity to decide, via a follow-up e-mail or telephone call initiated by the researcher, to either accept or decline.

The risks and benefits to individual residents were considered and discussed with the potential resident-participants before they were asked to review the consent forms. The main risk to resident-participants was in disclosing personal information that they would later regret because, for example, it caused embarrassment. Resident-participants in the study were reminded throughout the study that all information provided would be kept in the strictest confidence and coded to protect anonymity, and that they were able to review and comment on their contributions following the transcription of each interview and the different stages of data analysis. The benefits to resident-participants included the opportunity to share their thoughts and feelings in regard to their experiences during the first six months of Family Medicine residency training and knowing the information they contributed would lead to a better understanding of residents' learning needs.

At the study site a conveniently accessible interview room was used for interviews and focus groups; therefore, privacy was ensured so resident-participants could talk freely. Kvale (1996) reported that interviews should be conducted carefully and sensitively. Throughout the study, efforts were made to respect the resident-participants' demanding schedules. For example, at the beginning of each interview resident-participants were asked when their next commitment was to ensure sufficient time was set aside to organize the next interview, to address any questions and concerns, and to avoid introducing new topics so close to the end of the interview. It was also important, given the sometimes sensitive nature of the discussions and disclosures, to provide resident-participants with time for closure before they moved on to their next responsibility. The resident-participants were a valued and valuable part of the research process and outcome – not just a means to collect data.

*Study Resident-participants*

Eighteen resident-trainees agreed to take part in this study - six men and twelve women whom were doctors completing their two-year Family Medicine residency training at a hospital teaching site affiliated with the University of Toronto (Class of 2004, Class of 2005, and Class of 2006). The average age of the resident-participants was 28 years. The series of in-depth individual interviews were conducted with two men and three women who were incoming first year residents (Class of 2006). Two individual interviews were also held with one second-year resident (Class of 2004).

All study resident-participants completed their undergraduate medical training at a Canadian University. Two resident-participants completed undergraduate degrees at American Universities prior to applying for medical school in Canada. Two resident-

participants transferred from other medical specialties (Internal Medicine and Surgery) into Family Medicine. Two resident-participants were also concurrently enrolled in the Community Medicine Specialty program. As part of their five year residency to become Community Health physicians they needed to complete the two year Family Medicine residency before completing three years specializing in Community Health medicine.

*Data Collection*

I decided to begin the study by holding focus groups to develop themes, help articulate more focused areas for exploration, and later triangulate information with other data. Six focus groups were held between May and July 2004. Three focus groups were with incoming first year residents, two focus groups were held with residents at the end of their first year, and one focus group was with residents at the end of their second year. Although the ideal size for focus groups is four to eight people (Kitzinger, 1995), two of the focus groups had only two people. One of those focus groups was with the second year residents and the other focus group was with two incoming residents. The small numbers ended up being an advantage because the resident-participants met with me for a minimum of ninety minutes, were eager to share either their reflections or current experiences, and openly commented on each other's contributions.

In order to put the group at ease and build rapport, I began the initial interviews by asking resident-participants why they had chosen Family Medicine for their postgraduate training. This question naturally led to a discussion of what their experience had been or was like. Efforts were made to find a balance between ensuring that similar questions were asked of all the resident-participants and remaining open and responsive to the direction in which the resident-participants took the conversations. Reflection was

frequently used to encourage resident-participants to elaborate on their comments. An interview guide was initially created, but was quickly abandoned. The iterative approach meant many of the initial questions were no longer relevant. As well, if I listened carefully, reflected frequently, and occasionally interjected open-ended questions generated from previous transcripts, the resident-participants were able to give me rich descriptions.

Unfortunately, one of the focus groups with the incoming first year residents did not record well. Although there were two tape recorders going at all times, the inevitable happened where the wrong button was pushed on one recorder and the other recorder ran out of batteries. The interview was able to be partially transcribed and, because I was transcribing the interviews almost immediately after they were completed, I was able to write a summary of the interview while the general contents were still fresh.

The two incoming residents who were in a focus group together agreed to continue their participation by being interviewed individually. One of the second year resident-participants agreed to two subsequent in-depth individual interviews, which took place in May and June 2004. Five incoming first year resident-participants agreed to be interviewed; the individual interviews began in July for the incoming resident-participants (first month of their residency) and the last interview was held December 21st, 2004. Efforts were made to interview each resident-participant once monthly, which resulted in a total of 18 individual in-depth interviews. Most interviews lasted approximately ninety minutes, but ranged from sixty minutes to one hundred and twenty minutes.

I began most individual interviews with, "How has the past month been going?" This was purposefully done so the resident-participants had an opportunity to talk about what was important to them, rather than me deciding for them. Examples of some questions that were asked in most of the individual interviews are depicted below in Table 1.

Table 1

*Examples of Interview Questions*

- Describe a patient encounter.
- Describe a challenging situation.
- How has the past month been going?
- Do any moments stand out for you in the past month?
- Describe your approach to the clinical encounter.
- How do you think patients see you?
- What has it been like caring for your own patients?
- What are some of the good things about seeing returning patients? Not so good things?
- Describe your role in the doctor-patient relationship.
- What has been your biggest surprise? Frustration? Struggle?
- How have you changed in the past few months?
- Has your role changed?
- Describe your relationship with your supervisor.

During the transcription, which usually began within twenty-four hours of an interview, I documented comments, questions for clarification, and future lines of questioning. I reviewed these notes prior to beginning subsequent interviews. If I noticed a line of questioning in one interview that I had not raised in another interview, I

made a note to myself to include the question(s) at the next interview. As well, analysis began with transcription so the interviews were constantly being cross-referenced.

Approximately one quarter of the interviews were held over the telephone. Most of the telephone interviews occurred toward the end of the study when the resident-participants' schedules and commitments were becoming heavier. Although telephone interviews were not part of the initial design, it was important to honour the resident-participants' other commitments and to collect as much data as possible. Telephone interviewing is an important and common method of data collection and is often used for collecting sensitive data (Cohen et al., 2005). These interviews were conducted similarly to the face-to-face interviews in that the interview questions often emanated from previous interviews and results of data analysis. The interview was conducted using a speakerphone and was recorded.

It is worth mentioning that one first year resident-participant taking part in the individual interviews was very helpful in that all of the interviews lasted over ninety minutes and the individual was extremely articulate and contemplative. In fact, this individual commented several times about enjoying being a part of the study because it provided an opportunity to reflect and talk about the experience. There were also two in-depth interviews held with a second year resident-participant in May and July. Again, this particular resident-participant was very giving with time and met for two ninety-minute plus interviews. This second year resident-participant generously took the time to review and comment on early findings, which both helped validate the results and further refine directions for inquiry.

*Summary – Chapter 3*

This chapter provided a detailed account of the different considerations made in deciding how best to develop a deeper understanding of the early experiences of postgraduate training in a Family Medicine program.  A case study approach using individual and focus groups provided opportunities for resident-participants to share their stories and to reflect upon their experiences.  An overview of the recruitment process, ethical considerations and study resident-participants was provided to give the reader a further sense of context before moving to a discussion of findings.  While this chapter focused on the different decisions and choices in designing this study, the next chapter focuses on the decisions and choices related to analyzing and presenting the data.

**Chapter 4**

Decisions and Choices: Data Analysis and Presentation

This chapter begins with a discussion about the decisions around data analysis and ends with a discussion about the choices that were made to present the results of the analysis.

*Data Analysis*

The process of qualitative data analysis that I followed was based on the work of Miles & Huberman (1994). Their framework consists of four phases (a) data collection, (b) data reduction, (c) data display, and (d) conclusion drawing and verification. Miles & Huberman (1994) acknowledge the need for a researcher to be explicit about the procedures and thought processes used to analyze the data collected in a qualitative study in order to address concerns regarding validity and verifiability, while also recognizing that qualitative data analysis is considered an art, an intuitive process. A sample outline of the general framework used for data analysis is provided in Appendix J.

*Transcription*

I began data analysis with transcription. All of the interviews conducted for this study were recorded using two audio tape recorders and were fully transcribed from beginning to end by the researcher as soon as possible (usually within forty-eight hours), to encourage accurate recall and reflection. Patton (1990) encouraged immediate transcription for purposes of rigor and validity. The interviews were transcribed verbatim, including repetitive statements. Patton (1990) reported that verbatim transcription of recorded interviews provides the best database for analysis. Significant

pauses and emotional expressions such as laughter or sighing were typed in and bracketed. If there were areas of ambiguity or uncertainty in terms of what resident-participants said, they were contacted by telephone or e-mail for clarification while the interview was still fresh in their memory. Follow-up was needed in two different interviews with two different individuals.

In order to prepare the transcriptions for data analysis, the interviews were transcribed into a table where the interview was typed longitudinally in the left hand column, while the right hand column was left blank for coding purposes.

*Reading to Understand*

Data analysis was done after each interview was transcribed. Data analysis is inevitably interpretive because it is a reactive interaction between the researcher and the decontextualized data, which is in itself already an interpretation (Cohen et al., 2005). Efforts were made to minimize this effect by analyzing the data as soon as possible and comparing it with earlier findings. This way it was much easier to see where the data fit with previous analysis. Again, Patton (1990) recommended analysis after each interview because insights may be lost that affect interpretation.

The data were analyzed using a cross-case approach as opposed to individual case analysis. Cross-case analysis means grouping together answers to common questions from different people or analyzing different perspectives on central issues (Patton, 1990). This strategy was chosen because I was interested in better understanding the collective experience rather than focusing on individual variation of experience. Completed transcripts and early efforts at analysis were shared with both resident-participants and committee members for their input and feedback.

*Coding – Using the Categories of Concerns, Changes, and Influences*

As Miles & Huberman (1994) point out, qualitative data comes in the form of words rather than in numbers. The issue then is how to move from these words to data analysis. Glesne & Peshkin (1992) recommended liberally using matrices, graphs, flowcharts, and other sorts of visual representations to make meaning of the data. Taking my cue from these researchers, tables and charts were frequently used to organize the data and to deepen my understanding. These charts and tables are interspersed throughout the thesis to display my thinking during analysis.

Prior to even rereading the transcripts from beginning to end, stories about adjusting to responsibility had been noted as an underlying theme resonating throughout the focus groups and individual interviews; however, I decided to set aside this impression until more of the data had been analyzed.

Since the purpose of this research was to gain a better understanding of resident-participant's voiced experiences by exploring the resident-participants' concerns, changes to practice, and the influences they attributed to these changes, it made sense to begin by using these themes as sensitizing concepts to further organize the coded data. Sensitizing concepts are concepts that the analyst may inductively bring to the data (Patton, 1990). Sensitizing concepts give the analyst a general sense of reference and provide directions along which to look (Blumer, 1969). The role of sensitizing concepts in qualitative research is to help make sense of and present the data, but not to the point of forcing the analysis. The concepts used in this study were *Concerns*, *Changes*, and *Influences*. Concerns were considered the voiced challenges of the resident-participants during the first few months. Changes referred to what changes to practice or feelings occurred

during the first few months.  Influences referred to what and who influenced these changes to practice.

Discourse analysis is a systematic examination of the words and phrases used by research resident-participants for themes related to content, meaning, and tone (Patel, Kaurman & Arocha, 2000).   Meaning condensation is a form of discourse analysis. Meaning condensation was used in this study to code the data by abridging the voiced experiences expressed by the resident-participants into shorter formulations (Kavle, 1996).  Open coding and analysis of transcripts are ongoing and occurred after each focus group or interview.  Each narrative text was thoroughly examined looking for references to concerns, changes, and influences.

As I reviewed the transcripts, if I noticed the resident-participant was discussing a change, I would highlight the passage, reread it several times, and then lift the quote that captured the essence of the change and write it on a cue card for further analysis and reference.  As an example, one passage I reviewed was, "In addition to that, my biggest influence I think has been *watching how my staff physician interacts with patients* [italics added]".  I identified and wrote the italicized phrase on a cue card, along with the code word influences.  If a direct quote that captured the essence of the change was not apparent, the meaning of the passage was condensed into a few words.  For example, "She [supervisor] was the one that came up with telling me that I had a style that suited this particular patient and that's when I first starting thinking, 'Oh I have a style'".  The phrase '*supervisor's feedback*' was attributed to this passage and the concept influence would be attached to it.  Again, these phrases were recorded on cue cards for later analysis.

At the end of the study all of the data pertaining to the resident-participants' experiences had been identified and condensed. The cue cards were then sorted into piles marked Concerns, Changes, and Influences for easier management. Tables 2 to 4 depict examples of this early data analysis.

Table 2

*Sample of Early Data Analysis About Concern*

| Category of concern expressed by resident-participants | Number of times concern expressed |
| --- | --- |
| 1.  Knowledge | |
| • Needing to ask for help | 2 |
| • Feel bad about saying "I don't know" | 4 |
| • Feel uncomfortable with lack of knowledge | 10 |
| • Priority knowledge first, process second | 3 |
| • Biggest challenge | 2 |
| • Need to rely on own knowledge | 2 |
| 2.  Responsibility | |
| • To patient | 7 |
| • Signing prescriptions | 1 |
| • Expectations, seen as the expert | 1 |
| • Decision making | 8 |
| • Less supervision | 5 |
| • What if I get it wrong | 3 |
| • Medically legal | 8 |

Table 2 (continued)

| Category of concern expressed by resident-participants | Number of times concern expressed |
|---|---|
| 3.  Clinical interview | |
| • Content | |
| -Need to ask all the right questions | 6 |
| -Make right diagnosis | 18 |
| -Treatment and Management Plan | 12 |
| -Decision making about treatment and management plan | 6 |
| • Process | |
| -Multiple complaints | 7 |
| -How do you set an agenda; meet patient expectations | 12 |
| • Time Management | 20+ |
| -No organized approach | 1 |
| -Pressures | 1 |
| -Quick decisions | 1 |
| -Exhausting | 1 |
| -Resources, time consuming | 6 |
| 4.  Doctor-Patient Relationship | |
| • Patient | |
| -Building trust and confidence | 9 |
| -Meeting expectations – satisfaction | 8 |
| -Life context | 3 |
| -Making decisions without knowing patient | 3 |

Table 2 (continued)

| Category of concern expressed by resident-participants | Number of times concern expressed |
|---|---|
| • Physician | |
| -Concerned what patient thinks of me | 2 |
| -Finding a style/an approach | 2 |
| -Self-doubt/credibility | 5 |
| -Pretend you are confident | 5 |
| -Patients' problems affect me | 1 |
| -What if I get it wrong | 3 |
| -Adjust to relationships with other health care professionals | 7 |
| • Difficult patients/issues | |
| -Bad news | 4 |
| -Mental health issues | 4 |
| -Drug seeking | 5 |
| -Demanding patients | 5 |
| -Behaviour change | 1 |
| 5. Environment/Administrative - Adjustment | |
| • Waiting room | 1 |
| • Blood work/laboratory results | 3 |
| • Mailbox | 4 |
| • Consultation letters | 1 |
| • Computers | 3 |
| • Billings | 5 |
| • Discharge summaries | 1 |
| • Form filling | 1 |
| • Writing prescriptions | 4 |

Table 2 (continued)

| Category of concern expressed by resident-participants | Number of times concern expressed |
|---|---|
| • Family meetings | 1 |
| 6. Future Practice Management/Career/Life | |
| • Children | 1 |
| • Where and how am I going to practice | 1 |
| • I know nothing about the business end | 1 |

Table 3

*Sample of Early Data Analysis About Changes*

| Category of concern expressed by resident-participants | Number of times concern expressed |
|---|---|
| 1. Approach to Practice | |
| • Come in earlier | 4 |
| • Review chart ahead of time | 4 |
| • Get equipment ready | 4 |
| • Better note-taking – relevant, make end-note reminders | 3 |
| • Increased comfort with computers locating some resources, environment | 5 |
| 2. Approach to Medical Interview | |
| • Agenda setting better up front – actively seeking expectations – asking "What else?" | 5 |
| • Organization to history different | 2 |
| • More directive | 2 |
| • More limit setting/boundaries | 2 |

Table 3 (continued)

| Category of concern expressed by resident-participants | Number of times concern expressed |
|---|---|
| • Red flags/prioritizing/asking more focused questions | 10 |
| • Treatment/management plan more directive | 3 |
| 3. Knowledge | |
| • More comfortable/confident with knowledge | 2 |
| • Listen more in lectures | 1 |
| • No exams so do more focussed reading | 1 |
| • Increased confidence/comfort filling in for other doctors | 2 |
| 4. Approach to Doctor-Patient Relationships | |
| • Think more broadly, life context important | 7 |
| • Need different approaches | 3 |
| • Don't make assumptions/understand expectations | 5 |
| • Bring people back more comfortable | 6 |
| • Listen more – broadly hidden agenda | 5 |
| • More relaxed – I can use humour | 3 |
| • More reciprocal relationship | 2 |
| • Behaviour change difficult | 2 |
| • Importance of relationship | 1 |
| 5. Physician Identity and Development | |
| • I don't need to be the expert | 4 |
| • Fear of responsibility gone | 4 |
| • Being wrong is OK | 2 |
| • Setting boundaries | 1 |
| • Don't have power over patient's decisions | 1 |

Table 4

*Sample of Early Data Analysis About Influences*

| Category of concern expressed by resident-participants | Number of times concern expressed |
|---|---|
| 1. Continuity of Care | |
| • Recognize patients can come back | 6 |
| • Improves time management because | 5 |
| patients' past medical history and | |
| background | 3 |
| • Feel ownership of patients | 3 |
| • Can focus on patient – get to know | |
| medically/socially – build relationship | 3 |
| • Get so see outcomes of treatment and | |
| management plans | 2 |
| • Get confidence in wait and see approach | 1 |
| • Longitudinal, horizontal program- ownership | 1 |
| of patients | |
| 2. Experience | |
| • Patients | |
| -Repetition teaches the donkey – confidence | 5 |
| in knowledge | |
| -Recognize what's urgent, what's not | 3 |
| -Get through pivotal moments, i.e., death of | 1 |
| a patient | |
| -Recognize the importance of the doctor- | 3 |
| patient relationship | |
| -Recognize the need to understand a patient's | 3 |
| expectations/agendas | |

Table 4 (continued)

| Category of concern expressed by resident-participants | Number of times concern expressed |
|---|---|
| • Office practices | |
| -Mailbox – helps you realize what's urgent, what's not | 3 |
| -Familiar with office practices | 3 |
| -Better at filling out forms/requisitions/laboratory work | 2 |
| -Knowing expectations of staff/supervisors | 1 |
| -Writing prescriptions /pharmacy | 1 |
| -Time management – billing forms put in front of you, time slots go to 15 minutes, "makes you more mercenary and creative with how you manage time" | 1 |
| 3. Feedback | |
| • Patient/Family | 9 |
| -Being asked for an opinion | |
| -Patient satisfaction = greater confidence | |
| • Colleagues/health care professionals | 6 |
| -Supervisor feedback – positive or negative – includes verbal/observation | |
| -Watching supervisors in action | |
| 4. Role Modeling | 10 |
| • Home visits | |
| • Role modeling – positive or negative | |
| • Rotations – influence practice, watching others, getting feedback | |
| • Seminars and talks | |

*The Overarching Theme - Responsibility*

The next challenge was to construct categories or themes that captured some recurring pattern that cut across bulk the data (Taylor & Bogdan, 1984). The most common way of inductively creating categories and subcategories is to continuously compare all of the units of data noting patterns, making contrasts or comparisons, and clustering remarks and experiences, keeping in mind, categories in qualitative studies are conceptual elements that cover many individual examples of the category, (Miles & Huberman, 1994). Glesne & Peshkin (1992) also recommend using simple frequency counts to help identify patterns.

The category of concerns became the focus of attention because this category was created to reflect the resident-participants' voiced challenges and struggles as they made the transition into postgraduate training and therefore, most accurately captured the primary focus or preoccupations of the resident-participants. The content of Table 2 was reread alongside the binders of transcribed text several times to gain a deeper understanding of how the pieces of data fit together. By moving back and forth between Table 2 and the context of the stories through the text, a deeper level of understanding began to emerge. My initial impression that responsibility was central to the resident-participants' early experience seemed accurate. As I continued to move back and forth between the interview texts almost all of the data could be referenced back to the theme of adjusting to responsibility.

*The Sub Themes – Knowledge, Practice Management, and Relationships*

The next step was to deconstruct the category of concerns to see if, by using the theme of responsibility, further light could be shed on the data. Table 5 depicts how the resident-participants' concerns, when further analyzed, started to fall into the three sub themes of knowledge, practice management, and relationships. Items that had been assigned earlier to other subcategories under concern, such as responsibility, were re-analyzed and shifted to the new sub themes. For example, concerns that previously came under the heading responsibilities such as "writing prescriptions" and "medical legal responsibilities" were moved to the subcategory practice management and the subcategory knowledge.

Table 5

*Early Analysis of Adjusting to Responsibility in the Areas of Knowledge, Practice Management, and Relationships*

| Category of concern expressed by resident-participants | Number of times concern expressed |
|---|---|
| 1.  Knowledge – Content and Process | 100+ |
| • Medical legal responsibility | 8 |
| • Need to ask all the right questions | 6 |
| • Make right diagnosis | 18 |
| • Treatment and management plan | 20 |
| • Using knowledge to make decisions | 10 |
| • Priority knowledge first, process second | 4 |
| • Biggest challenge | 2 |
| • Need to rely on own knowledge | 2 |

| | |
|---|---|
| • Multiple complaints | 7 |
| • How do you set an agenda | 12 |
| • No organized approach to using knowledge | 11 |
| • Resources – time consuming | 6 |

| Category of concern expressed by resident-participants | Number of times concern expressed |
|---|---|
| 2. Relationships | |
| • Patient | 30+ |
| -Building trust and confidence | 9 |
| -Meeting expectations – satisfaction | 8 |
| -Responsible to patients | 7 |
| -Life context important | 3 |
| -Family expectations | 1 |
| -Making decisions without knowing patient | 3 |
| • Physician | 30+ |
| -Concerned with what patient thinks of me | 2 |
| -Seen as the expert and feel uncomfortable | 12 |
| -Finding a style/an approach | 2 |
| -Self doubt/credibility | 5 |
| -Needing to ask for help | 2 |
| -Feel bad saying "I don't know" | 4 |
| -Pretend you are confident | 5 |
| -Patient's problems affect me | 1 |
| -What if I get it wrong? | 5 |
| -Less supervision | 5 |
| -Adjust to relationships with other health care professionals | 7 |

Table 5 (continued)

| Category of concern expressed by resident-participants | Number of times concern expressed |
|---|---|
| • Difficult patients/issues | 20 |
| -Bad news | 4 |
| -Mental health issues | 4 |
| -Drug seeking | 5 |
| -Demanding patients | 5 |
| -Counselling about lifestyle change | 1 |
| 3. Practice Management | 30+ |
| • Writing and signing prescriptions | 2 |
| • Family meetings | 1 |
| • On-call medicine | 1 |
| • Telephone Medicine | 1 |
| • Waiting room | 1 |
| • Blood work/laboratory results | 3 |
| • Mailbox | 1 |
| • Time management | 16 |
| • Consultation letters | 1 |
| • Computers | 2 |
| • Billings | 3 |
| • Discharge summaries | 1 |
| • Form filling | 2 |

Although frequency counts were made during this stage of analysis to help further

understand the resident-participants' experience, the frequency counts were only one

variable considered when trying to interpret the meaning of the resident-participants'

experience.  It was the resident-participants' words taken in context that played the

central role in guiding further interpretation.  I used Tables 3 (Changes), 4 (Influences),

and 5 (Knowledge, Practice Management, and Relationships) along with the interview texts to further understand and establish the significance of the resident-participants' experiences.

Given the earlier analysis, it became clear that the resident-participants' concerns with adjusting to responsibility revolved around three sub themes: *knowledge*, *practice management,* and *relationships*. Knowledge included the resident-participants' level of knowledge (what they knew) and how they used their knowledge in the clinical context. Practice management related to environmental and administrative duties such as office procedures, computers, billing, charting, and time management. Finally, relationships referred to supervisors, health care professionals, peers, and patients.

One way of validating whether or not these new sub themes fit was to revisit the categories of changes and influences to see if the data items aligned with the new sub themes of knowledge, relationships, and practice management. The cue cards were used to locate the data bits in the interview texts and to review the surrounding context to help ensure that each data bit made sense and worked with the corresponding sub theme. For example, "Getting equipment ready prior to the appointment" referred to changes in the sub theme practice management and "Setting boundaries" referred to changes in the sub theme relationships. This process was repeated for each cue card that had been earlier identified as a change or influence.

 The categories of knowledge, practice management, and relationships were reviewed to ensure that the data located under each theme connected in a meaningful way and that the differences between themes were distinct and clear. Guba (1994, p. 128) suggests that two criteria, "internal homogeneity" and "external heterogeneity" should

judge themes or categories. All data seemed to fit in one of the three areas and there were very few overlapping or unassignable data items. Each area seemed to have internal and external plausibility (Patton, 1990), meaning the individual categories appeared to be consistent and each area seemed to comprise a whole picture.

*Data Presentation*

Once the data had been analyzed, deeper interpretation could begin and choices could be made about how to present the data and results. Unlike quantitative research, where numbers are often used to present the findings, there are no standard modes of presenting the results of interview studies. However, the aim of a qualitative report is to inform the reader of the importance and trustworthiness of the findings (Kavle, 1996). One way of doing this is by presenting the data using multiple methods that use a progressively narrow lens; moving from description to interpretation and finally to making inferences (Miles & Huberman, 1994). Patton (1990) contends that diagrams and charts are one of the best ways to make sense of data, to better conceptualize links, and draw conclusions. Miles & Huberman (1994, p.261.) write of moving up from the empirical trenches to a more conceptual overview of the landscape, where the researcher is no longer dealing with observables, but with unobservables and is connecting the two with "successive layers of inferential glue".

Most results of this study are included in a chart to further conceptualize the findings. As Miles & Huberman (1994, p. 22) claim "you know what you display" and constructing the charts in this study was a valuable way to organize and deepen my thinking. The charts were used as scaffolding to build a better understanding of how the resident-participants' experience of the first six months moved them toward becoming

Family Physicians. By repeatedly moving back and forth between the data displays and interview texts, it became clearer to me how the categories intersected and were related.

The charts were a useful device to visually present the results, as well as to describe the different themes, and to order the often complex relationships for better understanding. Using charts to display data can supplement the text by summarizing categories that were discussed (Glesne & Peshkin, 1992). The charts build upon one another enabling analysis to become progressively more interpretive at each stage. For example, the initial chart on responsibility is used as a way to organize, describe, and compare the resident-participants' perspective on responsibility during two different training junctures, whereas the final chart uses the previous findings to conceptualize causes and relationships.

*The Journal – Describing the Resident-participants' Experience From Their Perspective*

Patton (1990) suggests that an interesting and readable report provides sufficient description to allow the reader to understand the basis for further interpretation, and sufficient interpretation to allow the reader to understand the description. There are several ways qualitative researchers can do this. Journalistic interviews, dialogues, therapeutic case histories, narratives, metaphors, and visualizing are a few (Kvale, 1996). In this particular study, I wanted to better understand how resident-trainees experienced the first few months of their Family Medicine residency. What experiences did they comment on? How did they reconstruct or represent these experiences? What seemed important to them? As the interviews took place over a six-month period, what changes or transitions, if any, seemed to occur? Individual and focus group interviews were my primary source of data to answer these questions. The challenge was how to coherently

portray the scattered stories and different voices of the interviewees into a richer, more coherent composite (Kvale, 1996).

One way of handling this dilemma was by condensing the rich stories into one voice, which could be heard through a journal. By taking advantage of a journal format, I could make weekly entries that allowed me to chronologically portray and highlight the, often subtle, transitions and themes that emerged during analysis of the resident-participants' stories. Using this method as a starting point for displaying the data seemed a powerful way to represent the voices of the resident-participants without me subjugating their words. A journal provided a rich forum for illuminating the critical pieces of the transitional process and provided a contextual backdrop that may not have been captured using another descriptive method. By frequently moving back and forth between the journal entries and the transcribed text, a window was created into the resident-participants' experience.

Since all "telling" is an interpretation regardless of whose voice is heard and all interpretation is a fiction despite reliance on facts (Cole and Knowles, 2001), the completed journal was sent to the resident-participants via e-mail for feedback and validation. This was one way of increasing the trustworthiness of my interpretations and was used throughout the study (Glesne & Peshkin, 1992). Resident-participants were explicitly asked to read the journal for its accuracy and to ensure that although resident-participants may have recognized a story they had shared, the story was sufficiently disguised that the resident-participant was comfortable with its inclusion. Several, but not all resident-participants responded. Most comments were very positive in that they were amazed that their stories could be synthesized to reflect a common experience with

which they agreed. One resident-participant commented that an area had not been highlighted enough, while another resident-participant felt a different area had been highlighted too much. Most comments related to the authenticity of the journal in capturing their experience. This feedback helped validate the findings. Before making changes to the journal, relevant portions of the interview texts were reread to check for accuracy. Changes in emphasis in the journal were made based on this feedback. The revisions were so minor that the text was not re-circulated again.

*Concerns and Changes*

While description is an important component of qualitative analysis, description needs to be balanced by interpretation (Patton, 1990). The next step was to use direct quotes to both reconstruct and to give meaning to the resident-participants' early experience of responsibility during the transition to postgraduate training. The decision to rely heavily on quotes was made because it is one way of counteracting the limitation of a single interpreter. The researcher's interpretative decisions, choices, and process are explicitly laid out so the reader can make his or her own interpretation, alongside those of the researcher.

During data analysis, a code was created to follow each quote so the individual resident-participants could not be identified, but the piece of data could be located for later reference. The code refers to the type of interview, date, page number, and sometimes initial of the resident-participant. For example, (F; 8/23:12) refers to a focus group on August 23, page 12. If several resident-participants expressed almost identical thoughts or feelings, only one quote was used, but it was bracketed by several codes to highlight the frequency of the comment. Sometimes no quotes were used following an

interpretation of the data, but codes were used to support the interpretation or claim. These codes were used during the writing up of the study to ensure accuracy and to locate myself while reconstructing the story, but were removed during the final written presentation of the study because they became distracting. Subheadings were included to both highlight my findings and to guide the reader along the path of my thinking.

The quotes were used to recreate how the tensions and uncertainties of adjusting to responsibility in the areas of knowledge, practice management, and relationships chronologically enfolded during the first six months of training and then the analysis moved to presenting the subsequent changes that occurred over time. A chart is provided within this chapter to outline and compare the concerns the resident-participants felt they needed to adjust to as they made the transition into postgraduate training.

As with the journal, the results of this stage of analysis were e-mailed to the resident-participants for review. Study resident-participants were encouraged to read over the text and provide feedback. The response was not strong as only three study resident-participants offered comments. Again, most comments related to feelings of surprise that their personal interviews could be used to authentically recreate their story. One resident-participant commented that they recognized some of the quotes as emanating from their interviews, but felt comfortable with the level of anonymity.

*The Clinical Encounter*

Eraut (1994) emphasizes that the knowledge and ideas absorbed during undergraduate training take on new meaning when they are used in practice, so my research lens was narrowed again to take a more focused look at how the specific changes the resident-participants described in practice manifested themselves in the

clinical encounter. The clinical encounter was chosen to frame the next stage of analysis because it is in this context that the practice of Family Medicine is primarily experienced. It is the context in which resident-participants are responsible for using their knowledge, carrying out practice management tasks, and establishing relationships. The clinical encounter acts as a platform to demonstrate and conceptualize how the resident-participants' concerns initially revealed themselves in practice and how the subsequent changes that occurred enfolded in practice with patients.

The data were used for a more inductive search for how the categories manifested themselves in the context of everyday practice. The resident-participants' stories were heavily used to reconstruct how their experience of the clinical interview changes as their training progresses. In order to visualize the dramatic change the resident-participants described in their approach to the clinical encounter, a chart was created to conceptualize their descriptions. The chart entitled "The Clinical Interview" was sent to resident-participants for their input and feedback. It seemed particularly important to receive feedback about how the clinical interview was conceptualized as this analysis of the data felt like it involved more risk than the previous displays. Input from resident-participants included statements such as "Wow, this is true, but I had no idea you could get that from talking to me" and "That's cool". No feedback necessitated changes.

Miles & Huberman (1994) urge taking risks with the data as it forces one to begin to theorize about the social phenomenon under study. I considered the feedback from resident-participants particularly important to this study because the data had been used not only to interpret, but also to conceptualize how the resident-participants experienced the clinical interview (used their knowledge, developed relationships, and adjusted to

practice management tasks), both at the beginning and end of the six months.  Residents

and preceptors in a Family Medicine program will use the knowledge generated from this

study.  House (1977) suggests the more naturalistic the study, the more the study relies on

its audiences to reach their own conclusions, draw their own generalizations and make

their own interpretations.

*Influences*

The next stage of analysis was to flush out the role of influences in shaping the

changes to practice resident-participants had described in the previous chapter.  Guba

(1994) describes how, once the problem of convergence is dealt with (classifying data

into categories), the researcher needs to deal with divergence (fleshing out the

categories).  To better understand how the influences intersected with the changes that

occurred, I once again revisited the cue cards describing influences.  However, the cue

cards in isolation were not enough to make sense of the influences.  I needed to work

backwards.  I returned to the interview texts to provide context and then used the coded

quotes on the cue cards as a guide to begin making sense of how the influences

contributed to the changes the resident-participants described.  It started to become clear

that resident-participants were attributing five main types of influences to changing their

behaviour and attitudes including (a)  experience of practice, (b) continuity of care, (c)

the need to manage their time, (d) feedback, and (e) role modeling.

In reviewing the interview texts, I noted that sometimes an influence was

discussed in isolation, but usually an influence was discussed in relation to a concern or

change to practice that the resident-participant had made.  Quotes from the cue cards and

interview texts were used to substantiate the inferences and links that were made.  A chart

entitled "Influences that Shaped Change" was created to better visualize what influences contributed to what changes as the resident-participants adjusted to their new responsibilities in the areas of knowledge, relationships, and practice management. While I was creating this chart, I was moving back and forth between the cue cards, the tables, and the texts, asking myself questions such as, "Which came first, the change or the influence?", "When did this change occur?", "Was this change attributed to more than one Influence?", "Is this a Change to how they are working with their knowledge?", "Is this a Change to how they are viewing patients?", or "Did more than one person have this experience?" While this chart is not exhaustive, by condensing the data into key bits, it did give me a more holistic sense of the resident-participants' stories so I could begin to see more clearly the connections, patterns, and relationships that were occurring between the influences and changes.

While the Influences Chart leads off the discussion, this chapter concludes with another chart entitled "Conceptualizing the Transition from Undergraduate Medical Student to Postgraduate Family Medicine Resident". While the earlier Influences Chart focuses on what influences the resident-participants attribute to creating change, the subsequent chart takes interpretation of the findings further by conceptualizing how these influences shape and change the resident-participants during the first six months of practice.

*Forming an Identity*

During the final phase of data analysis, the findings from previous chapters are taken to a final interpretive level where they are used to synthesize the results into a coherent story that chronologically describes and highlights how the resident-

participants' experience of the first six months of postgraduate Family Medicine training both changes and shapes their identity. As with the earlier findings, a chart entitled "Learning to become a Family Physician" is used to capture the key points in this process.

*Summary – Chapter 4*

This chapter provided an overview of my decisions and choices in relation to the data analysis, and the presentation of the results. To summarize the data was transcribed and analyzed following each interview using a cross-case approach to better understand the collective experience of the resident-participants on the central issues. The themes Concerns, Changes and Influences attributed to changes were used to code the data. The coded data was moved to cue cards where meaning condensation was used to assign shorter formulations to the resident-participant's experiences. By moving back and forth between the data, first looking at the themes in isolation and then collectively, the subthemes of Knowledge, Practice Management and Relationships began to emerge. By deconstructing and then reconstructing the data it was clear that the resident-participant's collective experience of adjusting to Responsibility in these three areas was the core underlying theme that anchored their experience. Once the data had been analyzed, deeper interpretation took place in the form of data presentation. Multiple methods were used such as a journal, quotes and charts to progressively narrow the lens moving from description to interpretation and finally to make inferences.

This sets the stage for the next four chapters, which focus on presenting the findings of data analysis more comprehensively. The results will be presented using varying levels of description and interpretation and will build on the findings of the

proceeding chapters, successively narrowing the lens from providing a more nuanced understanding of the resident-participants' experience during the first six months of a postgraduate training to a more wholistic conceptualization of this experience.

# Chapter 5

## Description of Results

### *Construction of the Journal*

In this chapter, I will present the first iteration of the results using a journal format. I constructed tables using the themes of concerns, changes, and influences through the process of listening to the resident-participants' stories, and transcribing and analyzing the data. Although the resident-participants sometimes offered different examples to describe an experience, many of the stories were similar and there was often clear consensus during focus groups about the meaning of an experience.

As my understanding of the resident-participants' experience began to deepen, a decision needed to be made about how to weave the separate threads together into a tapestry that gave voice to the experience in both an authentic and meaningful way. Merriam (1988) stresses how a hallmark of case study research is its ability, through rich description, to provide the reader (the outsider) with the experience of having vicariously been there. A personal journal became a way of realistically describing the first six months of postgraduate training from the resident-participants' perspective.

Although descriptive accounts are probably the most basic form of presenting data, they still involve thinking about what will and will not be included out of hundreds of pages of data. This study was no exception. I wrestled with the question, "What did I want to represent and communicate through the journal?" Sometimes the choice was very clear. For example, undergraduate training played an important role in how the resident-participants understood their current experiences. Other times, the choices were not so clear-cut and I had to make decisions.

In the end, I decided I wanted to take few liberties with the data to stay as close to the voices of the physician's as possible. I wanted to bring as much authenticity to the meanings expressed to me as possible. While many entries in the journal are almost verbatim from the transcripts, I took little editorial license. Some stylistic variations between the different voices have been edited to make it seem as one voice. My fingerprint is probably most evident in the sequence of the journal entries. Despite remarkably similar themes, no two physicians were identical in the telling or sequence of stories.

I reviewed individual transcripts a minimum of ten times, paying close attention to the timing of experiences, either verbally identified by the physician during the interview or by the date on the transcript. I was conscious when writing the journal of trying to synchronize as closely as possible the timing of stories with the date of entry. As well, in terms of bringing a deeper level of authenticity to the context of the journal, there is reference to different rotations, which mirror the rotations any physician, anywhere, completing a Family Medicine residency program would experience.

The voice of the journal (Alex Adams, age 28) is a composite of the voices of the resident-participants in the study. The age was chosen to reflect the average age of the resident-participants. A name that was not similar to any of the resident-participants was chosen to protect confidentiality and provide greater anonymity. A gender-neutral name was deliberately chosen to author the journal. Very few, if any, gender specific issues emerged from the data. This may be because this study did not specifically focus its lens on gender issues related to the residency experience. This could also be because the medical training experience itself tends to produce gender-neutral physicians (Beagan,

2000). As the data did not exclusively support a female or male perspective, choosing a gender-neutral name seemed to be the best decision. In this way, the voice of the journal would be more inclusive and reflect the experiences of a typical physician in a Family Medicine residency program.

Of course, not all experiences were similar or told in the same way or during the same time frame. I deliberately have Alex refer to peers to highlight these differences. In this particular Family Medicine residency program, regardless of what rotation Alex is currently on, he/she spends a minimum of three half-days in the Family Medicine Clinic. Alex's educational background reflects the experience of most Family Medicine resident-participants. Alex completed a 3- or 4-year degree (usually in the sciences) at a recognized university and then applied to medical school. Alex then completed a four-year undergraduate medical degree, which consisted of two years of primarily didactic learning followed by two years of a clinical clerkship, which was primarily an in-hospital experience. Alex graduated with an MD (medical doctor) degree. In order to be licensed to practice as a Family Physician in Canada, Alex now has to complete two years of a supervised residency program.

The following passages represent the personal journal entries of a Family Medicine resident-participant which were used to construct a composite picture of the first six months of his/her Family Medicine residency program. The entries are presented in a different font (Arial) to indicate that they portray the reflections and perspectives of a typical physician beginning his or her postgraduate training as opposed to the reflections of the researcher. A deeper interpretation and discussion of the findings will be discussed in subsequent chapters.

*Journal - "Lo and Behold, I am the Doctor"*

**July 8 20XX**

It's the night before my first official day as a Family Medicine resident-participant. I can't believe that just two short months ago I was a clinical clerk. Albeit a senior medical student, but still regarded as a student. Now I am a doctor. I have to keep saying it to myself to believe it, because I don't feel like a doctor. I worked hard in school, but there is a difference between earning a degree that says you have the qualifications to be called a medical doctor and being a doctor. … a real life practicing Dr.

I am so excited, but terrified at the same time. It's been a long road to get to this point. When I took the plane from Halifax it was the first time I was stepping on the plane as Dr. Adams. All I could think of during the entire flight was what if the dreaded "Is there a doctor on the plane?" announcement comes on? I'm going to have to step up and identify myself. There is so much responsibility with being a doctor. People expect certain things from you … like helping them … curing them. I sat there thinking, "Oh, no, I'm not ready for this." As I was getting on the plane, I realized there was an internist on board that I vaguely knew. As he walked down the aisle, I started giggling and said, "I'm so happy you are here." I'm sure he wondered who I was and what I was thinking! Great start.

**July 9**

It's finally the end of the first week! My head is swimming. I spent most of the week sitting in on orientation meetings learning about expectations regarding the program, on-call, home-visits, the computer and how to bill. We got a tour of the hospital and clinic, reviewed what seemed like endless numbers of forms and learned about something called the mailbox where lab results and blood work are put everyday. Never mind the millions of new faces I met. At this particular teaching hospital, I am going to be in the Family Medicine clinic three half days a week for the next two years and doing one-month rotations through different specialties. It was so exciting … every time I saw a patient I thought I am going to be caring for you for the next two years.

I had so many firsts as a *real* doctor this week … I saw my first patient, answered my first page and made my first diagnosis and treatment plan (okay, with my supervisor's blessing). I

know I did some of these things as a clerk, but this time I'm the doctor.  I have medical legal responsibilities.  There are consequences to my decisions now.  Ahh …

It's weird introducing myself as Dr. Adams. I was telling one of my friends earlier in the week, I don't know whether I am trying to convince the patient or convince myself  who I am.  At the end of a couple of appointments, patients asked when they were going to be seen by the doctor.  I was a little deflated.  I'm not sure who they thought I was.  I felt a great deal of satisfaction saying, "I'm the doctor". I definitely feel like I have more legitimacy being a resident-participant.  I can definitely feel the power differential between doctor and patient that they talked about in the textbooks.  As a student I felt like the patient and I were basically on the same level.  We both looked at my supervisor for the answers!

I'm doing my obstetrical rotation right now.  I haven't done obstetrics in two years.  I have pretty much forgotten everything I knew about obstetrics.  It's a challenge to recall everything I learned and use that knowledge in the role of a more senior medical person.

One of the first things I am going to do with my pay cheque is buy some professional clothes.  I want patients to know that I think my role is important and I take it seriously. There's different ways of displaying your maturity and being professional even if your face doesn't display the wrinkles of experience.

**July 16**

It's been another long week. Although I saw a few patients last week, this is our first real week with clinics and everything.   I'm surprised they only give us 30 minute appointment times. It took me five minutes just to figure out if my patient was in the waiting room or not and another 10 minutes to figure out how to log onto the computer.  I had this one patient who needed blood work.  By the time I got the right requisition together the patient could have taken her own blood. Being unfamiliar with the setup of the clinic doesn't do much for my confidence.  Right now everything, including finding the washroom seems like a challenge.

I wrote my first prescription this week.  It was for eight Tylenol two's.  A narcotic … Even though it was only for a few tablets, I don't think I was psychologically prepared.  I was thinking inside, "No, no I'm not qualified yet.  What if they overdose? What if I'm starting this person on the

road to addiction?" I was afraid I wouldn't fill the prescription out properly, or they would get to

the pharmacy and the pharmacist wouldn't be able to understand it and then need to contact me,

but not get hold of me. I actually reviewed how to use the Tylenol's with the patient twice and

carefully wrote all of the directions again in the chart. It was a bit of overkill and I'm sure the

patient wondered if I knew what I was doing. I just want to make sure I'm doing the right thing and

not make any mistakes. I have to make sure I think of all the medical-legal implications.

I remember when I did emergency shifts as a clerk. My supervisor would always say to the

patient, "You need to be followed up by your family doctor". *Lo and behold*, now I'm it. I'm that

person. I'm the Family Physician. And that means I'm responsible for everything about the

patient. Not just follow-up on his sprained ankle, but the drinking problem that led to his injury

and subsequent high blood pressure.

**July 23**

There is definitely a weight that comes with the doctor title. What sort of doctor is thinking to

himself or herself, "I just don't want to kill anybody"? I need to portray confidence to the patient

so they will trust me, but underneath I am thinking, "Please don't let me make a bad decision that

hurts somebody." I know I'm not the only one who's thinking this way. Charlotte told me the

other day she just repeats the mantra "Do no harm" to herself just before she gives the patient a

treatment and management plan. We talked about how being on-call at night and doing

telephone medicine is the worst. You have to answer telephone calls from patients you don't

know anything about and you can't see the patient to decide if they're really sick. It's stressful

deciding what to do and it's even more stressful deciding whether you should call your supervisor

at 2:00 am for advice or just wait. I think three times before I pick up the phone. And what if you

don't call, make the wrong decision and the patient crashes? Who's responsible then? In

clerkship it was an easy way out to say, "I'm just a student. I'm going to defer to the resident or

staff person to answer that question". I don't have a default option or backdoor anymore. Forget

trying to "do good", the focus is just on trying *not* to make a decision that harms somebody.

**July 30**

I'm realizing there is a definite downside to calling myself Dr. Adams. Sometimes, I feel really bad saying "I don't know" to patients because patients expect more of me than they did as a medical clerk. Now that I am the doctor, they see me as the expert. Patients are asking for my opinion all the time. "Doctor, what do you think of this?" "Doctor, do you think I should do that?" I notice patients listen very attentively to what I say. I certainly don't recall that happening in clerkship. Sometimes the patients barely acknowledged I was in the room. You can tell some patients hang off your every word and are going to go right home to put your advice into action. It's very daunting. You have to be really careful what you say. It makes you want to appear confident to fulfill their expectations and build that trusting relationship, but the pressure inside to get it right is enormous. I have to remind myself that I am still a student and learning. Patients seem to have this perception that doctors know everything … Well, I don't! I could really hurt somebody.

There is just so much medical information to know and manage on so many different levels. It's not like the algorithms and decision trees we studied in school. I had no idea that simple blood pressure could present in so many different ways. Just as I think I understand, another patient comes in with yet a different presentation. I feel like I will never know all I'm supposed to. It helps if you have an understanding supervisor who comments on the good things you've done. I hate it when I have a supervisor who comes barging into the room and just takes over. I had that happen the other day. I'm already feeling inadequate having to step out of the room and ask. I never tell the patient I don't know. I just say I need to confirm something with my supervisor and step out. When I come back in, I try to confidently present the treatment and management plan, as if my supervisor just confirmed my ideas. When this particular supervisor came barging into the room without me asking for that kind of help, it just made me feel worse. How am I supposed to build any trusting relationship with the patient?

**August 6**

I feel this tremendous sense of responsibility in terms of caring for the patient as a person that I didn't feel as a clerk. In clerkship, I often didn't see a patient more than once so the idea of developing a relationship or getting to know them beyond their disease presentation wasn't really

on my radar screen. Patients didn't see me as their doctor and I didn't see them as my patients. I saw myself as this kind of cheerful medical student. The patient knew I was going to go and regurgitate everything back to my supervisor and it was that person who was *really* going to decide the treatment and management plan, not me.  In my last year, I might be asked to come up with a tentative management plan, but it was expected that I didn't know what to do. I certainly didn't feel the same sense of responsibility towards patients or ownership of the relationship that I do now.

If the truth must be known, I wasn't all that concerned what patients thought of me in clerkship.  It sounds crass, but sometimes I wasn't even worried about whether I was improving the patient's condition or not so much as I was just worried about learning all I could about the science, how to diagnose and what my supervisor thought of me. My job was just to get information and to fulfill my supervisor's expectations. Clinical clerkship in my mind was all about getting an education where residency is about doing an apprenticeship, on-the-job training.  I'm responsible for following these patients for the next two years.  I'm concerned now about building a trusting, working relationship with the patient. I worry about whether what I am doing for patients is the right form of management or treatment and whether it is going to have a good or bad effect.  Worries, I didn't necessarily feel before.

**August 13**

I'm doing my geriatric inpatient rotation right now.  I did not expect to have so much independence especially around decision-making.  I am responsible for a large number of acute care patients whom I know nothing about.  Last night the nurse called at 3:00 am expecting me to make a decision.  I couldn't even suggest that they send the patient to emerg because they were already in the hospital!  During clerkship, I couldn't make a move without someone checking on me. Now sometimes I'm responsible for making decisions without asking anybody. I was comparing notes with some of the other resident-participants yesterday wondering if they feel as overwhelmed as I do. Sam says he doesn't find residency that different from clerkship in terms of the expectations around decision making.  He had a fair bit of responsibility for decision-making about patients in clerkship.  We did our undergraduate training at different medical schools so

maybe that makes a difference.  Charlotte did her medical school training elsewhere again and says she just wishes the supervisor would just tell her what to do rather than encouraging her to think about it.  Charlotte says she was rarely responsible for making diagnosis or treatment or management decisions about the patient as a clerk and finds it very stressful right now. I'm somewhere in the middle. I can't decide whether I like it when somebody basically micromanages my treatment plans or not.  I like trying to make the decision and then double checking with my supervisor to make sure I got it right.

The novelty of being a doctor has lost a little of its shine.  I didn't realize how time consuming all of the practice management issues were like writing orders, filling out prescriptions, calling pharmacies, filling out paperwork, reviewing lab results and writing consultation notes.  I knew being a physician wasn't necessarily a nine to five job, but I didn't know it was going to be a 24-hour job.  I see my patients during the day, go home at seven after I finish charting and then sit and ruminate about all my potential mistakes until the next morning.  I don't think I can sustain this level of anxiety.  I saw a patient this week that had been in a-fib.  The diagnosis was new and he hadn't been anticoagulated yet.  He came in saying he had been feeling unwell.  Although his cardiologist was across town, I discussed the situation with my supervisor and we decided it was best to send him directly to his cardiologist rather than try to treat him in the office or send him to emerg.  His specialist had all of his records and already knew him.  I spent the rest of the day and night thinking "Did I do the right thing by telling him to get in his car and what if … what if there was a 10 car pile up and it was all my fault??" It helps to know I'm not the only one sitting at home second-guessing myself.  My friend Charlotte says she feels the same pressure and that she hasn't gone a week yet without having to call at least two patients back to check on something or change orders she's given.  Misery loves company!

**August 20**

A lot of the time I just feel like I am treading water and trying not to drown.  I suppose thirty minutes seems like a long time to see a patient, but when the patient is new and has multiple medical problems, it seems to evaporate in a blink of an eye.  Sometimes I don't even know where to start. Half my energy is focused on not showing patients how insecure I feel and that

sometimes I don't have a clue what to do.   The other half of my energy is focused on trying to

figure out what's wrong with them so I don't do more harm than good.  That's my medical-legal

responsibility, but when they have so many problems, I just get overwhelmed.  It was so much

easier in clerkship when the supervisor sent us in with instructions to take a focused history of

this guy's stomach problem or get a comprehensive headache history.  Now I don't know where

to focus my questions.  I don't know how to organize what I know.  Should I take a

comprehensive history of their fatigue?  Focus on their headaches?  What about their back pain?

It seems like almost every patient is new so I need to take time to find out a little bit about them.

Once I have gotten the information, I have to decide what I am going to do. I can't even imagine

doing this in 15 minutes.  I am nowhere near to having any sort of organized approach to

managing the interview.  Heaven forbid they have a mental health problem.  I may as well throw

in the towel.  Meanwhile there is a video camera pointed at you in the room … not only the patient

thinks I'm an idiot, my supervisor gets to watch me being an idiot.

Speaking of supervisors, there seems to be as many different styles of supervisors as there

are patients.  Just like working with patients, I am learning to improvise and adapt my style to

whatever supervisor I have.  If my supervisor seems to value a more patient-centered approach,

in chart review I tend to highlight those moments.  If the supervisor seems to be more evidenced-

based in their approach, I tend to focus my report on the medical aspects of the encounter.  It

doesn't really change what I do in the actual office visit; it just changes how I report the

encounter.  What supervisor is on can also make a big difference in how my day goes.  There are

supervisors who give me just a little bit too much freedom in decision-making and that just

unnerves me, rather than building my confidence.  There's the supervisor who tells me what to do

when I already know the answer and that's plain irritating.  I like the supervisor who asks for my

opinion first and then suggests alternative ways of thinking about something.  It's great when I get

specific constructive feedback especially on procedural skills.  And it's great when I get specific

positive feedback.  It's so confidence boosting.  My goal for after Christmas is not to be so

dependent on the supervisor.  I'm going to aim to have a clear treatment and management plan in

mind before I consult. It's too easy to start completely relying on your supervisor for decision-making. After Christmas I will have completed ¼ of my Family Medicine program!

**August 27**

In clerkship you always had the safety net of somebody else making the final decisions. The senior doctor would basically tell you what to do and you would write the orders out. You never felt like you could have possibly done anything wrong *or* right because it was ultimately someone else's decision. Now I am making decisions on my own and there are real life consequences. I have to rely on myself. I keep thinking, "Did I do the right thing?" "Should I call the patient back?" Even though you have access to your supervisor throughout the day and your patients are discussed during chart review, I still go home thinking maybe I should have done something differently. My threshold for uncertainty is very low right now. I'm beginning to realize that as the primary care physician I may always feel this way. I just hope the anxiety attached to feeling so responsible becomes more manageable. It must, because it's not like there aren't doctors out there functioning on a day to day basis. I remember an emerg physician once saying to me, "You are going to make mistakes. You are going to miss things. That's okay, just make sure you learned from your mistake and don't let it happen again."

I had coffee with Sam the other day and he says he never tells patients he doesn't know. He just says, "Hmm, let me check this out" or "I think this warrants a second opinion". That way he says, patients never know that you don't know and you can still maintain their trust and appear confident. I didn't want to tell him that was one of the first things I figured out how to do!

During chart rounds at the end of the day, one of my supervisors compared and contrasted my style with the last resident-participant who had this certain patient. She commented that my style might work better with this particular patient. I never really thought of myself as having a "style" with patients. That comment kind of put me on a different professional plane. Okay, "I" have a style. I have a way of interacting with patients that is unique and my own. I know I have always watched other doctors in action and tried to emulate some of the approaches that I thought were good, but her comment kind of shocked me. I had never thought of myself as really having a style, a professional style. But now that I am a doctor, and I have my own patients, I can

see that.  I really like this supervisor.  She's good at giving feedback without crushing you.  Also she gives you compliments.  You gotta like that.

**September 3**

    We practiced communication scenarios in undergrad, but it was always how to handle the initial appointment, not how to manage the ongoing relationship.  I don't know whether it's because I'm doing my residency in a big city, but I never realized how prevalent difficult patients were in a family practice.  When I say "difficult" I mean those patients who are drug seeking, inappropriate with boundaries, angry no matter what you do, have addiction problems or mental health problems …Ugh !!!  In clerkship you were only on a rotation for a month or so, so rarely saw the same patient more than once.  I just grit my teeth when I see someone who I've seen before and was a problem in the waiting room or on my patient list for the day.  There is definitely a downside to continuity of care.  Challenging patients come back!  I never really had to worry about seeing difficult patients on an ongoing basis.  I haven't had my rotation in psychiatry yet and I can hardly wait. I could definitely use the knowledge and experience.  The four weeks I had in clerkship certainly wasn't enough time to give me the assessment and communication skills I seem to need on an almost daily basis in family practice.

    I did my first home-visit this week.  It was to see this older guy who had end stage renal disease because of diabetes.  It was really an eye opening experience because I had seen him in the clinic on different occasions.  I thought I had been really good at taking his social situation into consideration when I was giving him my treatment and management plans, but obviously not.  He was still non-compliant with medication and having difficulty making it to appointments on time.  After I saw him in his own home I definitely had a deeper appreciation for the bigger picture.  One of the things I realized was I needed to involve his son more, which I hadn't even considered before.   It's too bad I couldn't do one home-visit on all my family practice patients because it definitely improves your ability to care for them. I've started to empathize with some of my more complicated patients that I want to see them back more often.  That way I can find out over time how all the pieces of their illness and life fit together.

I am looking forward to the day I feel comfortable with my knowledge level! I hate not knowing and pretending to feel confident about something. It's time consuming having to leave the patient to look something up or find a supervisor. Sometimes when I am confident with a topic, I don't know how to use what I know. I had this patient with a new diagnosis of diabetes the other day. I must have spent fifteen minutes talking non-stop about everything I felt he should know about diabetes. I wasn't sure what the really important pieces were for him to know in that appointment, but I didn't want to miss anything. Rather than giving comprehensive care, I think I just overwhelmed him! He looked a little dazed walking out.

**September 10**

I had one of those landmark or pivotal moments this week. I lost my first patient. It was a patient I had become very close to. While it wasn't shocking that he died, it wasn't expected either. It was a lot more difficult than I anticipated. When the nurse phoned me at 4:00 in the morning to tell me he had no vitals, I said, "No vitals? What do you mean? How bad are they?" People talk about their life flashing in front of them just before they are going to die. I think it's a similar experience for a doctor when your patient dies. All of my treatment and management decisions immediately flashed before me. Should I have ordered this test? Or that test? Should I have ordered more blood cultures? Should I have been checking up more frequently? Should I have done anything differently? Did I miss something?

After the nurse hung up, I just lay in bed and thought about these things. And then I realized I had to call his wife and family. All of a sudden a whole new set of questions were rolling through my head. What would be the best time to call her? Should I wait … maybe she was alone? How would she handle it? I didn't want her to rush to the hospital at 5:00 in the morning half asleep in a highly emotional state. And then I started thinking again specifically about the last 24 hours of his care. Should I have done anything differently? I assumed his wife would ask me the same questions I was asking myself and I needed to have answers ready. When I finally did call his wife I didn't blurt it out, but I delivered the news as quickly as possible. She was immediately upset and I kept saying that I am so sorry and that he passed away peacefully. I remembered to

ask her if there was anybody with her, which there was. She thanked me for calling and hung up. I guess there wasn't really too much else to say at that point.

The next day was hard. It was difficult to come back into the hospital and focus on my other patients. I felt like I had taken a blow to my confidence and I was preoccupied emotionally. I really wanted to talk with my supervisor and tell her what had happened. I wanted to go over everything to make sure I hadn't missed anything. She was incredibly supportive. I called the wife later in the day to see how she was making out. I was bracing myself for her to be asking me all the questions I was asking myself which turned out to be ridiculous. Those questions weren't even on her mind. All she wanted to do was thank me! I was kind of shocked, but comforted. I guess it just goes to show you, if you treat people with compassion and respect, they appreciate that you have done your best and don't blame you, but I was still thinking in the back of my mind, "Was my best good enough"?

One of the things that really bothered me about this experience is that I had seen this gentleman earlier in the day and I had a bad feeling about him. Even now, I can't put my finger on anything specific. I just intuitively felt like he wasn't doing well. If I could have found something concrete, would that have made a difference? Also, I was a little annoyed with the nursing staff. I had ordered a urinalysis three times and it was never done. Maybe it would have shed some light, maybe not. I read the nurse's chart, they should have read what I charted. I was at the helm of his care. I was the one in the hospital every day checking on him and organizing family meetings. At the end of the day, I am the one ultimately responsible. I feel a little bit like it is "my patient" that lives or dies. I guess I should have been a little more assertive around making sure I got those results. The doctor-nurse relationship is difficult to navigate.

Often in clerkship you can really be kind of crapped on by nursing staff, but I don't blame them because you are usually in the way, hanging around without a real role. You can't really do anything constructive for them. You can't write orders independently, you can't find stuff, so you are like a complete impediment. But then in residency, that all changes. Suddenly they are looking to you to call the shots and be responsible for the direction in management. You are usually the first one called and often your supervisor isn't around so you need to make the

decisions.  I learned a good lesson the other day.  I was in my Family Medicine clinic, but was

also on the Family Inpatient service.  This nurse paged me and said the patient's blood pressure

was dropping.  I raced up only to find his blood pressure hadn't changed that much.  At first I

started to get annoyed, but then I caught myself.  I thought, okay if I show that I'm annoyed and

question this person's judgment, then next time they may not call me and that may be the time I

should really know about it.  I might be burning an important bridge. I know if I called my

supervisor and got crapped on because they thought I was worried over nothing, that's just going

to make me second guess myself the next time I might need to call.  And there will be a next time.

They say you have a teaching role in residency, but I never really considered it would be with

other health care professionals.  I now make a point to thank the nurse every time and if I have to,

I focus the discussion on communication and expectations rather than her judgment.  I've seen

too many physicians' just "diss" the nurse in a really disrespectful way and I don't think that's

right.  We're all in this together.  Besides there have been some moments when nurses have

saved my behind.

I am going to bed now.  I couldn't sleep a moment ago and suddenly I feel very tired.  I

obviously need to purge myself of the last 24 hours.  Beats the junk food I usually consume after

emotionally draining days.

**September 17**

I thought I would feel a little more comfortable with being a doctor by now, but there is just so

much to know.  I'm continually getting hit with that.  We had a seminar on hypertension the other

day.  You would think that I would be completely comfortable dealing with hypertension by now.

It's not like I don't have any knowledge base.  I just spent four years of my life learning this stuff.

In fact, this is like the second time around. But there are so many different ways that people

present with hypertension … Like yesterday, I had someone with hypertension and diabetes, as

well as, someone with hypertension and nasal congestion.  The treatment and management

plans had to be completely different.  I had to think about all these different things. I can read

about hypertension in a book and that's great, but somehow until I see the different permutations

and slight nuances it's difficult to see how I apply the knowledge that I read.  I keep telling myself

that I will feel more comfortable as time goes on, but everyday is different so it's hard to imagine that day coming. Sometimes I panic when I think of the program only being two years. How can anybody confidently learn all there is to know in two years ???

Maybe in another six months from now I will have seen enough different cases of hypertension to feel more comfortable. That'll be great on so many levels. I'll have more confidence in myself and wake up every morning feeling like *I do know* what I am doing. I won't have to pop out of my office to ask for help so the patient will feel more confident in me. I will be more time efficient. If I don't have to pop out of the room and think so hard about what I need to do, I'll have more time to listen to the patient about other things.

A specialist is lucky. They just have to know about one part of the body really well and their responsibility ends there, whereas, I am responsible for the whole picture. The specialist just jumps in at a certain point, does a consultation, "This is angina" or "This is endometriosis", whereas the Family Physician never steps out. They don't need to care that the patient's relationship just ended or that they have depression. A specialist doesn't have to "walk" with the patient, the way I do.

**September 24**

This has been a tough rotation. I had to break bad news again this week. It doesn't get any easier. I admitted this patient for one thing, only to discover close to discharge that he had inoperable pancreatic cancer. The whole case was complicated because of the family dynamics. The patient's son had just lost his wife to breast cancer a few months earlier. What really struck me during the past week was just how much patients and families look to you for everything. "Is he going to die?" "Is he in pain?' "Are we doing all we can?" I realize in these situations you need to be a listener, then a talker. The family needed to vent because they were going through a terrible time. At one point, I was totally preoccupied thinking this family may sue because their father was admitted for one thing, but ended up having another. They never even mentioned that. They were just grateful that they could talk with me and appreciated the care I was giving their father. It reminded me a little bit of the earlier situation I had where the husband died and I thought the wife would have all these tough questions, but she didn't. Both families just wanted to

be heard and know their loved one was receiving good care.  In a strange way it made me feel good to be needed that way, but if I am honest with myself it was not what I expected.

I've had to deliver bad news a few times now … by myself … I'm realizing that when you have bad news to deliver, if you try to deliver it in the most humane and sensitive way possible that you can walk away feeling good. When you deliver the news there is no way that you can change the diagnosis.  But you can be there for the patient and family.  You can help them come to terms with it and move on from there.  I think the doctor has enormous power at that moment. I can either drop the ball or really help make a difference to the patient and family.

I did have a patient say to me this week, "Thank you so much.  I really enjoy coming to see you."  I thought, "You mean me?  You like to come see me?"  I almost looked around to see who else was in the room.  That felt so good!

**October 1**

I had an "Oh, my God, this is what it means to be a doctor" moment today.  I was in teaching rounds for my paediatric rotation.  They were having "morbidity and mortality" rounds, where they were discussing the death of a 3-year-old girl.  Essentially, this little girl came in to emergency in crisis because of an accidental medication overdose, but it wasn't recognized until too late and she ended up dying.  There were a lot of people in the room who had been involved and a lot of other people who were sort of experts, asking a lot of difficult questions.  They had a picture of the girl post mortem pinned up for everybody to see.  It made the talks even more poignant because she still had her pigtails in.  Just the intensity of being a physician in that room, to have cared for her unsuccessfully and to have the judging eyes of your peers on you … the responsibility of being a physician is enormous.  I wasn't involved, but I still felt the weight in that room. Good God, this is a tough job.

I had this patient today that I started seeing the 2nd week I was here.  I thought at the time there was something just not quite right about him, but I couldn't put my finger on it.  I was just starting to build a relationship so I didn't want to ask him about psychiatric issues.  I just focused on his abdominal pain and the management. But little by little I got to know him, and by the fourth visit, realized he is living in a shelter and has lots of other issues going.  I thought "Wow, I've

really built something with this guy and I knew there was something else going on". Three months ago I wouldn't have thought twice about a patient with abdominal pain looking not quite right. I would have thought "Oh, they are just here for abdominal pain; that's my focus. I'll never see him again and move on". I guess it's my clerkship hangover or reflex kicking in. Now, I really want to be sure this guy is doing all right. It's hard to find the balance between being overly focused on one thing to the exclusion of all others, and trying to handle all the issues in one visit.

**October 8**

I'm definitely enjoying my residency experience more than my clerkship. I feel like I have more of a sense of purpose. Even though residency has a lot of responsibility and stress, I have a job to do that's going to make a difference and have an impact, whereas before I never really thought I had much of an important role other than to learn for myself. Now I feel like I am it. I saw this woman for prenatal care, delivered her baby and am now providing care for the mother, husband and baby. It's just as rewarding getting involved with the family of elderly patients. I absolutely love that. I didn't realize just how much I would enjoy working with families and seeing patients at different stages in the "life cycle". I really feel like I'm making a positive difference in people's lives and that feels very, very satisfying!

Another great thing about residency is I get to read what I want to read! One of the hardest things about being a clerk was having to read 400 page textbooks on some kind of topic that didn't seem very relevant. How was it going to apply or help me later? It reminded me of high school when I had to memorize all these math formulas and thought, "When am I ever going to use these again?" Now when I read, it's for my own benefit. Disease presentations don't translate well from textbooks. I have to see it before I can really understand it. I see people in the clinic and realize I don't know enough about this or that, so I go home and look it up. But it's different. It's reading with a purpose.

**October 15**

I went home for a week's holiday. It was incredibly relaxing. I was a little surprised at how quickly I was able to separate myself from work. I don't feel as time pressured and stressed as I

did in clerkship so maybe I don't have as much "unwinding" to do.  I have time for more of a social life now so I lead more of a balanced life.

I couldn't completely get away from my new status of "Doctor".  Note that I wrote the word "Doctor" with a capital "D". My family kept presenting all of these aches and pains that I never knew they had and asking for my opinion.  "What do you think of this bump?" or "I've been having trouble with my bowels.  Is that a sign of colon cancer?"  When I went to play a game of touch football with my friends, I was inundated with questions, "I was thinking of going to medical school.  Do you think I will get in?" or "My Mom has this mole on her cheek.  Do you think it might be cancerous? I have a doctor, but I just wanted a second opinion."  Questions from friends and family aren't isolated to holiday time.  Sometimes I feel like "Telehealth."  Apparently, now that I am a real "Doctor" I am a vessel of wisdom, medical and *otherwise*, to be accessed at any time! It's both flattering and annoying.

**October 22**

I think being patient-centered is about understanding the patient's agenda even though that's not quite the take-home message I got in medical school.  They went on and on in medical school about the importance of being patient-centered.  You would have sessions on communication with standardized patients who would tell you all the things you did wrong and how to handle different situations.  But it was different.  You got very clearly defined problems; the angry patient who wanted antibiotics or the classic drug seeker.  You didn't have to figure out what the problem was.  You just had to deal with it.  I find the hardest thing about dealing with people is figuring out their problem. They don't know that they are angry or why they are angry.  I don't know if you can teach that.  To learn I think you just have to have see patients, have a few interactions go terribly wrong.  People aren't clearly labelled.  There is no "angry patient" scenario in the office.

Identifying the patient's hidden agenda is truly an art. My supervisor would like to hear that I thought that!  You often don't know there is a hidden agenda until you are in the middle of it. I had this rosy idea that everybody had a legitimate agenda that they would clearly identify at the beginning of the interview.  It takes time to get to know a patient and figure out what they may really want.   Sometimes people aren't telling you things because they don't want you to know

that they have a problem with alcohol or drugs.  Other times they are too embarrassed to tell you they are depressed or in an abusive situation.  I need to know these things because they effect my decisions, my ability to recommend treatment.  It's an awesome feeling when patients return to me for follow-up appointments, especially after confiding in me about sensitive issues.  It means they have confidence in my care and trust my judgment.

We have this thing called "Partners in Care" where we have to bring in videotapes of some of our patient encounters or book patients for the physician and social worker to observe.  I was a little sceptical at first, worried they would just be really critical of my communication skills.  But actually it was pretty good.  I got some good tips on time management strategies on how to set the agenda at the beginning of the interview and how to structure the interview more efficiently.  I also got to observe the 2nd year resident-participant in action.  We don't get much of a chance to observe each other.   It's too bad, because you can really learn from watching others.

**October 29**

I'm doing my paediatrics rotation now.  When I did my paediatric rotation in clerkship, God forbid that you should touch a kid. "You're not the doctor, you're just a student.  Bring me the real doctor for heaven's sake".  I feel there is this immense pressure to prove myself now.

I messed up the other day. My supervisor had been observing the session and she said, "You never really established their agenda at the onset.  You prematurely assumed you knew".  She suggested that I spend a few moments at the beginning of every interview clarifying the agenda. I went home that night and ate chocolate, vowing never to start another interview without clarifying the patient's agenda again.  In fairness to the supervisor, it was good feedback.  When I understand the patient's agenda, it is so much easier to focus the interview.

I know I said it was an art, but setting an agenda is easier said than done.  Every time this week I tried to set an agenda, I lost complete control of the interview.  Patients gave me these huge lists and I didn't know which issue to explore. It's hard to be patient-centered and organize the interview efficiently.   I keep getting told that I don't need to deal with everything in one appointment, but it's hard to ask people to come back.  If they have five problems, are they supposed to come back five times?   How do I know what to focus on?  I realize some patients

would like to talk with you all day and you have to cut them off.  I worry about being fair to patients and seeing them appropriately.  I worry medically-legally, "Can do a good job in 15 minutes?"  But I realize, down the road, I have to make a living at this.

**November 5**

   I was talking with Jeff the other day and we were saying how nice it was not to have the pressure of studying for an exam every six weeks. If you weren't reading, you were studying for an exam.  If you weren't studying you were worrying about getting into a residency program.  The role knowledge plays in my life has changed.  Now I'm more concerned with learning how to use it effectively with patients, whereas before, I was just focused on absorbing it. Developing relationships with patients has now taken center stage. I get to think about and just focus on patients now, my patients. It's a nice change.  No, it's a great change.

   I think as your responsibility for the patient goes up, you listen more.   It's not that I didn't totally listen to patients in clerkship, but I was listening for different things -  mostly to things associated with their presenting complaint.  I was often thinking, "How does this fit in with page 23 in my anatomy text?"  I confess, sometimes I would actually drift off and think of other things … like what I was going to do that night with my friends or planning my weekend.  But now I am totally focused on the patient.  I watch them more closely, catching their facial expressions.  I ask about their families and social supports. When you are totally responsible for the patient, you realize you need to know these things.  If they can't afford the medication, what's the point of prescribing it? I'm pretty good now at figuring out the different hospital resources I can access, but community resources are definitely something I need to work on.  If the right supervisor or nurse is on, they will help, but otherwise I'm lost.  I confess there are times I avoid asking about certain things like housing and finances, even though I know they are important issues, because I don't know what to do.  How should I help them?  Where can I refer them?  Is this part of my job? Time is precious.  I only have so much time to devote to any single patient.  I know psychosocial issues are important, but if I don't know how to efficiently help people it becomes a huge stress. There's this one supervisor who just amazes me.  He seems to know all these resources and has them on the tip of his tongue.  Anything you would need to support your patient and provide better

care, he seems to know.  He knows all the services that take non-OHIP covered people,

pharmacies that don't charge a dispensing fee, accessible house options etc.  I never realized

how important it was to have a working knowledge of community resources. In Family Medicine

it's critical.

**November 12**

I'm beginning to realize how difficult it is for patients to change.  I was talking with Sam over

lunch.  We were both laughing about what rotten choices we had made for lunch.  I was having a

pizza slice and pop and he was having a hamburger and fries.  Great nutritional value!  Yet, we

expect our patients to change their diet and lifestyle when we tell them to.  It takes so much time

and effort.  You really have to be persistent with patients and really, really practical.  "What do

they need?"  "How much money can they afford to spend on groceries?" I'm beginning to realize

you can't deal with everything in one visit.  Knowing I am going to be here for two years helps me

mentally get rid of that sense of urgency to fix everything in one visit.  I saw a physician give a

patient a booklet about managing their cholesterol.  Sometimes you pick up good practice tips

watching more experienced physicians. It seems a time effective way of dealing with the lifestyle

issues.

Most patients don't seem to realize that what they are doing to their bodies now has

consequences later.  Some people aren't even on the map when it comes to lifestyle.  All you can

do is periodically bring it up; harm reduction instead of trying to focus on changing their behavior.

I always thought a Family Physician's mandate was primary prevention.  It's so tempting to say, "I

told you so", but that's not helpful to anyone.  It's easy to give out advice; but it's another thing to

monitor and reinforce the change.  In clerkship I was so idealistic about these things, but I guess

that's because I never saw the outcome or the patient for follow-up. It's not enough to tell

someone to change and think your job is done.

It's the same with treatment and management plans.  You can't force your decisions on

people.  You can inform them and help them make choices, but there are limits to what you can

do for people.  I had a patient who refused renal dialysis because he had seen family members

go through dialysis and the whole concept was very daunting for him.  It was very frustrating.  I

was trying my best to convince him. "You are feeling miserable and you are going to die. This at least is going to prolong your life and improve your quality of life." But he didn't see it that way. It was frustrating, but I had to take a step back. Initially, I thought my job as a physician was to convince him to take dialysis. That was the evidence-based recommended treatment for his condition. But in real practice, patients just don't fit algorithms. I need to relinquish the idea that I don't really have the ultimate power over patient decisions. It's kind of ironic considering I was so concerned about my level of responsibility for the patient a few months ago….

**November 19**

I hesitate to say it, but I think I'm feeling a little more confident with my knowledge … maybe because I keep seeing some of the same things over and over again. As my mother says, "Repetition teaches the donkey". I've been caring for some of the same patients since July now. In fact, over 50% of my patients are return visits. That makes life so much easier, even with the difficult patients. You already know a little bit about the patient's personality and background and have established some rapport so the appointments seem more focused. I notice I'm not as tentative when I talk with patients who I've already established a relationship with. I'm more relaxed during the encounter. I've actually made management plans without harming any patients. That's very reassuring and confidence-boosting. And if I can be so humble … I might have even helped a few people! You never want to get too confident in this business though. An experienced physician once told me, always to be prepared for the curve ball - because you're going to get them when you least expect it!

I'm kind of glad I've decided to keep this journal. I've been forced to reflect. For example, I've noticed patients seem to care as much or more about the quality of the relationship with you as they do about your level of medical knowledge. It's easy to forget that most patients only have a layman's understanding of medicine so the quality of the relationship becomes very significant. It's really important to patients that they can trust the doctor. You build that trust through listening and showing concern. I hadn't really thought about the relationship in those terms before; from the patient's perspective. It definitely takes some of the self-imposed pressure off to appear perfect and know everything. But I must say from my perspective, it's so much easier to

communicate with a patient when I know both what the problem is and how to deal with it.  If I'm not confident in my medical knowledge, then it's hard to genuinely pay attention to the communication stuff because I'm just so preoccupied with trying to figure out what I don't know. I'm so afraid I am going to miss something and then there is the pressure of knowing there are patients sitting in the waiting room. It's such a great feeling when I am confident about the patient's problem and situation.  Everybody's happy.  That's happening more and more.  I need to pay attention to the times I am getting it right and not dwell so much on the times I am less than perfect.

**November 26**

Sam and I had lunch again yesterday and were comparing notes.  The other day I had to call a patient back to change my instructions, but my feelings about doing so were totally different from a few months ago.  I didn't feel embarrassed or anxious. It was just something I needed to do.  It's okay to miss things, as long as I take the responsibility for following up on them. I have a much better sense of what I don't know now than I did earlier.  That's a good thing.  It means I can identify quicker when I need to ask for help or look something up.  There's less time wasted second-guessing myself and creating situations where I need to call somebody back.

The pressure to get the diagnosis right the first time isn't as intense.  Sam says his new system with either a new patient or new presentation of disease is to make sure he asks all the relevant "red flag" questions to ensure he hasn't missed anything life threatening.  I remember memorizing those red flag questions in undergrad.  They were the questions that told me whether the problem was acute and needed immediate attention.  Sam says if he asks all the critical questions that help him rule out those acute problems then he knows he can relax, take his time with the appointment and doesn't worry that he has missed something.  It also helps him decide which issue to focus on which is one of my biggest problems right now.  I never know where I should be focusing my time and energy. Even if I have seen something once sometimes doesn't help, because it doesn't look the same the second time.  I was dealing with someone who was hypertensive the other day and diabetic.  That was one set of questions … the next day I had someone who was pregnant and hypertensive … that was another set of questions.

Knowing and asking the "red flag: questions makes sense and I can guarantee it probably takes less time than my approach, which is to try and recall the 400 zillion questions I know related to the problem.  I guess old clerkship habits die-hard. I used to get rewarded for being thorough.  Now, it's too time consuming.  I think Sam's right; it's more important to ask the relevant questions. If only I could permanently let go of the "I'm going to harm somebody" fear. There is comfort in asking everything you know about something because you feel reassured that you didn't forget to ask anything and you minimize the possibility of forgetting to ask the one really important critical potentially lifesaving question.  But, I'm so afraid they are going to walk out and I've missed something critical.  These people are depending on me.

It doesn't help that different supervisors have different approaches to things themselves. One day one physician is telling you you're doing a good job treating diabetes, the next week a different supervisor is telling you your approach is all wrong.  Just when I think I have my knowledge around a disease down, then somebody says "No that's not quite right."  It makes me feel very shaky inside.

Being patient-centered has taken on a whole new perspective for me.  A few months ago, I thought I was being patient-centered by asking an open-ended question at the beginning of the interview just like they taught us in medical school.  But I found if I just let patient's talk at the beginning of the interview I would lose complete control of the interview.  Half the time the patient just kept talking and adding things because I was just sitting there smiling and nodding. Sometimes I was thinking I was being the consummate patient-centered physician by just letting patient's talk.  Other times I was frantically trying to organize some sort of plan of action in my head because I didn't know what to ask them next.  I remember a few of my interviews at the beginning where I don't think I said much of anything for the first 10 minutes.  In the end, I don't think the patient really got what they wanted out of the appointment.  Now, I definitely take a little more control of the interview.  I don't think I'm overbearing, but I do think the patient needs me to help structure the interview.  I still think I'm being patient-centered because the patient gets to tell me what's wrong at the beginning and I sit and listen without interrupting them.  But what I don't do is let them talk about anything.  I really didn't understand how to do that earlier.  I'm still not

great at focusing the patient at the beginning or prioritizing, but it's getting better.  I feel like I have a *little* bit more of an approach then I did before, but I'm still not great at it.

I have to learn to set boundaries.  I have a patient who I've been dealing with since starting in July.  He's a real mixed bag.  He's got psychiatric problems, a concurrent drug addiction and a precancerous lesion.  I've been trying to build a relationship so I can provide good care, but he's really trying my patience.  A couple of weeks ago he tested my limits.  He was demanding drugs and refused to leave. I felt very overwhelmed that day.  Clearly, my initial approach of being open was backfiring.  I wanted to be very open with patients so they would feel welcome and know I cared. I didn't want to alienate patients by setting limits or asking too many probing questions until we had established a relationship.   However, I realize if a problem develops it's too hard to backtrack and start setting limits.  When a patient asks me for narcotics and I'm not sure if they're warranted, I need to firmly tell them, "I don't prescribe pain medication on a long-term basis. That's just not my way of practicing".  I have to think of the medical-legal consequences of my actions.  I need to be clear about my expectations within the relationship from the beginning.  I think it helps *to build* a trusting relationship. I know I feel more comfortable when there are limits to the relationship.   As I get to know patients and their situations, I can open up.

**December 3**

I'm doing my emergency rotation right now and it started with a bang … or should I say a crash.  My shift was just ending when they brought an 80-year-old woman in from a nursing home who had just started to crash.  I rushed over with the fresh physician who had just come on. Even though the other physician took the lead, I intubated the patient the *first* time, delivered the shocks, did the femoral stab for blood gases and called out when she had a pulse. I was able to competently and quickly perform some of the skills that are physician-defining characteristics. It felt fantastic.  I know procedures like these don't ultimately define you as a doctor, but they are some of the skills I've always thought were what a competent doctor performs.  I walked home on a cloud, feeling really, really good about myself.

I've decided one of the keys to being a good family doctor is knowing whether a patient's really sick.   As a clerk, especially in the beginning, everyone seems to be sick. In fact, I don't

think there was much difference between what my mother would perceive as a problem and what I thought was a problem. I don't think it has anything to do with intelligence; it has to do with experience.  I've just seen more things now and have more confidence. Different rotations help with that because you get to really focus on one problem more closely and get to know the common issues related to that population. Even though I had a paediatric rotation before, this time I was far more hands on and really started to understand the different subtleties of ear presentations.  Emerg rotations are good for helping you learn how to priorize problems quickly. It's a completely different mentality.  Everything is treated as acute.  You learn how to assess who's sick and who's not in a very time efficient way.  That skill helps in my Family Medicine clinic where I've developed a lot more confidence in my ability to decide which issue I should focus on and what can wait.  Rotations are also good for the ego.  I've noticed several times now that the specialist will defer to me when the patient has multiple problems that are not in his scope of practice.  When I was doing a rotation in the dermatology clinic last month there was this patient who said their eczema always got worse with her periods and depression.  The dermatologist just shrugged and turned to me. I was able to step up to the plate and handle the situation.  A few months ago it never would have occurred to me that I would have something to contribute and I never would have had the confidence to step in.

It's official.  If I say, "Anything else?" at the beginning of the interview enough times, I will get the patient's list or hidden agenda.  I think I finally got the knack of it.  I learned another trick too: I follow this up by asking "Which one are you here for today?" It definitely saves time.  I've been caught so many times going after the first complaint only to find out that's not really what they want to talk about.  Sometimes the first complaint is what really did bring them in, but it's still not what they want to talk about.  I find if I clarify their agenda at the beginning, I'm closer to being on time and patients are happier.  I was telling my new strategy today to Charlotte at lunch, but she believes that patients sometimes don't know what they want or what's good for them.  She gave me the example of a woman who came into her office the other day complaining of back pain. Her blood pressure was 220 over something.  Turns out she was having the back pain because she was having angina.  Charlotte says it's her job to understand medically what's going on with

the patient and to nail down the diagnosis.  I don't know … I still think if I let the patient give me their list at the beginning I'll still be able to figure out what's wrong.

**December 10**

I never really appreciated before all the different hats a Family Physician wears.  I think one of the roles of being a Family Physician is figuring out what role the patient wants you to play.  Are you their counsellor?  Are you the coordinator of multiple medical specialists?  Are you the manager of their diabetes?  Am I the gynaecologist today or the psychiatrist?  Who does the patient need me to be?  Some patients are really easy to figure out. The difficult patients are the ones where you have no idea.  They are vague and you can't really seem to find any problems.  You spend all this time with them wondering "What do you want from me?"  It's very difficult.  Like I said before, figuring out the patient's expectations is the biggest key to figuring out your role.  In the beginning of residency I only owned one hat; now I have a closet full.

Patients are so different.  You can't have a cookie cutter approach to everybody.  I'm starting to realize that different people have very different pain thresholds. They all have a very different sense of responsibility and people take different amounts of risk in their lifestyle.  Don't expect compliance, but be happy when you get it.  You can't assume anything with anyone.  That's what it boils down to.  Everybody's different.  You have to be totally open-minded when they walk through that door.  I've gone from being very rigid to flexible.  I'm getting very good being a chameleon … sizing the situation or patient up and being who I need to be.

After Christmas, my time slots are going permanently from 30 to 15 minutes.  My supervisor thinks I can manage.  I don't know, sometime it seems like a race you can never win.  If I am going to make these 15 minute time appointments work, I am going to have to be more mercenary.  When I start to see the interview slip out of my hands, I'm just going to have to slam on the breaks, rather than having to play catch up later.  I am going to have to find out what's on their agenda in the first two minutes, ask them what they want to talk about, and then ask all the "red flag" questions and stay focused.  I'm going to tell them we have time to cover one issue well in the session; it's going to be the most important thing on their agenda or the most dangerous thing they might not be aware of.  It's difficult to be patient-centered in 30 minutes.  You gotta go

from the minute you get the patient in the office.  You have to get your history, do your physical, write your prescription, and write your note.  If you get behind with one patient, everybody is late. That's when I start praying to the "Time Gods" for no shows!

I have learned a few little time saving strategies over the last few months. If I know the patient is coming in for a procedure, I'll get all the equipment ready ahead of time.  I now come in a little early and make sure I quickly review the chart and last note before my patients start arriving, especially when I know they are a complicated patient or have mental health problems. I can have the requisitions all ready to go and just hand it to them at the end of the appointment.  My notes are getting better, especially my treatment plans.  I try to make a really clear treatment plan by underlining and circling important things so I can quickly review and identify them the next time the patient comes in.  I'm also getting better at writing during the appointment.  It's hard to find that balance between writing, making eye contact and listening attentively.  I've gone from overwriting in the appointment, to not writing notes on any patients until the end of the day.  Both bad choices!  Thank goodness I no longer have to worry about the logistical things, like understanding how long labs take to come back and how to work the computer.  That probably adds at least an extra hour of time to each day!

I just have to remember that in medicine, even though time can be your enemy, it can also be your best friend. One of the things they teach you in medical school is that sometimes taking a "wait and see approach" is a legitimate option. Sometimes it feels like a bit of a cop out, but it really does work.  I had this patient the other day that had back pain.  I was pretty sure it was a little bit of muscle strain related to some heavy lifting they had been doing.  I recommended heat and rest and to come back and see me in two weeks.  Sure enough the pain disappeared.  Plus you have patients tell you all the time about lumps and strange symptoms they've had in the past, but are no longer there.  Somehow they managed to get better without your "laying on of the hands".  Not everything needs to have an immediate diagnosis or needs treatment.  It was also quite a revelation when I realized that nobody is going to die if they don't have their physical this week.  I've got this guy who I've seen three times now with the intention of doing a preventative

health exam each visit.  But some legitimately more pressing issue comes up each time so I haven't got to it yet. No worries, he can always come back!

**December 17**

　　Today, I felt like a doctor.  How do I know?  I didn't go to the supervisor once today for help.  I saw all my patients on my own.  I didn't go into that room.  I didn't go into the AV room *all* day. At the end of the day when we were sitting down for chart review, my supervisor said to me, "I didn't see you all day."  And I replied, "I didn't need to see you."  We both looked at each other stood there for a moment and then laughed.  I said, "Wow, I didn't need you."

Today was a good day.  I don't feel like I am ready by any means to strike out on my own.  I still have so much to learn, but at least I feel like a doctor now.  There's light at the end of the tunnel! I remember the first few weeks and I was so afraid I was going to kill somebody.  I wasn't even sure I wanted patients to know I was a doctor, but now I feel like a doctor … their doctor.  I am the Family Medicine resident.  But make no mistake, I am not, and I repeat not ready for independent practice!

　　I stuck my foot in my mouth today.  I told Charlotte about last week where I didn't have to see the supervisor once.  I could manage on my own.  Charlotte said she hadn't had a day like that yet and looked totally dejected.  I felt really bad.  I know Charlotte has really struggled more than most of us to stay on top of things.  Lesson learned - Never criticize a Type A personality; that means most medical resident-participants!  Medical students are too busy criticizing themselves and Charlotte's no exception.  I reminded Charlotte it was the first time and I had a lot of return patients who I knew for follow-up.  I said I still relied pretty heavily on my supervisor.  Charlotte said when she thinks about it, she definitely needs less micromanaging by her supervisor. I reminded her how we had to go over almost every case in detail at the beginning.  The supervisor had to control everything we did.  Maybe "control" is too strong a word … "guide" us.  It's how I imagine a parent is like with their first child.  In the beginning you have to watch them closely, but little by little you let them go to do their own thing.  We agreed that supervisors give us a lot more trust now.  They don't rush in like they use to.  Now the focus is more on making sure we have thought through the treatment and management plan. Charlotte pointed out that there are more

and more situations where she feels competent enough to challenge her supervisor on his or her choice.  Perhaps we are children no longer, but adolescents struggling with independence issues?

Speaking of feedback, there is nothing more satisfying than hearing from a patient that they think you are doing a good job.  It doesn't matter how many other people may be telling you the same thing, including your supervisor; it's just far more powerful coming from a patient.  It is very, very satisfying.  I mean, after all, it's them you are trying to help. I love it that they identify me as their doctor.  One of my patients didn't want to start the medication a specialist recommended until they had checked in with me.  That's so cool. The absolute best is when patients ask for a card or whether they can refer their friends and family.  It's an awesome feeling.  I must be doing something right!

*Summary – Chapter 5*

I used a journal format to provide a composite account of the residents' reflections and perspectives on their experiences during the first six months of their Family Medicine residency-training program.  This format was chosen as an initial method for describing the findings of this study to provide the reader with a beginning understanding of the collective experience of the resident-participants from their perspective.

Throughout the journal or constructed composite, Alex frequently refers to his/her undergraduate experience and uses it as a benchmark for comparison.  The study resident-participants used their experience as medical students to give voice to their current experience.  It is clear that adjusting to new responsibilities, regardless of whether the adjustment was relatively minor or very difficult, focused on the patient or the residents themselves, was the common, underlying thread that was entwined through all of the resident-participants' experiences during the first six months.  Chart 1 entitled

"Shift in Responsibility" was constructed to capture and further deconstruct the resident-participant's experience of responsibility in the first few months of postgraduate training. The table acts as a bridge between this chapter and the next chapter which looks more closely at the theme of Responsibility.

In this next chapter, further description using direct quotes will be balanced by deeper interpretation to chronologically portray the tensions and uncertainties the resident-participants experience in the first few months of postgraduate training as they adjust to their new responsibilities.

Chart 1 – Shift in Responsibility

*How Family Medicine residents perceive the shift in Responsibility from Undergraduate to Postgraduate Training*

| Responsibility | Undergraduate | Postgraduate |
|---|---|---|
| **Knowledge** <br> **(diseases or management strategies)** | • Absorbing knowledge for exams, evaluations <br><br> • Pathophysiology/disease focus <br> • Narrowly focused/Comprehensive histories <br> • One issue – differentiated problem <br><br> • Minimal clinical decision-making in context of medical uncertainty <br> • Focus of interview usually provided <br> • May suggest diagnosis <br> • Limited/no treatment and management plan <br> • Limited/no follow-up <br> • Learning didactic, supervisor directed | • Using knowledge in practice (diagnosis, clinical reasoning, decision making) <br> • Medical ***and*** social history/context <br> • Focused ***relevant*** histories <br> • Multiple issues – undifferentiated problems <br> • Frequent clinical decision-making under conditions of medical uncertainty <br> • Needs to set agenda <br> • Provides diagnosis <br> • Treatment and Management plans <br> • Follow-up <br> • Learning self-directed |
| **Practice Management** <br> **(charting, billing, paperwork, time management, medical-legal)** | • Comprehensive Charting <br> • No billing <br> • Limited/no follow-up of laboratory values <br> • Prescriptions co-signed <br> • No medical-legal concerns <br> • Time management not an issue <br> • Limited/no community resources | • Focused charting <br> • Billing <br> • Urgent box <br> • Prescriptions, labs <br> • Medical/legal concerns <br> • Time management <br> • Community Resources |
| **Relationships** <br> **(patients, families, supervisors, healthcare professionals)** | • Student status - No power and authority <br> • Limited power differential – student = patient & health care professionals <br> • Meeting supervisors expectations <br> • Limited expectations from patients/health care professionals <br> • Patients there to learn from, not build relationships with <br> • Supervision – reactive role, reliant relationship | • Doctor status – Have power & authority <br> • Power differential – expert doctor - patient & health care professionals <br> • Meeting patient expectations <br> • Expectations from patients/health care professionals <br> • Need to build relationships with patients <br><br> • Supervision - proactive role, collegial relationship |

## Chapter 6

Results: Concerns and Changes

This chapter begins by discussing the Chart 1 entitled *Shift in Responsibility* that outlines, from the resident-participants' perspective, the changes in relation to responsibility they had to adjust to as they began postgraduate training. The chart was created to synthesize and capture the resident-participants' experience of the shift in responsibility in the areas of knowledge, practice management, and relationships as they moved from being a medical student to a doctor. From the resident-participants' perspective it is this shift in responsibility that gives rise to their concerns about adjusting to training at the postgraduate level. This Chart acts as a conceptual bridge for presenting and discussing the next set of findings.

Whereas in Chapter 5 I used a journal format to describe the resident-participants' experience from their perspective, in this chapter I will use direct quotes from the study to begin organizing and interpreting how the resident-participants' emerging concerns and subsequent changes occurred in relation to their new responsibilities. The sample quotes will be used to give voice to these important concerns and key changes, drawing links and showing relationships. This chapter also lays the groundwork for a subsequent chapter that highlights the influences resident-participants attributed to changes they made as they learned to adjust to their new responsibilities.

Subheadings are used to highlight the concerns and changes in the three areas as they emerged, both to act as a guide to the reader, but also to draw attention to the source of the researcher's interpretation. The point of qualitative data is not to suggest that there is only one way to interpret the data because there are many, but to ensure that the reader can also see what the researcher saw, and whether or not he or she agrees with it (Giorgi, 1986).

*From Student to Doctor – A Shift in Identity Begins*

This study commenced in the first few weeks of residency training, a short two months following the completion of undergraduate medical training. The transition from medical student to Family Medicine resident came with a new sense of responsibility that was in dramatic contrast to how study resident-participants saw their role in undergraduate training, "… I was in a way still enjoying my days of not having the ultimate responsibility yet and not wanting it …".

At the end of their undergraduate training resident-participants saw themselves as students whose responsibility had been to acquire the necessary body of knowledge and experience needed to earn the title of doctor. It seems that, once medical students crossed the floor to officially receive their diploma deeming them "Dr.", a new sense of responsibility was set in motion that had not previously been felt. "I feel this sense of accomplishment that I have gotten here, yet there is this enormous responsibility that goes with saying that. Even the title of Doctor took some getting use to…There is a certain amount of needing to say it. And to believe it and to make it real in a way …". After all, they had spent several years directly and indirectly being reminded that they weren't doctors. "Its reinforced every single time you introduce yourself as a student, [that you aren't the doctor]." A resident-participant described how nurses saw them as impediments because they didn't have the authority to independently write orders or do anything practical for them. Resident-participants also recalled how patients had seen them as messengers who gathered and delivered the necessary information to their supervisor as instructed. From the patient there had always been a sense of, "Bring me the real doctor, you're just a student".

Further information in this chapter about the shift in identity will be organized in sections related to (a) responsibilities, (b) concerns, and (c) changes.

*New Responsibilities*

Following graduation, the resident-participants were finally doctors, even if they felt it was only in name. They were to move on to postgraduate training, yet were acutely aware that only a scant two months separated their doctor status from that of student status. As one new resident-participant so succinctly summarized, "The biggest challenge [to being a resident-participant] is adjusting to not being a clerk". Another resident-participant reflected on how the focus had shifted from "stuffing in knowledge" to developing relationships with patients, "…you are not jumping as much through other people's hoops … you know the systematic hoops of written tests and oral examinations and OSCEs. So now the importance of those things has changed, developing relationships with patients and those kinds of things take centre stage…".

*Responsibility to patients.*

How resident-participants viewed their responsibility in relation to patients was one of the biggest self-perceived shifts described by resident-participants and this shift took place immediately. "As a clerk, I was more focused on the disease, the problem, learning about the disease and learning how to treat it. I was a little less worried, you know, about what the patient necessarily thought of me." Another resident-participant commented that patients had replaced examinations as their benchmark or barometer for success. And yet another resident-participant stated, "You realize that the relationship wasn't there [with patients in undergraduate training]. You are now here for an apprenticeship, on the job working, being responsible for patient care, really responsible". As undergraduate students, resident-participants truly saw their role with

patients as one of student where they were there to learn from patients, whereas now they were

responsible for the well being of those same patients.  Supervisors held orientation meetings to

reassure resident-participants that (a) they recognized the resident-participants' limitations and

(b) their expectations as supervisors did not exceed the resident-participant's current capabilities.

However, this did little to alleviate the resident-participants' anxiety.  Now that they were

doctors, there was a sense of responsibility to and for the patient that did not previously exist.

One resident-participant described it as, "a duty of care".

*Responsibility for the outcome of care.*

As undergraduate medical students the resident-participants' experience had primarily

been with patients who had acute medical problems.  The resident-participants rarely played a

role in providing follow-up care; follow-up was always a referral back to the Family Physician.

The Family Physician was responsible, not them.  Now … "lo and behold" they were the Family

Physician.  "Now you are the family doctor and you have to do it [follow-up]."  The patient, as

well as the disease, suddenly had a name and a history.  "You have to look at the bigger picture

now.  You can't be like the specialist and only focus on one thing."  For the first time, resident-

participants felt responsible for the outcome of care.  "Three months ago I wouldn't even thought

twice about seeing a patient with abdominal pain looking like something's just not right … I'd

think I'll never see him again and move on.  Whereas now you realize, I want to make sure this

guy is doing all right."

*Responsibility for fulfilling patient expectations.*

In their new role as doctors, resident-participants realized patients now had expectations,

whereas in past, patients saw them as students with little responsibility for their care.  The voiced

support of experienced supervisors could not compete with the increased sense of expectations the resident-participants felt from patients. Resident-participants described how patients now saw them as the "expert" and held a perception that the doctor knows everything. "I'm introducing myself as doctor now, they have an expectation that they are coming to see the doctor … there is an expectation that there is going to be a lot more knowledge…". This experience was in stark contrast to how they perceived themselves during undergraduate training. "It was completely expected [by supervisors and patients] that you didn't know what to do." In fact for most resident-participants, postgraduate medical training is the first time they really feel that patients have any expectations of them. "Now you are the one they are looking to, to meet that expectation whereas before you were sort of the intermediate, it was neither your fault nor your responsibility, nothing was expected of you."

*Responsibility for meeting program and professional expectations.*

This sense of increased expectations was also felt from supervisors, particularly in relation to being on-call. In the past, resident-participants could default to the resident in charge, but now they were that responsible resident. Resident-participants described it as a "huge stress" trying to decide if they should call their supervisor, especially at 2:00 am. "In past you could call a senior, but now it's completely … you are it. You have a back up, but that back up is no longer a resident-participant, it's a staff … and before calling a staff you think a couple of times … you think three times." This new sense of responsibility for decision-making extended to other health care professionals and administrative staff. Suddenly the doctor resident-participants now had the power and authority to make decisions, which was not there before.

*Responsibility for decision-making.*

Resident-participants were keenly aware of the limitations of their student status during undergraduate training and that they did not have any authority for making medical decisions. A supervisor's signature or approval was needed before they could proceed at almost every level of decision-making. As clinical clerks (senior medical students), consultation was expected and encouraged before taking any course of action. It was difficult for resident-participants to feel responsible for the patient as a person or for the outcome of care as they did not have any power or influence around decision-making. "So you don't feel like you could have possibly done anything wrong or right because its sort of someone else's decision as to what the plan is."

Now as residents they were the doctor and, for the first time, saw themselves as responsible for the patient's care and the subsequent outcome; however, these new responsibilities also held consequences that were not present before. The stakes were higher. The repercussions of making a wrong decision were no longer about getting a low grade or poor evaluation. Now there were life and death consequences associated with how they used their knowledge. "… No one is going to come in behind you and correct everything you just said. No one is going to come in and ask all the questions over again. No one has to co-sign your orders. It's a big responsibility and its one of the things that really jars you into realizing that I'm not a student anymore, I'm practicing to be a doctor here and everything I do is going to have consequences now."

## Concerns With Knowing how to Fulfill the Many Roles of Being a Family Physician

One of the main reasons resident-participants cited for choosing Family Medicine was the variety and the opportunity to do and be many things for patients. However, despite this recognition, in the beginning, resident-participants struggled with how to fulfill the many roles,

especially in the same office visit. "The first few months are just so overwhelming … you have to come to grips with meeting new people, meeting new patients and sorting out their issues and what your role is with them."

*Concerns about killing patients with their knowledge.*

Several resident-participants compared the first few months of adjusting to their new responsibilities, especially with patients, to treading water with the hope that they were not going to drown. Despite the many competing pressures and best intentions, the resident-participants felt in the first few months, their fear of "killing everybody" took precedence over building relationships with patients. In fact, one resident-participant recalled how the first few months of residency were purely about fears of "killing everybody". "Do no harm, that's the attitude you have, nothing more, nothing less. Not do good, especially on-call, please, I just don't want to kill somebody…".

*Concerns that level of knowledge is not adequate.*

Resident-participants' concern about their knowledge level was most often associated with harming patients. "I'm going to harm her because I do not have enough knowledge." The first few weeks for the resident-participants often felt overwhelming as the implications of having autonomy and responsibility set in. "I never had to rely on my own knowledge for things … I would always run it by someone else … and now I have to rely on myself."

*Concerns with knowing how to use their knowledge.*

During undergraduate training resident-participants' focus was on acquiring knowledge. During postgraduate training this focus shifted to using that knowledge. Resident-participants described being preoccupied with both the level of their knowledge (what they knew and didn't

know) and the uncertainty about knowing how to use their knowledge in the context of practice.

The resident-participants pointed out that reading about a disease in a textbook was not the same

as knowing how to treat the disease in real life. For example, they may have felt comfortable

with their understanding of the mechanics of hypertension from undergraduate training, but each

patient seemed to present with a slightly different permutation or nuance of hypertension. "…It's

a challenge. Hypertension can present in so many different ways, like they are hypertensive with

diabetes or they are hypertensive but they have nasal congestion".

*Concerns about making a diagnosis.*

Unlike disease algorithms during their undergraduate education, patients did not come in

neat little boxes. It was hard to know what relevant questions to ask about hypertension when

the context of the disease kept changing. Depending on the circumstances, sometimes resident-

participants felt they knew too much, and therefore couldn't prioritize, other times, they felt they

didn't know enough. This led to resident-participants feeling very inadequate about their level of

knowledge, particularly in the clinical interview when they had to regularly make decisions. It

was a challenge to "get the diagnosis right", but necessary, if they were to provide good care to

the patient. "Diagnosis and treatment and management plan. Those are my priorities. I need to

know what to do."

*Concerns about ability to clinically make decisions.*

Along with concerns about the level of their knowledge, resident-participants were

preoccupied about "knowing how to put theory into practice with patients". Resident-

participants described how the goal during undergraduate training was to gather as much

information as possible from the patient, not necessarily decision making or thinking about how

to use that information. " … you know all of the questions to ask because we're really, really good at taking histories when we finish medical school and probably know what to examine but its formulating that problem and formulating the solution to that problem …". In other words, independent diagnostic reasoning and clinical reasoning became issues of concern for the first time. One of the resident-participants explained, "I didn't have to do that as a clerk [make decisions regarding diagnosis and treatment and management]. Now I have to decide what the right medication is myself".

*Concerns with making the right diagnosis.*

The struggle and uncertainty with knowing how to use what they knew efficiently and effectively were frequently echoed by resident-participants. They asked questions such as

1. "What in your knowledge is relevant?"

2. "What's not relevant?"

3. "What are the right questions to ask in order to make the right diagnosis?"

4. "Should I order this test? That test?"

5. "Should I wait for a test or go ahead and treat?"

6. "I'm always thinking I'm not sure, I'm not sure" and

7. "What if I miss something?"

Resident-participants repeatedly commented on the enormous pressure they felt to ask all the right questions in order to make the correct diagnosis so they could come up with the perfect treatment and management plan for patients. One resident-participant explained, "There is an underlying concern that the patient is going to die if I don't get the diagnosis right".

*Concerns about knowledge base being adequate.*

A consequence of feeling responsible for patients, but feeling inadequate in their knowledge base to do so competently, meant that content took precedence over process. As one resident-participant succinctly put it, "My priority is knowledge first, process second". Resident-participants discussed how in the beginning they were more preoccupied with not harming the patient than establishing a relationship with the patient. Caring for the patient seemed to be equated with providing the correct diagnosis and medical management. It was difficult to make the process of a medical interview and the patient's social context a priority when resident-participants felt so insecure about their knowledge level and about their ability to make the best decisions on the patient's behalf. "You want to have a certain level of communication with patients, you want to develop a relationship where they can trust you, but you can't act like you're someone they can trust if you're not even confident about your medical knowledge." As another resident-participant said, "I'll probably spend less time thinking about it in future [knowledge] and focus more on social aspects". The resident-participants' lack of confidence in their knowledge base interferes with their ability to develop deeper doctor-patient relationships.

*Concerns about dealing with multiple patient concerns.*

Although continuity of care is a hallmark of family practice, the idea of seeing patients over a series of office visits did not seem to be an option resident-participants entertained early in their residency. There was the fear they would miss something of importance if they didn't attend to it immediately. One resident-participant reflected, "I think part of the problem is you feel more comfortable just dealing with one problem at a time and not feeling okay with saying just come back and see me. I think that was part of what I had to get over". In the past, they had been told what information to get or on what disease to focus. The patient's problem had often

been identified for them. Now if patients presented with clearly defined problems, they were able to revert to their memorized list of questions, but when patients presented with multiple issues/complicated life contexts they had no organized approach. "I felt like throwing up my hands and going to my supervisor. She's got too many complaints. I don't know what to do and it's very overwhelming."

*Concerns about dealing with "difficult" patients.*

During undergraduate training, most resident-participants' encounters with patients were transient so the opportunity to deal with different patient personalities and patient problems was limited. Difficult patients were described as drug seekers or those with serious mental health issues, who didn't know what they wanted, or who wouldn't take their advice. "In clerkship you were only there for a month, the maximum you had to deal with them [difficult patients] was a month." In the past, "somebody else" dealt with the difficult patient, but now they were responsible and continuity of care meant they had to learn how to manage the situations.

*Concerns about agenda setting.*

Resident-participants described how, in undergraduate training, they did not feel responsible for eliciting the patient's agenda or expectations as that was the senior doctor's role. "I would just be there to get the symptoms down, the physical history and the real doctor would come in and deal with the patients expectations of what they wanted, but now it's up to me."

*Concerns patients will see them as incompetent.*

Resident-participants discussed strategies they used to contain this anxiety and to compensate for not knowing what to ask. All resident-participants commented that it was important to appear confident with patients. "Try and appear confident, even if you are feeling

insecure or half of the time you have no clue what you are doing.  Never say 'I don't know' say, 'Hmm, let me check on that'.  There's all these little tricks that you learn that cover up the reactions with patients when you don't know."  Another way resident-participants tried to compensate for feeling they did not know the relevant questions to ask was by taking a broad focus with patients for fear of missing something.  Resident-participants described having "a low threshold for uncertainty" and, as a result, frequently called patients back.  "In past it was always someone else's decision as to what to do, whereas here it is up to you and you think 'Did I do the right thing?'  'Should I call the patient back?'."

*Concerns about making mistakes.*

Resident-participants also spoke about having a low threshold of tolerance for the possibility that they make a mistake.  "We're very hard on ourselves … we don't like to make mistakes … it's like we're our own worse critics …".  In the first few months they would go home at night thinking about the medical decisions they had made earlier that day, "… I'd ruminate like 'Oh, my God, I can't believe I did that, I was stupid, I can't believe I missed that'."

*Concerns about medical-legal consequences.*

All resident-participants commented that before offering advice, writing a prescription, or recommending a treatment plan, they considered the medical-legal ramifications of their decisions.  As a student, they were given very little responsibility for independently making treatment decisions or management recommendations, whereas now they were encouraged to autonomously make decisions.  As a result, resident-participants reported being very cautious in their interactions with patients and health care professionals.  They were seen as the "expert," and were responsible for the outcomes of their decisions.  Their advice and recommendations

carried consequences. "You also have to think medically-legally. You don't want to burn yourself in any way."

*Concerns about office management.*

These anxieties were compounded during the first few weeks and months by all of the other "firsts." There were many practice management tasks that were not resident-participants' direct concern/responsibility during undergraduate training. Many of the new tasks were related to the enculturation process associated with any new work setting, but also to understanding and fulfilling the, often diverse, administrative requirements of the particular office setting and hospital. Resident-participants described the first few weeks as particularly overwhelming as they became oriented to the administrative practices of their new setting. This included learning how staff at the front desk functioned, where to find requisition forms, and how to work the computers. Despite orientation sessions, one resident-participant described the first month as being, "Just a zoo filled with new adjustments". Another resident-participant commented that, "Finding out if they [patients] are in the waiting room or not, and then how you are going to go out and call them and then the pieces of paper you need to get signed to get them blood work and where do you find those and there's just so much of the system and the logistics that I think that in the first months is the most overwhelming part". This same resident-participant went on to explain that in the first month everything was new so patient care often took a back seat while struggling to learn the system.

*Concerns about billing.*

Resident-participants are exposed for the first time during residency to the business side of medicine. This means learning how to assign a billing code to each medical encounter in

order to get financially compensated.  "So as a family doc, you suddenly have to become savvy in business, in how to run things so you feel like you are getting compensated for your time."

*Concerns about signing prescriptions and filling out paperwork.*

A practicing physician is responsible for completing a litany of paperwork such as laboratory requisitions, discharge summaries, referral letters, insurance forms, and prescriptions. Although medical students are exposed to most of the different forms and have even had some experience completing different paperwork, a supervisor's signature or approval was needed before they could proceed at almost every level of decision-making.  For example, many resident-participants, as undergraduate students, were expected to write prescriptions, but they had to be co-signed by their supervisor. As a result, taking responsibility for the outcome of independently completing forms was new.  Resident-participants were concerned about the negative consequences of not completing forms/prescriptions properly.  "It's under my name.  I have to make sure I know it's the right drug.  I go through this list.  I get a prescription, I go back to the patient and I say, 'This is what you are taking' … I read it through for myself too … I have the responsibility when I put my signature on there."

*Concerns about time management.*

Learning to manage one's practice also meant being cognizant of time and how to manage it.  Unless it's an annual health exam, practicing physicians generally book patients for 10 to 15 minute office appointments.  In the beginning adjectives and phrases like "exhausting", "overwhelming", and "a race you can't win" were used to describe how resident-participants felt about trying to keep on time during 30-minute office appointments.  Resident-participants felt it was "too short" to try and accomplish all the things they needed to do in the visit.  "You gotta

have your history, you have to do your physical, you've got to write your prescription, you've got to write your note and it all has to be done and if you start lagging behind everybody starts getting late. That's when you start praying for people not to show up."

One resident-participant reflected about how all resident-trainees were warned that time management was going to be an issue in Family Medicine. "Its one of the things I expected, but never really understood it until I did it. People always said you're always really rushed for time and you only have this many minutes. But I don't think you really understand the impact of that until you do it." Once again, this concern was linked back to their earlier experiences as a clerk, "I've never been or had the responsibility to carry patients and see them quickly and have them out and done on time. That was never really my responsibility; it was someone else's responsibility".

*Concerns about charting.*

Struggles with time management were a concern for resident-participants throughout the study and seemed to permeate most practice management issues. For example, most resident-participants felt their lack of ability to talk and write at the same time compromised their efficiency in the interview. "Charting more efficiently that's probably the area that I need to get better at. My notes are still a whole page and they should probably be half a page or less." In the past, completeness and comprehensiveness in the recording of findings was encouraged, whereas in real office practice where time management is a priority, learning to chart concisely becomes the new standard. Easier said then done when the resident-participants are interested in establishing a relationship with a patient and don't want to break eye contact. As well, medical-legal issues become a concern for the first time during residency training. What should they minimally chart?

*Concerns about community resources.*

Resident-participants also indicated that locating resources related to community and knowledge was another issue that compromised their ability to use their time in the clinical interview effectively. "It takes time away from the patient because I have to be like 'Oh, excuse me' and I have to leave them for like 3-5 minutes because I have to find someone to talk and ask what's a good resource or where do I find that."

*Dealing with Concerns Leads to Change*

As with any move to a new environment, the first few weeks for resident-participants were about acculturating themselves to their new setting and learning the system. Although charting, locating community resources, and time management continued to be challenges voiced by all resident-participants throughout the study, other concerns related to practice management, such as adjusting to new administrative processes and locating the appropriate paperwork, were soon resolved. Several of the resident-participants suggested that it took them at least a month to feel comfortable with the "nuts and bolts" of practice management such as knowing where the speculum is kept. "I am familiar with the computer system now. I am familiar with the layout of the family practice office. I know where this test requisition, where this referral letter is and when to check my mailbox." Taking time to locate office equipment, find the necessary paperwork and consult with their supervisor compounded feelings of inadequacy that already existed. One resident-participant commented that, in the beginning, mastering practice management issues was more important than actual patient care and that in fact they saw interacting with the patient as only a small concern in the beginning.

*Broadening patient care focus.*

It seemed that, once resident-participants acclimatized to their new surroundings and felt more comfortable; they could focus their attention more fully on other issues. "There is a sense of freedom. It's a release. It's almost like … you feel more confident." Mastering practice management skills indirectly seemed to influence a resident-participant's outlook on patient care. "You realize now that you are doing all the paperwork: filling out the forms for all this other stuff and participating in family meetings which you may not have done as a clerk, you realize how central your role is and how this patient fits into their community."

*Beginning to prepare paperwork prior to patient arrival.*

Increased confidence in practice management issues also affected change in the resident-participants' ability to manage the office visit more effectively. Less time it seemed was spent locating laboratory forms and locating in-hospital resources, which meant they could focus more time and attention on the patient. As time went on, resident-participants recognized the need to prepare necessary paperwork before the patient arrived. "So it used to be when a patient came that's when I filled out the paper work. If they needed new scripts that's when I used to do it. So now I do it beforehand…. Then I have more time to spend on the more important issues that they are coming for."

*Arriving early to read chart and get equipment ready.*

Several resident-participants discussed how they now came in earlier to get ready for patients. For example, reading the chart ahead of time to familiarize themselves with the patient's medical history was critical for managing the clinical interview more effectively. As well, they were less preoccupied with trying to anticipate what equipment they would need in the

office visit if they organized themselves ahead of time. "I've made changes in that I do try and get all of the pap stuff ready so I am not fumbling as they have their legs up in the stirrups."

*Changing approach to charting.*

Becoming more efficient with charting was another way resident-participants identified learning to manage their time and practice more effectively. For example, effort was made to make specific notes at the bottom of the patient's chart as reminders for the next visit. Learning the art of writing, talking, and listening became a priority.

*Beginning to set agendas.*

Resident-participants began to realize they needed to elicit the patient's agenda at the beginning of the interview if they wanted to manage their time efficiently. "I think initially when I first started in residency I was more focused on asking all the right questions and then the more time I spent in the family practice clinic the more I realized if I don't figure out what their [patients'] agenda is today I'm going to be spending even more time with them."

*Learning to set limits and boundaries.*

Resident-participants learned that setting an agenda often involved setting limits, something they had little experience doing during their undergraduate training. "A lot of us didn't have any boundaries. We didn't know how to set boundaries. If somebody asked you personal questions, do you answer them? We don't know. It's a really big issue in the first few months because you're getting much more personal with people than you have ever had to before." One resident-participant talked quite candidly about initial struggles with setting boundaries. "At the beginning you kind of end up in one of two camps. Either 'I'm the doctor

you're the patient this is it' or you're trying so hard to please and be friendly and be nice that you

end up not having any boundaries…"

Most resident-participants commented on how they did not initially feel comfortable

setting boundaries with patients with whom they were trying to establish a relationship, but

realized that they were going to have to do this if they expected to manage the interview

efficiently. "I have more confidence in drawing boundaries and being able to say, 'No, I can't

address all of these issues that you want to talk about today, we only have time for a certain

amount'." Another resident-participant reported, "… you have to realize that you have to set

boundaries with people and put your foot down sometimes.  You have to be more assertive than

you want to be".

*Asking more focused questions.*

In the beginning, resident-participants weren't sure what to ask or where to focus their

time and attention, but as they gained experience in identifying the reason for the patient's visit,

they were better able to ask more focused questions relevant to the patient's presenting

complaint.  "You have a responsibility to address their expectations when they are coming in, so

you have to find out what their concerns are and their expectations are.  And then I've figured

out key questions to go into …I'm picking better questions, more strategic questions … I think

I've learned that through trial and error."

*Developing an organized approach to the interview.*

One resident-participant described how, in the beginning, either a really broad approach

would be taken, delving into every medical system, or a more narrow focus would be taken on

the presenting complaint and no consideration would be given to the broader context.  A similar

experience was voiced by all the resident-participants in that, once they became more competent in clarifying the patient's agenda and expectations, the resident-participants were able to begin organizing the interview differently. All resident-participants stressed that time pressures forced then to become focused and ask only the relevant questions; if they didn't know what the relevant questions were, time management continued to be a struggle. "What in your knowledge is relevant and learning to adapt a style so you can cover your bases for that visit. You have to be able to quickly scan their [patients'] past medical history and find out if there is something that is relevant to this. Are there pieces that need further investigation? How soon?" As a result, resident-participants' interviews began to feel like they had a sense of direction, rather than haphazard events.

*Understanding the relevance of red flag questions.*

Resident-participants also began to recognize that if they knew the relevant red flag questions to ask they could relax and attend more to patients. "What is key to being a good family doctor is knowing, 'Is this person okay?' or 'Are they sick?' … Its building that confidence to know which one it is … I think when you were a clerk, everything seemed like a problem to you."

*Learning to take a "wait and see" approach.*

As resident-participants became more confident in their ability to recognize what was urgent and what was not, they became more comfortable asking people to come back rather than feeling they had to address everything in one office visit. "I've realized that nobody is going to die if they don't have their physical this week." Becoming familiar with the relevant red flags to determine if something was urgent also meant resident-participants could relax and take a "wait

and see" approach, a position they were not comfortable with a few months earlier. "We use that a lot in Family Medicine [watchful waiting] and I think you need experience to get to that point where you're comfortable doing that … it's okay not to answer right now and its okay not to do tests right now, its okay to not try and fish around to figure out what's exactly going on."

*Learning to become more self-directed in their learning.*

"Paying attention" in lectures, doing more self-directed reading and consulting with peers were also strategies mentioned, but less frequently, by resident-participants to feel more confident with their knowledge.

*Becoming increasingly comfortable with medical uncertainty.*

Resident-participants described how, as the fear associated with the responsibility of using their knowledge to heal, not harm patients began to subside, it was replaced with a sense of comfort in knowing that it was okay not to know. "The whole idea of its okay not to have the diagnosis when you see the patient or have the right solution. I think I am getting more comfortable with that." Most resident-participants seemed to come to this juncture in their training where they felt "comfortable enough" with their knowledge base to feel like they were no longer masquerading as the doctor, but were the doctor. Comments such as, "It's not the end of the world to miss something", "I don't need to be the expert in everything" and "It's okay to be wrong" were reflected more frequently from the resident-participants as time went on.

*Relationship with patient becoming more important.*

As resident-participants felt more comfortable with their level of uncertainty and subsequently with their role, they were able to concentrate more on their relationship with the patient. "I realized I was really their doctor when I had enough knowledge base because nobody

can ever learn enough right?  But when you are comfortable enough, you go beyond that …  I think that's when I made the transition.  Not just making a diagnosis, but learning how to really talk with people."

*Listening to the patient differently.*

Being responsible for patients in the long term also meant being a trustworthy and knowledgeable person for the patient because the choices made were going to affect their life. "They [patients] have to be able to trust you so you have to be able to establish rapport at the beginning."  Resident-participants described how they listened to patients now … or at least listened differently.  "As your responsibility for the patient goes up then the more actively you listen.  Sometimes in clerkship I knew I had somebody covering me I would just go in there for the experience and sit there and trail off and think of other things."

*Managing time.*

At the end of six months resident-participants were still commenting on their struggles with time management and weren't eagerly anticipating that their appointment time was soon going to be reduced.  "A big challenge is trying to move from the 30 minute time slot that we were given in the beginning to 15 minutes.  That's been really difficult and to discipline myself that even when I am running behind to make sure that I write my notes as I am going along."

*Focusing treatment and management plans.*

Most resident-participants commented that, as they became comfortable with the concept that patients could come back and as their confidence in their knowledge grew, their treatment and management plans became more focused and directive than they had been initially.  "I am more directive or more specific about what treatment they are on and what they should do … I

feel more confident about the decisions I make, but I also realize that I can always call a patient back if I am uncertain about something…". However, resident-participants also noted that the diversity of medical issues for which they were responsible in Family Medicine made it difficult to maintain a sense of confidence. "I am not completely comfortable with my medical knowledge. That continues to be a struggle that I face and that I think I've faced since day one. Some things are better as I see more patients with that medical problem and I become more comfortable with that issue, but I find in family practice that there are just so many issues … it is hard to be on top of everything."

*Growing confidence in clinical judgment.*

Resident-participants' sense of confidence in their clinical judgment, both with medical and social issues, began to change. "I had this patient who I saw the first day when he was a new patient and the minute I saw him, there was just something not right about him, I just couldn't put my finger on it. … by the third time I saw him, little, by little, you gain experience from him … you start getting the flavour 'Okay, I was right'. You get those gut feelings."

*Developing realistic patient expectations.*

One resident-participant described how the realization began that not all patients were going to follow-up with their recommendations and that not all treatments worked for everyone in the same way. "Patients … have so many individual factors. They [patients] are not OSCE stations, they're not check marks you have to get, they are people and they are your patients and you are their doctor."

*Recognizing role of community resources.*

As time went on, resident-participants began to recognize the importance of knowing community resources and how to efficiently link patients to the right resource, although they did not feel competent in this skill. "I feel like there are so many resources in "X", that I still feel like I'm not doing my patients as well as they could be done because I just don't know the resources that are out there." This same resident-participant echoed the sentiments of many resident-participants when commenting on the value of observing "experts" in their field manage different situations. "Again, there is this one particular preceptor that I work with and she just amazes me that she just has the resources at the tip of her tongue and anything you could ever want to support your patient with she knows where they are and whose covered by OHIP and who gets people in fast. That's the kind of resource knowledge that is incredibly valuable for a Family Physician and I'm still building it".

*Becoming aware of self in relationship.*

Resident-participants also commented in the beginning how they were not even aware of having a "style" with patients. "This supervisor told me one day that I had a style that suited this particular patient and that's when I first started thinking, 'Oh, I have a style'." At the end of six months, some resident-participants were actively trying to develop their style.

*Broadening approach to care.*

In the beginning of the residency program resident-participants realized that, as the Family Physician, they had many roles to fill with patients; however, they weren't sure how to go about that. One resident-participant described how the approach in the beginning was just "to be nice" to everyone. In other words, one approach fit all. But as time went on resident-

participants realized patients were individual people.  Many resident-participants used the analogy of hats to describe how they had learned to adapt their approach to different patients.  "I think I realized I have to be different people to different people … I wear a lot of hats. I change because that's what Family Medicine is. I am a chameleon."

*Limits of responsibility.*

Resident-participants also wrestled with the limits of their role or responsibility with patients, wondering where it began and ended.  It seemed difficult to find the right balance.  "I feel all this pressure to follow-up and take on even further responsibility, which is not my responsibility …I can't help but feel a responsibility that implores me to fill in where they [patients] are not acting and to take the extra steps even though on the one hand I am thinking if they choose not to act in a way that serves their health who am I to call their home and interrupt their privacy and nag them."

*Relationship with supervisor.*

Resident-participants commented on how their relationship with supervisors seemed to change with time, going from very reactive and dependent to more proactive and autonomous.  In the beginning they reverted to "student status", adopting the role with preceptors that they had as undergraduates.  In other words, reporting patient findings to supervisors, but waiting for direction and guidance.  With time and experience, resident-participants became more confident and proactive in the relationship.  In fact, they seemed to use this relationship as a benchmark toward autonomy; when they didn't need a supervisor's feedback, guidance, or involvement as often, this was a sign that they were doing well and becoming more independent.

*Relationships with health care professionals.*

Resident-participants' role with other health care professionals, particularly with nurses, also changed with time. As students during undergraduate training, they were well aware of their limitations and lack of "usefulness" to nurses, as they could not make decisions around treatment and management orders. "… you are always in the way [with nursing staff], hanging around, you don't always know what's on the go, you can't do anything for them, you can't write orders, you can't find stuff …". But all of that changes once they shift to the role of doctor, suddenly the nursing staff are looking at them to "call the shots" and "be responsible for the direction in management", especially on-call. Reciprocally, resident-participants must establish and navigate a new relationship in light of their new responsibility. One resident-participant recalled an incident where the nurse paged several times and frantically reported that a patient's blood pressure was dropping. The resident-participant reluctantly left the clinic and went up to the floor only to find that there was really very little change in the patient's status. "At first I started to get a little bit annoyed, but caught myself and started to think okay if I show that I'm annoyed and second guess this person's judgment this time then they're not going to call me the next time and maybe the next time is when I should really know about it."

*Developing concept of doctor-patient relationship.*

During the last month of interviews, resident-participants were asked to reflect on the changes they had seen in themselves over the past six months or issues about Family Medicine they had not expected. Most comments centered on their conceptualization of the doctor-patient relationship, which isn't surprising as none of the resident-participants had felt truly responsible for patients previously and had limited opportunity to develop relationships beyond a first encounter.

"It's much more relationship building, far more than I anticipated and far more than we knew to expect. It [Family Medicine residency] really takes you away from the biomedical stuff which has been your focus up until that point and makes you realize that the psychosocial stuff that everybody fluffs off during medical school is actually what's really central. That seems to come out and be very surprising to a lot of people in the first couple of months of family practice." Another resident-participant stated that, "You don't see the 'angry' patient, you don't see the 'anxious' patient, and you have to figure these things out yourself and it's difficult. Nobody presents as the neatly labelled standardized patient you practiced on during undergraduate training".

*Changes in the concept of what patients want and need.*

Resident-participants also commented on the central role patients' families played in care and how they had not anticipated this. As well, resident-participants seemed surprised by the value patients and their families attached to "open communication". "Patients care more about the openness and honesty in their relationship with you than they do about your medical knowledge and that's been important for me to put things in perspective." This same resident-participant went on to explain, "That's not really how I view things because I already have enough knowledge when I am looking for a physician that's not my number one priority, but for people who don't have a whole lot of medical knowledge they just want to believe that you are being open and honest and that's the most important thing. Open honest and caring".

*Worry changes to caring.*

One resident-participant reflectively commented about moving from "worrying about patients, to caring about them", but was unsure whether all resident-participants had reached this

point. "I think some people are still worrying about everybody all of the time and being very anxious. It's draining. It's very draining and it's not useful for you or your patient to sit at home and worry about them." The resident-participant went on to suggest that when you let go of your own anxiety about making the right diagnostic and treatment decisions you invariably start making better choices for the patient because you genuinely care about him or her. "But you care about them and that's when you are going to make the right treatment decisions and where you are going to make the right decisions and the right connection with them that you need to make." This comment suggests that, for at least one resident-participant, the focus had gone from dealing with personal anxiety and agenda to that of the patient's concerns and agenda.

*Changing role of knowledge.*

One resident-participant commented that undergraduate training is focused on helping you learn the necessary medicine so you can competently diagnosis, treat and manage patients. But once you are out practicing you begin to realize that you need to take more things into consideration before you can make appropriate recommendations using that knowledge. "… you begin to look at the disease process on the person's overall functioning, on their life, what are the effects if any? 'What are their wants and needs surrounding this?' 'Is their family involved?' You begin to realize that not everybody has a diagnosis and not everybody that has a diagnosis has an illness … and you become a little more comfortable with the fact that you don't have to diagnose everybody. And everybody you diagnose, you don't have to treat."

However, most resident-participants conceded that in the beginning they weren't comfortable focusing on the bigger picture, the patient's life context, agenda, or expectations until they felt at least minimally confident with their own medical knowledge. "As you become more and more comfortable with the material, you become more and more concerned with the

patient's agenda because I think throughout training there is this anxiety. However, the more you try to force your agenda on to the patient by trying to get down the medical stuff, the more you realize they have something they may want to talk about. Its difficult as a first year resident-participant 6 weeks out of medical school to sort of listen to those concerns because your real concern is to make sure you don't miss something or at the other end of the spectrum to make sure the patient doesn't die."

*Gaining comfort and confidence in level of knowledge.*

As time went on resident-participants became more comfortable with their medical knowledge when they felt more confident in their ability to prioritize and distinguish what was important. "…most things you realize are not urgent. And the urgent things you try to rule out. I am definitely better at it now than I was a few months ago or six months ago. It's continual." The generalized anxiety resident-participants experienced in the beginning with not knowing was beginning to diminish as they began to develop their own knowledge resources. "Once you have an arsenal it makes it easier to not know things because you know where you can reliably and quickly look something up or who you can reliably and quickly get an answer from. In order to be comfortable not knowing something you have to be able to find it out really. It's okay that I've never seen your condition before because I know who I can call."

*Lowering anxiety level regarding adjusting to responsibility.*

One resident-participant recalled, "I used to go home and think about it [medical decisions] for days and days and days and now the days have gone to hours". One resident-participant summarized thoughts on how, over time, adjustments had been made to the new responsibility associated with being a resident. "That whole sense of responsibility has set in

nicely. It's not a fear thing anymore. It's more of a 'I think I might have missed this, but I'm going to call the patient back'. You feel like you are not as much, 'Oh, my gosh, I didn't catch that'. The idea of its okay not to have the diagnosis when you see the patient or have the right solution. I think I am getting more comfortable with that. Okay, I may have missed this. It's not life threatening and as long as I do my follow-up and all I can to make sure that follow-up is there, I'm okay."

*Beginning to feel like doctor.*

Towards the end of the six-month study period resident-participants began talking about moments where they felt they were truly the "doctor" and not the medical student. For some it was a pivotal moment, others felt it was an accumulation of experiences that made them feel this way. "I think after a bit of experience, knowing what your comfort level is, knowing how the clinic works, getting the patient back and just knowing what you can do …. I think that's when I began to feel, that you are their doctor. Then coming in and actually making the plan, making the follow-up and treating as necessary and then … not having to review every case before the patient leaves with your supervisor, I think it was a bit of that transition, building your confidence."

*Adjusting to responsibility.*

One resident-participant reflected, "Before you felt just so responsible like 'Oh, my God I had to make sure everyone was doing the right thing or else', that's just bad … but now I recognize it's a partnership. I'll do my end and I'm actually going to expect that you do your end". This is a far cry from the sentiments resident-participants voiced in the first few months. "Responsibility is the most overwhelming piece."

*Summary – Chapter 6*

In this chapter I used quotes to begin unravelling the meaning of the resident-participants' experiences in the first few months of practice as a resident. As postgraduate training commences, the resident-participants describe being concerned with needing to adjust to many new responsibilities they did not feel they had as medical students. Even though the resident-participants may have anticipated many of their new responsibilities, the experience of feeling responsible and having responsibility for the first time represented an enormous shift that caused specific concerns in the areas of knowledge, practice management, and relationships. The resident-participants described the enormous underlying responsibility they felt to fulfill the patient's expectations, which the resident-participants initially felt was that of medical expert. The fear of inadvertently killing someone with their knowledge in trying to fulfill this role dominated their thoughts and subsequent actions in the first few weeks and months of residency. As the resident-participants felt more comfortable and confident in their role, changes began to happen, both to their practice and to their concept of who they are in relation to the patient.

In the next chapter, these changes are highlighted using the routine office visit where resident-participants are now responsible for using their knowledge, carrying out practice management, and establishing relationships in the context of practice.

**Chapter 7**

The Clinical Interview

As learners in any profession make the transition from training into practice, the

knowledge and ideas initially absorbed take on new meaning and significance (Eraut, 1994). In

the previous chapter quotes were liberally used to both chronologically illuminate themes and to

draw links between the concerns and changes the resident-participants described. In this chapter

I will further explicate how a newly graduated doctor begins using the knowledge and ideas

learned during undergraduate training in everyday practice.

Patton (1990) describes the explication phase of qualitative reporting as creative

synthesis where the different pieces of an experience are merged into a total experience.

Whereas, Cohen (1985) describes the need to pause and place the themes back into the overall

context or horizon from which the themes emerged. Some researchers have described a typical

day to amalgamate their findings and to portray the resident-participant's experience in its

totality (Flinders, 1987; Peshkin, 1993). I chose a clinical encounter or interview to describe the

resident-participants' experiences because it is in this context that the resident-participants learn

to use their knowledge in the doctor-patient relationship. The clinical interview was used to

conceptualize not only how the resident-participants changed in their approach to use of

knowledge, issues with practice management and concept of the doctor-patient relationship, but

how these three sub-categories intersected during the first six months of practice.

I reconstructed the resident-participants' experience at two different points in time: the

first few weeks of clinical practice and then again at six months. In providing two similar

interviews, but at different time points, I was able to depict the dramatic change that enfolded as

the resident-participants struggled with their new responsibilities. I created this portrait by using

earlier forms of data displays and interview texts to reconstruct the resident-participants'

experience in the clinical interview. A general organizational framework for conducting a

clinical interview was used to anchor and present the findings (Dent & Harden, 2005; Martin,

2003). The same clinical scenario was used in both interviews to highlight and contrast the

changes to practice.

In the next few pages, I will describe two fictional interviews to highlight the resident-

participants' experiences in the clinical encounter at two different points of time during their

clinical training in Family Medicine: the beginning few weeks and the last few weeks. Where

possible, I made efforts to duplicate (a) the type of patient encounter, to emphasize the changes

that seem to occur during these two different time periods in both the content and process of the

interview, and (b) the resident-participants' voiced thoughts and feelings. The entries are

presented in a different font (Tahoma) to indicate that they portray the description of the resident-

participants' encounter with a patient.

These changes have been summarized in Chart 2 entitled *The Clinical Interview*, which is

located at the end of the chapter. It is noteworthy that, although this presentation of the results

reflects the experiences of all resident-participants, the time frame and intensity of these

experiences do differ amongst the resident-participants.

*The First Few Weeks of Practice ...*

<u>Prior to the Encounter Beginning</u>

Although the resident-participants have only been given a name, chart and possible reason for the visit, they do not open the chart to familiarize themselves with the patient's past history prior to the visit, but go directly to the waiting room to retrieve the patient and begin the encounter.

The resident-participants have difficulty knowing whether they should introduce themselves in the waiting room or wait until they have brought the patient into their office. They also struggle with what to call themselves (just last name? just first name? first name and last name?) and whether to shake hands (boundary issues emerge). Most resident-participants feel like they are masquerading or posing as the doctor, feeling inadequate both about their knowledge base and how to use it in the best service of the patient. Despite their strong desires to responsibly care for the patient, they are anxious, hoping their inexperience will not harm the patient and they will know what is wrong with them.

The resident-participant leads the patient down the hallway to their office where they sit down in the chair associated with the desk and allow the patient to choose their own seating position.

<u>Beginning and Middle of Interview (Data Collection) are the Same Thing</u>

Rather than establishing the reason for the visit, the resident-participant usually begins the visit by inquiring about the patient's social history, "What do you do for a living?" or by asking a general social question, "What do you think of the weather we are having?" It seems resident-participants begin the visit this way because they feel they are either building rapport with the patient or because they are not sure how to structure the opening of the interview in a meaningful way. If the patient discloses anything sensitive, the resident-participant is not comfortable acknowledging the issue, or sits silently indirectly encouraging the patient to continue with their story either not wanting to interrupt or not sure what to do. If the resident-participant stays with the social issue, they become increasingly "lost" and lose control of the interview. Even though the front desk may have indicated the patient's stated reason for the visit in the computer, the resident-participant often follows their social inquiry up with, "What brings you in today?" in hope that the patient will establish the focus and lead the interview. The resident-participant

may begin reviewing the chart for the first time after the patient is seated and the interview has begun. The resident-participant's focus and priority is getting the diagnosis right.

If the patient presents the resident-participant with multiple complaints, the resident-participant quickly become overwhelmed and is unsure of how to proceed. If patients do state a complaint, the resident-participant assumes that this is the only issue patients wish to talk about and quickly begins history taking using a very focused and often over-inclusive approach. For example, if the patient indicates they have been having headaches, some resident-participants begin asking a series of close-ended questions. "When did they start? What makes them better? What have you taken to relieve the symptoms? Are they just on one side of your head or do they feel like a band?" Resident-participants experience a sense of relief that they know the diagnosis and the associated questions to ask, so the previously memorized list of "headache" inquiry questions come tumbling out before they forget one. Often these focused medical histories are also overly inclusive, in other words the resident-participant indiscriminately asks every headache related question they can think of. If the resident-participant is unsure of what to ask in relation to the presenting complaint they seem to take a broad, sweeping and often disjointed history. There is a sense they are asking whatever question pops into their head. For example, "When did the headaches start? Do you smoke? Are you experiencing any diarrhea? Have you lost any weight? What about blurry vision? Does diabetes run in your family? What do you do for a living? Are you under any stress?" Although the patient's interests always seem to be at the centre of both of these approaches, it is the resident-participant's agenda that seems to dominate. There is an underlying fear that they will miss "the question" that may inadvertently harm the patient, leading to a lawsuit. The patient's illness experience and associated life context are secondary to "nailing the diagnosis" accurately. Right from the outset resident-participants want to provide the best care to their patients, however in the beginning the best care is narrowly translated as getting the diagnosis right.

After fifteen – twenty minutes of history taking, followed by a brief physical exam, they reassure the patient that they know what is going on, but need to briefly consult with their preceptor or double check on a medication. After locating the preceptor, the resident-participant often proceeds to give a too brief, a disjointed or an overly inclusive report to the preceptor. There is an impression that they are

unsure of the relevant pieces of the inquiry.  The resident-participant often forgets to ask the patient

common medical questions related to headaches (Do you have a history of these types of headaches?) or

questions to rule out possible other causes (differential too narrow) or to find out how the headaches fit

into the patient's life context.  This behavior is often indicative of an interview with either too narrow of a

focus or an overly broad approach with no focus.  The patient's social history is often absent from the

inquiry.

After providing a synopsis of the visit, the resident-participant responds to the preceptor's

questions and awaits further direction.  There is not anything proactive or collegial about the resident-

participant's approach to this relationship.  They welcome the opportunity to share the responsibility,

receive feedback and direction.  Depending on the preceptor, they may accompany the resident-

participant back to the office to check the accuracy of the resident-participant's report and to role model

an appropriate treatment and management plan. If the resident-participant returns alone, they feel

obligated to explain their absence and to ensure the patient they just needed to ask some clarifying

questions.  The resident-participant asking the pertinent questions they omitted earlier follows this.

End of the interview – Treatment and Management Plan

The resident-participant presents their diagnosis, treatment and management plan in one run-on

sentence, indiscriminately purging themselves of all information they know on a topic. Again there is an

underlying fear that they will omit a key piece of information that may inadvertently harm the patient or

lead to a lawsuit. Offering to answer the patient's questions or eliciting the patient's thoughts or feelings

is avoided or forgotten.  If there is a medication involved, the resident-participant reviews the medication

several times with the patient, needing more to reassure themselves of the correct dosage and

recommended use, than to elicit the patient's understanding of the medication.  During the management

phase of the interview, the resident-participant's primary struggle is with choosing the appropriate tests

and referrals for the diagnosis.

Community resources are often forgotten and are only addressed if raised by the preceptor or

patient.  Preventative health issues and lifestyle changes relevant to the patient are rarely evident in the

management plan.  This is because they either have not thought to include them in their earlier patient

inquiry or because they are unsure how to incorporate or approach issues such as substance use and diet. There is an awkward silence as the resident-participant is unsure how to end the interview. Often the resident-participant reopens the interview by inquiring, "Is there anything else you wanted to talk about today?" They are unsure whether they should walk the patient out, show them to the door or remain seated.

### After the Encounter

Before getting the chart for the next patient, the resident-participant struggles to complete the billing form trying to recall what was said in the orientation meetings. The entire office visit lasts 45 – 60 minutes and charting is left until later.

The office visit does not end there for the resident-participant. The morning's roster of patients is reviewed with the preceptor and peers during chart review at the end of the clinic. In the beginning, patients may have to be phoned back to change or clarify treatment and management plans following this meeting. Many resident-participants report they spend the evening ruminating, wondering if they made the best choices for their patients earlier in the day, especially in regards to diagnosis and treatment and management.

## *Six Months Later …*

### Prior to the Encounter Beginning

In order to feel prepared and so they can manage their time better, the resident-participant comes in early to review the patient charts for that days clinic. If they have seen the patient previously, they pay particular attention to the last visit where they have frequently highlighted the follow-up plan. If it is a new patient to them, they quickly scan the patient's Past Medical History (PMH), including medications, and review the previous physician's last note. Unlike the first few weeks they are aware of the stated reason for the office visit and when appropriate get equipment or lab requisitions ready ahead of time. Now when they review their roster of patients and see returning patients, there is frequently a

feeling of satisfaction and pleasure, however if they had difficulty with the patient previously there is a feeling of dread.

Resident-participants are more comfortable in the role of doctor and confidently walk to the waiting room.  They now call the patient by name, using both their last and first name in case they mispronounce either name.  If it is a new patient, they may not introduce themselves or shake hands, preferring to wait until the privacy of the office where they can say their name clearly and make eye contact.  Often they deliberately encourage the patient to walk ahead of them to the waiting room so they can observe their general appearance. As well, they now invite the patient to sit down in the chair beside the office desk no longer allowing patients to choose their seating.

### Beginning of Interview

The interview begins with a short welcome and then the resident-participant proceeds to clarify the purpose for the visit. Interviews no longer begin with non-directive open-ended questions.  The resident-participant now makes a conscious effort to determine the reason(s) for the visit and to establish an agenda at the beginning of the interview. "Anything else?" becomes a common refrain.  Resident-participants no longer assume the first complaint is the real complaint or the only complaint.  If the patient seems to have too many complaints for the fifteen minute office visit they make efforts to negotiate what issues are going to be dealt with today and which complaints the patient will make additional appointments for.  Once the agenda is determined some resident-participants, depending on their confidence in the issue and familiarity with the patient, are more comfortable taking a few minutes to explore where the headaches fit into a patient's life context (without fearing they will lose control of the interview).  However, most resident-participants immediately begin taking a focused history of the presenting complaint.

### Middle of Interview – Data Collection

The resident-participant's headache history is more appropriately focused without being overly inclusive.  Resident-participants now incorporate specific "Red Flag" questions pertinent to headaches to quickly help them decide if they should pursue additional lines of questioning relevant to headaches or rule out more acute conditions. Some lifestyle questions related to headaches, such as smoking or

caffeine use are now asked but only in narrow relation to the presenting complaint, while others continue to be forgotten or ignored

If a physical exam is necessary this is carried out in a more confident manner. Although the medical interview itself is more organized and with a focus and purpose, the approach to the interview continues to be dominated by a doctor-centered approach as resident-participants continue to struggle with confidence in their knowledge base.

Resident-participants are more comfortable indicating to patients they need to step out to discuss their findings with the preceptor or do not provide any rationale for needing to step out of the office. The report to preceptors, as with the medical interview with the patient, is far more organized and relevant. Although key pieces of the patient's history are still omitted and straightforward diagnosis missed, resident-participants are more proactive and confident in their diagnosis and subsequent recommendations for the treatment and management both to the preceptor and with the patient. The resident-participant is also more proactive in the interaction with the preceptor, often asking well-formulated questions and seeking specific advice.  If additional information is needed to manage the office visit, resident-participants are able to identify the specific gap in knowledge and able to independently seek out the relevant information as opposed to waiting for direction from the preceptor. Resident-participants feel preceptors no longer feel they need to "micro-manage" the resident-participant's office visit and, depending on the preceptor, allow resident-participants to send patients home without first consulting.  In fact, the resident-participant is almost resentful of needing to "check in" with a preceptor if they are confident of the diagnosis as it creates problems with time management. Although the resident-participant-preceptor relationship is more consultative and collegial, the level of supervision often seems dependent on the preceptor's comfort level and style of supervision and not necessarily on the resident-participant's skill level.

End of the Interview – Treatment and Management Plan

Resident-participants are more comfortable inquiring about the patient's illness experience and retrieving more meaningful and relevant social history.  Although treatment and management plans continue to be overly exhaustive at times and presented as "run on sentences," there is more of an effort

to individualize some aspect of the treatment and manage plan rather than providing "one size fits all" recommendations. Resident-participants are more comfortable taking a "wait and see" approach and asking patients to come back, rather than feeling they need to address everything in one visit.

However, addressing lifestyle issues continue to be a struggle. For example, resident-participants may recognize alcohol may be an issue but purposefully choose to defer discussion until "they have established more of a relationship with the patient." When resident-participants do choose to address lifestyle issues such as alcohol use, it seems to be a one-way conversation in the form of direct advice giving.

Although inclusion of community resources in treatment and management plans is still minimal, there are efforts to seek out recommendations from preceptors or health care professionals within the unit. As well, reports to preceptors involve a more meaningful social context history rather than either no reference to a patient's life context or illness experience or broad information such as occupation. Since some patients are not reviewed with the preceptor until chart review, resident-participants sometimes find themselves needing to call patients back to clarify information or alter treatment and management plans.

Time management is less of an issue (although it remains an issue) as resident-participants gain confidence in writing prescriptions, locating lab requisitions and completing billing forms. Concentrated efforts are made to write and talk during the office visit.

<u>After the encounter</u>

Less time is spent charting at the end of clinic and following the final report, although it continues to be a challenge. Resident-participants spend less time in the evenings reflecting on decisions made earlier in the day.

*Summary – Chapter 7*

The clinical encounter was used to summarize and show how the knowledge and ideas the resident-participants learned during undergraduate training played out in practice and changed over time during postgraduate training. The changes that occurred were often dramatic

as the resident-participants struggled with what seemed like simple tasks such as knowing how to introduce themselves to more complex tasks such as developing effective treatment and management plans. Initially resident-participants were unsure of how to use their knowledge in an organized way with patients. Understanding how to bill, manage their time, and locate paperwork added to their feelings of inadequacy. Resident-participants were overwhelmed with the responsibility of needing to establish relationships with patients and often avoided or ignored issues seemingly not related to the patient's presenting complaint. Resident-participants relied heavily on their supervisors to guide them.

As time passed, the resident-participants began to change their approach to the clinical interview and to develop more effective strategies for managing the clinical encounter. For example, their interviews had more organization and their history taking became more focused and discriminating. No longer did they feel supervisors needed to micromanage their decision-making, as they were able to identify their gaps in knowledge. Resident-participants became acclimatized to their new environment, although time management continued to be a struggle. As relationships were being built, resident-participants learned to establish expectations and to set limits.

By using the clinical encounter as a contextual backdrop for getting a more holistic sense of the resident-participants' experience, relationships can be seen between the resident-participants' stage of practice and their concern. For example, in the beginning all resident-participants were concerned about how to introduce themselves, whereas six months later the resident-participants were comfortable with their greeting and this was no longer an overwhelming concern. The fictional interviews allow readers to see relationships between the resident-participants' stage of practice and the sub-category itself. For example, initially the

resident-participants were more concerned about their level of knowledge, but this later shifted to how they were using their knowledge in the interview with patients. Finally, the fictional interviews show relationships between sub-categories. As the resident-participants became more confident in their knowledge base, the resident-participants expressed more of an interest in understanding the patient's life context.

The clinical encounter also made it possible to better envision and understand how the resident-participants' concerns led to the need for change. Initially, it was awkward greeting the patient in the waiting room. It was time consuming to begin getting the equipment together to do a Pap test while the patient was waiting. It was awkward and time consuming to be flipping through the chart reading the patient's past medical history while the patient was sitting in front of them. In the next chapter, I will continue to use the clinical interview as a backdrop for a closer look at the influences resident-participants attributed to the changes that occurred.

Chart 2 – The Clinical Interview

*Adjustment to Responsibility*

| First Few Weeks | End of Six Months |
|---|---|
| **OPENING** | |
| Begins encounter without reviewing chart | Reviews list of patients and gets any necessary equipment ready<br>Reviews chart prior to seeing patient |
| Unsure how to greet patient/introduce self | Comfortable introducing self as doctor |
| Opens interview by focusing on social history or begins asking close-ended questions regarding initial complaint | Opens interview by referring to front desk stated agenda/last note agenda |
| No attempt to elicit or set agenda (endeavours to address all complaints in one interview) | Efforts to clarify and set agenda<br>Deliberate effort to elicit  patient expectations |
| Begins reviewing chart while talking to the patient | Begins charting |
| | May or may not inquire about patient's illness experience |
| *No real distinction between beginning and middle of interview* | *Clear distinction between beginning and middle of interview* |
| **DATA COLLECTION** | |
| Disorganized history - Narrowly focuses on first complaint with close-ended questions / disjointedly asks any/all questions related to the presenting complaint (overinclusive)<br>No reference to lifestyle risk factors | Incomplete but organized HPI which may or may not include relevant lifestyle risk factors |
| *Some* Red flag questions and some pertinent negatives may or may not be evident in history<br>Difficulty prioritizing & discriminating | Asks most relevant Red Flag questions<br>Evidence of a differential – asks most pertinent negatives |
| May not ask any PMH questions | Asks questions related to PMH |
| May begin charting | Continues to chart |
| Does not inquire about social history | May inquire about social history |
| No inquiry into preventative health behaviours | Limited inquiry into relevant preventative health behaviours |

Chart 2 – The Clinical Interview (continued)

| First Few Weeks | End of Six Months |
|---|---|
| **PHYSICAL EXAM** ||
| Supervisor may review history/physical with patient | Supervisor rarely reviews history/physical with patient |
| Consultation with supervisor – Reliant and reactive | May or may not consult with supervisor – Collegial and proactive |
| **TREATMENT & MANAGEMENT** ||
| Management plan an over-inclusive run on sentence | Presents management plan |
| One size fits all management plan focused on diagnosis | Some effort to tailor to patient |
| No effort to elicit questions | Some efforts to elicit questions |
| No inclusion of community resources | May include community resources |
| No recommendations outside of presenting complaint | May make recommendations outside of presenting complaint |
| Unsure of how to end interview – May ask "Is there anything else I can help you with?" | Deliberately closes interview by setting time and agenda for follow-up appointment |
| Estimated Time – 45 minutes | Estimated time 20 – 30 minutes |
| Stays late to complete charting | Charting almost complete |
| May need to call patient back to alter treatment and management plan after chart review | Rarely needs to call patient back |

**Chapter 8**

The Influences that Changed Practice

I used the three categories of concerns, changes, and influences to better understand the experiences of newly graduated doctors beginning postgraduate training in Family Medicine. Changes and concerns have been described and interpreted using commentary and quotes from the resident-participants and were used to create two fictional interviews to provide the reader with a portrait of how the changes and concerns intersect. The changes that took place during the first six months of clinical practice in the Family Medicine residency program did not happen in a vacuum, but through the context of practice. Based on re-reading the texts, reading the context around the quotes on the cue cards, and working with the data about concerns and changes, I determined that the resident-participants described five types of experiences they attributed to influencing the changes that occurred during the first six months of clinical practice. These five influences are described in Table 6.

Table 6

*Influences Defined*

| Type of Influence | Definition of Influence |
|---|---|
| Practice Experience | The experience of providing care to patients in the context of the Family Medicine clinic |
| Continuity of Care | The experience of providing care to the same patient more than once |
| Time Management | The experience of providing care within the confines of time limited appointments |
| Feedback | Verbal feedback from patients, supervisors or health care professionals |
| Role Modeling | Observing the behaviour of a supervisor, health care professional or peer |

The described influences will be presented using a sample of quotes to contextualize our understanding of how, from the resident-participants' perspective, these influences shaped change in the context of practice. Not all identified influences affected every change. Sometimes an influence would act in isolation to change resident-participants' practice, but more often than not it was the compounded effect of a combination of the influences over time that resident-participants attributed to changing their practice. It is for this reason that interpretive commentary will be used throughout the text and subheadings to guide the reader by illuminating the links and by highlighting relationships.

Chart 3 entitled "Summary of Impact that Influences had on Changing Behavior and Attitudes" was created to better visualize what influences contributed to what changes as the resident-participants adjusted to their new responsibilities in the areas of knowledge, relationships, and practice management. This chart is located at the end of the Chapter. While I

was creating Chart 3, I was moving back and forth between the cue cards, the tables, and the texts, asking myself questions such as, "Which came first, the change or the influence?", "When did this change occur?", "Was this change attributed to more than one influence?", "Is this a change to how they are working with their knowledge or is this a change to how they are viewing patients?", and "Did more than one person have this experience?".

*Knowledge*

*Organization of the Interview*

In the beginning resident-participants voiced concerns over not having an approach to the medical interview. For example, they struggled with how to open the interview, establish a focus, organize their history taking, and appropriately close an interview in a time efficient way. In the first few weeks and months they had described how they were "open and nice" to everyone. Not because they were deliberately trying to ask open-ended questions or be patient-centered but because they weren't sure how to organize the interview. "You just really don't know how to approach things and as a student you really don't get that stuff."

Resident-participants described feeling overwhelmed with reconciling how to efficiently accomplish a large number of tasks, including establishing a relationship with the patient, in a short period of time. Resident-participants described how, through the experience of practice, they began to recognize that they needed to establish an agenda at the beginning of the clinical encounter to focus and organize the interview. This meant learning how to elicit the patient's expectations, prioritizing agenda items, and setting boundaries and limits.

Several forces over time conspired to influence these changes. The experience of practice helped resident-participants to learn when and when not to ask open-ended questions so

they could better maintain control of the interview. During the course of the interview the patient's feedback also modified resident-participants' approach. For example, patients often give clues either verbally or nonverbally in response to the resident-participants' line or type of questioning. In the beginning resident-participants tended to miss these clues, but with the experience of practice they began to recognize and pick up on some patient cues. "I think that there is a certain amount of trial and error where people realize for themselves, sort of catch on to it by accident perhaps, that if they deal with people in certain ways and if they ask questions in certain ways that they get to the end result." This seemed especially true if supervisors provided feedback on the resident-participants' interactions with patients and highlighted communication breakdowns or missed opportunities.

Observing the supervisors in action also influenced the resident-participants' approach to the medical interview. "I've heard other physicians here do the 'What can I do for you today?' line and I did make a conscious decision that I didn't like that one as much as 'What brings you in today?'" Resident-participants commented that what they perceived to be negative role modeling also influenced their approach in the interview and helped them further define how they wanted to practice medicine with patients. "In the beginning I would just give patients a conventional answer that I would sort of hear other doctors say; now I give them what I would say. The continuity of seeing people more and more. Just learning what works. You just have to kind of go with the flow and figure out what style will suit you best."

The experience of continuity of care was also instrumental in teaching resident-participants the value of adopting a "wait and see" approach, which in turn removed the self-imposed pressure to "fix everything" in one visit. "I feel more comfortable saying come back for

that issue. Especially when it's not urgent and it has been a chronic problem for X amount of time and you really don't need to deal with it now."

The pressure to manage their time efficiently was the most frequently cited reason resident-participants gave for recognizing the need to develop an organized approach to the clinical encounter. "I still think its [time management] about making the interview as efficient as possible, still letting the patient tell their story, but directing them into telling it in the most efficient way possible. I hate to rush people and then once I get behind then I think now I really can't rush them because they have waited all of this time so it becomes a lengthening exercise and then I get further behind. So working on those skills is still a priority." The verbal feedback received from patients and the clerical staff manning the front desk was a constant reminder that time was passing. Patients would often complain about the amount of time they were kept waiting and the front desk staff would call into the office to let resident-participants know they were running behind schedule. At the end of six months, resident-participants were still wrestling with time management issues that were often related to poorly organized interviews.

*Data Collection*

In the beginning resident-participants struggled with knowing what in their knowledge bank was relevant to the history. For example, in the beginning three different types of data collection strategies seemed to be described. The resident-participants' medical histories tended to be (a) narrowly focused on one disease with no evidence of a differential, (b) overly inclusive where resident-participants indiscriminately asked every question they could think of that might relate to the presenting complaint, or (c) void of any line of questioning because they weren't sure what to ask. There did not seem to be an organized or logical approach to problem solving or clinical decision-making. This was clearly evidenced by the number of times resident-

participants complained about not knowing where to begin with patients who presented with multiple issues. All of the resident-participants voiced concerns in the beginning with their ability to generate differentials, clinically reason around the diagnosis (especially if there were multiple issues), make decisions regarding the diagnosis, and create reasonable treatment and management plans.

In the beginning resident-participants seemed under the impression that the algorithms they had acquired for clinical decision making for diagnosis had prepared them for practice, but with experience quickly began to realize what they had learned did not necessarily translate well into practice. "Putting it into practice is a new concept … because you've finally gained this breadth and wealth of knowledge that you feel now you want to use. You've got it and now you can just use it. It's like an algorithm. A patient comes in with complaint A and you go down the road and ask the right questions for disease X, so you prescribe drug whatever. And then you realize that those algorithms are useless when it comes to patients in our care because they don't apply, they don't apply at all." The experience of practice itself meant seeing the same disease scripts over and over again, which seemed to help resident-participants develop an organized approach to more common problems. "You just get more comfortable because you just keep seeing the same things over and over again…."

Experience over time was the factor resident-participants most often attributed to a shift in an increased sense of comfort and confidence in their knowledge base, although some described this shift more clearly and earlier than others. "As time goes on you just start to get comfortable because you just keep seeing the same things over and over again and eventually the stupidest of all of us can …. we have a saying repetition teaches the donkey."

Resident-participants begin to ask more relevant or focused questions with the experience of practice. "I'm picking better questions, more strategic questions. I guess that's based on knowledge and trial and error." The supervisor's feedback seemed to accelerate this process, especially when resident-participants were asked to return to the office visit or call the patient back to retrieve forgotten information. In the beginning, watching supervisors model their line of questioning to a specific complaint in the context of practice helped resident-participants to modify their own history taking. "Having preceptors sort of help you sort through it, that sort of helps you to figure out priorities, how to manage something like this or other similar frameworks so you kind of have a framework for what happens before you try it with a patient."

The pressure of time management highlighted the need to know which questions to ask to determine "what's urgent" and "what's not" and reinforced the need to learn the pertinent "red flags" to quickly rule in and out acute problems/differential diagnosis. "I feel like I can get at the meat of issues faster now. Just by asking a bit more selective questions." But the experience of continuity of care diminished the earlier sense of anxiety and pressure resident-participants felt with not knowing any context around a patient's medical background. "It feels really nice knowing that as soon as you see a person you know what their issue is and what their past medical history is and stuff. So when I talk with them I feel very comfortable ….when you know a patient, you don't waste or spend time regurgitating basic information so it's quicker." The experience of continuity of care seemed critical in reinforcing the idea of a "wait and see" approach, relieving some of the self-imposed pressure to not miss anything. This is demonstrated in the following reflection:

> "I think just seeing people over time where you realize that there are always things that maybe they didn't tell you about the last time. For example, maybe she never mentioned to me that she has back pain, so she's telling me now about

the back pain but she's had the back pain for the last year and it hasn't really gotten any worse and it hasn't given her any problems, she just happened to mention it. And realizing even if she had mentioned it a year ago and we had done nothing, nothing would have changed, nothing would have gone bad and you see a lot of people with chronic things like that. And they got better on their own and you start to get the perspective that things do get better on their own a lot of time. A large number of things most people are basically healthy, most people do not have underlying horrible diseases that you have to go fishing for. Most of the time if you can't get the answer on history and physical chances are its not going to be something horrible because you are going to learn the triggers."

As a result of using a "wait and see" approach resident-participants were able to better prioritize and "leave out" questions. "I think its about knowing how to prioritize, its about being able to improvise, its what's most relevant now, learning what can I do and what can I leave."

The results of previously ordered diagnostic tests that were deposited in their "mailbox" everyday also acted as a feedback loop that strengthened resident-participants' confidence in clinical decision-making. One resident-participant commented that, although checking on laboratory results and filling out paperwork was one of their least favourite activities, it was instrumental in helping them recognize what was important to address immediately and what could wait. " … having all these new stacks of papers in my mailbox and having to check them out and it's a learning curve I guess because you have to find out what's urgent and what's not urgent and you have to remember to call patients back …."

In the beginning resident-participants did not read the patient's chart ahead of time, but at the end of six months all resident-participants commented on how, with new patients, they reviewed both the chart to get a sense of the patient's past medical history and care, and the last progress note written. "It became obvious to me that looking at the chart would be a very good

thing to do in the whole initial meeting of the patient." If it was a patient returning to them they were now familiar with the patient's past medical history and they paid particular attention to their own (often highlighted) plan noted in the chart from the last visit. Resident-participants learned from practice experience that not being familiar with a patient's past history (medical and social) and treatment meant they often asked redundant questions. It also interfered with their diagnostic thinking, which in turn affected their ability to efficiently gather relevant data. The patient's negative feedback of, "It's in the chart" also motivated resident-participants to familiarize themselves with the patient's history before having contact.

*Treatment and Management Plans*

Most resident-participants felt they had little opportunity as undergraduates to independently develop treatment and management plans and, as a result, felt inadequately prepared in this area going into postgraduate training. In the beginning the resident-participants' treatment and management plans were either minimal, because they were unsure of the diagnosis/relevant management, or exhaustive because they tentatively knew the diagnosis and did not want to leave anything out in case they harmed the patient. In the beginning resident-participants also seemed to feel it was their responsibility alone to "fix everything" while the patient was relegated to a subordinate role. With the experience of practice, resident-participants began to realize that patient's thoughts and feelings played a role in their treatment and management plan. "I need to relinquish the idea of I don't really have power over the patient's decisions and that's been frustrating."

Continuity of care was instrumental in increasing the resident-participants' sense of confidence in their diagnostic ability, and recognizing that the bits and pieces they omitted did not affect the outcome of care. The experience of practice seemed to help resident-participants

recognize that understanding the patient's social context was key to creating an effective

treatment and management plan. "I think you become more aware of the importance of that

[social context] the more you practice. You take the focus off the knowledge, but it also

becomes part of your knowledge because your realize that if you emphasize more of the social

part the patient might be more compliant with medicines or they might be better able to deal with

whatever disease they have." This concept was also reinforced through the supervisor's

feedback that necessitated the resident-participants' return to the encounter to ask additional

social context questions in order to construct a treatment and management plan.

Concerns about time again helped the resident-participant begin to discriminate in terms

of what information was important to address and what information could possibly wait. The

experience of seeing the outcome of treatment plans through continuity of care was key to

influencing how they viewed what was an acceptable management plan. "If somebody has a

wound infection, you realize if you don't give them antibiotics that most times it won't become

infected anyway. As you realize that, it makes you more confident with departures from the

algorithm and as you become more confident with that you become more willing in the doctor-

patient relationship to tolerate deviations because you then realize that the deviations are

probably of less consequence than you thought earlier on in your training."

Patient feedback helped resident-participants realize that patients were not able to

necessarily digest and comply with everything they recommended during the previous office

visit. "I can recognize now that the patient's can't get there that fast and its okay that the patient

isn't there right away." As they got to know patients and their histories, they described

providing management plans that were more tailored and realistic. "You become more realistic,

you realize this homeless person that comes to you in the clinic that you are not going to get him off the street between now and next visit."

*Practice Management*

*Charting*

One of the most consistent changes cited by the resident-participants was their charting habits. In the beginning efforts to chart during the interview were minimal, whereas, by the end of six months most resident-participants were perfecting the art of writing and talking at the same time. "I feel like I can write my notes better. I can talk and write a bit better now." Experience from practice had taught them that their recall was not as effective as they had hoped and the anticipated negative patient feedback about charting during the interview was not forthcoming. However, the time needed to complete their charting at the end of the clinic was the most common reason cited for changing their recording habits. The supervisor's feedback also played a role in helping resident-participants adjust the quality of their charting from being either too minimal or too comprehensive.

*Paperwork*

In the beginning locating paperwork and equipment, and understanding the different protocols of the clinic were frustrating and time consuming. Through the experience of practice, resident-participants became familiar with the layout of the clinic and their frustration quickly diminished. However, the amount of time spent trying to locate paperwork and equipment during a busy clinic day influenced them to collect and organize anything necessary ahead of time. "So it used to be when a patient came that's when I filled out the paper work. So I would fill out the requisition form whatever. If they needed new scripts that's when I would do it.

Now I can do it beforehand.  So that saves time.  So when I fill out his requisition form ahead of time when he's ready to go even if I haven't focused on that topic with him."

*Community Resources*

In the beginning, the resident-participants' knowledge of community resources was limited to non-existent.  The need to manage their time highlighted this shortcoming.  As time went on they began to develop a working bank of frequently used resources primarily through seeking information from supervisors and clinic health care professionals.  "If you become more familiar with resources, that tends to save time as well."  Many resident-participants commented on how impressed they were of the depth of knowledge supervisor's, social workers, and clinic nurses seemed to have about relevant community resources.  "This one particular preceptor that I work with a lot, she just amazes me that she just has these resources at the tip of her tongue and anything you could ever want to support your patient with she knows where they are and whose covered by OHIP and who gets people in fast.  That's the kind of resource knowledge that is incredibly valuable for a Family Physician and I'm still building."  Nursing staff were identified as an influence in relation to locating community resources and for role modeling basic clinical skills.  "If you watch a really competent nurse who has had a lot of experience with kids, giving needles all day long and maybe one kid cries that really teaches you a lot about how to interact with children."  Patient feedback in terms of appreciation and the experience of seeing the benefits of referrals through continuity of care reinforced the role of community resources in care.

*Billing*

Billing was a practice management concern cited at the beginning of the residency, but the repeated experience of having to fill out billing forms at the end of every clinic resolved this concern. "…whenever you are seeing a patient it's there because the billing sheet is on the front of every single patient's chart."

*Time Management*

The pressure the resident-participants felt to manage their time efficiently in the clinical encounter was voiced throughout this study. In the beginning most clinical encounters took anywhere from 45 to 60 minutes. Resident-participants felt they needed to address and resolve every issue in the first few weeks and had a difficult time prioritizing issues. "Then you realize that time is a problem and there are only so many questions that you can answer and you sort to of have to make priorities." At the end of six months, the average interview could be completed in less than 30 minutes and some within the target time of 15 minutes, depending on the issue. The need for resident-participants to manage their time efficiently was constantly being reinforced both directly and indirectly. For example, supervisors reminded them that they needed to be ready for chart review, the front desk reminded them that they had a waiting room full of patients, and patients reminded them that they had been kept waiting. "You realize you are constrained by time, you are constrained by what you can do for the patient. There are other patients waiting. There are all these other things going on and it's your time as well."

Supervisors were key in providing practice management advice in terms of tips and short cuts to manage time. "… if you are super, super busy dodge this. If someone brings this, your automatic response should be … Its reasonable to recommend…."

The experience of practice itself and continuity of care were pivotal in helping resident-participants recognize that they didn't need to manage everything in one visit, but could bring patients back.  "I'm realizing more and more, I can't do everything in one visit so making more sizable management chunks or even you are going to have to come back for a second visit for this because we are not going to get to that today.  Breaking it up rather than trying to do too much in one visit."  Continuity of care also created a familiarity with patients and their backgrounds that helped expedite office visits in a practical way.  "In terms of my own patients, I would say because I know them now, so all of my follow-up appointments are much faster and that feels really good.  It feels really nice knowing that as soon as you see a person you know what their issue is and what their PMH [past medical history] is and stuff."

*Relationships*

*The Resident-participant*

During the first few weeks for all, and on into subsequent months for others, the resident-participants felt like they were masquerading as the doctor.  They were not necessarily medical students in training, but they did not feel like they deserved to be called doctor given the amount of responsibility they held.  They described how inadequate and uncertain they felt, particularly in relation to their level of knowledge.  In the interview, they often handed over control to the patient and were reluctant to commit themselves to a diagnosis or an opinion.  At the end of the six months most resident-participants felt like the doctor and those who were still not comfortable felt less like they were role-playing.  When resident-participants described having more confidence in themselves in the role of doctor, they equated this with having more

confidence in their knowledge base from practice experience. Confidence in knowledge seemed to translate into more proactive decision-making and general involvement with patients.

The experience of continuity of care with patients was also frequently voiced as increasing the resident-participants' level of comfort and confidence in their ability to provide quality care. "The big difference is continuity. Without continuity you can't really establish that sort of confidence and follow-up and relationship. You feel … you feel like a real doctor." The initial sense of anxiety and pressure resident-participants voiced in the beginning around not knowing their patient's medical background was diminished through continuity of care. "It feels really nice knowing that as soon as you see a person you know what their issue is and what their PMH [past medical history] is and stuff. So when I am talking with them I feel very comfortable."

In the beginning, both positive and negative feedback from supervisors and patient's played a large role in determining how resident-participants felt about themselves, which is indicated by the following reflection:

> "I find at the end of the day there is very little satisfaction that comes at the end of the day unless you had a really good encounter or something has gone really well with the patient, at the end of the day you just kind of feel drained and relieved that you made it so its nice to get some feedback be it from a patient or a supervisor that it is going well and how deflating it is too, to hear that you didn't deal with that particularly well or 'I wouldn't have given that medication' or 'I wouldn't have investigated it this way'."

Another resident-participant described how important their supervisor's feedback was in helping them gauge their performance and feel like the doctor:

"I actually got feedback from one of my preceptors during my second or third month saying that he felt when he was watching me over the video that I was really presenting myself as the doctor and I was presenting a lot of confidence and going in as the doctor so that encouraged me to think of myself that way because … it was okay that I was doing that. Because I wasn't really sure how far you're supposed to over step. Am I over stepping? Should I be slowing down? Should I be speeding up? Like where am I ? He actually thought I had a good mature attitude and a good competence level where the patients felt like I was their doctor … that was his impression. And so I think that it helped a lot getting that kind of feedback early on so I felt like it was okay to step out a little bit and feel like I was the doctor."

Experiencing "pivotal" moments with patients "as the doctor in charge" for the first time also seemed to be very influential in shaping how resident-participants experienced their responsibility as the doctor. Some seemed to feel "losing" patients was a form of negative feedback as it was a reflection of their competency. After the first death of a patient, one resident-participant recalled spending a lot of time second guessing decision-making in regards to the treatment and management plan and wanting to be certain everything had been done "perfectly". "It's a blow to your confidence. You realize that you don't know everything and you can't control everything and that people are going to die on your watch, so to speak".

Often the patient's or their family's feedback was the exact opposite of what resident-participants had anticipated. One resident-participant recalled mentally reviewing all decisions, preparing to medically-legally defend treatment choices with the family. Instead, the family simply thanked the resident-participant. "I was bracing myself for her to be asking me all the questions I was asking myself which was ridiculous because of course those questions weren't on her mind and all she wanted to say was 'thank you'." These "first" practice experiences

seemed influential in helping resident-participants own their new patient care responsibilities. "I was the primary physician in hospital.  I was working under the supervision of another doctor, but I was certainly the doctor that saw him everyday.  I was writing the orders.  I was the doctor that was at the helm of his care... Its ultimately my patient who dies or lives or does well and I have responsibility for that patient."

The experience of role modeling or watching other physicians in action seemed to influence who they wanted to be as physicians both positively and negatively.  Patients' verbal and nonverbal feedback regarding the resident-participants' relationship and performance as their doctor was perhaps the most influential factor in helping resident-participant's feel more secure and confident.

> "First of all the title is there and that's all well and good but you can tell from the way that they interact with you that they see you as their physician.  Its not kind of 'Look, Oh the resident-participant and somebody is watching you on the TV and that's the real doctor.  They talk to you.  They are asking you.  What do you think about this and what do you think I should do about that?  There's trust and they believe in you.  Its not like they are desperate and they are just needing to talk to anybody.  They are seeking you out right?  They see you as the person they identify to other people as their doctor.  And that's really cool!"

Several of the resident-participants commented that being at a hospital site where they had a "longitudinal" program provided an opportunity to develop long-term relationships with patients.  "I think the value of the longitudinal Family Medicine program is you know you are going to have to deal with this patient for the next two years as opposed to a lot of Family Medicine programs where you are there for four months at a stretch (and can't offer regular follow-up appointments)… you feel a real sense of responsibility, ownership of that relationship.

These are my patients." Another resident-participant commented that knowing he/she would be following the same patients for two years had changed his/her "mental sense of urgency" especially in respect to helping patients with lifestyle changes. Other resident-participants commented that continuity of care helped them learn that boundaries could be "customized" and that they didn't have to take the same approach with every patient. Building relationships with patients over time increased the resident-participants' confidence in their medical management and ability to meet patient's needs. "I am more confident in my own skills, more confident that I have something to offer, that I do have a knowledge base and can provide helpful clinical doctor skills to the patient."

*The Doctor-Patient Relationship*

The resident-participants' approach to the doctor-patient relationship in the beginning of residency seemed very 'resident-participant-centered', meaning they were more concerned about their own agenda than the patient's. Competent care from the resident-participants' perspective seemed narrowly focused on, and defined by, the medical outcome. Resident-participants seemed more absorbed with wanting to make sure they got the diagnosis right and less concerned about developing a reciprocal therapeutic relationship. For example, in the beginning resident-participants were preoccupied with how to introduce themselves to patients and described being overly cautious and rigid in their style with patients. At the end of six months resident-participants seemed to describe more of a patient-centered style with patients, meaning they were able to comfortably share some power and had broadened their histories to include meaningful inquiries about their patients' life contexts.

Several interconnected forces seemed to influence the shift from resident-participant-centered to patient-centered relationships. The experience of practice itself was often attributed

to changing resident-participants' conception of what it meant to be a competent Family Physician. "You start going down that road [of telling the patient what they need] and then having to stop yourself and go whoa, wait this is patient centered care and it's the patient's ideas that matter. I just have to be sure that what they decide is at least safe and help them find the resources and means to follow up properly and safely." As resident-participants' confidence that their level of medical knowledge was adequate increased with the experience of practice, the fear that they were going to inadvertently harm a patient decreased and they were able to broaden their patient focus.

> "As you become more and more comfortable with the material you become less anxious, you become more and more concerned with the patient's agenda because throughout the training I think there is a sort of anxiety. The more you try to force your agenda on the patient by trying to get down the medical stuff, the more you realize they have something they may want to talk about and it may not necessarily be about the middle ear infection, the sore throat, whatever. That may be the reason they are presenting, but they want to talk about other things. Its difficult for a medical student or a first year resident six weeks out of medical school to listen to those concerns because your real concern is to make sure you don't miss something or at the other end of the spectrum, to make sure the patient doesn't die."

The experience of practice also helped resident-participants learn how to set boundaries as they began to determine with what level of intimacy they were comfortable.

> "If somebody asks you personal questions, do you answer them? Boundaries are a really big issue and I think its fairly common in the first few months because you are getting much more personal with people than you have ever been before and they'll get personal right back with you and they probably think its okay. Its very difficult to be thrown into that situation and thinking 'What do I do?' 'Do I answer these questions?' 'Do I tell them that's personal?' 'Do I back off and be

more like the doctor person?' 'And what does that mean?' 'Which role do I take?' I think there is some role confusion early on in respect to that and in respect to boundaries and personal relationship versus professional relationship with people."

Rather than primarily providing episodic care where resident-participants felt the priority was disease management; the experience of continuity of care gave them the opportunity to develop ongoing relationships with patients, which influenced their comfort level in broadening their focus beyond the immediate medical complaint. "Some of my patients I know super well and I feel comfortable enough to deal with their immediate issues and then ask a few other questions that I know are on their minds… like relationship issues or job issues." Resident-participants seemed to feel more comfortable taking the time to extend their focus beyond the patient's presenting complaint if they were familiar with the patients' medical history. "I have a better understanding of what medications they are on and better understanding of what illnesses they have so I don't have to ask all of those questions again and so I feel like I have a little bit more time to ask them how they are doing otherwise." Knowing the patient could return took the pressure off, "feeling like I have to deal with all of these issues in one go. It helps a lot. It really does". This meant resident-participants could listen to the patient differently. "I don't have all these burning questions in the back of my mind. I would say it's kind of like surveying the land instead of just focusing on one hot spot … it's a very different way of looking at things."

The patient's direct verbal feedback about the resident-participants' performance as the Family Medicine doctor increased the resident-participants' confidence in their ability to fulfill the role. "No matter how many other people are telling you that you are doing a good job sometimes that type of feedback cements it for you because you are actually hearing from the person that you are trying to help and trying to be a doctor for." Efforts to build relationships

with patients were validated through patients "return visits" resulting from continuity of care. This was especially true when the patient's endorsement included recommending the resident-participant to family and friends. "It's when they start referring their husband or wife or their boyfriend or girlfriend to you that you start to think, okay, I'm doing something right." Resident-participants felt this meant that patients trusted and respected them as doctors. Reciprocally, if patients did not return or asked to see their supervisor, resident-participants felt inadequate and second-guessed their competence. "I think the patients' feedback is most important for me, so if I have a patient coming back and the patient says I would like you to be my family doctor, I would like to see you. For me, that makes my day … even more than the supervisor, for the patient's feedback is important and it makes me feel good."

Any and all positive feedback from patients, supervisors, and health care professionals was deemed vital by all of the resident-participants. This feedback was significant in helping the resident-participants feel confident in the role of doctor and Family Medicine resident. "Feedback is big. When someone says you did a good job today like your supervisor in that context, or you have a good mentor who says you have done well in the last six months, it really feels great. You need that feedback." Another resident-participant went on to explain that it was the patient's feedback that was ultimately responsible for influencing feelings about the relationship as the patient's doctor. "Just hearing patient feedback like 'Oh, you are a really good doctor and I hope you stay here' and 'I'm going to refer my friends to you', especially if you have a high opinion of that patient, no matter how many other people are telling you that you are doing a good job sometimes that type of patient feedback cements it for you because you are actually hearing from the person that you are trying to help and trying to be a doctor for."

Patient feedback also influenced how resident-participants saw their role with the patient in relation to what patients expected from them as doctors. "Patients care more about the openness and honesty in the relationship than they do about your medical knowledge and that's been important for me to put things in perspective."

The experience of seeing different patient personalities and needs helped the resident-participants recognize that not all patients either benefited from or wanted the same approach to the relationship and to their problems.

> "I always change myself based on what sort of cues I pick up from patients. I always start initially the same way, 'What brought you in today?' or 'How can I help you?' and then the way in which they present that to me gives me ideas of what they are looking for and what kind of person they are. I definitely change after I get a sense of who they are and how I might approach them."

Through the experience of continuity of care, resident-participants were able to build working, therapeutic relationships. The pressure to manage their time efficiently also influenced their approach to the relationship, but not always in a positive direction. "I feel that as our training progresses their expectations for you to juggle those roles more quickly, assume more roles in the same visit, essentially do more in less time."

The pressure of needing to manage their time also encouraged resident-participants to learn how to set limits with patients on the number of agenda items they could address in a single encounter.

> "At the beginning I felt like I had to try and deal with everything in one go and at one sitting. I'm better at making agendas with patients and setting boundaries. Even with patients coming in inappropriately or making unreasonable demands. I feel like I can be a bit more firm and assertive with them. I'm getting better at setting boundaries I was new to that."

The supervisor's observation of their interactions with patients and subsequent feedback also influenced their approach with patients. "The more feedback I get, the better I get dealing with patients." Finally, observing their supervisors with patients (role modeling*)* also influenced, both positively and negatively, who they wanted to be as the doctor in relation to the patient. "People skills, their ability to cut people off, the way they approach things, their body language, their demeanour, their expressions, their ability to feed off another person and to see what that other person is giving them."

*The Supervisor*

The resident-participants were initially very reliant and dependent on their supervisors for guidance around medical management in the clinical encounter. "I definitely noticed that if I think back to the first couple of months our supervisors tended to be a lot more … not micromanaging but a lot more in detail going through the cases trying to control or not even control, but guide you a little more." Resident-participants seemed to wait for their supervisor's direction rather than make decisions on their own. They waited for their supervisor to formulate questions rather than proactively identifying their own gaps in knowledge. They also seemed to welcome their supervisor's input and presence in the clinical encounter. Having supervisors model their approach to an encounter was always welcomed. Negative modelling could be as powerful as positive modelling in helping resident-participants develop an approach. "Some staff are very much relationship focused and other people were like very much medically legally focused. You take that and you notice it and you analyze it and you apply it in whatever way you think is best for you." The supervisor's feedback, both positive and negative, also played a large role in their sense of self as a physician. If the feedback was positive it bolstered their

sense of confidence especially in their clinical judgment, but if it was negative they felt inadequate. How a supervisor provided feedback also influenced whether resident-participants were going to incorporate the feedback or dismiss it.

> "It's interesting interacting with different preceptors because you might have three different preceptors on three different half days and they all have different ways of doing things and some of them really want you to do things their ways and some often really just want you to do things well and will ask you why you did things your way if that's not what they would do. I think some of the preceptors don't ask questions in a very respectful way, 'Why would you do it that way?!' or 'Next time you should do it this way!' A very condescending, top down, very paternalistic approach. It's not helpful, if anything it entrenches you back into what you were doing in the first place which may or may not have been good, but it doesn't make you want o say 'Oh, okay, I want to do it your way'. But other ones you see them interact with patients or they come up with ideas and make suggestions in a really respectful way, say 'In my experience, you know this kind of thing might have worked with a patient like that you might want to give it a try'. When they make suggestions like that they more kind of make you feel like they want you to think about it. They want to give you suggestions, they want to help you, but they are not telling you that you are wrong. They are not telling you that there is a right and a wrong way of doing it. So I think those kinds of preceptors, where they are good role models and don't necessary need to say anything and you are just watching what they are doing or they are giving you ideas, but they are giving you ideas in a very respectful one on one way, more of a discussion, that tends to influence you more. Things you might adopt into your own practice."

The supervisor's positive feedback, specifically about the resident-participants' approach to the clinical encounter, made resident-participants more cognizant of their style in the interview, and perhaps more importantly, more confident in their ability in the role of doctor.

"Its always nice to get reassurance and there is certain supervisors who I can think of who are good at that and are good at making you feel like, 'You know what, you did the best you could with that interaction.' It's nice to get that validation to feel like you know what you did well with that encounter." As time went on, the amount of direct feedback from supervisors seemed to decrease. Resident-participants interpreted this as a sign that they were doing well and were not in need of correction. "Staff not bringing something up to me is sort of an implicit validation of what I am doing. If they haven't brought it up, I must be doing okay. I must be doing okay … I hope." Many resident-participants voiced disappointment over the decrease in feedback as their training progressed; good or bad, feedback was always welcome. "I just think it's less educational. That was my concern, be it good feedback or bad feedback."

As resident-participants gained confidence in their ability to manage the clinical encounter with the experience of practice, the relationship between supervisor and resident-participant seemed to become more collegial and less subordinate. "I'll pop into my supervisor's office all the time and say … 'Um, what should I do with this?' and if she says probably what you think and you would agree that builds my confidence that she thinks the same way that I do."

*Summary – Chapter 8*

In this chapter, I used the clinical encounter as a backdrop to highlight the five main influences resident-participants attributed to helping them make changes (a) practice experience, (b) time, (c) feedback, (d) role-modeling, and (e) continuity of care. Although one influence could be a more dominant or significant force for change in a given circumstance or to a specific resident-participant, it was the combined effects of the five different influences that over time

seemed to propel change and adjustment to practice.  Chart 3 at the end of this Chapter

summarizes the impact that the influences had on changing behaviour and attitudes.

Through practice experience resident-participants were able to develop an organized

approach to problems which in turn gave them confidence in their ability to successfully care for

patients.  Through continuity of care and patient feedback, resident-participants were able to see

the outcomes of their treatment and management choices.  A feedback loop was created that

either reinforced positive results or encouraged change based on less successful outcomes.

Supervisor's and patient's positive feedback helped resident-participants tolerate the anxiety

associated with the enormous responsibility of caring for patients and gave resident-participants

confidence in their developing role as Family Physicians. Watching supervisors and other health

care professionals in action also helped resident-participants learn new approaches that

contributed to or modified their own their own approach.

Time was both the resident-participants' enemy and their friend.  Knowing that the

process of continuity of care allowed patients to return, the resident-participants' anxiety

associated with needing to make immediate decisions and to manage all problems in one visit

was diminished.  As a result, they began to recognize the benefits of taking a "wait and see"

approach to practice.  The pressure of time constraints also influenced their approach to the

clinical encounter.  Resident-participants described the necessity to have an organized approach

to the medical interview, which meant learning how to prioritize problems and to ask questions

that are more discretionary.  Conversely, this same time management pressure made them more

mercenary in their approach with patients and was an ongoing source of anxiety and frustration

throughout the study.

The various influences that occurred through the experience of practice shaped and changed the resident-participants' experience. It is possible to see how tasks and behaviours change, and how the resident-participants' concept of themselves and their role changes in relation to these experiences. The next chapter will use these findings to elaborate on how the experience of postgraduate training shapes the resident-participants' concept of themselves as postgraduate Family Medicine residents.

Chart 3 – Summary of Impact That Influences Had on Changing Behaviour and Attitudes

| Responsibility | Presenting Behaviors and attitudes in the first few weeks | Transitional INFLUENCES * that shaped changes | Behaviors and attitudes at the end of six months |
|---|---|---|---|
| **Knowledge** | • Disorganized approach to clinical interview<br>• Data collection - Overly inclusive/narrow medical histories<br>• Management plans – One size fits all, run on sentences | • PE , TM, CC, F, RM<br><br>• PE, TM, CC, F, RM<br><br><br>• PE. TM, CC, F | • Agenda setting<br><br>• Histories more focused, relevant Red flags, Review chart<br>• ↑ Tailored management plans |
| **Practice Management** | • Charting begun/completed at the end of clinic<br>• Unfamiliar with environment and location of paperwork<br><br>• Unfamiliar with community resources<br>• Billing, computers - time consuming<br>• Time management - One hour interviews, address every issue | • TM, PE, SF<br><br>• PE, TM<br><br><br>• RM, CC, F, TM<br><br>• PE<br><br>• PE, F CC, RM, TM | • Begin to chart during interview, make end notes<br>• Organize equipment/paperwork prior to start of clinic<br><br>• ↑ Knowledge of community resources<br>• Billing, computers non-issues<br><br>• Time management - 30 minute interviews, invite people back |
| **Relationships** | • Resident – Feel masquerading as doctor<br><br>• Patient – Resident-centered (Narrow focus on disease management, one way interactions, no/rigid boundaries)<br>• Supervisor – reactive, dependent, subordinate | • F, CC, PE, RM<br><br><br>• PE, CC, F , TM, RM<br><br><br><br>• SF, S-RM, PE | • Resident – ↑ Confident in role of doctor, identify with role of family medicine resident<br>• Patient – ↑ patient-centered (Broader focus inquiry of patients life context, reciprocal, limit setting/flexible boundaries<br>• Supervisor – proactive, ↑ independent, collegial |

∗ **PE -** Practice Experience, **TM -** Time Management, **CC -** Continuity of Care, **F -** Feedback, **RM** - Role Modeling

**Chapter 9**

The Identity Formation of the Family Medicine Resident-trainees


In the beginning of the study period, the categories of concerns, changes, and influences were used to understand the resident-participants' early experience of postgraduate training. During analysis it was clear that adjusting to new responsibilities was the overarching theme. Related subthemes of knowledge, practice management, and relationships emerged to further deepen understanding of the resident-participants' experience. In this chapter I will 'draw conclusions' (Miles & Huberman, 1994, p.22) by assembling and 'mutually laminating' (Silverman Murray, Jock & Charles, 2003, p.178) the findings to provide a more wholistic conceptualization of the resident-participants' experience during the first six months of postgraduate training.


*Where Are We Going?*

In Chapter 8 I used the subthemes Knowledge, Practice Management and Relationships to discuss how the five influences (Practice Experience, Time Management, Continuity of Care, Feedback, Role Modelling) played a role in shaping or changing the resident-participant's professional identity. In this chapter I will expound on the interpretation of the five influences of change with Chart 4 entitled "Conceptualizing the Transition from Undergraduate Medical Student to Postgraduate Family Medicine Resident". Chart 4, which can be found on the next page, is used to conceptualize how the various influences intersect at different points in time to shift the

Chart 4 - Conceptualizing the Transition from Undergraduate Medical Student to Postgraduate Family Medicine Resident

*Shaded areas show degree of emphasis placed on Concern in comparison to other areas of transition during shifts*

| Over 6 Months ➡ | INCOMING MEDICAL GRADUATE | Experiences Influencing Shift | RESIDENT "DOCTOR" | Experiences Influencing Shift | FAMILY MEDICINE RESIDENT |
|---|---|---|---|---|---|
| **KNOWLEDGE** | **Responsible for:** Learning knowledge necessary to be called doctor<br><br>**Concern:** Passing examinations and evaluations | (Practice Experience / Time Management / Supervisor's Feedback and Role Modeling) | **Responsible for:** Medical outcome -Immediately providing correct diagnosis, treatment and management<br><br>**Concern:** Knowledge level and experience inadequate for level of responsibility/ clinical decision making | (Continuity of Care / Time Management / Patient Feedback) | **Responsible for**: Providing comprehensive care over time - focus broadens to include patient's perspective and understanding of patient's life context<br><br>**Concern**: Learning how to use knowledge efficiently in clinical encounter (agenda, boundaries, interview organization, relevant questions) |
| **PRACTICE MANAGEMENT** | **No Responsibility**<br><br>**Concern**: None | | **Responsible for:** Lab results, billing, time management, charting, office administration<br><br>**Concern**: Adjusting to new environment and professional responsibilities | | **Responsible for:** Office administration and professional responsibilities<br><br>**Concern**: Charting, time management, community resources |
| **RELATIONSHIPS** | **Supervisor-centered**<br>**Focus**: Data collection<br>**Power**: No power<br>**Role**: Student<br>**Concern**: Meeting supervisor's expectations<br>**Supervisor**: Dependant | | **Resident-centered**<br>**Focus**: Data collection, diagnosis, treatment and management<br>**Power**: Resides with resident<br>**Role**: Medical Expert<br>**Concern**: Not harming patients<br>**Supervisor**: Dependant | | **Relationship-centered**<br>**Focus**: Medical history & patient life context<br>**Power**: Shared<br>**Role**: Generalist: Medical manager, advocate, counselor, gatekeeper, resource consultant<br>**Concern**: Meeting patient expectations<br>**Supervisor**: Peer |

Legend: ☐ No Concern   ☐ Least Concern   ☐ Moderate Concern   ■ Greatest concern

resident-participants' identity from the phases of Incoming Medical Graduate to Medical Doctor and finally to Family Medicine Resident.  In the first half of this chapter, I will use the chart as a basis for discussing the resident-participants' experiences in relation to each of these phases and the subsequent influence the experiences had on the adjustment to the next phase.  The findings will then be used to present a beginning framework for understanding how the experiences of the first six months of postgraduate training shape the resident-participants' concept of what it means to be a Family Physician.  In doing so, it will be possible to see how the resident-participants' concerns are resolved or changed, and how the resident-participants' concept of themselves and their role changes in relation to these experiences.  Chart 5 located at the end of this chapter entitled "Learning to Become a Family Physician – The First Six Months" will be used to not only synthesize these findings, but to lift them to a more inductive level where the reader is left with a deep understanding of how the experience of the first six months of a postgraduate Family Medicine program shapes the resident-participants professional identity.

*From Medical Student to Postgraduate Family Medicine Resident –*

*The First Six Months of Postgraduate Training*

*"The Clerkship Hangover" – Profile of the Incoming Medical Graduate*

> "In clerkship I wasn't the doctor, I wasn't responsible, I was just the student.  No one, neither the patients, nor the nurses, nor my supervisors really expected anything of me-certainly not in terms of actual decision-making around treatment and management of patients.  I had all the time in the world with patients.  My only concerns were making sure I got all the right medical information for my supervisor, passing my exams and getting my reference letters for application into residency programs ready. There is such a change from being a clerk (senior

medical student) to a real doctor. I'm responsible now." (Composite of quotes from study).

These few short sentences vividly capture the core sentiments the resident-participants voiced during the first few weeks of postgraduate training as they made the transition from undergraduate medical student to postgraduate resident. The memories of their experience as undergraduates were still very fresh and acted as a contextual backdrop for describing their current experiences.

### *Acquiring knowledge the primary concern.*

For resident-participants, the focus of their undergraduate training was on passing examinations and receiving good evaluations from senior physicians. This meant they were concerned with acquiring as much medical knowledge as they could through clinical experience, textbooks, patients, and superiors. A major preoccupation in the final year of medical school was identifying suitable faculty to write reference letters and strategically aligning themselves for "matching" with their chosen residency program. Learning was not motivated by a sense of responsibility for addressing a patient's problem, but by the need to memorize the necessary body of knowledge to impress their supervisor in order to get good evaluations and to pass the various end-of-rotation examinations.

### *Establishing relationships not a concern.*

Resident-participants reported that they highly valued contact with patients during their undergraduate training, but their motivation was primarily to see first hand the diseases they had read about in textbooks. In fact, they rarely saw the same patient more than a few times and it was always through a lens that was focused on getting a thorough work-up of the patient's presentation and disease for the supervisor. The patients were there to learn from, not

necessarily to build relationships with; subsequently, patients were seen primarily as learning

opportunities, not as responsibilities.

*Being seen as medical students by others.*

As reported earlier, resident-participants recalled seeing their supervisors during

undergraduate training as evaluators of their performance, not as colleagues.  The revolving

nature of rotations meant resident-participants had transitory contact with patients and health

staff, limiting their opportunity to establish relationships.  Even during their final year of

undergraduate medical training, they still felt health professionals and patients acknowledged

them only as medical students.

*Limited responsibility.*

The resident-participants were keenly aware of the limitations of their student status

during their undergraduate training.  A supervisor's signature or approval was needed before

they could proceed at almost every level of decision-making.  Resident-participants described

how they did not feel responsible for the patient as a person because they did not have any power

or influence around decision-making for treatment and management plans.  Even as senior

medical students, resident-participants recalled that consultation was expected and encouraged

before taking any course of action.  This meant minimal responsibility for the patient, medical

decision-making, treatment, and management plans.  As a result, coping with the uncertainty of

being responsible for diagnostic and therapeutic choices was never experienced.

The practical ramifications of such things as time management and the medical-legal

consequences of decision-making held little to no concern for resident-participants.  As they

collectively and repeatedly voiced, their experiences were closely supervised and ultimate

responsibility for the patient, and therefore outcome of care, did not lie with them.  As a result, they did not feel like the doctor, perhaps doctor in training, but not the doctor.

*Medical students… not doctors.*

Resident-participants clearly voiced that they viewed their undergraduate and postgraduate medical training as distinctly different stages of medical education with two very different sets of expectations and experiences of responsibility.  The resident-participants described themselves as medical students during undergraduate training and did not view themselves as real doctors.  At the end of their undergraduate training, the resident-participants felt they had earned the right to be called doctor, but as they began their postgraduate training to become Family Physicians they felt they were doctors in name only.  For resident-participants the leap forward toward the identification of the role of doctor arrived the day they were given responsibility for patients.

Like the effects of a hangover, the effects of the undergraduate training experience lingered longer than expected.  For some, the effects lasted only a few weeks while for others it lasted on into the first few months.  The undergraduate training experience had a powerful impact on influencing the resident-participants' adjustment to postgraduate Family Medicine training during the first few weeks.

*"Lo and Behold I am the Doctor" - Profile of the Resident Doctor*

> "There is such a change from being a clerk to a real doctor.  I'm responsible now. I'm
>
> expected to be the expert. What if I kill somebody? There is just so much to know and it
>
> sure doesn't present like it does in the textbooks.  I need to ask all of the right questions
>
> in order to make the right diagnosis, treatment and management plan. I pretend to be

confident so patients will trust my judgment. I don't even know where to find the right lab requisitions, never mind how to handle the patients with multiple issues in a time effective way. It's mentally exhausting, I often wonder if I can do it. On good days, I feel like I am just treading water." (Composite of quotes from the study)

From the resident-participant's perspective, undergraduate training was about being a medical student; the beginning of postgraduate training was about adjusting to being a doctor. The resident-participants were quick to point out that only two short months separated their experience of being seen as the medical student to being seen as the doctor. Although they had been learning and preparing themselves to be the doctor for four years, suddenly they were the doctor. In the beginning some of them did not feel like the doctor and none of them felt like competent doctors, but they all knew they were the doctor.

*Masquerading as the doctor.*

In the beginning, resident-participants described feeling like they were masquerading and expressed concern about their ability to assume the mantle of doctor, given the enormous responsibility with which it came. They felt this, not because they had fooled people, but because they lacked confidence and did not feel like the expert that people associate with the term doctor. For the first time they felt the weight of being medically-legally responsible. Most resident-participants described feeling ambivalent about assuming the title doctor, because they felt they were still closer to being students. Initially, resident-participants did not refer to themselves as family practice residents, but as doctors.

*Practice management responsibilities.*

The feelings of masquerading as the doctor were compounded by the introduction of a variety of practice management tasks that were not the resident-participants' direct concern or responsibility during their undergraduate training. Billing, booking patients, charting, and locating and responding to laboratory results were always somebody else's responsibility. Once they felt more comfortable with the environment and the related expectations, they felt more confident and could focus their time and attention elsewhere. However, as they were adjusting to their new role as doctor, acclimatizing to the procedural and organizational demands of the clinic setting just added to already existing feelings of inadequacy and uncertainty.

*Seen as the medical expert.*

Resident-participants described the pressure they initially felt when they realized patients were now interacting with them as though they were the medical expert. For example, patients were now asking their opinion, addressing them as doctor, making eye contact, and appearing to listen to their recommendations. The pressure to appear competent was enormous because, as doctors, they were more accountable and their actions and decisions now held consequences. Efforts to maintain an image of competency were not as necessary during undergraduate training because supervisors, health care providers, and most patients expected that they did not know. As doctors, there was now both the expectation (primarily from patients) that they should know, and the responsibility of actually needing to know.

*Impression management.*

One way the resident-participants dealt with their initial anxiety of being seen as the expert was by consciously putting forth an image that they were indeed competent and capable.

Resident-participants described, without a hint of embarrassment or self-consciousness, how they deliberately developed strategies to ensure that the patient was never aware of their uncertainty. For example, rather than acknowledge to patients that they did not know an answer, they would imply that they needed to double-check a medication. This allowed them to excuse themselves from the office without losing the patient's confidence in their ability to doctor while they sought out their supervisor's advice. The resident-participants rationalized how it was important to give patients the impression they were confident so that the patient would trust their medical judgment and recommendations. Resident-participants described how they felt supported by supervisors who maintained what they perceived to be an illusion of their competence in front of patients when they needed the supervisor's assistance in the office and felt betrayed by those supervisors who took over or rushed in to unexpectedly save them.

*Concerned with level of knowledge.*

The resident-participants' described how, in the beginning, using their knowledge in the clinical encounter was their paramount concern. In fact, most of the initial concerns the resident-participants voiced revolved around their level and use of knowledge. From the resident-participants' perspective, wearing the title of doctor meant that they were the medical expert. Patients expected them to have the experience and expertise on which they could rely and trust, a role with which resident-participants were not entirely comfortable. Moreover, as the medical expert, resident-participants described how the need to "nail the diagnosis" was the most important thing they had to do. Subsequently, the need to ensure that they did not harm patients became the priority and superseded their interest in developing relationships with patients.

This anxiety could be heard most dramatically when resident-participants described their struggles with knowing how to use their knowledge in the clinical interview. Initially all

resident-participants felt their knowledge level was inadequate to responsibly advise patients. Concerns over what they knew took precedence over how they used what they knew.

*Problem identification and differential diagnosis.*

As undergraduate medical students the resident-participants rarely felt responsible for problem identification; however, as postgraduates, they were responsible not only for identifying the possible problem, but also for developing a differential diagnosis.  In Family Medicine, patients often present for the first time with symptoms that have not been explored before; therefore it is common for patients' medical problems to be in need of further definition.  The responsibility to independently generate a hypothesis as to what may be wrong with the patient and learning how to rule in or out potential diagnoses based on positive and negative findings caused a great deal of anxiety.

*Knowing what to ask given the context.*

In order to make a diagnosis, resident-participants had to know what in their knowledge base was relevant to ask.  Resident-participants recalled that, during undergraduate training, a senior physician often identified the medical problem for them and their responsibility was limited to taking a focused but comprehensive history.  Resident-participants further described how the algorithms of medical questions they had memorized in undergraduate training were no longer helpful in everyday practice, particularly when patients were now presenting with both undifferentiated and multiple problems and each patient's life and medical context were different from the next.  For example, resident-participants described that, although they knew the basic theory underlying high blood pressure disease, the contextual history kept changing so no two cases

were ever similar. In other words, it was difficult to recognize what was important through pattern recognition and to discriminate because the target kept moving.

*Treatment and management plans.*

Resident-participants voiced concerns over being responsible for the treatment and management of patients, a skill they had limited experience with as undergraduates because they were not responsible for the outcome of care. Often their role was to provide follow-up explanations to patients and answer questions after the senior physician had constructed a plan and delivered it to the patient. Although the resident-participants in this study did not describe their approach to presenting treatment and management plans in detail, they did voice that, as doctors, they were now medically-legally responsible for the outcome of the patient's care. This meant they needed to ensure they did not miss anything and provided very thorough medically focused treatment plans. For the first time, as doctors, the resident-participants were experiencing the uncertainty associated with being responsible for making diagnostic and therapeutic decisions on behalf of patients. In the early weeks of clinical training, most of the resident-participants described triple checking prescriptions, evenings where they called patients back to ensure they had followed through with the plan, and nights ruminating over whether they had the diagnosis and treatment right.

*Interview skills and organization.*

The resident-participants did not feel they had a high level of medical interviewing skills. In particular, they voiced concerns about not knowing how to prioritize the issues and how to organize the medical interview once they had decided which issues to address. As noted previously, during undergraduate training the problem or focus of the interview was always

identified for them; inquiring about issues beyond the presenting medical complaint only increased the risk of further losing control of the interview. There was no time to address anything but the presenting medical problems if the resident-participants were going to provide competent care to the patient.

Resident-participants also described not having an organized approach to the medical interview. Again, the resident-participants recalled that the emphasis during their undergraduate training was primarily on the middle of the interview, not the beginning or end of the interview. The emphasis was on mastering comprehensive and focused histories, not on identifying the problem, setting agendas, clinically reasoning to make a diagnosis, or using the data to construct a treatment and management plan. Concerns with knowledge use and organization were anxiety provoking not only because they felt the patient saw them as the expert, but also because they felt responsible for the patient's care and were alarmed that they would inadvertently harm rather than heal their patients. The consequences of feeling responsible for patients, but inadequate in their knowledge base to do so competently mean that content took precedence over process.

*Feeling and having responsibility for the patient's care.*

As doctors, resident-participants reported a sense of ownership for the patient's care that they did not have during their undergraduate training. From the outset of residency, feeling responsible for the patient's care was the core motivating influence for wanting to be a competent physician. However, the weight of suddenly feeling medically-legally responsible for patients meant competent caring was narrowly defined by the resident-participants as accurate diagnosis, and effective treatment and management plans. As the patient's doctor, resident-participants felt medically-legally responsible for the consequences of their care and treatment choices, which added to their anxiety. As a result, much of their time and energy in the clinical

encounter was primarily focused on ensuring they had the diagnosis right.  Understanding the patient's illness experience and building relationships were secondary and not considered necessary to make a diagnosis.

*Disease-focused or resident-centered approach to the clinical encounter.*

In the first few weeks and months of clinical practice, the resident-participants described an approach to the clinical encounter that could be characterized as doctor-centered or disease-focused.  For example, the resident-participants admitted their singular focus in clinical encounters was to diagnose the patients' medical problem and come up with a comprehensive treatment and management plan using evidence based medical guidelines.  To accomplish this objective, the direction and control of the medical interview needed to reside with them.  One way of maintaining control of the interaction was by independently determining the focus of the interview based on the patient's initial complaints.  The patients' input was rarely solicited for fear of losing control and because resident-participants did not recognize the value of the patient's perspective to care.

Where the similarity to a disease-centered approach ends is that resident-participants recognized that, as future Family Physicians, they were responsible for more than just the presenting problem; they were responsible for the whole of the patient's care.  This meant they needed to know about the patient's past medical history and broader social context; however, their preoccupation and anxiety with not feeling confident in their knowledge prevented this from being a priority.  The resident-participants did not feel they had the prerequisite experience or expertise in being a doctor that could allow them to focus beyond their own need to get the diagnosis right.  Only once they were reassured that the patient was medically cared for could they relax and focus their attention beyond the patient's disease.  At the start of postgraduate

training the resident-participants intellectually recognized, but did not appreciate or understand the role broader personal and social matters played in providing optimal medical care.

*Reliance on supervisors.*

As undergraduate medical students, the resident-participants recalled being reliant on their supervisor for guidance. In the beginning of postgraduate training, resident-participants described a relationship with supervisors, which was similar to their dealings as medical students to their teachers. They were dependent on the supervisors for guiding their clinical decision making and ensuring they did not harm anybody. Resident-participants described how they watched carefully as supervisors interacted with patients hoping to pick up useful practice tips. The resident-participants were quick to point out how observing both the positive and negative patient interactions of supervisors had influenced who they wanted to be as doctors. Although they described being micromanaged by their supervisors in the beginning, this close relationship seemed helpful in allowing them time to separate and develop a sense of confidence in themselves. In fact, one resident went as far as describing the supervisor relationship in the first few weeks as that of parent and adolescent child.

*The pressure to manage time.*

The need to manage their time as the doctor was a new concern for resident-participants and one that seemed to have both an up side and a down side throughout this study. As undergraduate medical students, time management had not been their concern or responsibility. The need to manage their time in postgraduate training was not entirely unexpected, as they had heard grumbling from more senior peers about the challenges of time constraints. However, the reality of just how little time was available to competently accomplish all of the responsibilities

they had was still surprising.  For example, resident-participants were suddenly responsible for paperwork such as consultation letters and following up on laboratory results that were never their domain before.  Ensuring that charts were properly completed took time.  Making sure they had the diagnosis right and had created the ideal treatment and management plan took time.  In the beginning, the biggest source of anxiety related to time was the management of patients in the office encounter, especially since they felt responsible for comprehensively addressing all of the patient's medical problems, big or small, in one visit.

*The Shift from Incoming Medical Graduate to "Resident Doctor" –*

*Influences that led to Change*

*Time*

The constant pressure to manage their time became a pivotal influence in shaping the resident-participants' approach to practice.  For example, resident-participants began coming in early to read the chart and get equipment ready.  They started to learn how to chart and talk at the same time.  How they organized the interview changed.  For example, they began to learn the necessity of inquiring about patient's expectations and the need to set agendas at the beginning of interviews if they were going to manage their time well.  They recognized that sometimes it was necessary to set boundaries or limits if they were going to maintain control of the interview.

*Experience of Practice*

With the resident-participants' experience of practice, the positive outcomes of change became evident and led to more.  For example, as they learned how to prioritize problems and to discriminate what was important, they began asking more focused questions and became more confident in identifying the relevant red flag questions to ask.  As they learned how to tolerate

uncertainty, they were able to trust the 'wait and see' approach and did not feel compelled to address all the patient's concerns in one visit. As they became more confident in their own clinical judgment, they relied less on their supervisor's opinion. With experience, they became more flexible in their approach with patients and did not feel they had to rigidly control the interview. Each of these changes or experiences, in combination with the others, played a role in helping the residents adjust to the role of doctor. This allowed them to begin focusing their attention beyond the medical complaints.

*Supervisor's Feedback and Role Modeling*

At the beginning of postgraduate training, the resident-participants described a dependant relationship where they continued to rely on their supervisors for feedback; however, the focus was now on identifying learning gaps in order to provide competent patient care. Watching and observing supervisors and other health care professionals in action seemed to act as a benchmark for developing their approach to practice.

In the first few weeks, the experience of practice, the pressure to manage their time and the supervisors' feedback helped resident-participants adjust to their new identity as doctors. From the resident-participants' perspective, adjusting to the role of doctor primarily meant becoming more confident in their ability to use their hard-learned knowledge in the practice of caring for their own patients.

If the first few weeks and months were primarily about making sure they had made the right diagnosis and using their knowledge, then the next few months were more about establishing relationships and broadening their idea of what it meant to be a Family Medicine resident.

*"I am the Family Practice Resident" –*

*Profile of a Family Medicine Resident at Six Months*

"I don't know if I am ever going to feel comfortable with the knowledge. I do know that as long as I know what red flags to ask to know whether this person is sick or not I can always bring them back. I'm not going to be the expert in everything but as long as I know how to find the answer then I'm okay. Besides patients mostly want you to listen and know you care, they don't care if you don't know everything in that instant. There's nothing better than having a patient refer to you as their doctor." (Composite of resident voices)

In the first few weeks of practice, resident-participants described how, as the doctor, they were concerned about living up to the patient's expectations of being the medical expert. Being the expert meant being the doctor whom the patient could trust to correctly diagnose and effectively treat every medical issue in the first appointment. Through experience and patient feedback, resident-participants began to realize that the patient's concept of the trusted medical expert was different from theirs. Resident-participants' identity as the family practice resident began to evolve with the continued experience of practice, continuity of care, patient feedback, and pressures of time.

*Approach to the Clinical Encounter*

*Sharing power.*

The resident-participants began describing how their approach to the medical interview was not always achieving their goal of providing comprehensive, yet efficient medical care. For

example, often near the end of clinical encounters, patients would offer new and relevant information about a problem that would change the resident's course of care or the patient would introduce an entirely different reason for the visit than the one the resident had established. As a result, the resident-participants began to realize that they needed to share power in the interview with patients. This meant they needed to involve the patient more in the interview process from the outset if they were going to meet their goal.

*Setting agendas.*

Resident-participants began to adjust their approach to medical interviews by setting agendas at the beginning of encounters, eliciting the patient's input and exploring the patient's life context. The resident-participants described how the results of these changes contributed to a better understanding of the meaning and significance of patient-centered care in practice. For example, as the resident-participants learned to establish agendas at the beginning of interviews that included the patient's perspective, they realized that patients often held different expectations for the visit despite presenting with the same medical problem(s).

*Broadening the approach to and concept of patient care.*

Resident-participants began to realize that they needed to have more than one approach to patient and medical care if they were going to meet these varying expectations. Depending on the circumstances, some patients needed more of a counsellor, others an advocate, still others a resource person. Being flexible with their approach also meant altering their interview style and boundaries to match the needs of the patient. For example, sometimes resident-participants needed to be a listener, sometimes a confidant, and still other times firm and directive if they needed to phone the Children's Aid Society. Interestingly, "I need to wear different hats" was a common analogy used by many of the resident-participants to describe how they conceived of

their relationship with patients, something they did not realize in their early weeks. The resident-participants' initial approach to the clinical encounter was broadened to include an approach that took the patient's needs and perspective into consideration, alongside their need to provide competent medical care. Not only did their concept of who they needed to be in the relation to the patient change, but also their concept of the patient's role in relation to them.

*Resident-centered to relationship-centered.*

Residents felt, as the doctor, that they were solely responsible for the outcome of care; the success or failure of treatment rested solely on their shoulders. As the resident-participants became more confident that they were not going to harm patients and more comfortable in their role as doctor, they became more aware of the impact their approach had on care. There was a shift away from a resident-centered approach, where the resident was solely responsible for care, and a move toward a more relationship-centered approach where the responsibility was shared with the patient.

Towards the end of the study, resident-participants were beginning to comment on how the relationship needed to be reciprocal if it was going to work and that there were limits to their responsibility. It was their responsibility, as the Family Medicine resident, to provide the expert recommendations, but it was up to the patient to carry them out. It was their responsibility to create a trusting relationship so they did not miss anything important, but it was the patient's job to disclose all the relevant information. It was their responsibility to understand the patient's expectations for the visit, but it was the patient's responsibility to understand that there were limits to having their expectations met. They were to set the agenda and keep the office visit on time, but the patients were to show up on time and have reasonable expectations for what could be accomplished given the time constraints. The resident-participants were supposed to establish

boundaries and in turn, the patients were supposed to act appropriately and not overstep them. Finally, as Family Medicine resident-participants, it was their job to offer to be responsible for the patient's care for the next two years, but it was the patient's job to accept that offer.

*The Shift from Resident "Doctor" to Family Medicine Resident*

*Influences That Led to Change*

In the beginning, the resident-participants primarily attributed the supervisor's feedback, role modeling, time pressure, and practice experience as helping them adjust to the role of doctor. As training progressed, continuity of care, patient feedback, and the pressure to manage their time became the predominant experiences that influenced their adjustment to the role of Family Medicine resident.

*Continuity of care.*

Through the experience of continuity of care, resident-participants began to identify with the responsibilities associated with being the Family Physician. The influence of seeing patients over time was not felt in the first few weeks of the postgraduate residency because very few patient encounters were return visits. As the study progressed and resident-participants began to develop a practice, regularly seeing a patient over time became an increasingly powerful influence. Confidence in their knowledge base, capacity to generate differential diagnosis and ability to construct viable management plans began to increase. No longer did every disease presentation seem like a new experience. As patients returned for follow-up visits, the resident-participants were able to see the outcome of their treatment choices, which helped to dispel one of their biggest initial fears, that they would harm patients rather than help.

During undergraduate training, the transitory nature of patient contact made it difficult to appreciate the link between understanding the patient's life context and perspective to providing competent care. During their postgraduate training , the resident-participants in this study expected to learn how to access and link patients to services within the medical community, such as the dermatologist or physiotherapist, ,but they underestimated the need to access and link patients to community resources. At the end of this study, resident-participants recognized the necessity and value of having a working knowledge of community resources to which to direct patients. Having this knowledge both saved time in the clinical encounter and strengthened their ability to care for patients. At the end of this study, all resident-participants commented that they considered their knowledge of community resources to be poor and an area they would have to continue to work on in the coming months.

*Time – the benefits.*

As in the first few weeks, time continued to play both a positive and negative role. Nowhere better are the benefits of time seen than through the experience of continuity of care. Time relieved resident-participants of the self-imposed pressure to resolve every issue in the same appointment, which subsequently gave them confidence in a "wait and see" approach that is common in the practice of Family Medicine. Resident-participants in this study described how relieved they were to see patients with whom they were familiar. This meant they had already begun to establish a relationship and did not need to spend precious clinical encounter time learning the patient's past medical history. This in turn meant they could spend time getting to know more about the patient's lives.

Having the time to get to know patients helped resident-participants develop a greater appreciation of the relevance of the patient's life context to providing comprehensive care. Each

time the patient returned, the resident-participants had a broader understanding of both their medical background and their social history, which meant they felt far more confident about their diagnostic and treatment choices. The experience of seeing patients over time meant resident-participants could develop relationships that were deeply satisfying and reinforced their commitment to choosing Family Medicine as a profession. As well, the experience of providing continuous care to patients reinforced the residents' responsibility to the patient as their primary caregiver, which in turn reinforced their identity as the family practice resident.

*Time – the pressures.*

Time also continued to have a downside that often threatened to override the benefits of continuity of care. The resident-participants clearly voiced their frustration with having to function under the daily pressure of time constraints and sometimes felt it affected their ability to provide comprehensive care. Time pressure often dictated what issues they did or did not focus on in the clinical encounter. For example, if the residents felt confident about their ability to manage the medical problem within the allotted time they could afford to encourage social conversation, recognize patient cues, or explore psychosocial concerns, otherwise they needed to remain focused on the patients' medical matters. Knowing that their clinical encounter time was being reduced in the near future from 30 to 15 minutes was daunting and, for some, discouraging. The resident-participants explained how they were just beginning to feel confident in their ability to provide competent medical care while involving patients in the process within the time allotted. The resident-participants questioned their ability to provide the same level of care in half the time.

*Patient feedback.*

During postgraduate training, the resident-participants were responsible for patients, which shifted their motivation for feedback to satisfying the patient's expectations. The patient's verbal feedback about residents' performance went a long way in boosting their confidence and reinforcing their identification with the role of primary caregiver. The patient's feedback also influenced the residents' perspective on what patients' expected from them as their Family Medicine resident. For example, resident's voiced their pleasant surprise at realising patients just wanted to know that the resident cared about them as patients and did not worry if they did not immediately know all of the medical answers. As resident-participants adjusted to what it meant to be a Family Medicine resident, the patient's feedback became an additional measurement on their yardstick. For example, resident-participants interpreted the message of patients who referred family and friends to mean they could be trusted to provide competent care. Reciprocally, resident-participants interpreted no shows (patients who were booked for return visits but did not show up) or patients who challenged their clinical judgment to mean they could not be trusted to provide competent care.

*Changes Lead to a Shift in Identity*

The findings in this study suggest that the resident-participants' experiences in the first six months of practice reflect a shift in role identification as they adjust to being the family practice resident. In the first few weeks for some, and on into the first few months for others, the focus was on adjusting to the responsibilities associated with being the doctor. In the beginning, this adjustment was influenced by the powerful imprint of undergraduate training as the resident-participants felt they were doctors in name only and still strongly identified with their experience of medical school. Resident-participants needed to adjust to the responsibilities associated with

the role of doctor before they could make the shift to identifying with the family practice resident role.

As doctors, resident-participants felt they were responsible for being the medical expert, but were concerned their level of knowledge and experience were not adequate given the immense responsibility. The supervisor's feedback and role modeling, along with practice experience and time helped influence the resident-participants' adjustment.  As the resident-participants gained confidence in their ability to provide competent care, they began expanding their focus to the doctor-patient relationship.  The experience of continuity of care, alongside patient feedback and time solidified their identification with the role of family practice resident. The resident-participants began to recognize that being an expert, especially to patients, meant more than being able to use their medical knowledge competently.  Being an expert also meant acting as an advocate, counselor and gatekeeper to medical and social resources.

As resident-participants adjusted to the role of family practice resident, their approach to the doctor-patient relationship shifted from being resident-centered to relationship-centered. For example, the resident-participants learned to put on different hats depending on the patient's need and circumstance.  Their approach to the relationship was as much reliant on the patient as on the disease.  In fact, the outcome of care was no longer exclusively their own ideas and expectations, but included the patient's ideas and expectations as well. I n other words, the weight of responsibility did not always have to be with them.

*Learning to Become a Family Physician – The First Six Months*

This study set out to better understand the doctor's experience of the first six months of a Family Medicine residency program.  In doing so, it is now possible to conceptualize the challenges newly graduated doctors experience as they begin to learn what it means to be a

Family Medicine resident and the influences that shape this experience. From the resident's

perspective, the shift in responsibility that they experience as they begin their Family Medicine

training is enormous. This shift involves adjusting to significant changes in how they use their

knowledge and how they approach relationships. As resident-participants first experience and

then adjust to these challenges, they begin the process of becoming socialized into the profession

of Family Medicine. These forces are recursive and integrative, working together to shape the

resident-participants' concept of what it means to be the Family Physician. The impact of this

experience propels the resident forward sometimes slowly and sometimes fast, but always

toward understanding what it means to be a doctor in Family Medicine. In this final presentation

of the results, a framework for conceptualizing the first six months of Family Medicine

postgraduate training will be outlined.

*Responsibility*

Residents experience undergraduate training and postgraduate training as two very

different worlds that are primarily separated and defined by the experience of responsibility. The

world of undergraduate training is governed by supervising doctors who have the power and

authority to make decisions around patient care. As a result, everyone, including the medical

student, looks to these supervisors for answers and guidance. In the undergraduate world, the

medical student feels protected from the responsibility associated with making decisions in a

profession often filled with uncertainty, as their role is limited to acquiring knowledge, passing

examinations, and meeting supervisor's expectations. At the end of this training period, newly

graduated doctors felt they had earned the right to be called doctor, but upon reflection at the

postgraduate level of training, were unsure they were prepared to meet the expectations this role

held.

Although resident-participants spent several years focused on preparing to become a doctor, entry into the world of postgraduate training as the doctor is still experienced as a culture shock as the level of responsibility between the two worlds is perceived as enormous. For new graduates, being the doctor means they are now seen as the medical expert, medically-legally responsible for using their knowledge to diagnose and treat whatever medical problem is presented to them. Patients and health care providers now look to them to provide answers and give guidance, which causes a great deal of anxiety as they do not yet feel they possess the experience and expertise necessary to be considered the medical expert. Compounding this anxiety is the need to adjust to new environment and practice management responsibilities, such as billing, for the first time. Being the doctor, responsible for care brings with it consequences and expectations not experienced as medical students which adds to the uncertainty as new graduates begin using their knowledge in practice. The first few weeks (and months for some) are spent working through the anxiety that comes with adjusting to the disjuncture of responsibility that the new doctors perceive exists between the two worlds of undergraduate and postgraduate training.

In order to feel comfortable with this perceived leap in responsibility, new doctors need to feel more confident in their ability to use their knowledge safely with patients. This is primarily achieved through the experience of seeing patients, especially returning patients, where doctors can see the positive consequences of their previous medical decision-making. Over time, patients' feedback also plays a meaningful role in helping the doctor recognize they can indeed meet the patients' expectations for care. This experience adds to their increasing sense of confidence in being able to fulfill their responsibilities first as doctor and then more broadly as the Family Medicine resident.

*Knowledge Utilization*

When newly graduated doctors move from an undergraduate setting, where the focus was on acquiring knowledge, to an environment where the focus is now on learning how to use that knowledge in practice, it presents new challenges. The doctors' undergraduate experience prepares them to take focused histories and do physical exams on patients whose diagnosis or problems have been predetermined by someone else. Postgraduate experiences require doctors to be responsible for autonomously using their knowledge in a context where the problems are often undifferentiated. This means having to identify and diagnose the problem based on the patient's symptom presentation before they can treat, rather than being given the diagnosis and told to verify the symptoms. In other words, how doctors use and access their knowledge has been reversed. New doctors quickly realize that the knowledge and ideas they learned in the context of undergraduate training only have limited meaning at the postgraduate level. Being able to use their knowledge in the context of a Family Medicine setting means learning how to use their knowledge in a different way.

Initially the anxiety around being responsible for clinical decision making about patient care causes the doctors to rely on the familiar list of close-ended medical questions they memorized as medical students. However, with time and practice, the doctors begin to realize this style of interviewing is often time consuming, not productive, and frequently misleading. It is through the experience of practice, or more specifically, the combined forces of observing their supervisor, listening to patient's feedback, and needing to manage their time that helps the doctor learn different strategies, such as agenda setting, to reorganize how they access and use their knowledge in the clinical interview. In doing so, the resident-participants learned to ask more focused and relevant questions which led to confidence in their knowledge base. With

experience, the doctors began to understand the importance of using red flag questions to rule in and rule out a diagnosis, and help them discriminate between what needs immediate attention and what can wait.

The questions they had memorized as medical students took on new meaning as they learned to use them in the context of a Family Medicine clinic where the problems they encountered were often not well defined and needed to be triaged. Feeling confident in their ability to use their knowledge to help, not harm patients, is critical in helping new doctors feel more confident in this role, which leads to comfort in broadening their focus of care.

*Doctor-Patient Relationship*

The role of the doctor-patient relationship in providing competent care had limited meaning as doctors begin their postgraduate training. When the newly graduated doctor began the postgraduate program, a shift in relational power with the patient was experienced, moving from that of a student-patient relationship to that of doctor-patient relationship. Subsequently, (from the doctor's perspective), the meaning of this relationship takes on new significance. As the doctor, they feel responsible for the patient's care and recognize the patient now looks to them for expert advice. For the first time, there is pressure to meet patient expectations and handle the consequences associated with their new authority to make decisions. The new doctor is very motivated to meet the needs of the patients for whom they are now responsible; however, their concept of what this means is based on their limited experience in the role of doctor as medical students and their observations of senior doctors during undergraduate training. As a result, the new doctors' priorities are to accurately diagnosis the patients' disease and provide a comprehensive treatment and management plan.

As doctors gain confidence in their ability to medically manage patients within the clinical interview they are able to broaden their approach to inquire about other issues beyond that of the presenting medical problem. Subsequently, new doctors realize that the patient's concept of their role is not limited to that of medical expert. With the ongoing experience of seeing and interacting with multiple patients, new doctors begin to realize that despite having the same disease presentation, the patient's needs and expectations for care can vary considerably. The doctor's understanding of what it means to be patient-centered in the context of a doctor-patient relationship begins to take on meaning beyond a set of previously learned questions. In order to provide competent care, attention must be given to understanding the patient's individual social context, alongside the medical context. This understanding leads to the development of a more flexible and reciprocal approach to the doctor-patient relationship - an approach where the patient's individual differences are taken into consideration, yet balanced with their own concept of what it means to provide competent care.

*Learning What it Means to be a Family Physician*

Newly graduated doctors do not enter a postgraduate Family Medicine program knowing what it means to be a Family Physician and must learn what this means before they can identify with the role of Family Medicine resident. Postgraduate training represents a significant shift in identity as newly graduated doctors make the transition from medical student to postgraduate resident. Socialization into this role begins with the new doctor (Family Medicine resident) becoming more confident and comfortable in the role of doctor. The resident's conceptualization of what it means to be the doctor has been shaped by their undergraduate experience, which focused more on disease and content than relationships and process. Family Medicine residents begin postgraduate training with a narrow concept of what it means to be the doctor and an even

more limited concept of what it means to be the Family Physician.  To the new Family Medicine resident, being the doctor is narrowly defined as medical expert.  It means being seen by patients as responsible for having the necessary expertise and experience to diagnosis, and treat, whatever medical problem is presented; this is experience and expertise they do not feel they have.  It is from this perspective that Family Medicine residents begin their postgraduate training.

Learning what it means to be a Family Physician is essential to identifying with the role of Family Medicine resident, a process that begins with becoming comfortable in the role of doctor.  This occurs as Family Medicine residents gain confidence in their ability to medically manage patients' care through practice experience and seeing the consequences of their treatment decisions over time.  The Family Medicine residents' initial feeling of anxiety about harming patients with their knowledge is replaced with a sense of satisfaction that they can help.

The experience of personally being responsible for seeing patients over time is an influential force in shaping the Family Medicine residents' conceptualizations of what it means to be a Family Medicine physician.  As Family Medicine residents begin to develop relationships with patients over time and hear patients' feedback they begin to realize that, in order to provide competent care, their role cannot be limited to that of medical expert.  This is not what patients want and not what Family Physicians do.  The Family Physician is often the entry point for patients' medical and social problems that frequently involve care and direction beyond that of a diagnosis.  Family Physicians must be generalists who are responsible for playing multiple roles in the lives of their patients and families, beyond that of medical expert, such as medical manager, advocate, counsellor, and resource consultant.  As Family Medicine residents gain confidence in the role of doctor and their concept of what it means to be a Family Physician

begins to evolve, the residents' identity shifts from that of medical expert to Family Medicine resident.

*Summary – Chapter 9*

The findings of this study provide a window into the resident-participants' personal world, allowing a better understanding of how their experience of the first six months of postgraduate training begins to shape their concept of what it means to be a Family Physician. These findings have been captured in Chart 5 entitled "Learning to be a Family Physician", which can be found at the end of this chapter.

Newly graduated doctors do not begin a Family Medicine postgraduate training program knowing what it means to be a Family Doctor, but must learn what it means to fulfill this role. From the residents' perspective, this process begins with adjusting to the significant shift in responsibility that occurs when they make the transition from being medical students in undergraduate training to doctors responsible for care during postgraduate training. This adjustment involves learning how to use their knowledge and how to develop relationships in a Family Medicine context where they are now responsible for the patient's care over time. Initially this causes a great deal of anxiety as the resident-participants feel they do not have the necessary experience and expertise to fulfill this responsibility.

Learning what it means to be a Family Medicine resident begins with adjusting to the role of doctor, which comes with the experience of practice. The experience of developing relationships with different patients over time (continuity of care) was particularly instrumental in further helping the resident-participant learn what it means to be a Family Physician. It is through these experiences that resident-participants learned that this role is complex, multifaceted, and not limited to their initial concept of doctoring. At the end of six months,

resident-participants have a better understanding of what it means to be a Family Physician, although they do not feel anywhere near ready to take on the responsibility of independent practice. The resident-participants are aware that the next eighteen months are about increasing their knowledge base and gaining practical experience. However, most resident-participants now comfortably identify with the role of Family Medicine resident.

Chart 5 – Learning to Become a Family Physician – The First Six Months

**INCOMING CHALLENGES**

**EXPERIENCE**

**DEVELOPMENT AT 6 MONTHS**

**Responsibility**
Learning how to be the doctor responsible for the patient's care

The experience of being and feeling responsible for the outcome of their patient's care, using their knowledge in practice, establishing a practice and adjusting to new practice management responsibilities increases confidence and comfort in the role of doctor

As a sense of confidence and comfort in the responsibilities associated with being a doctor develops, the process of learning what it means to be a family physician begins, leading to identification with the role of Family Medicine resident

**Knowledge**
Learning how to use their medical knowledge in the context of a Family Medicine setting

The experience of using their knowledge in practice helps residents begin to recognize what in their knowledge bank is relevant to ask given the context. Returning patients allow residents to see the outcome of Rx and management plans and to begin recognizing what is urgent and what can wait

**IDENTITY FORMATION**

Increasingly confident that they can medically manage the patient's care means they are able to broaden focus of inquiry to include patient's life context and illness experience

Recognize that role is not limited to that of medical expert, but competent care as the family physician means being more of a generalist who plays multiple roles in the lives of their patients

**Doctor-Patient Relationship**
Learning how to establish relationships with patientsas the doctor

The experience of seeing different patient types, personalities and problems over time and hearing their feedback shifts residents concept of what patients want and need. Approach to the relationship becomes more flexible and patient-centered as residents learn to share power within the context of the clinical encounter

**Chapter 10**

Discussion

*From Medical Student to Postgraduate Family Medicine Resident –*

*The First Six Months of Postgraduate Training*

The purpose of this study was to develop a deeper understanding of how resident-participants experienced the first six months of a Family Medicine postgraduate program. The previous four chapters were focused on presenting the study results using a progressively narrower lens to illuminate the findings for the reader; concluding with a framework for better understanding what this experience means from the resident-participants' perspective. Regardless of the lens used, the resident-participants' stories resonate and reverberate with the tensions and challenges of adjusting to their new responsibilities.

In the first half of this Chapter, I will discuss what these findings mean in light of this analysis and how this account fits within the literature. In qualitative research, it is difficult to know the range of literature that may be relevant; therefore, it is not uncommon to conduct a literature review simultaneously with fieldwork, guided by the emerging findings (Patton, 1990). In this study, the literature review continued throughout the study as it was difficult to know how and what experiences the resident-participants would describe at the outset.

During analysis of the resident-participants' stories, *Responsibility* emerged as the overarching theme; therefore, I will begin this chapter by briefly commenting on where Responsibility fits within the larger body of medical education literature before moving to a more in-depth discussion. Further analysis of the theme Responsibility led to the creation of the three sub themes of *Knowledge*, *Practice Management*, and *Relationships*. These three sub themes help describe the resident-participant's experience of adjusting to new responsibilities as

they began postgraduate training and will be used to frame the discussion of Responsibility.  This

section will conclude with a discussion of how the simultaneously occurring tensions in the three

sub themes intersect and traverse to affect change in the resident-trainees' developing identity.

In the second half of the chapter, the reader will be asked to take a step back to view how

the knowledge generated in this study fits more broadly within the medical education literature

and contributes to what we know about the postgraduate experience of new trainees during this

time frame.  This later discussion begins by revisiting the research questions that were initially

postulated and moves on to a more in-depth exploration of the findings using the literature.

*The First Six Months from the Resident-trainees' Perspective -*

*Adjusting to Responsibility*

Resident-participants felt the transition from undergraduate medical student to

postgraduate doctor was daunting and represented a huge leap in responsibility.  From the

resident-participants' perspective, they moved from a protected setting where they had very

limited power and authority to one where they were responsible for the outcome of patient care.

Other studies looking at the transition of medical students into postgraduate education have

identified responsibility as a variable contributing to the stress of change (Calman & Donaldson,

1991; Hesketh et al., 2003; Luthy et al., 2004; Prince et al., 2004), but not as the central

organizing theme.  The methodology and questions asked of resident-participants in these studies

were not the same as in this study; therefore, these differences would account for responsibility

not being more of a central theme.  However, it is important to note, despite the different lens

used to explore the experiences of postgraduate resident-trainees in these studies, the theme of

responsibility did emerge.

In this study how resident-participants viewed their role and responsibilities during the first few weeks of postgraduate training was in stark contrast to how they recalled their role and responsibilities throughout their undergraduate training. The resident-participants in this study clearly voiced that they viewed their undergraduate and postgraduate medical training as distinctly different stages of medical education with two very different sets of expectations and experiences of responsibility. This is supported by the literature, which suggests that a sense of responsibility begins with the idealistic medical student (Putnam & Campbell, 1989), but when a person in a socializing process moves from school to the profession, each setting needs to be considered independently (Noack, 1980).

Although a sense of responsibility was "pounded into them" (Reiser & Rosen, 1984, p. 81) from the outset of medical school, it was for learning the knowledge necessary to diagnose the patient's medical disease. The resident-participants did not feel responsible for the outcome of the patient's care. Undergraduate training was about learning the prerequisite knowledge to call themselves doctors whereas postgraduate training was about using that knowledge to care for the patient; from the resident-participants' perspective, two distinctively different experiences. When the resident-participants began postgraduate training, where they suddenly felt accountable and liable for the outcome of patient care, they experienced a huge shift in responsibility, especially in the areas of Knowledge, Practice Management, and Relationships.

While other studies identified responsibility as a contributing variable to resident-trainee's adjustment at the postgraduate level of training, this study was able to explicate and expound upon what adjusting to new responsibilities means from the resident-trainees' viewpoint. In the next few paragraphs, responsibility will be deconstructed and discussed using the emergent sub themes of Knowledge, Practice Management and Relationships.

*Knowledge*

The resident-participants were concerned not only with their level of knowledge being adequate, but also with knowing how to use this knowledge in the context of practice. Eraut (1985, 1994) suggests that the knowledge and ideas learned in one context take on new meaning when used in another context. As the doctor responsible for the outcome of care, the resident-participants needed to learn how to use knowledge they had previously learned in the classroom and had used in a limited context to diagnose, clinically decision-make, and construct treatment and management plans.

In the beginning, the resident-participants were concerned both with their level of knowledge and their ability to use their knowledge in practice to heal not harm patients. Not only did the resident-participants feel their knowledge level was inadequate, they were concerned about their ability to clinically make decisions, generate a differential diagnosis, and develop management plans. The resident-participants' initial concerns are similar to other studies that suggest first year postgraduates feel inadequately prepared to commence practice, particularly in the areas of clinical decision-making, patient care skills, diagnostic reasoning, and treatment plans (Clark et al., 1999; Jolly & MacDonald, 1989; Prince et al., 2005; Rolfe & Sanson-Fisher, 2002). In fact, concerns related to knowledge level, knowing what is relevant, making a diagnosis, organizing the interview, and developing an appropriate treatment and management plan have become increasingly more prevalent in recent years (Prince et al., 2000; Prince et al., 2005; Radcliffe, 2003; Wall et al., 2006; Watmough, Taylor & Garden, 2006).

The study resident-participants felt that their initial concerns related to knowing how to use their knowledge effectively in practice were partially a result of their restricted responsibilities for patient care during undergraduate training, which meant their experience was

often limited to taking focused histories or physical exams. The literature substantiates the resident-participants' viewpoint in that medical students' tasks are initially restricted to collecting focused histories and performing focused physical exams (Benbassat et al., 2005).

*Clinical decision-making.*

The study resident-participants described how the algorithms of medical questions they had memorized in undergraduate training were no longer helpful in everyday practice, particularly when patients were now presenting with both undifferentiated and multiple problems and each patient's life and medical context was different from the next. Subsequently, it was difficult to recognize what was important through pattern recognition and to discriminate because the target kept moving. From the resident-participants' perspective, the diagnosis was often provided to them as medical students and the focus was on working backwards to substantiate the diagnosis, whereas now, the resident-participants described having to work in reverse, meaning patients presented with symptoms and complaints and they had to figure out the diagnosis by working forward.

The literature suggests that undergraduate training tends to reflect specialty practice where the patient's diagnosis has often been predetermined or at least hypothesized prior to the first visit. Other studies substantiate the resident-participants' experience in that newly graduated doctors report that how they use their knowledge to clinically make decisions is different from how they initially learned to use it in practice as medical students (Benbassat et al., 2005; Kassierer, 1983; Prince et al., 2000; Regehr & Norman, 1996). This problem is particularly significant in Family Medicine because patients often present for the first time with a myriad of (often unrelated) symptoms that need to be explored, in comparison to subspecialties where the diagnosis or differential diagnosis is often provided. During undergraduate training, the resident-participants

were often insulated from the uncertainty of having to generate and make diagnostic and

therapeutic care choices (Merton et al., 1957).  As a result, the responsibility to independently

generate a hypothesis as to what may be wrong with the patient and learn how to rule in or out

potential diagnoses based on positive and negative findings caused a great deal of anxiety.

*Using context.*

In an earlier chapter of this study, Dreyfus & Dreyfus's (1980) five-stage model of skill

acquisition was described to demonstrate how expertise was acquired through the experience of

using knowledge in practice.  Learners move through stages (novice, proficient beginner,

competent, proficiency, and expert) as they learn to use their knowledge in practice.  Although this

study did not specifically use this model to do an analysis, the resident-participants' collective

concerns about using their knowledge in the clinical setting would suggest that they were making

the transition from novice to proficient beginner.  For example, the novice rigidly adheres to rules

with little situational perception.  The proficient beginner has some experience and begins to use

broader guidelines and context to make decisions; however , still has difficulty prioritizing

importance within situations.

*Interview organization.*

It was through the experience of using their knowledge in practice that the resident-

participants began to realize they needed to develop an approach to the clinical interview that

moved beyond data collection.  The concept of needing to learn how to organize knowledge in

the clinical interview has been mentioned in other literature, but which elements of the clinical

encounter changed have not been specifically articulated (Prince et al., 2005; Wall et al., 2006).

The experience of seeing and managing different patient problems and patient personalities over

time helped the resident-participants recognize that their approach needed to include eliciting the patient's agenda, inquiring about the patient's expectations, establishing agendas, and setting limits if they were going to focus the interview and manage their time appropriately. The study resident-participants reported these were skills they had not previously needed to either use or develop as medical students.

*Data collection.*

The resident-participants' approach to data collection also changed as they gained confidence in their ability to use their knowledge to help and not harm, and through seeing the outcome of their treatment and management plans. Gordon (2003) has done extensive work exploring how physicians gain expertise in using their knowledge to clinically reason. He reports that competency is acquired through the opportunity for deliberate practice with multiple examples and feedback, which helps to facilitate effective transfer of basic concepts. This was the experience of the resident-participants in this study. With time, the resident-participants began reporting that they used their knowledge more discriminately by recognizing what in their knowledge bank was relevant to ask based on the clinical context. Perhaps most importantly, as the resident-participants gained confidence in their ability to use their knowledge effectively, they felt comfortable enough to broaden their inquiry beyond an exclusively medical focus.

*Treatment and management.*

Resident-participants voiced concerns over being responsible for the treatment and management of patients, a skill with which they had limited experience as undergraduates because they were not responsible for the outcome of care. Thistlewaite (2002) identified the year following undergraduate training as the first opportunity most medical trainees get to

independently construct and deliver treatment and management plans to patients. For the first time as doctors, the resident-participants were experiencing the uncertainty associated with being responsible for making diagnostic and therapeutic decisions on behalf of patients. Authors of a recent study suggest that diagnostic tests are often taught during undergraduate training without reference to the patient's medical history, making it difficult for new graduates to understand how, when, and why to order tests when they are out in practice (Praschinger, Stieger, & Kainberrger 2007). In the early weeks of training, most of the resident-participants described triple checking prescriptions, evenings where they called patients back to ensure they had followed through with the plan, and nights ruminating over whether they had the diagnosis and treatment right. Most resident-participants did not describe this behaviour toward the end of the study. The resident-participants attributed their increased confidence in decision-making to seeing patients over time, where they could see the outcome of earlier their diagnostic and treatment choices.

*Practice Management*

The stress associated with adjusting to their new responsibilities as doctor is compounded by the introduction of a variety of practice management tasks that were not the resident-participants' direct concern or responsibility during their undergraduate training.

*Office management.*

As the resident-participants began postgraduate training, they were responsible for the first time for practice management tasks such as billing and completing laboratory work. The resident-participants were concerned about their ability to handle new responsibilities such as being on-call, and described the anxiety they felt with adjusting to new and often unclear role

expectations. New management tasks compounded already existing feelings of uncertainty and initially interfered with resident-participants' ability to feel confident in their new role as doctor. Feelings of insecurity around adjusting to new expectations in the first few days and weeks of starting postgraduate work have been reported elsewhere (Brown et al., 2007). Although many of these tasks relate to the enculturation process associated with any new work setting, several studies have reported that newly graduated Family Physicians feel inadequately trained in practice management issues (Breitwieser, Adye & Arvidson, 1981; Daugird & Spence, 1990; Prince et al., 2004; Rose, Edward, Anne & Rathur, 1999; Stone, 1994).

Practice management issues can influence clinical outcomes (Mast, 1997a) and overwhelm some physicians early in their careers (Rose et al., 1999). A recent study looking at the learning environment for junior doctor training found knowing the system and role expectations were critical to helping them acclimatize to their new setting and responsibilities (Kendall, Hesketh & MacPherson, 2005). These last findings support the experience of the resident-participants in this study in that, once they felt more comfortable with the environment and the related expectations, they felt more confident and could focus their time and attention elsewhere. The experience of practice helped them clarify what was and was not expected of them. However, some practice management responsibilities continued to provide challenges throughout the study regardless of experience and regardless of knowing what was expected of them.

A recent study found that providing Family Medicine resident-participants with curricula increased the resident-participants' confidence in managing these skills (Taylor, Mainous, Blue & Carek, 2006). This would suggest that much of the anxiety associated with acclimatizing to a new environment might be reduced by (a) providing opportunities to be responsible for some

practice management tasks during undergraduate training, (b) providing specific orientations at the postgraduate level aimed at teaching incoming resident-participants practice management skills, and (c) clearly outlining role expectations.

*Time management.*

As a newly graduated doctor, the need to manage time was a new concern and one all resident-participants struggled with throughout the study.  However, the reality of just how little time was available to competently accomplish all of the responsibilities they had was still surprising.  For example, resident-participants were suddenly responsible for (a) paperwork such as consultation letters and following up on laboratory results that were never their domain before, (b) ensuring that charts were properly completed, and (c) making sure they had the diagnosis right and had created the ideal treatment and management plan.  In the beginning, the biggest source of anxiety related to time was the management of patients in the office encounter, especially since they felt responsible for comprehensively addressing all of the patient's medical problems, big or small, in one visit.  Efficient and effective use of encounter time demands a high level of medical interview skill (Beckman & Frankel, 1984; Davidoff, 1997; Marvel, Epstein, Flowers & Beckman, 1999), which the resident-participants did not feel they had.  In particular, they voiced concerns about not knowing how to prioritize the issues and how to organize the medical interview once they had decided which issues to address.

In the beginning, resident-participants reported that even if concerns regarding the patient's social context were suspected, they were minimized or ignored because inquiring about social issues increased the risk of further losing control of the interview.  As well, most resident-participants felt there was no time to address anything but the presenting medical problems if they were going to provide competent care to the patient.  Rose et al. (1999) concurs that "trying

not to kill anybody" supersedes the need to accommodate other priorities such as how knowledge is used and managing one's time in the early stages of training.

*Managing resources.*

One of the skills necessary to be a Family Physician is the ability to deploy and manage resources (McWhinney, 1997). This means being able to judiciously use the resources of the community and health care system for the benefit of the patient. In Family Medicine, up to 50 per cent of patient visits to Family Physicians include a primary or secondary psychosocial reason for the visit (Katon, Williamson & Ries, 1981; Stoeckle, Zola & Davidson 1964; Williamson, Beitman & Katon, 1981). As a result, Family Physicians are often the entry point for many problems beyond disease; therefore, a working knowledge of community resources is essential to providing optimal care.

In the beginning, most resident-participants did not understand the relevance of the patient's life context to providing competent medical care and this finding is echoed in other studies (Mauksch & Hillenberg, 2001; Preven et al., 1986; Williamson et al., 1981). Reasons reported for these beliefs include (a) the need to rule out organic disease first and foremost, (b) time constraints, (c) feeling psychosocial issues have nothing to do with medical problems, and (d) misconceptions about what a patient wants or does not from the physician during an office visit. These same reasons for avoiding or not attending to a broader patient context emerged early in this study. While the resident-participants did expect to learn how to refer patients to services within the medical community such as the dermatologist or physiotherapist, they initially overlooked and then underestimated the need to access and link patients to community resources in a Family Medicine setting. At the end of this study, as resident-participants developed a deeper understanding of their role as Family Medicine residents, they recognized the

necessity and value of having a working knowledge of community resources in which to direct patients, but did not feel competent in this area.

*Relationships*

      *Commitment to establishing relationships with patients.*

From the resident-participants' viewpoint, they were now responsible for patients, which meant they were responsible for establishing relationships. As medical students, resident-participants described experiencing patient contact as transitory, with few opportunities to be part of the patients' care from beginning to end. As a result, the resident-participants felt there was neither opportunity nor incentive to develop any type of relationship beyond the superficial connection that time allowed. Perhaps more importantly, resident-participants viewed themselves as students whose primary responsibility was to learn from patients, not necessarily to establish relationships.

Nathanson (1958) suggested that patients are seen as objects from which to learn because students do not see themselves as having any real responsibility for the outcome of the patient's care. This perspective seems to be common as the literature is full of examples of how medical students see patients as disease puzzles to solve at the end of medical training and have a limited understanding of how a patient's life context and illness experience contribute to providing competent care (Lieberman, 1999; Rosenfield & Jones**,** 2004; Tsimisiou et al., 2007; Williams et al., 2001).

However, in their new role as doctor, the resident-participants felt a sense of commitment and responsibility toward patients they did not previously have. This finding is similar to other studies, which also found that doctors making the transition into postgraduate training commence

this stage with a high commitment to patients (Burr, 1975; Dunn, 1978; Luthy et al., 2004; Werblun, Deshler & Martin 1977). For the first time, resident-participants were concerned with establishing therapeutic doctor-patient relationships. However, the resident-participants were also concerned about their ability to live up to their own, and what they perceived to be the patient's perceptions of what it meant to be the doctor.

*Approach to the doctor-patient relationship.*

The resident-participants' initial concept of what it meant to be a doctor was predominantly defined as that of medical expert, which from the resident-participants' perspective reflected their experience of undergraduate training. As the resident-participants began postgraduate training, they did not feel they yet possessed the necessary expertise and experience to authentically represent this role. This concern was compounded by the knowledge that their clinical decision-making on behalf of patients held medical-legal consequences. Subsequently, these anxieties shaped their approach to the doctor-patient relationship, which can be described as doctor-centered or disease-focused (Batenburg, 1997; De Monchy et al., 1988; Stewart et al., 2003). Perhaps the term "resident- centered" could be used as resident-participants attended to their own agenda of accurately "nailing the diagnosis" which reflected their perception of what it meant to be the competent doctor. Attention to the patient's agenda or worldview was minimal.

Although most resident-participants felt they had been exposed to the elements of a patient-centered approach during undergraduate training, the resident-participants did not feel this exposure helped them understand how to use a patient-centered approach in concert with their medical knowledge. Candib (1995) cautions that learning a set of communication skills outside of the context of a relationship is not the same thing as learning how to develop a

relationship. Other researchers reported similar findings to this study in that resident-participants felt they had good communication skills, but felt they did not know how to effectively use these skills to communicate their knowledge well to patients (Dall'Alba, 1998; Wall et al., 2006). One other study was found where newly graduated doctors reported that senior colleagues did not appreciate their efforts to incorporate a patient-centered approach (Williams et al., 2001), but this was not reported in this study.

*Power and control.*

The study resident-participants described that, as medical students, they often felt there was little if any power differential in their relationships with patients. The resident-participants described that being medically-legally responsible for the outcome of the patient's care created an immediate shift in the power differential. Descriptions of how relationships with patients change from undergraduate training to postgraduate training have been reported in the literature, but not explored (Williams et al., 2001). The resident-participants in this study described how patients were implicitly handing them authority to make decisions on their behalf and were looking to them for their expert advice.

This shift in power extended to relationships with health care professionals who looked to the resident-participants for guidance in the care of the patients. This experience was in direct contrast to how resident-participants experienced their role as medical students, where they felt patients and nurses only saw them as messengers who gathered and delivered the necessary information for their supervisor as instructed.

Resident-participants described needing to learn how to take control of relationships and to set boundaries, behaviours the resident-participants felt they had little experience with as medical students. The resident-participants also described how having this new responsibility

and authority began to shape and change their ideas both about the type of care they wanted to provide patients and the type of care patients expected and wanted. Through experience and patient feedback, resident-participants began to realize that the patient's concept of the trusted medical expert was different from theirs.

*Continuity of care.*

During undergraduate training, the resident-participants reported that most of their patient contact had been transitory with little opportunity for follow-up care. Patients and doctors often have different criteria or expectations regarding the purpose and outcome of the clinical encounter (Greco et al., 2001; Stewart et al., 2003). When doctor-patient contact is limited it is easy for the beginning medical student to miss or overlook the relevance of understanding the patient's agenda to providing competent care. The experience of seeing returning patients in this study changed the resident-participants' awareness of what patients expect and do not expect in care from their physician. This is important because understanding the patient's perspective is considered a core clinical task and is linked to competence especially in the practice of Family Medicine (Arborelius & Bremberg, 1992; Dixon, 1986; Kurtz et al., 2005).

Dimitri and Feudtner (1997) wrote an in-depth article describing the problems that occur when medical students' and resident physicians' training occurs primarily in the context of transient, time-limited relationships with patients and families and felt the strategies used by the trainees often had "deleterious consequences" (p. 739). The experience of seeing patients in the context of an ongoing relationship was a pivotal influence in shaping the resident-participants' behaviours and attitudes in this study. Not only did this experience give the resident-participants confidence in their ability to medically manage the patient and a broader sense of what it meant to fulfill the role of Family Physician; it was also a pivotal influence in helping the resident-

participants develop an understanding of how important both the patient's viewpoint and background were to providing care. There is literature suggesting there is a disproportionate amount of specialty teaching during undergraduate education, and there are a few more recent studies recommending that medical students be given increased patient responsibility at an earlier point in their medical education (Dornan & Bundy, 2004; Gordon, 2003; Pitkala & Mantyranta, 2003), but no literature could be found speaking to the "type" (longitudinal versus transitory) of patient contact.

*Feedback.*

As the resident-participants' training progressed and they began developing relationships with patients, patient feedback took on an increasingly central role, all but replacing the supervisor's feedback. Patient feedback, more than supervisor feedback, influenced the resident-participants' confidence in their ability to use their knowledge, helped resident-participants learn to broaden their focus of inquiry, and helped them begin to understand that patients were interested in more than an accurate diagnosis. Perhaps most importantly, these experiences helped the resident-participants move from a more doctor- or resident-centered approach to care to a more patient- or relationship-centered approach to care. This study raises the possibility that, if Family Medicine resident-participants do not have the opportunity to develop an appreciation of the role of the relationship to competent care through continuity of care, their concept of what it means to be the doctor might remain anchored in their undergraduate experience of care. In other words, graduating doctors see their role as limited to that of medical expert where 'nailing the diagnosis' remains their priority.

*Summary - Knowledge, Patient Management, and Relationships*

Each of the sub themes of Knowledge, Patient Management, and Relationships created challenges for the incoming resident-trainees. In the first few months, the resident-participants had to learn how to begin using their medical knowledge in the clinical encounter in the role of doctor and how to develop therapeutic doctor-patient relationships. New responsibilities in Patient Management tasks compounded the already existing anxiety of learning how to manage the other new Responsibilities that came with beginning a postgraduate training program in Family Medicine. Although each of the subthemes created their own set of trials and tribulations that needed to be worked through, it was the combined force of these sub themes that led to change in the resident-participant's professional identity.

*The Resident-trainees' Developing Identity*

In this next subsection, I will discuss how the resident-participants' professional identity began to change and develop. This discussion will begin by reviewing how the resident-participants viewed their identity at the end of their undergraduate training, but before they began their postgraduate training in the role of doctor. Although only two short months separate the two periods of medical training, a distinction is being made because the resident-participants viewed their role as an undergraduate trainee, regardless of training year, as distinctly different from how they viewed their role as a postgraduate trainee on the first day. The discussion also begins here because the resident-participants often reflected on their experience as medical students to make sense of their current experience of training. The education literature clearly predicts how the powerful experiences of the undergraduate years, as embodied in the formal, informal, and the hidden curriculum, (Hafferty; 1998; Haidet, Kelly & Chou 2005) impact the acculturation experience of the medical student (Knight, 1981).

The resident-participants' preoccupation with their earlier training experience does not come as a surprise as all transitions involve a re-examination of whom and what we are, even if this process occurs at a largely unconscious level (Wilkie & Raffaelli, 2005). What was a surprise was just how powerful and lasting the influence of the undergraduate experience was on the resident-participants' early adjustment at the postgraduate level. It is for this reason that it is important to begin a discussion on the development of the postgraduates' identity by looking from the resident-participants' perspective at what their undergraduate experience was like for them.

*Socialization During Undergraduate Training*

The resident-participants' collective descriptions of their undergraduate experience mirror descriptions of the socialization process describing the acculturation of students into the profession of medicine (Becker et al., 1961, Dall'Alba, 1998; Haas & Shaffir, 1987; Konner, 1987; Mumford, 1970; Shapiro, 1987). This is important because not only does it lend validity to the resident-participants' perceptions of their undergraduate experience, it provides a platform for better understanding the resident-participants' concept of who they were as they began postgraduate training.

*Responsibility for Acquiring Knowledge*

For the resident-participants in this study, the focus of their undergraduate training was on passing examinations and receiving good evaluations from senior physicians. Studying for and passing examinations are part of the enculturation process of becoming a physician and students feel the results "can destroy or catapult their career" (Shapiro, 1987, p. 45). The resident-participant's described how, as medical students, they were concerned with acquiring as

much medical knowledge as they could through clinical experience, textbooks, patients, and superiors. Learning was not motivated by a sense of responsibility for addressing a patient's problem, but by the need to memorize the necessary body of knowledge to impress their supervisor in order to get good evaluations and to pass the various end-of-rotation examinations. Coombs' (1972) observation is supported by this study in that the pressure medical students experience to memorize knowledge instead of using it to reason prevents them from feeling like the doctor.

*Supervisors as Evaluators*

Becker et al. (1961) found that, in order to cope with the anxiety associated with needing to know so much, medical students gave high priority to understanding supervisors' expectations and evaluation criteria. As previously reported, the resident-participants in this study recalled seeing their supervisors during undergraduate training as evaluators of their performance, not as colleagues.

*Limited Decision-Making*

Combs (1972) reports that medical students are well aware that they know the least knowledge that would enable them to contribute in a significant way to the health care team, and that this lack of experience reinforces their identity as a mere medical student in training. A supervisor's signature or approval was needed before they could proceed at almost every level of decision-making. Resident-participants described how they did not feel responsible for the patient as a person because they did not have any power or influence around decision-making for treatment and management plans. The resident-participants' descriptions of their undergraduate experience concur with Comb's claim. The resident-participants clearly articulated that the lack

of opportunity and responsibility to use their knowledge to influence the outcome of patient care prevented them from feeling like a doctor.

*Medical Uncertainty*

Even as senior medical students, resident-participants recalled that consultation was expected and encouraged before taking any course of action. The literature suggests that one reason medical students are prevented from identifying with the role of doctor is that they are insulated from experiencing the medical uncertainties they will inevitably deal with later on in practice (Merton et al., 1957). The resident-participants were keenly aware of the limitations of their student status during their undergraduate training. This meant minimal responsibility for the patient, medical decision-making, treatment, and management plans. As a result, coping with the uncertainty of being responsible for diagnostic and therapeutic choices was never experienced.

*Limited Responsibility for Practice Management*

The practical ramifications of such things as time management and the medical-legal consequences of decision-making held little to no concern for resident-participants. In their role as medical students, the resident-participants did not feel they had responsibility for practice management tasks such as billing. Once again reinforcing, in the resident-participants' minds, that they were students.

*Limited Responsibility for Patient Care*

Previous research has found that if students are not given sufficient responsibility for patient care they do not identify with or feel like the doctor (Becker et al., 1961; Mumford, 1970; Savenius et al., 2006). As the resident-participants voiced in this study, from their perspective,

experiences were closely supervised and ultimate responsibility for the patient, and therefore outcome of care, did not lie with them.

*Identification with the Role of Medical Student During Undergraduate Training*

Identification with the role of the doctor is an important goal of undergraduate programs (Baszanger, 1985; Dall'Alba, 2002). Despite current attempts to introduce medical students to clinical experience at an earlier training stage in order to provide graduated patient responsibility, most resident-participants in my study still reported feeling like they were closer to being medical students at the end of their undergraduate training than doctors. Authors of other more recent studies about the enculturation process of medical students also report that graduating medical students felt more aligned with the role of student at the end of training than they did the role of doctor (Clack, 1994; Gude et al., 2005; Jolly & MacDonald, 1989; Nordentoft et al., 1991; Rolfe & Sanson-Fisher, 2002; Akre & Vikanes, 1991; Wise, Nicols, Chater, & Craig, 1996).

Resident-participants attributed their feelings of being a medical student at the end of undergraduate training to their experience of medical training during this time period. It seems that although a sense of responsibility towards becoming a physician is deeply rooted in the socialization process, it is the students' perspective, on the educational setting in particular, that reflects their behaviour and attitudes towards this responsibility (Becker et al., 1961; Fox, 1957; Savenius et al., 2006). The resident-participants in this study viewed themselves as medical students who were responsible for learning how to be the doctor responsible for patient care, but did not view themselves as having the responsibility of being the doctor. Again, the findings in this study are consistent with previous research in that doctors entering a postgraduate program

do not strongly identify with the role of doctor (Clack, 1994; Gude et al., 2005; Jolly &

MacDonald, 1989; Rolfe & Sanson-Fisher, 2002; Wise et al. 1996).

Becker et al. (1961) suggest that medical trainees adjust to the learning situation

according to their status rather than in reference to a future role.  The resident-participants

considered their status to be that of medical student during undergraduate training whereas, when

they made the transition to postgraduate training, their status officially changed to that of doctor.

Just as undergraduate training was about being a medical student; the beginning of postgraduate

training was about being a doctor.  From the resident-participants' perspective their role was

changing and role identification involves modifying earlier self-representations (Brent, 1981;

Wilkie & Rafaellli, 2005).  The following few paragraphs will discuss how the early experiences

of postgraduate training which involved adjusting to new responsibilities began to reshape earlier

self-representations.

*Identity development.*

Brent (1981) suggests that the most important task of postgraduate training is the

consolidation of a sense of professional identity and others echo this sentiment (Blackwell et al.,

1984).  The basis of a professional identity involves the delineation of a role for oneself and the

first few weeks for some, and months for others, was about feeling confident and comfortable in

the role of doctor.

*Identification with the role of doctor.*

Shuval (1975) and others (Grant, 1998) feel the real leap forward toward assumption of

the professional role of doctor occurs when students have direct patient contact in their third year

of undergraduate education. For the resident-participants in this study, the leap forward toward owning the role of doctor arrived the day they were given responsibility for patients.

Fox (1957) suggests that contact with patients has a distinct and different meaning for trainees in postgraduate training and this was certainly the case for the resident-participants in this study. The transition into postgraduate training meant for the first time they both had responsibility for patient care and felt responsible for patient care. Previous research substantiates this finding, in that if students are not given sufficient responsibility for patient care they do not identify with or feel like the doctor (Becker et al., 1961; Mumford, 1970; Savenius et al., 2006).

As the resident-participants began postgraduate training their concept of what it meant to be the doctor was based on their training experiences as medical students. From the resident-participants' perspective, undergraduate training was focused on knowledge acquisition and medical data collection. Patient care experiences primarily took place in specialty rotations where patient care was transitory and the emphasis was focused on medical diagnosis. Subsequently at the end of undergraduate training, the resident-participant's concept of what it meant to be the doctor was narrowly focused on the role of medical expert. While the resident-participants felt they had learned the prerequisite knowledge base to be called doctor, they did not feel they had the necessary experience using that knowledge to be considered the medical expert. Dreyfus & Dreyfus (1985) concur that expertise is only acquired after many years of experience. From the resident-participants' perspective the pressure to appear competent was enormous because, as doctors, they were more accountable and their actions and decisions now held consequences. The shift from the familiar subculture of school to the unfamiliar subculture

of work has been described as reality shock (Flynn & Heckelman, 1993; Kramer & Schmalenberg, 1979).

*Masquerading as the doctor.*

In the beginning resident-participants described how they felt they were masquerading in the role of doctor and expressed concern about their ability to assume the mantle of doctor, given the enormous associated responsibility. The experience of feeling confused, phoney and awkward is common for anyone learning to use new skills in practice (Wackman, 1976) but these feelings were particularly pervasive for the incoming trainees because for the first time they were learning how to use their knowledge to independently make clinical decisions in a context of uncertainty. It is difficult to acquire and sustain a sense of competence where almost every situation is new, and not knowing who or where you are in the scheme of things can initially cause feelings of dread (Bion, 1962).

Often, even students that are successfully socializing into professional roles will still feel like they are "phoney" (Noack, 1980, p.164; Shuval, 1975), which brings to mind the Impostor Phenomenon discussed in Chapter 3. Clance's and Imes' (1978) view of the phenomenon is where individuals believe they have fooled others into thinking they are intelligent and capable. However, the resident-participants' experience in this study seems closer to Harvey and Katz's (1985) view in which it is a normal, transient developmental experience associated with changes in responsibilities. In the beginning, the resident-participants did not describe themselves as impostors but, instead, described feeling like they were masquerading as the doctor. They felt this not because they had fooled people, but because they lacked confidence and did not feel like the expert that people associate with the term doctor.

According to Shuval (1975), the role tensions that occur, as professionals are making the transition from school to the workplace, are natural and will eventually move forward in favour of the professional role. Wackman (1976) concurs and feels it is through practice and experience that a sense of competence in the new role is gained. This is what happened in this study, meaning the resident-participants eventually felt more confident and comfortable in the professional role of doctor as they gained experience and practice.

*The role of impression management.*

One way the resident-participants dealt with their initial anxiety over being seen as the expert was by consciously putting forth an image that they were indeed competent and capable. This finding is similar to Haas & Shaffir (1987) who found that deliberate attempts at impression management by medical students are a way of appearing competent while warding off the anxiety of not knowing. Clearly, the need to manage impressions during undergraduate training carries over into the first few months of postgraduate training. In fact, from the resident-participants' perspective, impression management was more important at the postgraduate level then it was at the undergraduate level. The resident-participants described how the supervisor's image of self-confidence with patients suggested that the supervisors were technically competent to handle the patients' concerns, which inspired the patient's trust in the supervisor's ability to care for them. Being technically confident and competent was an image the resident-participants felt they needed to adopt, whether they felt this level of competence or not, to earn the patient's trust and respect. According to the study resident-participants, efforts to maintain an image of competency were not as necessary during undergraduate training because supervisors, health care providers, and most patients expected that they did not know. As doctors, there was now

both the expectation, primarily from patients, that they should know, as well as, the

responsibility of actually needing to know.

*Identification with the Role of Family Medicine Resident -*

*Gaining Confidence in the Role of Doctor*

As the resident-participants began postgraduate training, the role of doctor was narrowly

defined as being the medical expert. The resident-participant's viewpoint of their role

determined their goals and priorities in the clinical encounter. According to Bandura's (1977,

1986) theory of self-efficacy, an individual's perception of his or her ability to execute a

particular task, is the single most important determinant of the goals set by an individual and of

the energy and effort that will be invested to attain them. The resident-participants did not feel

confident in their knowledge base and ability to use their knowledge in the role of doctor;

therefore, the resident-participants did not feel comfortable and competent in the role of doctor.

Subsequently, the resident-participants' energies and priorities were focused on effectively

diagnosing and managing disease. This finding aligns with Pratt et al's (2006) extensive study

on constructing professional identities in medicine. Pratt's study found that feeling confident in

one's professional identity overlapped with feeling able to competently fulfill the role. Once the

resident-participants felt more confident in their role as doctor, which was synonymous with

feeling more confident in their knowledge base, the resident-participants' approach to care

changed, which led to further changes in their professional identity.

For the resident-participants, the mantle of doctor was not owned until they had

responsibility for patients and felt more confident in their ability to use their knowledge to heal,

not harm patients.

*The Experience of Practice Redefines Role*

A series of studies completed in the 1970s also found that incoming trainees did not immediately identify with the role of Family Medicine resident (Burr, 1975; Dunn, 1978; Werblun et al., 1977); however, these studies attributed a lack of identification with the role of Family Medicine resident to early training experiences primarily happening in settings outside of the Family Medicine unit. In this study, being located primarily in a Family Medicine setting did not ensure identification with the role of Family Medicine resident. The resident-participants needed to feel comfortable in the role of the doctor before they could begin identifying with the role of Family Medicine resident.

Feeling more confident that they were not going to kill anybody meant the physician trainees could broaden their approach to patient care to include inquiring about the patient's illness experience and to develop an understanding of the patient's life context. The experience of developing relationships with patients over time, continuing to see the positive outcomes of their treatment and management plans and hearing the patient's encouraging feedback redefined what it meant to be the doctor in the context of a Family Medicine setting. The resident-participants began to realize that the role of Family Physician was not limited to that of medical expert, but included that of counsellor, advocate, and resource consultant.

*The Transition from Undergraduate to Postgraduate Family Medicine –*

*The First Six Months*

All transitional moves that involve any significant change involve a period of unease, feelings of vulnerability, and a degree of identity confusion (Wilkie & Raffaelli, 2005) and in this sense the findings of this study are no different. The resident-participants in this study

entered the program not feeling comfortable in the role of doctor and not knowing what it meant

to be a Family Physician.  As resident-participants begin postgraduate training they are eager to

accept the responsibility of being the doctor, but are uncertain they have the necessary medical

experience and expertise patients expect from someone calling themselves the doctor.  Before

residents are able to begin broadening their concept of what it means to be a physician in the

context of a Family Medicine setting, the resident must begin feeling comfortable in the role of

doctor.  For some this is a matter of weeks and for others months.  As training progresses, from

the resident-participants' viewpoint, it becomes evident many of the skills and attitudes

necessary to be the Family Medicine resident were not part of their undergraduate training and

need to be learned.  This adds to their feelings of inadequacy, but the experience of seeing and

hearing different patients over time helps resident-participants to adjust their approach to the

practice of Family Medicine.  While each of these concerns was influenced by the resident-

participants' experience of practice in the context of a Family Medicine setting, it was the

collective experience of working through these concerns over time that began to transform and

change the resident-participants' concept of what it meant to be the Family Physician.  At the

end of six months, resident-participants do not feel like they are ready to be practicing Family

Physicians, but they do have a better understanding of what it means to be the Family Physician,

and most resident-participants feel comfortable in the role of doctor and as a result have begun

identifying with the role of Family Medicine resident.

*Knowledge Contribution*

While the first half of this Chapter used the findings in conjunction with the literature to

discuss one way to comprehend and understand the resident-trainees' experience during the first

six months of postgraduate training, the second half of this Chapter will move to a broader

discussion of how the knowledge generated by this study contributes to medical education. I begin the discussion by revisiting the research questions that were initially postulated. To reiterate, the aim of this study has been to provide and examine in a rich manner the voices and experiences of resident-trainees in the first six months of a Family Medicine training program.

*How do Doctors in the First Six Months of a Family Medicine Residency Program Describe their Experience? What are Their Concerns?*

The resident-participants felt there was a huge leap in responsibility from being a medical student to being a doctor, which led to concerns in the areas of knowledge, practice management, and relationships. The resident-participants' were most concerned about their level of knowledge and how to use their knowledge in the context of the clinical encounter. Practice management issues related to administrative tasks and role expectations compounded their initial anxiety. For the first time, resident-participants felt responsible for the outcome of the patients' care and were concerned more about harming patients with their knowledge than establishing relationships

*What Changes to Practice do Resident-trainees Describe in the First Six Months of a Family Medicine Residency Program?*

The resident-participants began postgraduate training feeling unsure of themselves in the role of doctor. As a result, the resident-trainees were focused on ensuring themselves that their level of knowledge was adequate to help patients and not on how they used their knowledge in the context of practice. As the resident-trainees became more comfortable that they were not going to harm patients with what they perceived to be a lack of expertise, their focus of inquiry changed and broadened to include the patient's illness experience and broader life context. As

trainees gained confidence in the role of doctor, their professional identity began to change or evolve into that of Family Medicine resident. Most issues related to practice management were quickly resolved as the resident-participants acclimatized to their new practice setting and the associated expectations.

*What Factors do the Doctors Attribute to Influencing These Changes to Practice in the First Six Months of a Family Medicine Residency Program?*

In the beginning, it was the recursive experience of using their knowledge in practice, hearing the supervisor's feedback, and the need to manage time that led to resident-trainees feeling more comfortable and confident in the role of doctor. As a result, the resident-trainees' approach to practice and the doctor-patient relationship changed. Subsequently, experiencing relationships in the context of a continuing care relationship, hearing the patient's feedback, and the continued need to manage their time became more influential in shaping the trainees professional identity.

*New Conceptualizations*

The answers to the question, "How do resident-trainees describe their experience during the first six months of a postgraduate Family Medicine Program?" provides insight into what the transitional experience is like from the resident-trainees' perspective thereby providing medical educators with a deeper understanding of the training experience. Understanding the resident-trainees viewpoint on their experiences is important because most medical education literature about the experience of medical training focuses on the socialization process of undergraduate medical students (Becker et al., 1961; Coombs, 1972; Haas & Shaffir, 1987; Mumford, 1970; Shapiro, 1987), the clinical preparedness of medical students making the transition to clinical

clerkship (Calman & Donaldson, 1991; Hesketh et al., 2003; Luthy et al., 2004; Prince et al., 2000; Prince et al., 2004; Prince et al., 2005), or explores specific, predetermined issues such as stress, communication or clinical skills (Bogg et al., 2001; Hill et al., 1998). Not only is there less research looking at postgraduate training experience, even fewer studies are focused from the viewpoint of Family Medicine resident-trainees, and no studies were found exploring the Family Medicine resident-participants' experience using multiple interviews over a period of time. As well, the findings from this study provide the reader with new conceptualizations of the first six months of training in a Family Medicine program in three broad areas.

*Mapping the first six months of Family Medicine training.*

First, understanding the concerns and changes of doctors beginning postgraduate training in Family Medicine and the influences the resident-trainees attribute to contributing to these changes allows us to begin mapping the experience. The resident-participants were able to describe from their perspective the challenges they encountered, the changes they made to practice, and what influences they attributed to those changes over the first six months of their postgraduate training. Many of the concerns voiced by the resident-participants have either been found or raised in other studies. In this study, where I begin to map uncharted water, is by outlining the transition process for resident-participants beginning a postgraduate training program in Family Medicine, and by identifying the changes to practice and the influences attributed to these changes that occur in the first six months of this process. The more we know about what the specific challenges and concerns are for incoming Family Medicine trainees, the more focused our support and learning interventions can be.

*Learning to become a Family Physician - the first six months of training.*

Second, the findings provide a conceptual framework for thinking about how resident-trainees begin developing an understanding of what it means to be the Family Physician in the first six months of training. Medical training has been described as a transformative process where the professional identity is constructed (Bleakley, 2002), but little is known about how this process is experienced from the resident-trainees' perspective at the postgraduate level and even less is known about the training experience of becoming a Family Physician. The findings of this study have suggested that incoming trainees must become confident and competent in the role of doctor before they begin developing an understanding of what it means to be the Family Physician.

Not having a strong identification with the role of doctor at the end of medical school has been linked to stress during subsequent training (Paice et al., 2002; Tyssen, Vaglum, Gronvold, & Ekeberg, 2000). This was the experience of the resident-participants in this study in that they described their level of anxiety as very high because they felt they were masquerading as the doctor. For doctors beginning a postgraduate training program, knowing that their initial feelings of anxiety and inadequacy related to adjusting to the responsibility of being the doctor are normal and experienced by their peers may minimize the stress experienced by incoming resident-trainees.

Once resident-trainees are relatively comfortable and confident in the role of doctor they are able to listen to patients differently which leads to different interactions with patients. It is now the resident-trainee's relationships with patients that helps the trainee begin to realize that being the patients Family Physician is not limited to that of medical expert, but extends to that of generalist prepared to act as counsellor, advocate and trusted advisor. Knowing how a new

resident-trainee begins to learn what it means to be the doctor is important because each medical discipline and specialty has its own set of knowledge, skills and attitudes.

*Adjusting to new responsibility in the first six months of Family Medicine training.*

Finally, a better understanding of how new trainees perceive and adjust to responsibility as they make the transition into a postgraduate program in Family Medicine has been laid out.  It has been suggested that the transition from student to practice is the most difficult to make in any profession (Lambert & Goldacre, 2006) and the resident-participants in this study described it as daunting.  Adjusting to new responsibilities has been identified in a few studies as part of the transitional experience of trainees beginning a postgraduate program, but there has been no exploration as to what this may entail.  This study was able to add to our understanding of how responsibility shapes the postgraduate trainees' experience by first identifying the three key areas of adjustment: Knowledge, Practice Management, and Relationships, and by outlining the changes that occur in these three areas and the influences resident-participants attributed to those changes.  This is important because the resident-trainees' adjustment to their new Responsibilities helps shape their concept of what it means to be a Family Physician

*Summary – Chapter 10*

In this chapter I used the literature as a platform for locating and discussing the findings of this study.  From the interviews with resident-trainees it is apparent that the first six months are significant for learning both what it means to be a doctor and a Family Physician and where a steep learning curve occurs as resident-trainees adjust to new Responsibility in the areas of Knowledge, Relationships, and Practice Management.  As the resident-participants adjusted to their new responsibilities, they gained confidence in their new role as doctor, which subsequently

led to a more comprehensive understanding of what it meant to be a Family Physician. This study was able to contribute to what little is known about the transition into a postgraduate Family Medicine program by illuminating from the resident-participant's perspective how the transition is experienced. In doing so, we have a better understanding of how the early training experiences of resident-trainees in a Family Medicine program contribute to consolidating their new professional identity.

In the final Chapter, I focus on a more general discussion of what the implications of this study may mean for medical educators, as well as, outlining areas for future research.

**Chapter 11**

Implications and Final Thoughts

Medical educators often claim that too little is known about the experience of resident-trainees making the transition into a postgraduate program (Clark et al., 1999; Hafferty, 1998; Haidet et al., 2005; Jolly & MacDonald, 1989; Mandel et al., 1988; Relman, 1990; Rolfe & Sanson-Fisher, 2002; Tyssen et al, 2000).  This study shed light on how the transition is viewed by trainees beginning a postgraduate program in Family Medicine.  This chapter links the particularities of this research back to the more general issues that arise within the field (Silverman, 2005), in this case, the medical education of Family Medicine trainees.

Since this study was about the experiences of Family Medicine trainees, this Chapter begins by using the Four Principles of Family Medicine to paint a portrait of the resident-trainees' development. This portrait shows the implications of the resident-trainees' progress for medical educators and program developers interested in supporting resident-trainees' transition into a Family Medicine program.  Aspects of this discussion are summarized in a final chart entitled "The Four Principles of Family Medicine – Strategies for Development in the first six months". The discussion then moves to the impact of undergraduate training on the resident-trainees' preparedness for postgraduate training, specifically in Family Medicine.  I then examine how the findings of this study have influenced my own experience of practice.  The chapter concludes with final reflections on the research study itself and directions for future research.

This study explored the first six months of a Family Medicine training program and found that resident-trainees begin with limited to no experience in the practice of Family Medicine and must learn what it means to be a Family Physician.  During the resident-trainees' two-year apprenticeship, they must learn the values and principles of Family Medicine, just as a

surgeon must learn through specialized training what it means to be a surgeon. The resident-

participants' stories of their early experiences of the first six months of training give us a window

into the beginning evolution of these principles, which has implications for medical educators

interested in supporting the development of these values in the training of future Family

Physicians.

In the following few paragraphs, three different contexts are used to discuss the

implications of this study for medical educators and program developers.

*Returning to the Four Principles of Family Medicine*

Family Medicine was defined, in an earlier chapter, by the College of Family Physicians

of Canada (2007) through four principles 1) The Family Physician is a skilled clinician, 2)

Family Medicine is a community-based discipline, 3) The Family Physician is a resource to a

defined practice population, and 4) The patient-physician relationships is central to the role of

the Family Physician (See Appendix A). Although the descriptions of the four principles

provided by the College of Family Physicians of Canada (2007) are neither detailed nor

extensive, the explanations do highlight the fundamental values the College of Family Physicians

of Canada expects that the competent Family Physician will incorporate in practice.

*The Family Physician is a Skilled Clinician*

Family Physicians provide comprehensive care using a patient-centered approach. This

means they are not only interested in understanding the patient's disease but also their illness

experience. Family Physicians are adept at working with patients to find common ground on the

definition of problems, treatment, and management.

The resident-trainees are discovering what it means to provide patient-centered care in the context of Family Medicine. From the residents' perspective as the doctor now medically-legally responsible for care, they are concerned that they may harm patients with their inexperience and lack of knowledge. Consequently, trainees tend to be preoccupied with ensuring they have made the correct medical diagnosis, thus also do not actively inquire about the patient's illness experience. Furthermore, resident-trainees are more concerned with what medical questions they ask patients then how they ask the questions. By six months, many of the patient-centered interviewing skills they learned during undergraduate training, such as inquiring about patient's expectations for care, take on new meaning as the resident-trainees begin to realize the role family, social and personal context plays in both diagnosis and management.

Resident-trainees understand how to take a comprehensive developmental history based on their undergraduate experience but their understanding of how to use this knowledge with patients and families is limited. For example, a biological perspective anchors many of life cycle transitions such as menopause, retirement, and parenthood. The personal meaning of these experiences for patients is often new to the beginning resident-trainee; therefore, the trainee's approach to management does not incorporate the patient's viewpoint.

Medical specialists who focused on the detection and diagnosis of acute medical problems presented much of their undergraduate instruction. As a result, their differential diagnosis is often limited to acute problems. In Family Medicine, unlike the medical specialties, patients often come to see their physician seeking reassurance for benign conditions, such as earaches or cold symptoms. These types of medical problems often do not lead to problems that are more acute and often resolve without medical intervention. For beginning resident-trainees who are overly concerned they are going to miss a life threatening diagnosis, learning to think of

common problems before less common disease presentations and to take a "wait and see"

approach are new experiences.

Using evidence-based medicine to guide clinical decision-making is not a new concept to

trainees, but the application of this concept takes on special meaning as a Family Physician

trainee. Commonly used evidence-based guidelines in Family Medicine are immunization

schedules and age-related screening recommendations, guidelines the incoming trainees are

familiar with, but have had little experience using in practice.

As doctors, beginning trainees feel solely responsible for the outcome of care and are

reluctant to share decision-making responsibility with patients. The resident-trainee's approach

to the clinical encounter and doctor-patient relationship is very resident-centered where the

power resides with them to determine the agenda for the office visit. The trainee needs to

maintain control of the encounter in order to keep the interview narrowly focused on the

patient's medical diagnosis. Trainees struggle to define the focus of the encounter and goals of

treatment. As the trainees feel more comfortable in the role of doctor, they begin to recognize

the need to share power in the doctor-patient relationship if they are to provide competent care,

but are unsure how. After six months, the trainees have learned that they need the patient's input

to set the agenda and focus the interview. However, treatment and management plans continue

to focus on medical management, while excluding the patient's input and consideration of the

patient's life context.

*Family Medicine is a Community-Based Discipline*

Resident-trainees are learning that Family Medicine is a community-based discipline

where Family Physicians are responsible for providing care in multiple settings and for multiple

patient problems.  The diversity and complexity of patient care that the Family Physician is responsible for providing is often overwhelming to the new resident-trainee.

Although the trainee may cognitively understand that Family Physicians use community resources and are a part of a team that delivers care, their priority is to diagnose the patient's problem.  Wise stewardship of scare resources and understanding how to delegate care does not seem to be a priority in the early months of training.

In Family Medicine, most problems are a combination of behavioural, social, and medical issues.  Family Physicians need to be skilled at not only dealing with undifferentiated problems, but with problems that often have complex psychosocial roots.  The resident-trainees did not need to deal with the uncertainty of diagnosis as a medical student; furthermore, the role of context in treating the medical problem was not always evident.  As the resident-trainee is now overwhelmed with the responsibility of identifying the patient's problem and constructing a treatment plan, the importance of context continues to remain obscured and an appreciation for the role of the patient's life context and the role of community resources to providing care is slow to evolve.

 As resident-trainees see patients over time and respond to on-call medicine, they begin to recognize that their patient's lives do not happen in a vacuum.  Unanticipated crisis and change happen outside of the clinical setting.  In the beginning, resident-trainees are more reactive rather than anticipatory or proactive to patient needs and problems.  An understanding of the critical role community resources play in supporting the Family Physician's ability to provide competent care is just beginning to develop at six months in to postgraduate training.

Resident-trainees recognize that they are members of an interprofessional team, but their concept of what this means is limited.  Trainees are unsure of the various roles of the different

health professionals and unsure of their role within the team given the layers of hierarchy and experience. Representing the role of Family Medicine trainee in different medical settings outside of the Family Medicine clinic presents a new set of challenges as they try to figure out where they fit in and what is expected of them on other services. Resident-trainees are more focused on developing and locating their own identity and role within Family Medicine and do not recognize the critical importance in Family Medicine of knowing how and when to delegate patient care to more appropriate services.

*Learning to be a Resource to a Defined Practice Population*

Family Physicians are as concerned with encouraging health prevention practices with individual patients as they are with addressing the patient's acute medical problems. However, Family Physicians are also concerned about the implications of the wider health care system and culture on their practice as a whole. For example, Family Medicine extends their responsibility of care to include not only the single patient in need of immunization, but also the effects of immunization on the population as a whole. This responsibility may take the form of advocating for changes in health care policy or wise stewardship of resources.

Throughout undergraduate training, patient contact was primarily transitory, with the focus of the encounter on the patient's disease. As new doctors the focus continues to be the individual patient versus viewing their practice as a whole. At the end of six months, resident-trainees concentrate on defining their role in, and becoming confident with, managing their own individual practices. The clinical encounter is about resolving the immediate medical problem of the individual as opposed to considering anticipatory needs or preventative care.

In the beginning, the resident-trainee focuses on learning and mastering basic practice management skills such as locating and completing paperwork, billing, booking patients and charting. Trainees are independently decision-making for the first time around what tests to order and what referrals to make; therefore, their judgment around when and how to use resources is just beginning to develop. Trainees are not aware of and do not feel responsible for broader issues related to managing a practice or evaluating the effectiveness of care on the practice as a whole.

New trainees do not see themselves as having a role or responsibility for public policy. New trainees are focused on developing a sense of what the resources are within the health care system and how to appropriately refer to them. A sense of responsibility for using those resources judiciously has not yet begun to develop. The resident-trainees' ability to identify learning needs and to find resources for self-directed learning is exploding and motivated by their professional insecurity in the role of doctor.

*Learning how to Establish Patient-Physician Relationships*

Family Medicine is a discipline that defines itself in terms of the relationship between patient and physician. Unlike other medical specialties, the Family Physician is committed to the person rather than a group of diseases, body of knowledge, special techniques, or patient population. For Family Physicians, there is no defined end to their commitment. The relationship does not end because the course of treatment ends or the illness is terminal. From the outset of postgraduate training, resident-trainees look forward to and are committed to caring for patients. However, as medical students the transitory nature of patient contact and delimited responsibility made it difficult to establish relationships. As a result, resident-trainees begin their

Family Medicine residency without an appreciation of the complexity and nuances of this relationship and its critical role in providing care in a Family Medicine setting.

In the beginning, the resident-trainee has limited experience with patients and limited understanding of what it means to be a Family Physician. Consequently, the trainees' approach to care is often reactive and limited to the patient's presenting problem. Commitment and caring are synonymous with accurately diagnosing the patient.

Resident-trainees focus on protecting themselves from becoming immobilized and overwhelmed by the anxiety they initially feel as they learn through practice what their strengths and limitations are. After six months of training, resident-trainees are beginning to recognize they have expertise to offer, but their sense of competency is still very fragile. Trainees are outwardly focused on learning what it means to provide effective care for patients and there is little inward retrospection or self-awareness about how their personal backgrounds and experiences contribute to this process.

New resident-trainees take their responsibility to develop a covenant with patients based on trust very seriously. They are committed to providing the best possible care to patients and their families, but struggle with knowing where their responsibility begins and ends. Consequently their approach to patient care often vacillates between being overly directive, where they tell patients what to do, and being overly passive, allowing the patient to dictate the direction of treatment and management. Incoming resident-trainees find it a challenge to develop trusting relationships, while at the same time establishing and maintaining boundaries.

*Snapshot of the First Six months of Family Medicine Training*

The Four Principles of Family Medicine locate the resident-trainees' development towards becoming a Family Physician as they progress through the first six months of

postgraduate training.  In summary, this study paints a portrait of Family Medicine physician trainees as individuals who are motivated to take on the responsibility of caring as doctors for patients, but enter a Family Medicine training program with limited to no understanding of what it means to be a Family Physician.

For most of the trainees, their four-week Family Medicine clinical rotation in undergraduate medical training was their only ongoing experience of a day-to-day Family Medicine clinical setting.  As well, from the resident-trainees' perspective, they were in the role of medical student during their undergraduate medical rotation, which gave them limited insight into the comprehensive role and responsibilities of being a Family Physician.  As the trainees made the shift from undergraduate to postgraduate training, they officially became doctors responsible for the outcome of patient care.  From the trainee's perspective, their concept of what it means to be the doctor had been cultivated during their undergraduate training and focused on that of medical expert.  It was from this vantage point, needing to be the medical expert, a role they were neither comfortable nor confident in, that the resident-trainees began their journey to become Family Physicians.

It is an oversimplification to say that until the resident-trainees feel relatively comfortable and confident that they can use their knowledge base in ways that do not harm patients, that they are unable to develop an understanding of what it means to be a Family Physician. Feeling confident in the role of doctor and learning what it means to be a Family Physician are not mutually exclusive processes, but interrelated and complementary.  Many of the tasks and roles of the Family Physician such as seeing patients over time, making a diagnosis, and seeing follow-up patients lead to increased confidence in the role of doctor.  Reciprocally these same

experiences are broadening the trainees' understanding of what it means to be a Family Physician.

After six months of training, resident-trainees are just beginning to realize that there are as many combinations and permutations of patient personalities, worldviews, and responses to illness as there are diseases, which result in the Family Physician needing to fill diverse roles. Most trainees have begun to develop practices and are experiencing the satisfaction that comes with developing ongoing relationships with patients.

*Implications for Medical Educators*

It is clear from the above description that the resident-trainee's transition into a postgraduate program has many new experiences and that the challenge of having and feeling responsible for the outcome of patient care is very stressful. The findings of this study help medical educators conceptualize where resident-trainees are in the process of adjusting to the challenges of new responsibility during the first six months of Family Medicine training. Knowing that the incoming resident-trainee does not feel comfortable in the role of doctor and does not understand what it means to be a Family Physician has implications for those interested in the program development and delivery of postgraduate Family Medicine training.

Although the implications are framed for medical educators, it should be noted that the discussion is also relevant to resident-trainees themselves who are beginning training for use in developing self-awareness and for self education. Transitions often raise feelings of anxiety and insecurity from the fear of not fully knowing how to adapt to a new professional role and working environment (Brown et al., 2007). Resident-trainees often assume that they are the only ones experiencing anxiety and self-doubt, and medical educators often assume new doctors

know what they are doing, which makes it difficult for resident-trainees to vocalize their

insecurities and to ask for help. The findings and subsequent implications provide both medical

educators and resident-trainees setting out in a postgraduate training program with benchmarks

for better understanding and locating the experience of training during the first six months.

In the following paragraphs, I briefly highlight some of the key challenges for new

resident-trainees as they begin postgraduate training in the areas of Knowledge, Relationships,

and Practice Management. This study's findings suggest possible strategies for assisting and

supporting the experience of resident-trainees in these three areas.

1. Knowledge

The shift into postgraduate training meant trainees were now responsible for using their

hard-earned body of knowledge to diagnose and treat patients. They did not feel they had

the experience and medical expertise that others associated with someone calling

themselves doctor. Not only did trainees feel anxious about their level of knowledge

being adequate, they struggled with what to ask and had little understanding of how to

ask.

2. Relationships

For the first time trainees both felt and had responsibility for the outcome of patient care.

While the trainees were highly motivated to care for their patients, competent care meant

being the medical expert, a role they did not feel confident or comfortable in. As a result,

the focus of the relationship in the first few months became the patient's medical

diagnosis. Many relational issues such as breaking bad news, inquiring about sensitive

topics and engaging with challenging patients were new. Trainees had limited experience

establishing relationships with patients in the role of doctor; therefore, struggled with

knowing how to set boundaries, the meaning of a patient-centered approach, adjusting to

a perceived power differential and their own emotional reactions to patients.

3. Practice Management

Perhaps one of the most pressing concerns in the first few weeks was the introduction of

a variety of practice management tasks (i.e. billing) that were not the trainee's direct

concern or responsibility during their undergraduate training.  Adjusting to an unfamiliar

work environment (i.e. locating paperwork) and understanding the role expectations of a

Family Physician trainee (i.e. on-call responsibilities) compounded already existing

feelings of anxiety and consumed precious time and energy for other tasks.

*Strategies to Support Learning*

The following suggestions emanated from the resident-participants' concerns as they

begin practice, their reported changes to practice, and their descriptions of various sources of

influence on those changes.  Aligning teaching efforts with the needs of learners is important

(Knowles, 1984) and the resident-trainees' stories help to speculate about possible interventions

to ease transition into postgraduate training, make learning more relevant, and to decrease stress.

Relevant adult learning theory and current medical education literature (Bandura, 1986;

Knowles, 1990; Kolb, 1984; Merriam, Sharan, Caffarella & Baumgartner, 2007; Slotnick,

Mejicano, Passin & Bailey, 2002) support these implications.   None of the instructional

strategies suggested are in and of themselves new to program developers and medical educators;

however, the resident-trainees were able to highlight, given their stage of development, which

learning strategies were most helpful to them.  Given that there are many competing curricular

demands and time is a scarce resource, being able to align instructional experiences with the

resident-trainees needs is important.

While most of the suggestions broadly focus on instructional strategies, some implications relate to instructional content and programme structure.

*Role modeling.*

It is important not to assume that new resident-trainees have relevant previous experience, knowledge, or comfort in the role of doctor. From introducing themselves to patients as the doctor, to presenting treatment and management plans, many of the tasks associated with the role of doctor responsible for care were new to the trainee. The resident-trainees recalled, as medical students, how observing both the positive and negative patient interactions of supervisors influenced who they wanted to be as doctors. However, now that they were doctors, the experience of observing others interact with patients took on increased significance because they felt responsible for the patients. Learning through role modeling was now anchored in personally meaningful examples, where they had a vested interest in the outcome.

For example, trainees closely watched and listened to see and hear how supervisors handled the patients and problems they presented to them for supervision. There are many examples throughout the study of how watching others influenced trainees' communication with patients, approaches to medical problems, clinical decision-making, and professional identity. Given the incoming resident-trainees' high level of performance anxiety, they are perhaps, more than at any other time in their training careers, receptive to guidance and support.

Role modeling has been described as the most important teaching method used by clinical teachers (Stewart et al., 2003) and at the heart of character formation (Kenny, Mann & MacLeod, 2003). Role modeling can demonstrate clinical competence, and teach skills and

compassionate care (Cruess et al., 2008).  Educators believe that when role modeling is accompanied by reflection on action professionalism can be taught (Stern & Papadakis, 2006). Supervisors should be actively seeking and deliberately creating opportunities to role model the behaviour and attitudes they want to impart to beginning resident-trainees and to be explicit about their choices.  The need to share tacit thinking by being explicit about decision-making is especially critical in the first few months of training when new trainees are highly motivated to learn, anxious about their abilities, and receptive to guidance.  Chart rounds, clinical encounters, and the nursing station are only a sample of the different contexts in which skills and approaches can be role modeled.

Role modeling also needs to be accompanied by specific feedback.  Supervisors cannot assume that trainees recognize the behaviour, attitudes, rationale, or thinking they intended the trainee to take note of through casual observation.  For example, practicing Family Physicians vary their introduction to patients depending on different factors such as age, gender, length of relationship, and previous encounters.  Explaining their rationale to use only the first initial of their last name with a child because the child cannot pronounce their last name needs to be labelled to make role modeling and learning more meaningful.  Supervisors should look for opportunities to make the implicit, explicit.

*Feedback.*

Learning from experience is considered a key requirement to acquire and maintain expertise in medicine (Guest, Regehr, & Tiberius, 2001), and feedback plays a pivotal role in guiding this process.  Recommending ways programs could incorporate feedback would be presumptuous given that each program has its own culture.  However, it is important to note that, from the trainee's perspective, the supervisor's feedback was critical to their development,

something they wanted more of and highly valued. The trainees had recently moved from a learning culture where they were dependant on supervisor feedback to determine their progress and to act as a safety net. In the first, few months' trainees continued to rely on their supervisors input to gauge their performance.

The supervisor's feedback shaped the resident-participants' approach to practice and gave them needed confidence in their ability to doctor. Resident-trainees found the role modelling that occurred in the clinical encounter and the feedback that occurred about their performance with patients in the clinical encounter particularly helpful. Trainees were just as eager to hear about what they were doing right as they were to hear about areas for improvement so they could self correct. It is important to note that trainees felt the supervisor's feedback declined as training progressed.

Postgraduate training represents a steep learning curve that commences the day resident-trainees arrive. Previous studies looking at the experiences of resident-trainees consistently report that supervisor feedback, support, and accessibility were highly desired, but often absent during postgraduate training (Brown et al., 2007). Resident-trainees feel very anxious about their ability to fulfill the role of doctor and supervisors are ideally positioned to influence their development. Bucher & Stelling (1977) looked at the transition of medical trainees into a postgraduate program and noted that as trainees felt increasingly comfortable with their skill level, they became less receptive to evaluation, direction, and criticism of others. Supervisors should take advantage in the first few months of resident-trainees' keen desire and motivation to learn. Given the central role of faculty to the growth and development of the resident-trainee on so many different levels, program developers may need to consider incorporating faculty development training to support preceptor's efforts.

While the supervisor's feedback was highly valued by trainees in the first few months, the patient's feedback took on increased significance in the latter few months. It was through receiving feedback from patients that trainees began to realize that the patient's concept of the trusted medical expert was different from theirs. For example, patients do want their doctor to take their symptoms seriously, but they also want the doctor to treat them as a real person and to ask questions about things other than the disease, such as their family or work (Arborelius & Bremberg, 1992; Dixon, 1986). Understanding the patient's perspective is considered a core clinical task and is linked to competence (Kurtz et al., 2005). The patient's feedback was also critical in helping the resident-trainees gain confidence in their ability to doctor and to feel valued. Finding ways to more systematically incorporate the patient's feedback into the trainee's day-to-day learning, such as using patient feedback forms, might be a strategy program developers may want to consider.

Incoming resident-trainees are adjusting to a plethora of new responsibilities, acclimatizing to a new environment, and bombarded by new information in the first few weeks of training. Most programs provide orientation programs and seminars to facilitate the transition experience of incoming trainees, however, the orientation goals of program directors and the reported orientation needs of residents are poorly associated (Grover & Puczynski, 1999). It is difficult for program directors to decide what information is most relevant and what information can be deferred to later in training. The findings of this study hint at what might be most pressing in the first few weeks.

*Practice management orientations.*

Perhaps one of the most pressing concerns in the first few weeks of undergraduate training was the introduction of a variety of practice management tasks that were not the

trainees' direct concern or responsibility during their undergraduate training. Although many of these tasks relate to the enculturation process associated with any new work setting, several studies have reported that new graduate Family Physicians feel inadequately trained in practice management issues (Breitwieser et al., 1981; Daugird & Spence, 1990; Prince et al., 2004; Stone, 1994). In fact, a recent study reported better orientations of incoming trainees was urgently needed after finding that new graduates continued to struggle with documentation, writing prescriptions, and reviewing charts (Nikendei, Kraus, Schrauth, Briem & Junger, 2008). Not feeling prepared in this area is a concern because practice management issues can influence clinical outcomes (Mast, 1997a) and overwhelm some physicians early in their careers (Rose et al., 1999).

Although there is agreement that the adjustment to postgraduate training can be a period of great personal and professional stress (Grover & Puczynski, 1999), there is limited information in the literature on orientating new residents to practice management issues. A recent study about the learning environment for resident-trainees found knowing the system and role expectations were critical to helping them acclimatize to their new setting and responsibilities (Kendall et al., 2005). Providing incoming resident-trainees with specific seminars orientating them to their administrative responsibilities and new environment might reduce some of the stress they experienced at the beginning of training.

More specifically, providing an orientation to practice management responsibilities at the outset of training would familiar trainees with new tasks. Simple strategies, such as labelling equipment cupboards and having incoming trainees spend a day behind the registration desk booking appointments, might help familiarize the resident-trainees with the day-to-day functioning of the Family Medicine clinic. As the trainees feel more comfortable in the role of

doctor and acclimatize to their new work setting, a second seminar could focus on community referrals and resource allocation. The trainees would have gained enough practical experience with patients to have developed a beginning understanding of why knowing and being able to access resources was important to becoming a competent Family Physician.

Shadowing more experienced physicians (supervisors) during the first few weeks would be another way of providing incoming resident-trainees with an orientation to their new role, responsibilities, and expectations. Shadowing would provide new trainees with an opportunity to see how practicing physicians organize the clinical interview, approach different patients, prioritize their time, and manage the different responsibilities of being a doctor. It would give resident-trainees a chance to establish a relationship with their new supervisor and a chance to become familiar with their new environment. Fears about being on-call, writing prescriptions, and performing some clinical skills could be explicitly addressed. In a recent study, where shadowing was used to ease the transition into postgraduate training, the resident-participants indicated that the experience is more valuable if they are able to participate and have some active responsibility for patient care (Berridge et al., 2007). Providing graduated responsibility over the course of a month might decrease some of the initial stress and anxiety incoming resident-trainees experience.

*Time management.*

Repeatedly throughout the study, the need to manage time was described as anxiety provoking and frustrating. It is surprising how little "time" is spent during medical training on helping resident-trainees learn how to effectively use time, considering the magnitude of this concern and the role it plays in shaping practice. Trainees in this study seemed highly motivated to learn any time management strategies that would help them more efficiently manage their

clinical encounters.  For example, interview organization and communication are the most effective tools a physician can develop to manage time,; however ,the link between communication and time management is rarely made in training.  Practising physicians have learned through experience different ways of managing their time in the encounter without compromising the doctor-patient relationship.

The trainees themselves identified several practical strategies they learned through experience to improve their time management, such as organizing equipment ahead of time, reviewing the chart prior to seeing the patient, and learning to talk and chart at the same time. Program developers or supervisors may want to consider providing specific workshops or seminars for incoming trainees reinforcing some of these very basic strategies, as well as, sharing other time management tips they have learned through their own experience.

*Boundary seminars.*

Not only is the skill of knowing how to set limits in the clinical encounter important for time management purposes, it is also important from a medical-legal perspective and for establishing therapeutic relationships.  As resident-trainees are learning how to establish relationships with patients, they struggle with how close or how distant they should maintain the boundaries.  Again, because the experience of patient care was often transitory during undergraduate training, learning how to set limits was not a skill the trainees needed to develop as medical students.  Providing a seminar as part of the resident-trainees' orientation that speaks to establishing boundaries and setting limits would be one way to teach these skills and could be reinforced through labelled feedback and role modeling.

*Organized framework for conducting a patient-centered clinical encounter.*

In the beginning, trainees were concerned with their level of medical knowledge being adequate to provide competent care, but within a short period, the trainees recognized they did not know how to use their knowledge in the context of the clinical encounter. Other postgraduate trainees have voiced the need for knowing how to effectively and efficiently use medical knowledge in the clinical interview (Clark et al., 1999; Jolly & MacDonald, 1989; Prince et al., 2005; Rolfe & Sanson-Fisher, 2002; Wall et al., 2006). In fact, issues related to knowing how to use knowledge such as knowing what is relevant to ask, organizing the interview, and developing an appropriate treatment and management plan have become increasingly more prevalent in recent years (Prince et al., 2000; Prince et al., 2005; Radcliffe, 2003; Watmough et al., 2006).

There is an overwhelming body of literature suggesting that how the clinical interview is taught is not reflective of how practising physicians think (Benbassat et al., 2005; Boshuizen et al, 1995; Kassirer, 1983). Subsequently, multiple problems at the postgraduate level of training occur in areas such as data collection, diagnostic reasoning, clinical decision-making, treatment and management problems, and the development of relationships with patients (Arocha et al., 1993; Bordage, 1999; Dall'Alba, 1998; Elstein & Schwartz, 2002; Gale & Marsden, 1983; Kassirer, 1983; Lussier & Richarde 2005; Mandin et al., 1997; Norman et al., 1992; Ong et al., 1995; Prince et al., 2005; Stewart et al., 2000; Thistlewaite, 2002).

Efficient and effective use of encounter time and medical interviewing demands a high level of skill (Beckman & Frankel, 1984; Davidoff, 1997; Marvel et al., 1999), which the resident-trainees in this study did not feel they had commencing their training program. The resident-trainees lacked experience in many of the skills necessary to conduct organized clinical encounters, which affected other areas such as clinical decision-making and gaining confidence

in using a more interactive approach. From a teaching perspective it would be helpful to provide new graduates, early in their training, with a conceptual framework for knowing how to use their knowledge in the clinical interview using a patient-centered approach. Perhaps most importantly, adult learners learn what they consider is important and adult learners want solutions to immediate problems (Imel, 1994). Providing trainees with an organized framework for conducting an interview from beginning to end would help trainees to understand how experienced physicians approach the clinical encounter.

The resident-trainees struggled with knowing how to set agendas, collect relevant history, and present organized treatment and management plans. Each of these demands coincides with one of three areas of an organized clinical interview: the opening, the middle, and the closing (Kurtz et al., 2005; Martin, 2003). One way of providing a framework to help trainees organize their knowledge is to use these three distinct parts of the interview to organize teaching. For example, the purpose of the beginning of the interview is to understand the reason for the visit from the patient's perspective and to set an agenda.

Specific interview skills might include asking open-ended questions, setting limits, and reflective listening. The middle of the interview is about relevant and organized data collection. Related interview skills might include signposting, bridging statements, and relevant close-ended questions. The purpose of the end of the interview is to present a treatment and management plan. Opportunities arise to introduce or revisit interview skills related to information giving and finding common ground. Curricular content might address how experienced physicians make clinical decisions in the context of the clinical encounter or how to incorporate sensitive questions related to challenging areas such as sexual history taking and substance use.

*Developing a practice.*

Most patient care during undergraduate training occurred in the context of a transitory relationship, which provided limited opportunities for medical students to build relationships with patients over time and to provide follow-up care. The influence of providing care in the context of a relationship that occurred over time was pivotal to learning. Subsequently, the development of this longitudinal relationship should be encouraged early in training. Ensuring the resident-trainee has early continuity of care experience with patients seems key to facilitating the resident-trainee's understanding that the practice of Family Medicine is as much about long-term prevention as it is short-term intervention. Not only does continuity of care allow the resident-trainees to gain confidence in their clinical decision-making, it helps them realize that not every problem has an immediate diagnosis and not every diagnosis needs an immediate solution. Learning to take a "wait and see" approach is critical to the practice of Family Medicine.

One way of providing the experience of continuity of care is by ensuring resident-trainees develop their own patient practice early in their training, where they have multiple opportunities to see returning patients and to provide follow-up care. Although seeing patients in the context of a walk-in clinic or urgent care clinic helps trainees learn how to recognize the red flag questions necessary to rule out acute problems, opportunities to see the outcome of their clinical decision-making choices through follow-up care are minimal. As well, opportunities to develop relationships, to get to know a patient's medical back ground, and to hear patient's feedback are limited. Programs may already provide incoming resident-trainees with the opportunity to inherit the established practices of the graduating trainees, but if they do not, helping new

trainees establish a practice where they have and feel responsible for patients, sooner as opposed to later, should be a priority.

*Summary – Strategies to Support Learning*

Program directors are provided with learning objectives and long-term outcome measures, which are useful in conceptualizing where their teaching and learning efforts are headed, but not sufficient for understanding the learning needs of the trainees. By giving voice to the resident-participants' stories, supervisors can better understand the anxieties and uncertainties experienced by new trainees as they make the transition from undergraduate training, experience supervisors may well have forgotten. Knowing how a resident-trainee experiences the first six months of training may also help medical educators craft curricula to respond to the early learning needs of incoming resident-trainees. Chart 6 entitled the Four Principles of Family Medicine – Strategies for Development in the first Six Months was created to summarize some of the suggested strategies for responding to some of these early learning needs.

Chart 6 - Four Principles of Family Medicine – Strategies for Development in the First Six Months

| Four Principles | Knowledge | Practice Management | Dr-Patient Relationship |
|---|---|---|---|
| **The Family Physician is a Skilled Physician** | Provide framework for how to organize clinical interview from beginning to end (agenda setting, focused histories, organized Rx plans)<br><br>Acknowledge knowledge learner does know<br><br>Share clinical decision-making thought process<br><br>Reinforce Red flag questions | Recognition of anxiety<br><br>Time management strategies – i.e. charting & talking, organizing equipment prior to appointment, pre-reading chart, highlighting end note, interview organization) | Inquire about patient's life context and illness experience during chart review<br><br>Role model sharing of power<br><br>Role model how and when to use open-ended questions<br><br>Reinforce advantages of continuity of care to decision-making |
| **Family Medicine is a Community Based Discipline** | Connect importance of eliciting patient's illness experience to diagnosing problem<br><br>Inquire/emphasize inclusion of supports and community resources in Rx and management plans | Teach/role model how to make a referral and use interprofessional supports<br><br>Teach/role model how to make a referral and use common community resources | Role-model and highlight different roles of family physician<br><br>Role model importance of understanding life context to creating Rx and management plans<br><br>Role model/teach pt-centered health teaching/behavior change |
| **The Family Physician is a Resource to a Defined Practice Population** | Review and role model how to counsel around common health concerns (i.e. STD's, contraception)<br><br>Review and role model how to utilize various information technologies within the clinical interview | Orientation that includes role expectations and practice management tasks (billing, prescriptions, lab referrals, on-call, office procedures & administration etc.) | Role-model importance of seeing patients over time to providing competent and preventative health care<br><br>Role model need for & organization of family meetings |
| **The Patient-Physician Relationship is Central to the Role of the Family Physician** | Review medical chart prior to meeting with patient<br><br>Role model how prior knowledge of patient used to provide care | Consider using patient-feedback forms<br><br>Teach/role model boundary and limit setting | Early continuity of care experience<br><br>Role model agenda setting, eliciting patient expectation |

While the preceding few pages focused on the trainees' experience of postgraduate training and the implications for medical educators, the next few pages will explore the trainees' perspective of their undergraduate training on their postgraduate experience.

*Implications of Undergraduate Training on the Postgraduate Experience*

Although the undergraduate experience was not the focus of this study, the resident-trainees frequently used their experience of undergraduate training to situate and understand their experience of postgraduate training. In doing so, the trainees were able to give voice to what they perceived to be consequences of their undergraduate training on their adjustment to postgraduate training.

*Responsibility*

The experience of having and being responsible for patients was critical at the postgraduate level for its influence on the resident-participants' approach to care, on their comfort and confidence in the role of doctor, and on their understanding of what it meant to be the Family Physician. From the resident-trainees' perspective, they view themselves as medical students at the undergraduate level and subsequently do not feel they have, or are in, a position of responsibility for the outcome of patient care. In the current undergraduate curricular design, involvement with patient care is a graduated process during training with responsibility for the decision-making and outcome of patient care firmly with the supervisor. Active responsibility for decision-making around the outcome of patient care does not occur until the postgraduate level of training; however, despite sharing decision-making with supervisors, incoming trainees still feel the responsibility lies with them. From the resident-participants' perspective, the shift in responsibility was enormous, daunting, and stressful. It raises the question of how best to

lessen the patient care gap between undergraduate and postgraduate medical training.  Perhaps if the level of responsibility for patient care during undergraduate training increased, the level of stress that new resident-trainees experience would decrease as they begin a postgraduate program and became increasingly responsible for patient care.

It would be presumptuous to make detailed recommendations as to how program developers could begin incorporating patient care responsibility into undergraduate training as this study did not focus on the undergraduate curriculum.  However, the findings of this study do suggest addressing a few areas that would likely have some impact on easing the transition of those choosing to pursue additional training in Family Medicine.

*Practice Management*

Practice management was an area that caused the resident-participants a great deal of anxiety at the beginning of postgraduate training because it meant learning another skill set.  The need to manage time caused particular frustration and remained an ongoing concern throughout the study.  Although the need to manage their time helped resident-participants learn how to ask more relevant questions, the pressure to manage the patient's medical problems in a time-limited framework often led to medical encounters that focused exclusively on disease and often encouraged a doctor-centered approach to the interview.  The resident-participants seemed highly motivated to learn any time management strategies that would help them more efficiently manage their clinical encounters, yet strategies for time management, especially at the undergraduate level, are rarely a formal curricular item (Dugdale, Epstein & Pantilant, 1999).

*Knowledge*

One author notes that undergraduate training in Canada is fragmented with most undergraduate clinical rotations lasting no more than six weeks, often constricting and distorting the learning experience for students (Snadden, 2008). For example, clinical experience and teaching at the undergraduate level often reflect a specialist approach where the diagnosis has been predetermined, the focus is on less common disease processes, and patient contact is transitory. Resident-participants claimed as medical students, that data collection was the focus of their clinical responsibility, which limited opportunities for independent diagnosis, clinical decision-making, or treatment and management. Individuals entering postgraduate training needed to learn many of the basic skills and values required to provide competent care as a Family Physician, which added to already existing feelings of anxiety and uncertainty. It appears that there is value in undergraduate medical education ensuring that medical students have multiple opportunities to see patients where the diagnosis has not yet been established or worked up, and where there is a need to formulate the diagnosis and present the treatment plans. Although the ultimate responsibility for decision-making would still lay with the supervising physician, extending the clinical experience beyond data collection would provide medical students with a more wholistic view of the medical encounter, and experience developing differentials, clinical decision-making, and postulating a treatment plan.

*Doctor-Patient Relationships*

As resident-participants enter postgraduate training, they are often learning how to develop relationships with patients for the first time and have a limited understanding of how to develop patient-centered, therapeutic relationships. Although the physician- trainees recall being exposed to the principles of patient-centered care during their undergraduate training, they

perceive that this training was not relevant to them at that time. It is a common refrain amongst undergraduate medical students that lectures on communication skills and psychosocial issues are not important, or certainly not as important, as the medical knowledge they need to learn to become a doctor (Frederickson & Bull, 1992). The resident-trainees in this study indicated it was not until they had responsibility for the outcome of the patient's care and the opportunity to see returning patients that they began to understand the relationship between using communication skills in the medical interview and developing the doctor-patient relationship. A recent study found that undergraduate medical students' approach to care became more patient-centered when they were provided responsibility for decision-making (Savenius et al., 2006). Not only does Savenius's study support the notion that having responsibility and feeling responsible for care influences approach to patient care, it also suggests that medical students can manage a level of responsibility.

Finally, there are few opportunities at the undergraduate level to provide care in the context of an ongoing relationship where the student is able to provide follow-up care. Given the enormous impact continuity of care has on shaping the resident-trainee's approach to practice, opportunities should be created for resident-trainees at the undergraduate level of training to see patients in an ongoing relationship. One way of creating opportunities for trainees to see returning patients for follow-up care is to lengthen the undergraduate Family Medicine rotation. In comparison to other specialty programs where rotations are six weeks in length, the Family Medicine rotation is only four. Although an additional two weeks does not seem like a significant extension of time, it would provide a larger window of opportunity to schedule follow-up appointments and give medical students a broader perspective of the many different roles a Family Physician fills on a day-to-day basis.

*Summary – Influence of Undergraduate Training on Postgraduate Training*

There has been a call for a better connection between the different learning experiences that contribute to the education of the practicing physician (Christakis & Freudtner, 1997; Glick, 2001; Hirsh, Ogur, Thibault & Cos , 2007; Whitcomb, 2005).  From the resident-trainees' perspective, the discrepancy between undergraduate and postgraduate training is enormous and has consequences for their learning.  The resident-trainees were able to shed light on the most pressing of these discrepancies for themselves and in doing so offer medical educators avenues for further exploration for making the transition more seamless.

*Personal Implications*

One of the motives for the focus of this study originated in the location of my own teaching experience, that of behavioural science.  I was interested in better understanding the resident-participants' perspective of their experience during the first few months of the Family Medicine residency program because incoming resident-participants have often seemed sceptical of the relevance of communication and interviewing skills.  As stated at the outset of this study, I am not alone in finding at the postgraduate level that behavioural science has not been well received or taken seriously by the majority of students (Benbassat et al., 2005; Frederickson & Bull, 1992; Metcalfe, 1983).  By exploring how physicians in the first six months of a Family Medicine residency program described their experience, I hoped that a deeper understanding of the resident-participants' experience during this time would shed light on their ambivalence.

Resident-participants clearly voiced that, until they began to feel confident that their knowledge level was adequate not to harm patients, they were not able to attend to process issues.  Resident-participants take their new responsibility to care for patients very seriously and,

as a result, all other issues are temporarily considered extraneous, including behavioural science. Issues related to communication and doctor-patient relationships do not become relevant until resident-participants feel confident that they are not going to harm patients with their knowledge. It is only then that resident-participants begin to broaden their concept of what it means to be a Family Medicine resident and begin to recognize the relationship between these skills and providing competent care as a Family Physician.

From a teaching and learning perspective, incoming resident-participants feel they are being asked to learn something that they do not feel is important. Resistance to change can arise when the learner or teacher have different learning agendas or when the teacher's strategy for change is not in line with a student's readiness for change (Mann, 1994; Miller, 1992; Miller and Rollnick, 2002; Rollnick, Mason & Butler, 2000). If trainees do not feel that the skills, knowledge, or attitudes related to behavioural science are of value to them or are confident that they can apply the subject matter, it may lead to resistance. For example, physician- trainees may avoid further learning in this area or make superficial changes to behaviour rather than the deep learning associated with integrated and maintained behaviour change. Causing resident-trainees to avoid curricular content or increasing resistance to learning content is not the intended outcome at any level of training. Avoiding important curricular learning is not the intended outcome at either the undergraduate or the postgraduate level.

The resident-participants in this study expressed what was most important to them in the beginning months. These concerns suggest a few potential ideas for making behavioural science more relevant to the resident-trainee's current learning needs, which might lead to increased interest and subsequently be incorporated into practice. For example, since incoming resident-participants are keen to learn anything that helps them provide competent care, perhaps

behavioural science should initially focus on process skills rather than content. Results of this study suggest that patient-centered interview skills such as agenda setting, eliciting patient expectations, limit setting, and time management strategies are all skills the new doctor lacks, but would be interested in learning. Specialized topics such as breaking bad news and domestic violence should focus on both content and process if they are to engage the resident-trainee. early in training and maybe should be left until later in training when the topics are more relevant for learning from the resident-participant's perspective.

The resident-participants were concerned with knowing how to organize and use their knowledge in the medical interview. These concerns are particularly relevant to behavioural science educators because the medical interview is the context in which relationships are established with patients. Doctors need to know not only what to ask but also how to ask. As medical students, it is necessary to memorize lists of facts and questions to consider. These lists are often interpreted as "to do" lists by inexperienced doctors when they begin to use this knowledge in practice because they have a poor understanding of how to discriminate based on relevant patient context (Martin, 2003). Considering most physicians conduct over 200,000 interviews in a career (Kurtz et al., 2005), providing postgraduates with a framework for organizing their medical knowledge while utilizing a patient-centered approach to care would be a wise investment of time. Reciprocally, focusing on the clinical interview would provide behavioural science teachers with an opportunity to raise communication and relationship issues.

*Final Reflections*

     *The research process.*

As this study ends, it is important to pause for a moment to reflect about the research process itself.  William Osler (1904), a pioneer in medicine, cautions against the lure of self-deception during the final stages of any treatment and management plan, feeling a lack of systematic self-assessment of methods could lead to the misapplication of remedies and so directly to a lack of confidence in findings.  Although the findings of this study are not a prescriptive treatment and management plan for the first six months of a Family Medicine postgraduate program, the concept is similar in that a moment of self-reflection on the process is warranted to cast the study in a pragmatic light.  Heeding Dr. Osler's advice, in the following paragraphs I will pause for a moment to reflect on the research process itself for those who might be interested in conducting similar research, and then share some of my ideas for future research.

     *The methodology.*

Wolcott (1990, p.30) recommends coupling the "litany of limitations" with a stress on what went right so these steps, strategies, or lessons can be applied in future research endeavours.  In retrospect, the methodological choice of using a case study approach was a good one because it allowed an in-depth look at the resident-participants' experience during a specific time.  The choice of using semi-structured interviews with focus groups and individuals was also good.  It allowed resident-participants to voice their concerns and experiences in a forum that encouraged confidential disclosure without the constraints of a rigid interview guide.  Gathering data over a six-month period of time and having repeated interviews with the same resident-participants were also good choices because it made the findings more trust worthy.  For

example, resident-participants were able to reflect on their experiences with the researcher as the experiences happened. It made it easier to distinguish whether a finding was a result of a single situation or part of a more consistent trend.

*The resident-participants.*

During the initial research design phase, I contemplated only inviting doctors in the first six months of Family Medicine residency. I was concerned that the reflections of resident-participants who were further along in their training might inadvertently bias the findings because the passage of time would affect their comments. In retrospect, using focus groups and individual interviews with resident-participants at different time junctures in their training, other than the first six months, and asking them to reflect on their first six months of training was extremely valuable. These resident-participants provided rich contextual explanations and additional insight into the initial training experience that often the resident-participants undergoing the experience were not able to do. The insights provided in these early interviews iteratively formulated questions for the beginning resident-participants to deepen their reflection on their experiences as they happened in real time. If this study were to be repeated, trainees at different time points would be more actively recruited because of their rich contributions. In reflecting on design decisions, these resident-participants strengthened the study by providing useful triangulation of the findings.

*Location, location, location.*

There is always a concern that when researchers are close to their subjects, there is a tendency for greater research bias. My many years working with first- and second-year Family Medicine trainees have undoubtedly left me with many preconceived ideas and assumptions.

Although I did not conduct this study in my own teaching backyard (hospital teaching site), I was conducting research around an issue of which I had intimate knowledge. Despite my keen interest in understanding the resident-participants' attitudes toward behavioural science, focusing my attention exclusively on this issue risked introducing my own bias, consciously or unconsciously. One way I addressed this was by taking a broader view of the research problem. In retrospect, using a wider lens to explore my question was clearly the route to go. By first understanding the particulars of the resident-participants' experience from their perspective, it was possible to better understand or situate the resident-participants' experience of behavioural science. As Stake (1994) so aptly explains, it was possible to see patterns and similarities that helped me make sense of my own experience.

*Where to From Here? Possible Directions and Areas for Future Research*

This research provided but one snapshot in time of resident-trainees' thinking and feeling as they began a postgraduate training program in Family Medicine; however, by listening to the resident-participants' collective voices, several themes, ideas and directions for future research were raised.

*Supervisor's Feedback*

How resident-participants interpret supervisor's feedback and input during postgraduate training is an area worth further exploration. Some resident-participants in this study felt the amount of feedback they received from supervisors significantly decreased as their training progressed. These same resident-participants interpreted decreasing feedback to mean they were performing competently. This may or may not have been the case. A supervisor's lack of feedback on a given performance could have resulted from many reasons, such as the supervisor

simply not having the opportunity to observe the resident. The ability to accurately assess one's performance in medicine is critically important because this enables the physician to know when to seek help and input (Eva, 2004; Gordon, 1991; Ward, Gruppen & Regehr, 2002)

The concern with resident-participants interpreting a lack of feedback early in their training to mean that they are performing competently is that novice physicians can have difficulty recognizing their own incompetence (Hodges, Turnbull, Cohen, Bienenstock & Norman, 1996). Beginning resident-trainees frequently over-estimate their level of performance, especially in relation to their supervisors' evaluations (Jones et al., 2002; Wall et al., 2006), and need help in calibrating their performance through feedback and benchmarks (Martin, 1986). Experience alone does not lead to meaningful learning (Langer, 1997) and those who know the least know least about what they do not know (Kruger & Dunning, 1999). Resident-participants who inaccurately or prematurely assume they are competent in an area because the supervisor has not provided feedback may not pursue further learning in this area. Given the importance of accurate self-assessment to identifying one's learning goals, it is important to ensure that the supervisor's message is the one that was intended. The resident-participants' interpretations of supervisor's feedback and how these perceptions influence the resident-trainee's concept of their progress should be explored further.

*Time Management*

One of the most frequently voiced concerns by the resident-participants was that of time management, and the findings of this study suggest that it influences how and on what the resident would focus. Assuming time does influence a doctor's approach to the clinical encounter, how does time influence what type of doctor the resident becomes? How does it determine priorities? How much time is too little time? Time is of particular concern to the

Family Physician because unlike many of the other specialties, patients often come with ill-defined, multiple, and psychosocial problems that take time to identify and treat (Phillips & Haynes, 2001). Time was a concern that continued to be voiced throughout the study and it did not seem to be an issue that was going to be resolved. Davidoff (1997) describes time in the practicing physician's life as one of the most precious of all medical resources, but we know so little about how to use it efficiently and what levels are therapeutic. Davidoff goes on to point out that it is all but absent from research agendas. Given that the responsibility to manage time efficiently begins at the postgraduate level, this may be a good place to explore how time influences the development of the doctors' approach to practice.

*Patient Feedback*

While the role of the supervisor's feedback decreased as the study progressed, the role of the patient's feedback became more important. In fact, the resident-participants voiced that it was one of the biggest influences in helping them feel more confident in their ability to doctor, in helping them understand the importance of the patient's perspective and life context to practice, and in helping them understand what it meant to be a Family Physician. Patient feedback to medical students improves the quality of the doctor-patient interaction (Greco et al., 2001). In a study exploring teachers' perception of success, teachers defined their success in terms of their pupils' behaviour and activities rather than in terms of themselves or other criteria. While not challenging the central role of medical expert's feedback in the development of the training physicians, and as physicians and patients have different criteria for defining what constitutes a positive outcome (O'Keefe & Britten, 2005), the patient's feedback does contribute positively to the development of the resident and could play a more central role in the learning process. However, medical educators rarely seek the patient's views either formally or informally

(Royston, 1997). There is not a lot of research exploring the best way to make use of this valuable input (O'Keefe & Britten, 2005), but given the potential benefits this is another area worth further exploration.

*Doctor-Patient Relationship*

This study also raised questions about resident-trainees' development of patient-centered attitudes in postgraduate Family Medicine. Helping resident-trainees develop patient-centered attitudes and approach to care is important. A patient-centered relationship is a principle at the foundation of Family Medicine (College of Family Physicians of Canada, 2004) and attitudes toward the doctor-patient relationship serve as an indicator of future care providers' intentions to adopt such an approach in their clinical practice (Tsimsiou et al., 2007).

Previous literature suggests that there is a decline in patient-centered attitudes during undergraduate medical training (Hojat et al., 2004; Spencer, 2004). This study suggests that as newly graduated doctors are given responsibility and feel responsible for patient care, they are far more motivated to establish relationships with patients. This study also suggests that doctors in a Family Medicine postgraduate program, where they have the opportunity to see returning patients, begin to understand the relevance of developing patient-centered relationships to providing care. This study only looked at the first six months of training. Does this interest in establishing patient-centered relationships persist? Do doctor's positive attitudes toward developing therapeutic relationships in a Family Medicine training program continue to develop? Alternatively, do they decrease? What role does seeing patients over time play in the development of positive attitudes toward patients? Given that patient-centered care has been recognized as an indispensable element of quality in the health care delivery system (Makoul & Schofield, 1999; Makoul, 2001), and that the transition into a postgraduate program might

provide an opportunity to influence the direction of developing attitudes, this would be another area of research worth pursuing.

*Interprofessional Communication*

This study commented extensively about doctor-patient communication, but little about interprofessional communication with health care professionals, hospital administrators, and others in the health care environment.  Training to become a Family Physician takes place in a larger context beyond the medical encounter and providing care in medicine is a team effort, regardless of the area of training.  I can only speculate as to the reasons why there were few comments in these areas, but repeating this study to gain a deeper understanding of the resident-trainees' perspective on other people and places in the health care system would be helpful to gaining an even deeper appreciation for their experience.

*Family Medicine Training*

Finally, the purpose of this study was to explore the resident-participants' experience of the first six months of a Family Medicine program.  Slotnick (2001) suggests that medical education is an identity development process where medical school, residency, and practice all contribute different experiences that influence how physicians come to see themselves.  In Canada, postgraduate training to become a Family Physician is a two-year process.  I did not explore the subsequent eighteen months or the experiences of the resident-participants just following completion of a postgraduate program.  If the results of this study were any indication, trainees at each of these junctures in training and practice would have had something different to say and contribute.  Moreover, what do these findings mean in light of the trainee who does not feel relatively comfortable and confident in the role of doctor at six months?  The results of this

study suggest the resident-trainees' broader identification with the role of Family Medicine resident is not halted, but slowed. Does not identifying with the role of doctor at a particular time juncture suggest that these trainees may need additional learning support?

For this study, I only looked at the development of postgraduate trainees in a Family Medicine program. One can only assume that the experiences of postgraduate training to become a surgeon, paediatrician, or dermatologist would be different. Further research needs to be done to determine how the experience in these specialties might be different. Are there any training experiences that are similar? Do other resident-participants in postgraduate training programs need time to adjust to being a doctor? Does their conception of who the doctor is change in response to their experience and if so how?

The experience of becoming a competent physician in any specialty is complicated, but the more we listen to trainees' voices, the more we will understand about this transformation, and in doing so, be better able to guide the journey.

*Concluding Remarks*

This chapter is the end of my journey and I have come full circle. The answers to the questions I set out to find have been explored, laid out, and discussed. I have suggested one way to comprehend and understand the new doctor's early training experiences during postgraduate training. The purpose of the study was to contribute a deeper understanding of what this experience is like for resident-trainees and to make a practical contribution to knowledge about resident-trainees' experiences during a critical time in their training. In fact, one of the most important criteria for evaluating case study research is its usefulness to the reader (Gall et al. 2005). Can the findings be applied to the readers' settings and be used to make meaningful changes in how they deal with the phenomena that the case study set out to explore?

By applying this criterion for myself, several lessons were learned that have deepened my understanding of this training period in a physician's life.  First, resident-participants feel there is a huge leap in responsibility that is very daunting when they make the transition from medical student to doctor, specifically in the areas of Knowledge, Practice Management, and Relationships.  Second, resident-participants do not begin a postgraduate program strongly identifying with the role of doctor, and based on their undergraduate experience have a limited concept of what this role means in practice.  Third, resident-participants must feel comfortable in the role of doctor, which means feeling relatively confident that they are not going to harm patients with their knowledge, before they can begin developing a deeper understanding of what it means to be the Family Medicine resident.  Fourth, it is through the experience of both feeling and having responsibility for the outcome of the patient's care over time, that resident-participants begin the process of learning what it means to be a Family Physician.  Finally, although the process for identifying with the role of doctor is similar for resident-participants, the length of time it takes to feel relatively comfortable in this role is different.  At the end of six months, while resident-participants do not feel like the Family Physician, they have begun identifying with the role of Family Medicine resident.  By listening to the resident-participants' voices, this study was useful in helping me locate the their experience during the first six months of training, which left me with a better understanding and appreciation of the journey.  It is hoped that medical educators and supervisors will find the results of this study equally helpful, as will resident-trainees themselves.

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## Appendix A

## The Four Principles

**The Family Physician is a skilled clinician.**

Family Physicians demonstrate competence in the patient-centred clinical method; they integrate a sensitive, skilful, and appropriate search for disease. They demonstrate an understanding of patients' experience of illness (particularly their ideas, feelings, and expectations) and of the impact of illness on patients' lives.

Family Physicians use their understanding of human development and family and other social systems to develop a comprehensive approach to the management of disease and illness in patients and their families.

Family Physicians are also adept at working with patients to reach common ground on the definition of problems, goals of treatment, and roles of physician and patient in management. They are skilled at providing information to patients in a manner that respects their autonomy and empowers them to "take charge" of their own health care and make decisions in their best interests.

Family Physicians have an expert knowledge of the wide range of common problems of patients in the community, and of less common, but life threatening and treatable emergencies in patients in all age groups. Their approach to health care is based on the best scientific evidence available.

**Family Medicine is a community-based discipline.**

Family practice is based in the community and is significantly influenced by community factors. As a member of the community, the Family Physician is able to respond to people's changing needs, to adapt quickly to changing circumstances, and to mobilize appropriate resources to address patients' needs.

Clinical problems presenting to a community-based Family Physician are not pre-selected and are commonly encountered at an undifferentiated stage. Family Physicians are skilled at dealing with ambiguity and uncertainty. They will see patients with chronic diseases, emotional problems, acute disorders (ranging from those that are minor and self-limiting to those that are life-threatening), and complex biopsychosocial problems. Finally, the Family Physician may provide palliative care to people with terminal diseases.

The Family Physician may care for patients in the office, the hospital (including the emergency department), other health care facilities, or the home. Family Physicians see themselves as part of a community network of health care providers and are skilled at collaborating as team members or team leaders. They use referral to specialists and community resources judiciously.

**The Family Physician is a resource to a defined practice population.**

The Family Physician views his or her practice as a "population at risk", and organizes the practice to ensure that patients' health is maintained whether or not they are visiting the office. Such organization requires the ability to evaluate new information and its relevance to the practice, knowledge and skills to assess the effectiveness of care provided by the practice, the appropriate use of medical records and/or other information systems, and the ability to plan and implement policies that will enhance patients' health.

Family Physicians have effective strategies for self-directed, lifelong learning.

Family Physicians have the responsibility to advocate public policy that promotes their patients' health.

Family Physicians accept their responsibility in the health care system for wise stewardship of scarce resources.

They consider the needs of both the individual and the community.

**The patient-physician relationship is central to the role of the Family Physician.**

Family Physicians have an understanding and appreciation of the human condition, especially the nature of suffering and patients' response to sickness. They are aware of their strengths and limitations and recognize when their own personal issues interfere with effective care.

Family Physicians respect the privacy of the person. The patient-physician relationship has the qualities of a covenant - a promise, by physicians, to be faithful to their commitment to patients' well-being, whether or not patients are able to follow through on their commitments. Family Physicians are cognizant of the power imbalance between doctors and patients and the potential for abuse of this power.

Family Physicians provide continuing care to their patients. They use repeated contacts with patients to build on the patient-physician relationship and to promote the healing power of interactions. Over time, the relationship takes on special importance to patients, their families, and the physician. As a result, the Family Physician becomes an advocate for the patient.

*Quoted from The Postgraduate Family Medicine Curriculum: An Integrated Approach – The College of Family Physicians of Canada, 2007.

Appendix B

Sample of Beginning Interview Guide

- What led you to choosing family medicine?

- How would you describe your experience so far?

- What has surprised you the most about your experience thus far?

- What is it like being a doctor?

- What is it like being a doctor in Family Medicine clinic?

- Has anything changed about your thinking, feeling, behavior in regards to being a doctor?

- What do you attribute those changes to?

Appendix C

Sample Outline of Recruitment

Thank you for coming.  I am in the process of completing my research requirement for my Ph.D. in curriculum, teaching and learning at OISE/UT.  I would like to invite you to take part in this study; therefore, today is about providing you with the necessary information to make that decision.  This means I will be providing you with a brief outline of my study, including research questions and design, as well as, answering any questions.  Your participation is totally voluntary and will in no way influence evaluations and there will be no repercussions for deciding not to participate.

Let's begin.

The purpose of this study is to gain a better understanding of a resident's experience during the first six months of postgraduate training in a Family Medicine program.  You will be asked to talk about your experience.  There are no right or wrong answers.  I am simply interested in developing a better understanding of what your experience of training is like from your perspective.

The specific research question is:

1.  How do doctors taking part in a postgraduate Family Medicine program describe their experience?

Sub questions might include:

2.  What are doctors concerned about?
3.  How does this experience change during training?
4.  What experiences do the doctors describe that influence this experience?

This information will be used to gain a better understanding of how new doctors from their perspective experience the first six months of postgraduate training.

This study will be using a case study approach.  Focus group, critical incident reports and individual interviews will be the methods used to gather data.  You can volunteer to take part in the focus group or the individual interviews.

**Focus groups** will be held separately with the first year residents and the second year residents.  This is a once only time commitment.  Volunteering to take part in the focus group would take approximately 60-90 minutes of your time and would be run over a lunch hour where food will be provided.  This will be an open-ended discussion about your experience during the first six months of the Family Medicine program.  A series of questions will be used to encourage discussion about this specific

time period, but essentially it is your time to describe what the experience was like for you.

The focus group will be audiotaped and then transcribed.  The information gathered from this group would be used to help formulate questions for the individual interviews.  The transcribed interview you took part in will be e-mailed to you for comments and feedback.  This is a very important part of the process.

I am also looking for volunteers to take part in the **individual interviews.** Involvement in the individual interviews is more time intensity, thus more of a time commitment.  Individual interviews will take place monthly for six months.  For example, you will meet with me individually for an interview in July, August, September, October, November and December during a time period that is convenient to you.  For example, during the lunch period or before/after a clinic.  The interview will last a minimum of sixty minutes and you will be asked to reflect about your experience during the past month(s).  Lunch will be provided if you choose to meet over lunch.  The interview will be audiotaped and later transcribed.  You will receive a copy of the transcription and asked for feedback and comments.

You will also be asked to complete a minimum of two critical incident reports.  A critical incident report is the written documentation of an event you have taken part in that is perceived as particularly significant.  In this study, I am interested in understanding your experience during the first six months of postgraduate training.  For example, it could be an event that happens in an actual Family Medicine office visit, on a specific rotation, in grand rounds or a conversation with staff/peers. You will be asked to write a short concrete description of the incident. It should include enough detail (time, place, who was present etc.) so you will have no difficulty recalling the event in discussion with myself.  I will pass around a copy of the instructions for the critical incident reports so everyone can have a better idea of what's involved.  The critical incident reports will also be analyzed looking for themes.

All information you share with me in relation to this study will be kept in the strictest confidence.  I will be the only one transcribing the data and will be changing the names on the data to increase confidentiality and provide anonymity.  The data will be aggregated into a table of themes so no data will be individually identifiable.  The only people who may have access to the data during the analysis for consultative purposes will be my supervisors Dr. Louise Nasmith, chair Department of Family and Community Medicine and Dr. Dennis Thiesson, chair of Curriculum, Teaching and Learning OISE.  The final report will be submitted for my research requirement for my PhD.  Again, any individually identifying data will be removed.  Should I decide to submit the results of this study to a peer-reviewed journal for publication or conference, I have asked for your permission to do so on the consent form.  Taking part in this study is completely voluntary and there is no monetary compensation or remuneration.  Lunch will be provided when interviews take part over the lunch hour.

Again, all information you share will be kept in the strictest confidence. Only information you share with me in the course of this study will be used. Your participation in this study will in no way influence your evaluation. Your decision not to take part in this study will in no way influence your evaluation. If you decide to participate and then decide to withdraw your consent for whatever reason, there will be no repercussions. Your participation in this study is completely voluntary. I will hand out a consent form for you to review.

Questions?

Appendix D

Sample of Information Provided to Potential Resident-participants on Completing

Critical Incident Reports

Critical Incident Report

Instructions to Resident-participants

A critical incident report is the written documentation of an event you have taken part in that is perceived as particularly significant.

In this study, I am interested in understanding events that you feel or think have influenced/changed your understanding of your role in the doctor-patient relationship. For example, it could be an event that happens in an actual Family Medicine office visit, on a specific rotation, in grand rounds or a conversation with staff/peers.

Write a short concrete description of the incident. Include enough detail (time, place, who was present etc.) so you will have no difficulty recalling the event in discussion with myself. Briefly comment on your thoughts and feelings at the time of the event and why you felt this event was significant. Be as descriptive as possible. In order to protect confidentiality, rather than providing specific names, use role descriptions as identifiers (staff, patient, nurse, peer etc.)

Appendix E

Ethics Review Protocol Form



University of Toronto

RESEARCH SERVICES – ETHICS REVIEW UNIT

## ETHICS REVIEW PROTOCOL FORM

**For information concerning submission deadlines, meeting dates, number of copies etc, refer to the UT Ethics Website: http://www.research.utoronto.ca/ethics_home.html**

**Provide the following information under the given headings. If a given question does not apply to your project, write N/A. Avoid technical terms that may not be understood outside your discipline.**

### 1. Background, Purpose, Objectives
Provide a description of the background, purpose, objectives and hypothesis for the research.

### 2. Research Methodology
Describe how the research will be carried out. Provide a description of the procedures to be used in the conduct of the research, (e.g. interviews, questionnaires, blood tests, chart reviews). State the period during which the procedures will be carried out, how long each will last and be specific about the number and frequency of the procedures.
- Where the research involves interviews, questionnaires, etc., provide a copy of the instrument(s), interview schedules, guides or observation criteria.
- Where the research involves the collection of information (e.g., from documents or databases), include a description of the information sought and the sources to be used.
- Explain how the data will be analyzed.
- Provide a justification for the proposed sample size.
- Provide a justification for the use of deception or placebo, if applicable.
- Describe the design of any experimental interventions to be used.
- Briefly describe the direct implications/applications of the research.

### 3. Resident-participants
- Describe who the resident-participants are and why they were selected.
- State the proposed sample size.
- Provide relevant inclusion/exclusion criteria. Describe any special issues with the proposed population, i.e. incompetent patients or minors.

4. **Recruitment**
   - Describe how and by whom resident-participants will be approached and recruited. Include copies of any recruiting materials (e.g., letters, advertisements, flyers, telephone scripts). State where resident-participants will be recruited from (e.g. hospital, clinic, school)
   - Provide a statement of the investigator's relationship, if any, to the resident-participants (e.g., treating physician, teacher).

5. **Risks and benefits**
   List the anticipated risks and benefits to resident-participants. Describe how the risks and benefits are balanced and explain what strategies are in place to minimize/manage any risks.

6. **Privacy and confidentiality**
   Provide a description of how privacy and confidentiality will be protected. Include a description of data maintenance, storage, release of information, access to information, use of names or codes, destruction of data at the conclusion of the research; include information on the use of audio- or video-tapes.

7. **Compensation**
   Describe any reimbursements, remuneration or other compensation that will be provided to the resident-participants, and the terms of this compensation.

8. **Conflicts of interest**
   Provide information relevant to actual or potential conflicts of interest (to allow the Review Committee to assess whether resident-participants require information for informed consent).

9. **Informed Consent Process**
   - Provide a description of the procedures that will be followed to obtain informed consent (consult the Tri Council Policy, Section 2 for detailed information on informed consent).
   - Include a copy of the information letter(s) and consent form(s).
   - Where written informed consent is not being obtained, explain why (see Tri Council Policy, Section 2)
   - Where minors are to be included as resident-participants, provide a copy of the assent script to be used.

10. **Scholarly review**
    If the research poses greater than minimal risk, provide sufficient information to allow the Research Ethics Board to determine whether the design of the project is capable of addressing the questions being asked in the research.

**11. Additional ethics reviews**

Where the research will take place in a location in which another ethical review committee also has jurisdiction over the research, provide a copy of any other Research Ethics Board's ethics review decision.

12. **Contracts**

Submit three copies of the research contract, if any.

**13. Clinical Trials**

For all clinical trials, provide the following:

- copy of the trial protocol, all amendments and a copy of the investigator's brochure.
- a copy of the budget.
- documentation of the research team's qualifications to conduct the research, i.e. C.V.'s or Chair's confirmation.

Appendix F

OISE/UT Ethical Review Statement of Intent

Title of Thesis/Project**:** "Exploring physicians experience of postgraduate training in a Family Medicine program"
    Exploring physicians experiences in the first six months of a Family Medicine program"

**Check one:  [ ] Q.R.P.  [ ] M.R.P.  [ ] M.A. Thesis  [X ] Ph.D. Thesis**

**Student Researcher: Dawn Martin**

**Faculty Supervisor: _Dr. Louise Nasmith (Chair -Dept. Family and Community Medicine, Dr. Dennis Thiesson (Chair – Dept. Curriculum, Teaching and Learning)**

**Department in which the project is being carried out: Education - Curriculum, Teaching and Learning**

**Contact Information for Student Researcher (provide the address/numbers where you wish to be contacted and/or receive mail):**

    **address: 21 Constance Street, Toronto, On M6R 1S3**

    **e-mail: dawn martin @sympatico.ca**

    **fax: 416 53--6160**

    **telephone: 416 – 588-8891 (hm) 416-667-3805  (pg)**

Special contact instructions for Faculty Supervisor: Louise Nasmith – 416-978-6473 Dennis Thiesson 416-923-6641

**When is Ethical Review required?**  An ethical review must be completed for each study that involves human subjects.  Such a study **involves the gathering of data about people through intervention or interaction with them or the gathering of identifiable personal information about people**.
- "Intervention" includes manipulations of a person or a person's environment that are performed for research purposes
- "Interaction" includes communication or interpersonal contact between the researcher and the subject (e.g., interviews, surveys, questionnaires).
- "Gathering identifiable personal information" includes information obtained from observations, records, documents, or databases from which individuals can be identified.

    "Research involving human subjects" also **includes** research involving:
    - secondary use of data (i.e., information collected for purposes other than the proposed research) that contains identifying information about a living individual, or data linkage through which living individuals may become identifiable; and
    - naturalistic observation, except the observation of individuals in contexts in which it can be expected that the resident-participants are seeking public visibility.

    "Research involving human subjects" **does not include** the following assessment activities:
    - quality assurance studies;
    - performance reviews; or

- testing within normal educational requirements,

**unless** the activities also contain an element of research in addition to assessment.

"Research involving human subjects" **does not include** the following data gathering activities:
- research involving only the use of published or publicly available information or materials performances, or archival materials (including records of public interviews or performances); or
- research involving the secondary use of data (i.e., information collected for purposes other than the proposed research) that contain no identifying information.

Studies that do not involve the use of data collected from/about human subjects, or that involve the use of data collected from/about human subjects where such data are in the public domain do not require ethical review.

**Please complete the following:** Indicate by a checkmark below, the category into which the proposal fits.

[ ]     This study does not involve data collection from/about human subjects.
        (No Ethical Review required; Ethical Review Protocol not required)
    If checked, provide a brief (not to exceed one page) description of the thesis or project that includes a description of the methods of data collection that will be used.


[ ]     This study involves the analysis of data obtained from/about human subjects where such data are in the public domain (i.e., either available from public archives or previously published material)
        (No Ethical Review required; Ethical Review Protocol not required)
    If checked, provide a brief (not to exceed one page) description of the thesis or project that includes a description of the methods of data collection that will be used.


[**X** ]      This study involves the analysis of data obtained from/about human subjects where such data are not in the public domain (i.e., the data are not publicly available or previously published material)
        (Ethical Review required; Ethical Review Protocol must be completed.)

[ ]     This study involves data collection from/about human subjects.
        (Ethical Review required; Ethical Review Protocol must be completed.)

[ ]     This study involves collection/analysis of data obtained from/about human subjects AND an ethical review of the research has been completed either:
        [ ] for a larger research project that includes this study, or
        [ ] at another institution
        (Check as many as are applicable)
        (Ethical Review required; attach a copy of the Ethical Review Certificate and approved consent materials for the previously-completed review)


_____ _____
Signature of Student Researcher                                    Date


_____ _____
Signature of Faculty Supervisor                          Date


**Departmental Coordinator's recommendation regarding Ethical Review:**

        [ ]        No ethical review required
        [ ]        Ethical review required

_____  _____
Signature of Ethical Review Departmental Coordinator     Date

If the student researcher/faculty supervisor and Ethical Review Departmental Coordinator have recommended that no ethical review is required, submit this form to the Education Ethics Review Committee for the Committee Chair's final determination whether Ethical Review is required. The Ethics Review Office will provide a letter to the student and supervisor indicating that no review of the research is required.

PROCESS:

For student researchers whose studies require an ethical review, the process is as follows:
1.  Complete the <u>Statement of Intent</u> form and an <u>Ethical Review Protocol</u> with the help of your faculty supervisor
2.  Submit the Statement of Intent and Ethical Review Protocol to the appropriate OISE/UT Ethical Review Departmental Coordinator, who will conduct a pre-review prior to submission to the Education Ethics Review Committee (EERC).  The purpose of the pre-review is to help you make the protocol as clear and complete as possible so as to reduce the time required for review by the EERC.
3.  On completion of the pre-review, the student researcher is responsible for submitting to the EERC the Ethical Review Protocol and all of its accompanying documentation, plus the completed Statement of Intent, the Student Researcher Checklist for Ethical Review Protocols, and the Departmental Coordinator Checklist.  The EERC is located at University of Toronto Research Services (UTRS), Simcoe Hall, 27 King's College Circle, Room 10A.

For student researchers/faculty supervisors who have determined that the study does not require ethical review, the process is as follows:
1.  Complete the <u>Statement of Intent</u> form (including your signature and the signature of your faculty supervisor).
2.  Give it to the appropriate OISE/UT Ethical Review Departmental Coordinator for signature.
3.  If the Departmental Coordinator agrees that no ethical review is required, take or send it to the Education Ethics Review Committee, located at University of Toronto Research Services (UTRS), Simcoe Hall, 27 King's College Circle, Room 10A.
4.  If the EERC Chair makes the determination that no ethical review is required, the Ethics Review Office will send you a letter indicating such. On receipt of this letter, submit a copy to the OISE/UT Registrar's Office, Graduate Studies Unit.
5.  If ethical review is required, follow the process above for studies requiring review.

OISE/UT Ethical Review Statement of Intent:
2000-01

Appendix G

University Health Network Research Ethics Board

UNIVERSITY HEALTH NETWORK
RESEARCH ETHICS BOARD
Annual Review and/or Termination Form

# Please attach a copy of the current consent form(s)

Annual Renewal and/or Termination Form will not be accepted without copy (ies) of informed consent form(s) (if applicable).

| Principal Investigator (UHN): | Department/ Division: |
|---|---|
| UHN REB number:     04-0164-BE | Expiry date of REB approval: 07/April/05 <br> (DD/MM/YYYY) |
| Study title: Exploring Physicians Conceptualization of their Role  Doctor-Patient Relationship During Family Medicine Training | |

### STATUS
ENROLLMENT

| | |
|---|---|
| ☐ No enrollment to date | Reason for no enrollment: |

☐ Enrolling subjects

☒ Enrollment complete but study is ongoing (check all boxes that apply below)

☐  Subjects receiving study intervention

☒  Post-Intervention follow-up of subjects (i.e., follow-up visits, data collection only)

☐  Intervention & follow-up complete for all UHN subjects - data clarification and/or data transfer ongoing (i.e., sponsors or coordinating centres)

☐ Premature termination of the study by investigator or sponsor
Reason for premature termination:

| Termination date:<br>(DD/MM/YYYY) | Total enrolled at UHN: |
|---|---|

| ☐ Study completed (i.e., no further subject involvement/data collection, clarification & transfer | |
|---|---|
| Date closed:<br>(DD/MM/YYYY) | Total enrolled at UHN: |
| Attach a copy of a final report, if available | |

## SUMMARY OF SUBJECTS AT UHN ONLY

| | |
|---|---|
| 15 | Number of subjects planned |
| 15 | Number of subjects consented |
| 0 | Number of subjects consented but did not meet inclusion criteria |
| 0 | Number of subjects prematurely withdrawn from study |
| 0 | Number of subjects receiving study intervention |
| 15 | Number of subjects in post-intervention follow-up |
| 0 | Number of subjects that have completed follow-up |
| | Number of subjects included in retrospective review (for chart review studies only) |

STUDY SUMMARY

1. Please provide a brief summary of the progress of the study to date (i.e., recruitment issues, preliminary findings).

2. Is there any new information in the literature or from other recent studies that would change the rationale or risk/benefit ratio for this study (e.g., changes in standard of care, new information about side effects, approval of another drug for this indication, etc)?

3. If any patients have been withdrawn from the study prematurely or withdrawn consent provide the reasons for patient withdrawal.

4. Have there been any subject complaints or feedback about the research? If yes, please describe.

5. a) Briefly, summarize all internal serious adverse events (SAEs) since the last approval, the action taken in response to the SAEs, and any resulting changes in procedures to detect such SAEs.

   b) In the opinion of the Principal Investigator, is there a trend in the internal SAEs? If so, identify.

   c) Have there been any deaths related to, or not to study intervention?

6. Has there been a change in the frequency and/or severity of adverse events that would result in a change to the protocol or consent form?

7. If applicable, has there been any report from the data safety monitoring committee? If applicable, please include the most recent report.

8. Since the last renewal, has there been any change in the Conflict of Interest information provided to the REB for Investigators involved in this study? (Potential Conflicts of Interest can include functioning as an employee or consultant to the study sponsor, direct or indirect financial interest in the drug/device or technology involved in the study or receiving honorarium or other benefits from the sponsor.)

9. Has the study now changed to include collection or banking of tissue or other specimens (i.e., fetal tissue, placenta, blood, other body fluids)?

10. Is the contact information on the consent form current?

11. Please provide current PI and study coordinator address, telephone and fax numbers, and email addresses.

☐ **Current consent form(s) attached** ☐**No consent form(s) for this study**
☐ **Terminate REB file**
☐ **Keep REB file open**

*UHN INVESTIGATOR'S SIGNATURE*

I confirm that I have reviewed any adverse events, if applicable, in a timely fashion during the course of the study and these have been reported to the REB. All revisions to the study protocol and consent form have been submitted. I am not aware of any new information that may affect the continuation of the study or require change in the study protocol.

UHN Investigator _____  _____  _____
                                         *Print Name*                              *Signature*

*Date (DD/MM/YYYY)*


**Return to:  UHN REB Hydro Building 700 University Avenue, 8th Floor South, Room 8-18**
**Ph. 416-946-4438**

**REMINDER:**
All changes to the study protocol, consent form(s), and all other study related documents must be submitted for REB review and approval prior to implementation.

Appendix H

Sample of Consent - Interviews and Critical Incident Reports

**Thank you for indicating an interest in participating in a research project that will explore your experience in a Family Medicine training program. Dawn Martin, will carry out all research as part of the requirements for completing the PhD degree at the Ontario Institute for Studies in Education of the University of Toronto. The following outlines the study itself and information about your participation. If you require any further information or explanation, please contact me at 416- 667-3805 (pager) or 416 588-8891 (home). My thesis advisors are Dr. Louise Nasmith who may be contacted at the Department of Family and Community Medicine 416-978-6473 and Professor Dennis Thiessen who may be contacted at OISE/UT 416-923-6641 ext. 7876.**

**The project is entitled:** "Exploring physicians experience of postgraduate training in a Family Medicine program"

**The objective of the research proposed is:** to gain a better understanding of how physicians during a Family Medicine training residency describe their training experience, how these perceptions change and what factors/experiences during training may influence these perceptions.

**Rationale for the Study**: Learning needs and beliefs change with the experiences training brings. These important sources of individual variation both internally and externally impact the educational process. There is a growing body of evidence suggesting that the more educators know about adult learners, the changes they go through and how these changes motivate and interact with learning, the better educators can structure learning experiences that both respond to and stimulate development. It has also been suggested that authorizing student's perspectives help educators begin to see the world from the student's perspective. This insight or knowledge resulting from this understanding can directly improve educational practice by making teaching more relevant to the students voiced needs.

Family Medicine residency training presents a window of opportunity to influence the continuing development of the physician's approach to the medical encounter. Physicians enter Family Medicine training with their own specific views of their role in postgraduate training and these characterizations change during training. Understanding resident's experience of training is important because it determines their attitudes toward the doctor-patient relationship and their conceptualization of their role as a Family Physician, which in turn influences their approach. If the institutional culture of medical schools is believed to shape the values, attitudes and behaviors of medical students then an understanding of the resident in the context (Family Medicine residency training) in which these changes take place needs to be explored.

**A Brief Overview:** This study will involve resident-participants from the Classes of 2004, 2005 and 2006 Family Medicine programme at Toronto Western Hospital, University of Toronto. Volunteers who take part in this study will be asked to take part in either one focus group **or** complete three individual interviews and to complete critical incident reports.

Your involvement in the process will require you to do the following:

- Participate in six one-hour interviews with the researcher (approximate time) that explores your experience of training during the first six months of a postgraduate Family Medicine program.
- You will be asked to reflect about such questions as "Describe your experience in the Family Medicine program" "How have these perceptions changed since you began the residency programme?" and "What factors/experiences have influenced these changes?"
- The interviews will be audiotaped and later transcribed.
- **Complete no more than five critical incident reports (minimum two). A critical incident report is the written documentation of an event you have taken part in that is perceived as particularly significant. In this study, I am interested in understanding events that you feel or think have influenced/changed your understanding of your role in the doctor-patient relationship. For example, it could be an event that happens in an actual Family Medicine office visit, on a specific rotation, in grand rounds or a conversation with staff/peers. You will be asked to write a short concrete description of the incident. The report will include enough detail (time, place, who was present etc.) so you will have no difficulty recalling the event in discussion with myself.**

## What are the benefits to you?

By participating in this study you will have an opportunity to reflect about your experience in the Family Medicine program and how it has changed since you began your Family Medicine training. The insights you contribute will lead to a better understanding of Family Medicine resident's learning needs.

## What risks are there for you in participating in this study?

There are no external risks to participating in the study. Only you, the researcher, and the thesis supervisor will be privy to the data that is collected. All raw data will be kept in confidence. Efforts will be made to ensure anonymity by using pseudonyms, minimizing individually identifying data and not identifying the teaching site in the final report. The data will not be available to the administration of the Department of Family and Community Medicine and will not be used to evaluate your performance as part of any school or system evaluation. You will have access to all raw data collected about you. You will have the opportunity to review the aggregated data from the focus group and interviews prior to the third interview. All the raw data collected during the study will be secured in a locked file and after two years will be shredded. This data collected from this study may be used for publication or presentation.

Because the numbers are small in this study, it may be possible to identify resident-participants from quotes that may be used in the final report. Steps will be taken such as using pseudonyms to protect individual identities and all resident-participants will be asked to keep shared information confidential to ensure anonymity.

Your participation in this research study requires a time commitment of about six months but you may, at any time withdraw from this study by simply indicating to the researcher your intention to withdraw. No evaluative judgment will be made about you if you choose to withdraw from the study. All raw data connected to your participation will be immediately destroyed.

**When will your participation begin?**

The early stages of the research will begin in May 2004. Individual interviews will begin in July 2004. The goal would be to have the research conclude by December 2004.

**Research Consent**

**If you have any questions about your rights as a research resident-participant, please call**

**Dr. R. Heslegrave, Chair of the University Health Network Research Ethics Board at (416)**

**340-4557. This person is not involved with the research project in any way and calling him**

**will not affect your participation in the study.**

I have had the opportunity to discuss this study and my questions have been answered to my

satisfaction. I consent to take part in the study with the understanding I may withdraw at any

time without affecting my academic evaluation. I have received a signed copy of this consent

form. I voluntarily consent to participate in this study.

_____     _____

**Subject's Name (Please Print)**                                **Subject's Signature**

Date: _____

I confirm that I have explained the nature and purpose of the study to the subject named above. I

have answered all questions

_____

_____

**Name of Person obtaining consent**          **Signature**

**Date:** _____

Appendix I

Sample of Consent - Focus Group


Thank you for indicating an interest in participating in a research project that explore your experience of training in a Family Medicine program.  Dawn Martin, will carry out all research as part of the requirements for completing the PhD degree at the Ontario Institute for Studies in Education of the University of Toronto.  The following outlines the study itself and information about your participation.  If you require any further information or explanation, please contact me at 416- 667-3805 (pager) or 416 588-8891 (home).  My thesis advisors are Dr. Louise Nasmith who may be contacted at the Department of Family and Community Medicine 416-978-6473 and Professor Dennis Thiessen who may be contacted at OISE/UT 416-923-6641 ext. 7876**.**

**The project is entitled:** Exploring physicians experience of postgraduate training in a Family Medicine program"

**The objective of the research proposed is:** to gain a better understanding of how physicians during a Family Medicine training residency describe their training experience, how these perceptions change and what factors/experiences during training may influence these perceptions.

**Rationale for the Study**: Learning needs and beliefs change with the experiences training brings. These important sources of individual variation both internally and externally impact the educational process.  There is a growing body of evidence suggesting that the more educators know about adult learners, the changes they go through and how these changes motivate and interact with learning, the better educators can structure learning experiences that both respond to and stimulate development.  It has also been suggested that authorizing student's perspectives help educators begin to see the world from the student's perspective.  This insight or knowledge resulting from this understanding can directly improve educational practice by making teaching more relevant to the students voiced needs.   Family Medicine residency training presents a window of opportunity to influence the continuing development of the physician's approach to the medical encounter.  Physicians enter Family Medicine training with their own specific views of their role in postgraduate training and these characterizations change during training. Understanding resident's experience of training is important because it determines their attitudes toward the doctor-patient relationship and their conceptualization of their role as a Family Physician, which in turn influences their approach.  If the institutional culture of medical schools is believed to shape the values, attitudes and behaviors of medical students then an understanding of the resident in the context (Family Medicine residency training) in which these changes take place needs to be explored.

**A Brief Overview:** This study will involve resident-participants from the Classes of 2004, 2005 and 2006 Family Medicine program at Toronto Western Hospital, University of Toronto. Volunteers who take part in this study will be asked to take part in either one focus group **or** complete three individual interviews and to complete critical incident reports.

Your involvement in the process will require you to do the following:

- Attend a 60 – 90 minute focus group that explores your experience of training during the first six months of a postgraduate Family Medicine program. You will be asked to sit with your peers (physicians in the same year at Toronto Western Hospital Family Medicine residency program) and discuss your perceptions of your role as the physician in the doctor-patient relationship.
- You will be asked to reflect about such questions as "Describe your experience in the Family Medicine program" "How have these perceptions changed since you began the residency program?" and "What factors/experiences have influenced these changes?"
- The focus group will be audiotaped and later transcribed.

## What are the benefits to you?

By participating in this study you will have an opportunity to reflect about your experience in the Family Medicine program and how it has changed since you began your Family Medicine training. The insights you contribute will lead to a better understanding of Family Medicine resident's learning needs.

## What risks are there for you in participating in this study?

There are no external risks to participating in the study. Only you, the researcher, and the thesis supervisor will be privy to the data that is collected. All raw data will be kept in confidence. Efforts will be made to ensure anonymity by using pseudonyms, minimizing individually identifying data and not identifying the teaching site in the final report. The data will not be available to the administration of the Department of Family and Community Medicine and will not be used to evaluate your performance as part of any school or system evaluation. You will have access to all raw data collected about you. All the raw data collected during the study will be secured in a locked file and after two years will be shredded. This data collected from this study may be used for publication or presentation.

Because the numbers are small in this study, it may be possible to identify resident-participants from quotes that may be used in the final report. Steps will be taken such as using pseudonyms to protect individual identities and all resident-participants will be asked to keep shared information confidential to ensure anonymity.

Your participation in this research study requires a one-time commitment of 90 minutes. At any time, you may withdraw from this study by simply indicating to the researcher your intention to withdraw. No evaluative judgment will be made about you if you choose to withdraw from the study and no explanation is necessary. All raw data connected to your participation will be immediately destroyed.

## When will your participation begin?

The early stages of the research will begin in May 2004.  Focus group interviews will begin in May 2004 and will end by August 2004.  The goal would be to have the research conclude by December 2004.

## Research Consent

**If you have any questions about your rights as a research resident-participant, please call Dr. R. Heslegrave, Chair of the University Health Network Research Ethics Board at (416) 340-4557. This person is not involved with the research project in any way and calling him will not affect your participation in the study.**

I have had the opportunity to discuss this study and my questions have been answered to my

satisfaction.  I consent to take part in the study with the understanding I may withdraw at any

time without affecting my academic evaluation.  I have received a signed copy of this consent

form.  I voluntarily consent to participate in this study.

_____        _____

**Subject's Name (Please Print)**                **Subject's Signature**

**Date:  _____**

I confirm that I have explained the nature and purpose of the study to the subject named above.  I

have answered all questions.

_____        _____

**Name of Person obtaining consent**                **Signature**

**Date:  _____**

Appendix J

Outline of Early Data Analysis

1) All data will be transcribed.  Analysis will begin by reading and rereading all data  (focus groups, interviews) to gain a holistic impression (comment on language used, absences, questions, beginning descriptive labels etc.)  The focus groups will be read first looking for themes.  This data will also be used to generate future interview questions.

2) Interpretive summaries of the focus groups, initial interviews and critical incidents will be written, searching for potential themes (identify and label themes that characterize each section of the text, trying to capture something about the essential quality of what is represented by the text).

3) Transcripts will be analyzed by listing themes identified in stage two.  Clusters of themes will be given labels to capture their essence i.e. brief quotations, descriptive labels.  Analysis will include movement back and forth between the list of themes and original data to make sure themes make sense and to obtain a generalized understanding.

4) A summary table will be created of structured themes, together with quotations that illustrate each theme.  The summary table will include those themes that capture something about the quality of the resident-participant's experience of their role in the doctor-patient relationship.  The summary table will include the cluster labels together with their subordinate themes, labels, brief quotations and references to where relevant extracts may be found in the interview transcript (i.e. page and line numbers).  Texts will be compared to identify common meanings and shared practices/experiences. This study will also be looking at texts to identify differences as well as similarities.

5) Further interview questions will be generated from the initial summary table.  This information will be used to help clarify issues and provide resident-participants with opportunities to deepen reflections.

6) The summary table of themes will be used to integrate further texts (interview data).  The original interviews will be used to code the other interviews, adding or elaborating themes in the process. Themes that emerge in later transcripts will be checked against earlier transcripts and integrated. Analysis will end with the final transcript (second individual interview and critical incident reports). The summary table will be used to identify patterns and link themes.

7) Before the final report is written, the summary table with themes will be presented to the individuals taking part in the individual interviews.  An opportunity will be provided to comment.  Reflections will be used to clarify final summary table.  As well, data from the summary table will be used to generate questions for the final focus group with the resident-participants from the incoming Class of 2006.  Findings from this focus group will be used to generate questions for one semi-structured interview with two resident-participants from the Class of 2006.  The data will be checked against the final summary table and integrated.

8) The final report will be written.  Themes will be presented together with illustrative quotations.  Each theme will be introduced and it's various manifestations discussed.  Relationships between themes will be discussed, including differences and similarities between training years.  A clear distinction will be made between resident-participant's comments and the researcher's (my) interpretation.  Discussion will occur between identified themes in relation to existing literature.  Implications for future research, theoretical developments and recommendations for improved practice will be addressed.