The Impact of Expansion

One family medicine department's experience with mandatory 2-year residency programs

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SUMMARY

Postgraduate training for family physicians has become increasingly centred on 2-year residency programs. The expansion of family medicine residency programs in Quebec raises challenges: to uphold program standards, to recruit and develop new teachers, to recognize and respect the needs of students, to balance program objectives with service requirements for house staff, and to adapt to change within family medicine centers and their affiliated hospitals.

RÉSUMÉ

La formation postdoctorale des médecins de famille est de plus en plus centrée sur des programmes de résidence répartis sur deux années. L'expansion des programmes de résidence en médecine familiale au Québec pose certains défis: maintenir l'excellence des programmes, respecter les objectifs académiques des professeurs en place, recruter et former de nouveaux professeurs, reconnaître et respecter les besoins des étudiants, adapter les objectifs du programme en fonction des autres tâches auxquelles sont soumis les professeurs et s'acclimater au changement dans les centres de médecine familiale et leurs hôpitaux affiliés.

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JULY 1988 MARKED THE FORmal beginning of the expansion of family medicine training expansion in Quebec. Following the Wilson[1] and Cox[2] reports nationally, and the Archambault report[3] in Quebec, the province moved from three pathways of postgraduate medical training to two. The rotating or mixed internship was eliminated, leaving the option of a 2-year family medicine residency or a specialty residency, to be followed by a discipline-appropriate provincial licensing examination.

This decision ended discussion about the most appropriate route for the training of family physicians,[4] which had taken place at many levels: The College of Family Physicians of Canada (both nationally and within provincial chapters); the Canadian Medical Association; the provincial licensing bodies (in Quebec, the Corporation professionnelle des médecins du Québec); the provincial ministries of health and social affairs, education, and finance; the Royal College of Physicians and Surgeons of Canada; the Federation des médecins omnipracticiens du Québec (the family and general practitioners' syndical body in Quebec); deaneries of faculties of medicine; and departments of family medicine that would be responsible for implementing any legislated changes.

The Archambault report was published in 1985[3]; the legislation supporting its implementation was passed in June 1987 and took effect in July 1988.

This article describes what expansion has meant to the McGill University Department of Family Medicine. We were confronted with issues pertaining to the philosophy of teaching family medicine. We had to recruit staff and residents, provide faculty development, and cope with increased workloads. We had to deal with the psychological aspects of change, with resident reactions and needs, and with new political experiences at our hospitals and university. Some of the results were quite positive. Others will need to be evaluated with time and experience.

There is a danger, so soon after being thrown into this expansion, that we cannot yet step back and gain perspective. But with the prospect of imminent expansion for other departments across the country, we thought a description of the McGill experience might be relevant. It should be acknowledged, however, that McGill's experiences may not reflect those of other family medicine departments in Quebec; similarly,

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Interim update: *Family medicine residents (left to right)* **Michael Taylor, Mary Hill,** *and* **Barbara Roback** *exchange information during a busy day of seeing patients.*

our own views may not reflect those of all members of our department. Despite these reservations, we felt that some interim comments might be worthwhile.

Impact of change

The prospect of expansion of the residency program in family medicine had been debated for several years at McGill. The family medicine leadership was optimistic about the long-range benefits of expansion and was determined that it would succeed. Some of the teaching faculty, however, voiced concerns and reservations about the practicalities of implementation.

Authors in diverse fields have noted that change is often difficult or painful, especially when it is imposed from outside, without enough time or opportunity for individuals or institutions to prepare themselves or to control events or timetables. Members of our own department questioned whether the speedy and often unpredictable nature of our own expansion showed too little respect for the time needed to adapt to change.

We had little opportunity for long-range planning. Uncertainties about the types and amounts of funding to come made realistic planning difficult; some saw expansion as merely a hypothetical exercise. After all, we had seen other government proposals or white papers die a slow death, strangled by absence of funds or monies injected too late. Hence there was a feeling at some levels within the faculty, the hospitals, and even our own department that if the problems of expansion were ignored and funding was not forthcoming, the problem would disappear. The challenge for the Department of Family Medicine was to convince itself to proceed with planning and to hope that if government funding appeared it would be sufficient to support the planned changes.

There were plenty of specific worries. Teachers needed to be convinced that enough hard dollars would be available to support the increased time they would need to devote to administration and to teaching. Faculty wanted assurances that funds would be available for additional secretarial support, not only in the implementation stages of expansion, but also in the critical and time-consuming planning stages. They needed to know that the increased time spent on planning would be acknowledged by the University. If they spent less time on research to assist with time-consuming expansion planning, what would become of their aspirations for promotion in a university heavily oriented to research and publication? Prospective faculty also needed reassurances. If they made a commitment to the teaching program, would there be funds to support them in the future? Specific concerns were also voiced about the teachers' relationships with the trainees and the quality of the education program.

Some members of the hospital community at large also reacted with insecurity and resistance. They were concerned about the loss of the rotating/mixed interns and the perceived loss of power that went along with their control of house staff. They saw family medicine as taking over, and relations became strained between some of the hospitals and their family medicine centers. At the same time, while hospital administrators were made aware of increased space and personnel needs for the expansion, they were naturally reluctant to approve such plans until funding was guaranteed. Because expansion took some time in coming, a combination of hard negotiations and gentle persuasion was needed. Expansion became an uncertain two-step financial negotiation process: pre-expansion to year 1, when the number of residents would jump from 85 to 120; and then year 1 to year 2, when the number would rise from 120 to 160.

Departmental structure and function

Founded in 1974, by 1987 the McGill Department of Family Medicine was gradually moving out of adolescence into young adulthood. Expansion and its implementation pushed us into premature parenthood, with many new offspring. Just as reluctant new parents can use the crisis of an unexpected pregnancy to promote personal growth and change, so the department moved closer to consolidation, forming a more centralized model, philosophy, and committee structure.

Issues of communication and information dispersal were paramount. Communication needs among staff whose job descriptions had expanded overnight led to a deluge of memos, and predictably more and longer committee meetings. Photostats proliferated; postage and courier costs increased. Secretaries became adept at grabbing people on the way out the door to act as messengers from one hospital to another in ways that Canada Post can only hope to emulate. At some point in this paper explosion, the marvel of fax entered our world, and very soon thereafter we could not function without it. Enhanced departmental managerial skills were needed.

Student concerns

Residents in the program during preparation for expansion manifested different reactions. Second-year residents generally expressed relief: thank goodness I will escape whatever happens. For the first-year residents whose training would overlap with those who would enter the new system, insecurity was prompted by rumor, by speculation, and occasionally by fact. They worried about loss of program intimacy, about less advantageous teacher-student ratios, about curriculum change, about the adequacy of patient volume for clinical exposure, and about decreased availability of teachers who might be burdened by increased administrative tasks.

Whatever the first-year residents did not think to ask, the fourth-year medical students applying to the program did. They were remarkably perceptive in anticipating problems, and their concerns seemed to stir up the first-year residents. The fourth-year applicants were also concerned about being forced into a training pathway to which they were unprepared to commit themselves at that time. Even those planning to take the family medicine residency route resented the system for changing the rules of the game. This resentment was exacerbated by the prospect of a Quebec licensing examination for family physicians, which at the time would be unique in Canada, but which had not been defined or developed.

Residency graduates face an increasing set of obstacles to practice in Quebec: for example, they must demonstrate competence in French; they must either agree to a rural practice or accept fees lower than their colleagues' if they choose to locate in an urban area. They saw the examination, which is expensive to write, as simply one more hurdle in their path. Furthermore, the trainees, like the teaching faculty, were confused about the distinction between licensing examinations and certification examinations and about the nuances of criteria for minimal competency and excellence. The issue of the examination blended in the students' minds with the upcoming expansion program as a whole, and anger and frustration became generalized. The students felt exploited – like guinea pigs for a new system – and the supportive psychotherapy skills of the departmental staff were stretched to unexpected lengths. This general state of

anxiety had a destabilizing effect on all those planning for or affected by the expansion.

Resident recruitment: philosophy versus practicality

The decision to implement a mandatory 2-year residency brought to a climax a long-standing debate between academic, community, and licensing groups. Who should be trained in a residency program: those with a strong academic record and presumed clinical promise, or those more clearly in need of a more rigorous and structured learning experience? The ethical questions raised by such a debate could be set aside. But what of the trainee who still preferred another route to training? Could these people be trained by the existing residency programs, or would they become fifth columns, triggering generalized resident dissatisfaction? How was one to deal with a trainee who really didn't want to be there – who cognitively or emotionally would not accept the content and objectives of family medicine residency programs? An outgrowth of these questions was the concern about whether programs that had aimed at academic excellence by trying to recruit the best available candidates would, by default, become mere trade schools offering education aimed at the lowest common denominator.

Notwithstanding such concerns, it was evident that the process of resident recruitment and selection would need to change, at least in the short term. The reliability and validity of the traditional interviews, deans' letters, letters of reference, and transcripts had been questioned for some time. With a projected 80 positions available in year 1 of the residency, did we need to be as discriminating? Perhaps a short list of elimination criteria would be more efficient than established, but often non-predictive, selection criteria.

On a practical note, changes in the Canadian Intern Matching Service (CIMS) meant a 1-month delay (until mid-March) in receiving the list of applicants matched to our program. (Our sister departments in Quebec escaped this particular problem; because they do not use CIMS, their contract lists of house staff were on their way to being completed by early winter.) This selection process was further complicated by the fact that the number of McGill students choosing family medicine training has remained roughly constant over many years. Thus, the market was stable or decreasing as we were expanding.

Graduates of foreign medical schools

Concurrent with expansion was another form of departmental growth. Quebec appeared to be an attractive place for physicians trained outside of North America. By government decree, 100 of these physicians would need to be incorporated, over a 4-year period, into postgraduate medical training by the four Quebec medical faculties. This number eventually rose to 140. Before being accepted into postgraduate training, these physicians were required to take part in a programme d'accueil, or a clinical evaluation program. At McGill, regardless of whether these physicians were destined for family practice or for a specialty, the programme d'accueil and any necessary remedial education arising out of this was assigned to the Department of Family Medicine. The number of physicians in a programme d'accueil at any point in time would vary from 8 to 12.

The graduates of foreign medical schools have proved to be keen and determined participants in the programme d'accueil. However, depending on individual training and countries of origin, some show a lack of preparation to enter a postgraduate program. Unfortunate life experiences or significant cultural differences have also occasionally introduced complex learning blocks into the equation. The Department of Family Medicine at McGill has been given no additional faculty or funds for this program.

Faculty recruitment and development

Expansion implied the need to recruit a large number of new teachers. McGill's position as a predominantly English institution within a French-speaking province posed some unique problems for recruitment, such as the need for physicians to demonstrate competency in French and the existence of regulations governing the language in which children entering Quebec might be educated. Moreover, McGill's

Team meeting: *Team members (clockwise from left) nurse* **Doreen Whitehead**, *resident* **Barbara Roback**, *resident* **Michael Taylor**, *resident* ***Eric Sicard***, *Secretary* **Krystyna Kirpa**, *and staff physician* **Mark Yaffe** *discuss patient management.*

salary scale ranked low in comparison with many other schools, and Quebec's medicare billing schedule for family physicians ranked, at best, fifth in the country (depending on whose statistics were quoted). Despite these obstacles, a small group of competent people from outside Quebec joined the Department. Other faculty were recruited from within the ranks of our own graduates. The risks of inbreeding were evident and worrisome, as were concerns about limited postresidency clinical experience, but the aforementioned limitations and the rapidity of departmental expansion gave us few options.

To meet an obvious need, faculty development programs were organized. When funds were available, individuals were sent to various activities across the continent. At the same time, Departmental and family medicine center–based faculty development activities were organized, including orientation programs for new faculty and more specialized workshops entitled "Small Group Teaching" and "The 'Problem' Resident: Whose 'Problem' is it Anyway?" While the implementation of a formalized faculty development program has been a benefit of expansion, and while participants have been enthusiastic, we nevertheless question whether enough has been done.

Physical resources

As enrollment grew from 85 to 160 residents over 2 years, we obviously needed to expand the physical resources of existing urban family medicine centers, to explore adding new ones, and to develop further the network of well-evaluated rural and community practices. The constraint imposed upon this planning by fiscal uncertainty we described earlier in this article.

McGill faced another challenge somewhat different from that in other family medicine departments in Quebec. Because McGill continued to attract trainees from across Canada, some of whom spoke little French and would never practise in Quebec, rural training sites had to be found or developed that allowed at least some opportunity to function in English. On the other hand, approximately 80% of Quebec's

population is francophone, and the Department recognized a responsibility not only to train competent family physicians, but also to shoulder its share of the health care of Quebec citizens. While most of our rural training sites continue to serve a francophone population, two sites have been established in the Eastern townships, and two outside the province, where English is the primary language. We now also coordinate French courses for anglophone residents.

Hospital relations and in-hospital training

If change was painful for the family physicians who might in the long term be the beneficiaries of government policy, what of the specialists, who had little to gain? The growth of family medicine residency programs in Quebec occurred after recent decreases in spaces allocated by government for specialty residences, in Quebec as in other provinces.[5] While family physicians could hardly be held responsible for government policy, family medicine was perceived by some as the bearer of bad news, and by extension, the cause. The concurrent loss of the rotating intern in Quebec meant that many hospitals expected family medicine residents to fill the service void.

Besides, while the family medicine curriculum was controlled by the College of Family Physicians of Canada, the content of these programs came under close scrutiny from people who might, in the past, have had little interest in the training of family physicians. Not surprisingly, many of the proposals from these latter groups were for hospital-based rotations that did not meet College objectives.

The solutions that were proposed or ultimately adopted were not necessarily generalizable from one hospital to another, because each was governed by unique mission statements, staffing needs, and local issues. Hospitals reluctantly decreased the number of clinical teaching units, and physicians who were primarily specialists assumed the unfamiliar role of service coverage in teaching hospitals. In some hospitals family physicians were asked to assist, but many felt their skills were inadequate for current in-hospital care, as they had not generally had the opportunity to maintain skills for such activity.

The decrease in specialty residents also created problems for the traditional teaching house staff pyramid. While some found this model satisfactory because it had withstood the test of time, had it been compared to other possible models? Would learning be harmed when the traditional hierarchy of specialty residents, family medicine residents, rotating mixed interns, and medical students was reduced to predominantly family medicine residents and medical students?

What is actually happening now? Preliminary feedback indicates that our residents are assuming a greater degree of in-hospital patient responsibility. For trainees with a strong foundation in basic and clinical sciences, and for those who enjoy taking initiative, this change is likely good. For others, the situation presents problems. Some residents appear more worried and stressed on certain rotations. Emotional lability or volatility are warning signs that individuals are too uncomfortable or stressed. Is this because of individual residents' problems? Does it reflect the loss of security that comes with a smaller house staff hierarchy? Does this reflect an inappropriate match of person or personality to a training program because other options were no longer available? Is the need to cover services in conflict with a return to the family medicine centers? These are just some of the questions that need to be answered.

Implications for the family medicine program

Concerns were voiced about how a family medicine center would change with expansion. A teaching unit that had previously had at most 20 residents was doubling to 40 residents. How was quality teaching to be assured or maintained? How would faculty know all their residents? How would they get all the residents together for a meeting or feedback session? How could one realistically hope to bring 160 residents together for a centralized departmental function? While the temptation was to decentralize, the departmental game plan and philosophy had appropriately changed to one of strong unification.

What about the size of family medicine teams? While teams used to be composed of three to four residents, expansion meant

(despite the creation of more teams) that a team could include up to six residents. How would staff find the time to meet the individual needs of residents? Questions were reluctantly raised (though often unanswered) about preceptor-to-resident ratios: not the optimal but the acceptable ratios. Would quality of supervision be affected?

Concerns about loss of intimacy in the program were paramount in the minds of both the teachers and the trainees. Would staff even be able to learn the names of all the trainees? Small teaching groups became larger groups. Methods of teaching core content had to change. How would this affect the teaching of subjects that in the past had depended on supportive group learning processes?

Faculty were also preoccupied with new complexities in resident scheduling. Some rotations had to be planned through the departmental teaching office, others through hospital teaching secretaries, and many others through the family medicine centers. Consecutive block time, although seemingly a pedagogically sound concept, became increasingly difficult to arrange, especially in family medicine.

The motivation for residents to participate in core activities was also affected. For some it became increasingly stressful to return to the family medicine center for patient care or to participate in teaching seminars. The usual pull between hospital service needs and care of family medicine patients was accentuated. Some residents with intrinsically less interest in family medicine questioned why they should be exposed to the philosophy of family medicine, to behavioral sciences, and so on. Helping such individuals was seen to be essential. Time-consuming and labor-intensive remedial programs were necessary for them, as well as for residents whose knowledge base was deficient.

Implications for faculty

The impact of the expansion on the faculty has varied, depending mostly on where they see themselves in their own professional life cycles. More experienced teachers have voiced dissatisfaction with the extra administrative work that the increased number of residents brings. They complain that they can't control teacher-student ratios and feel that they don't really know trainees as well as in the past. Scheduling and planning is increasingly complicated and tedious. The absolute number of residents with learning problems has increased, and in this era of natural justice for learners, rigorous documentation of learners' issues is mandatory. The plaintive cry from the faculty is: "Where is the justice for us?"

The time needed to plan for expansion was difficult to estimate or schedule in advance. Planning was simply added to the tasks that already existed. In his article, "The Ivory Tower: Rest Home or Rat Race?" Hennen[6] cites Dill and Aluise's three main characteristics of the academic doctor's role that can cause extraordinary stress: 1) the complexity of the role; 2) the multiple and shifting expectations placed upon the physician; and 3) the necessity to maintain currency in teaching, research, patient care, and administrative skills. Indeed, in our department, academic activities, such as reading, writing, research, and attending CME programs, have become more difficult to find time for, and very serious concerns have been expressed about how this will affect promotion. Good clinicians find less time to do what they are competent at and enjoy. More senior faculty report less contact with the trainees, less opportunity for direct observation of learners, and a lack of opportunity to step back and observe the process of change. Senior faculty also complain about the large number of meetings scheduled. They are worried that they have little time to interact with more junior faculty and to serve as appropriate role models for them. Concern is also voiced about the need to ensure that the academic physicians are in touch with the thoughts of the more community-based practitioners.

Stephens[7] has outlined a number of concerns faced by new faculty. These include questioning one's ability to do the job (fear of failure, or the impostor syndrome), anxiety about not having enough to teach, and fear that academia will not give the anticipated gratification or rewards. These issues may be more acute if a new faculty member is just out of a residency, with limited life experience.

Expansion has given some of our new faculty the opportunity to teach earlier than they might otherwise have done. The transition into a teaching role may be easy for some, but it can be a complicated process for physicians who haven't yet had the opportunity to solidify their clinical skills or identities. Some, therefore, doubt their own credibility as teachers. Others may act at the level of chief resident equivalents, functioning well as resident advocates,[8] but unable to see the broader educational or administrative aspects of a problem. A third group throw themselves into their new challenges with much enthusiasm, becoming overinvolved and risking burnout.

The concerns of the new faculty are often similar to those of the more senior teachers, but are experienced differently by people at different stages of the professional life cycles. Burnout is a word on the minds of many faculty. Revitalizing holidays are yearned for; yet the common complaint on return from vacation is that it doesn't pay to take them because there is no one to pick up the slack in one's absence; there is just double the work upon return.

Positive aspects of expansion

There is the risk that in lamenting the difficulties of expansion some of the benefits will not be obvious. First, the long-term goal of creating large numbers of better trained family physicians is likely achievable. The process of expansion has also brought the departments of family medicine from McGill, the University of Montreal, the University of Sherbrooke, and Laval University much closer together. Common issues are being discussed, and new collegial relationships are being formed between professors.

Within our own department we have been forced to examine almost every activity in which we are engaged and the premises on which these activities are based. This process of self-evaluation, although difficult at times, has generally been beneficial. As departmental members we have aimed for a central philosophy based on the need to deal with a common stress. Ideas about scheduling and creative financing have been examined. Core content programs have been modified; team structure and function has been analyzed. Teaching practices that are more consistent with the philosophy of family medicine have been developed in community and CLSCs (local community service centers), exposing trainees to multicultural, multi-ethnic populations and to a different age, sex, and disease profile. Second-year residents have assumed greater responsibility for helping first-year residents. Expertise in faculty development has grown, and positive experiences have been encountered in developing remedial programs. The new faculty members have contributed many innovative ideas, much enthusiasm, and a general positive sense of creativity.

Conclusion

This article started with the statement that it may be too early to assess the full impact of expansion. But we have made it through the first 1.5 years of expansion, and we were gratified to have received a renewed 5-year accreditation from the May 1989 survey of the College of Family Physicians of Canada and the Corporation professionnelle des médecins du Québec. We hope to consolidate what gains we have made, deal with anticipated problems as they arise, and, we hope, experience a generally less stressful existence.

What lessons have we learned? What advice might we give our colleagues facing the possibility of expansion? Whenever possible, programs undergoing expansion should aim to keep the lines of communication open. They should try to give participants in the program a sense of responsibility and control – to the extent that that is possible – and to foster a sense of belonging and involvement among the faculty.

The literature on stress and coping points out that people's perception of stress is influenced by many factors, including whether they feel in control, whether they know what to expect, and whether social support is available. Involving staff and residents in problem solving is an effective way to deal with outside constraints and unpredictability. Moreover, while centralization may be important, a sense of belonging – for both faculty and residents – can probably best be fostered through strong association with a family medicine center, in general, and at the level of smaller groups or teams, in particular. Mentorships

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des médecins du Québec, having decided to initiate a terminal examination to complete its licensing requirements for the province, established an agreement with the College to use the College's certification examination as one component of its own examination. It was supplemented by some multiple-choice questions on Quebec's health care system as well as a 40-station Objective Structured Clinical Examination to test physical examination and other skills. Pass-fail decisions were made separately for licensure and certification.

The licensing of physicians to practise medicine remains the distinct mandate of the provincial licensing bodies. The College acknowledges this role and clearly distinguishes the certification aspect of the examination from any provincial criteria established for licensure. The College's certification process strives not for a minimal standard of competence to ensure public safety but for a measurement of excellence in the family physician.

Conclusion

The certification examination as it exists in 1990 is simply the form it now takes along a continuous evolutionary process. Given present resources, it is an effective instrument for evaluating certain key areas of knowledge and skill that are required to be an effective family physician. Although the examination attempts to evaluate most of the College's educational objectives, it is limited in its ability to assess competence and knowledge related to practice organization, physician responsibility, and critical appraisal (research) skills. Nor does it evaluate physical examination skills and procedural abilities. The College is now looking at the possibility of developing a nationally standardized and objective in-training evaluation to complement the certification examination. ■

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among faculty may be an additional way of fostering this sense of belonging, and may also help integrate new faculty into a rapidly expanding and changing system.

Ideally, expansion should occur gradually, preceded by reasonable time to plan, to anticipate problems, and to adapt to change. In such an environment, one could also systematically study the effects of expansion on the educational program, on residents' well-being, and on faculty satisfaction. Finally, it should be acknowledged that, although change is often painful, it also represents the potential for growth. This concept is well exemplified by the Chinese symbol for stress, which represents both crisis and opportunity. ■

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