Medical Education

Problems Experienced by Residents in Internal Medicine Training

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A review of the literature and the experience of a residency program in internal medicine indicate that house officers have special problems during training. Some are shared by all residents, whereas others are unique to certain groups. These problems are caused by historical and cultural factors that have led to the current structure of many residency programs and often interfere with the parallel development of professional, personal and family growth. Program directors and chiefs of service need to be flexible and humane and should negotiate clear expectations with house staff to allow efficient functioning of the residency program and insightful personal growth.

Wolfe ES, Jones HW III: Problems experienced by residents in internal medicine training [Medical Education]. West J Med 1985 Apr; 142:570-572)

For the past ten years, the Department of Internal Medicine at the Kaiser-Permanente Medical Center, Santa Clara, California, has had a residency program in internal medicine.[1] Physicians in internal medicine residency programs have special problems that are shared by all residents, but historical and cultural factors alter the impact on different subgroups of residents: women, men, single residents, married residents and physician couples. The proportion of women entering the program has been higher than the national average for almost every academic year (Table 1).[2,3] This high percentage of female residents has enabled us to observe and describe some gender differences in how residents are affected by and respond to certain problems.[4-6] Professional socialization, conflicts between personal and professional commitment, the role of the spouse, pregnancy and sexuality are discussed and illustrated with specific examples. A more insightful understanding of these issues would enable faculty and program directors to be more effective teachers and counselors for residents and for students who plan to train in internal medicine.

Professional Socialization

Residency training is a synthesis leading to new knowledge, skills, values and perspectives that result in the formation of a professional identity. Problems with professional socialization often begin in medical school, when students are exposed to ways to plan for a fulfilling career as a physician. Some traditional mechanisms of coping with the stress of professional life are not suitable for the time of residency.[7] Hostility, cynicism and defensiveness may occur in response to the stress of training and difficulty in using anger constructively. Almost all residents experience anxiety about their clinical performance, and a few are either underconfident or overconfident about their ability.

Men who attempt to emulate a strong masculine role may displace emotions, display a lack of compassion and seem cool and aloof.[7] They are often unconcerned with the effect on their personal development that is mandated by this behavior. Women, too, experience problems during this process, and several factors may lead to difficulties in their creation of a professional identity.[8-10] There have been few women-physician role models, so that women residents compete in a predominantly male domain and are subject to skepticism and criticism from male physicians.[11] Colleagues and supervisors may perceive as "aggressive" behavior that would be considered assertive in a male resident. Women physicians experience another disadvantage when they are in training programs where they have been a rarity in that both patients and hospital personnel confuse them with nonphysician hospital staff and may refer to them as "girls."

Conflicts Between Personal and Professional Commitments

Residency training requires major time and learning commitments; therefore, conflicts inevitably occur between the time and energy needed for personal and for professional de-

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TABLE 1.—*Sex Distribution of PGY-1* Medical House Staff at Kaiser-Permanente Medical Center, Santa Clara, Compared With the National Percentage of Graduating Female Medical Students*

Year	Female (No.)	Male (No.)	Female (Percent)	Female Medical School Graduates† (Percent)
1972	0	3	0.0	9.0
1973	3	2	60.0	8.9
1974	2	5	28.6	11.1
1975	0	6	0.0	13.4
1976	4	3	57.1	16.2
1977	3	3	50.0	19.2
1978	2	6	25.0	21.4
1979	5	2	71.4	23.0
1980	3	4	42.9	23.2
1981	8	0	100.0	24.8
1982	5	4	55.6	25.0
Totals	35	38	Mean= 47.9	Mean=17.8

*Postgraduate year 1.
†From Crowley et al.[3]

velopment. "Role strain" occurs when residents feel guilt and resentment at the demands of hospital responsibilities if personal needs are neglected and they have similar feelings at home if career development seems compromised.[11] Ambivalence and guilt may lead to disruptive or destructive behavior. Some become more nonchalant about training and spend less time at the hospital.

Women residents who strive for this precarious balance between their personal and professional lives have some unique problems. Unmarried residents of either sex may experience considerable social isolation, but these important years of childbearing and motherhood place unusual stresses on women. These additional responsibilities may conflict with professional development and commitment. Coping mechanisms are strained and the stress interferes with personal and professional life.[12-14]

Male residents often are as concerned about family obligations, but women seem more anxious about responsibilities to their spouse and children.[15] Depression commonly occurs when hospital responsibilities interfere with residents' participation in important activities of their children.[16]

Role of a Spouse

An appropriate adjustment of a spouse or close friend to a partner's period of residency is essential to ensure continuing growth of the relationship. Spouses who are supportive are major assets; those with negative patterns of behavior interfere with the educational experience. Physician spouses are usually more empathic, especially if they are occasionally consulted about clinical problems or the training process. A nonphysician spouse is more likely to feel abandoned and to develop feelings of depression, isolation and hostility. A nonphysician husband may react to his wife's professional success with anxiety and loss of self-esteem if he believes he is not embodying a traditional masculine role.[7,11,14] Some husbands have difficulty responding creatively to a need for role redefinition, which leads to less career parity within a marriage. Marriage can be more stressful than nurturing for women.[17]

Illustrative Cases

CASE 1. A female resident had an interpersonal conflict with a male resident. There was a loud argument, which the woman interpreted as belligerent behavior on the part of her colleague. She discussed the problem with her husband, who then threatened the male resident.

CASE 2. The husband of a first-year resident telephoned the program director to complain about his wife's wages. He stated that her annual salary was too low when calculated as an hourly wage.

CASE 3. When it was time to plan schedules for a new academic year, the husband of one of the first-year residents requested that he be allowed to attend planning sessions. He stated that he needed to represent his wife's interest, implying that she was unable to be her own advocate.

CASE 4. This husband demanded that his wife be home by 5 PM on nights when she was not on call, so that she could prepare his dinner.

Pregnancy

Pregnancy during residency training presents specific challenges to program directors and results in unique problems for a resident.[13,18] Scheduling adjustments necessitated by planned pregnancies may cause hardship when responsibilities are displaced to others. Unplanned pregnancies may cause enmity when residents who choose to have abortions are critical of those who choose to go to term. Some program directors expect all women to defer childbearing until completion of training (K. Holub, "Pregnancy Memo Puts Conflict in Open," *San Jose Mercury News,* Aug 30, 1983, p 1). Even when residents carefully plan pregnancies and return to full-time responsibility after a prudent leave, there are problems coping with both the infant and the residency. The impact of a wife's pregnancy on a male resident is not of the same magnitude.

CASE 5. A third-year resident planned a pregnancy during her final year of training. She returned to full-time activity within a short time of the baby's birth. To continue breast-feeding, she brought the infant to the hospital frequently and, on occasion, nursed the baby during conferences. Nonphysician female employees who did not have this privilege expressed resentment about the breast-feeding and complained about the noise made by the infant.

Sexuality

Occasionally specific problems occur in the areas of sexuality. Both men and women residents are subject to sexual harassment and discrimination, but women report more incidents.[19,20] Male and female residents report episodes of sexual dysfunction that they attribute to the physical and mental stress of training.

Some female residents try to integrate themselves into the predominantly male profession by manipulating the way they, themselves, dress or react.[7] Women residents cry more than their male peers. However, crying is an effective way to release emotions that develop when dealing with illness and death and to demonstrate compassion or empathy.[15]

Recommendations

Residents will be more likely to achieve personal and professional goals if they are prepared for the stresses of both

training and clinical practice. Program directors should provide resource information and authoritative counseling. These issues should be discussed in medical school; residency programs would then continue to emphasize this important part of professional development.

Emotional support must be provided in every residency program so that stresses may be easily identified and ameliorated. This support may be offered in different ways. Stress reduction groups, patterned after those developed by Balint,[21] provide a forum to discuss personal and other problems encountered in training. These groups can be effective when led by program directors because of their direct knowledge of the educational program and its stress points. An alternative leader could be a psychiatrist who is well acquainted with the residency program and is sensitive to the needs of residents. Personal counseling by program directors is another effective way to help residents.

Involving spouses and friends in informal activities acquaints them with the vicissitudes of training. A pleasant social gathering early in the academic year provides contact with other spouses and enables networking to begin. The partners should be introduced to the hospital environment and its ambiance. A change in the professional status of either partner requires deliberate planning; a hiatus in the residency need not prevent the eventual completion of training.

Pregnancy during residency necessitates skillful time management. Scheduling a leave of absence before and after delivery requires flexibility within the program and the support of all members of a house staff. Limitations should be discussed and reviewed periodically for appropriate changes (of course, all legal requirements must be followed). Programs should consider accommodating breast-feeding and other important aspects of infant or child care. There will be a continuing need for day care centers and cooperative nursery schools; larger medical centers may want to help in their organization and administration.

Frank discussions about sexual harassment enable residents to express their concerns. An experienced colleague is a useful resource when this issue is discussed.

Conclusion

It is clear from a review of the literature and the experience of this residency program in internal medicine that house officers have special problems during training. Some are shared by all residents, whereas others are unique to certain groups. These problems often interfere with the parallel development of professional, personal and family growth. All physicians should be taught how to link professional and personal growth.

Program directors and chiefs of service need to be flexible and humane and should negotiate clear expectations with house staff to allow efficient functioning of the residency program and insightful personal growth. Attempts to solve these dilemmas by legislation are unlikely to be as successful as the flexibility, ingenuity and awareness of program directors.[22-24]

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