Residents' page

Jason Chang, MD

Did you hear the one about the various medical specialties? The internist knows everything, but does nothing; the surgeon knows nothing, but does everything; the psychiatrist knows nothing and does nothing; the pathologist knows everything and does everything, but it's a little too late.

Of course, the beauty of family medicine is that you have so much flexibility in how much of everything you can learn and do—and do in a timely manner. That beauty is not always apparent during residency training in family medicine, however. This month we offer a double feature that is sure to stimulate thought and discussion. First, we take a candid look at the academic aspect specifically pertaining to our identity in family medicine. Second, we address a term that is often overlooked during residency, but is covered in each provincial resident association agreement for a reason, "well-being."

Dr Chang *is a second-year family medicine resident at the University of Alberta in Edmonton and is a member of the Editorial Advisory Board of* Canadian Family Physician.

"Don't tread on me"

Why would you go into family medicine?

Ken Hotson, MD

In a field such as medicine, the education process is reflected in the many relationships between attending staff, administrators, senior colleagues, and residents. Often, these relationships evidence a deeply ingrained sadism within hospital organizations that, over the years, have resisted change. Family medicine residents are sometimes mistreated, especially as they rotate through regimented and highly disciplined departments. There, the response to our often misunderstood and maligned choice of profession is confusion or, worse yet, contempt.

The hostility and confusion that family medicine residents occasionally encounter in other departments is largely a result of our lack of collective identity. A department that has a mandate as broad as that of family medicine and that, by definition, serves a diverse patient population, finds it hard to foster a recognizable identity among its residents. And what sense of identity there is can get lost amid the images and ideals of the highly defined subspecialties through which family medicine residents rotate. All too often, family medicine residents simply "do time" in various departments within the hospital, adopting a service-oriented approach. Chameleon-like, they might mistakenly pretend to be surgeons or neonatal intensive care doctors, or neurologists for 1 month, only to change colour the next. Not getting dizzy while constantly rotating through a range of departments is a challenge that all family medicine residents face.

With a relatively short residency, family medicine residents can become complacent. Rotations are short and need only be experienced (or endured)

Residents are encouraged to e-mail questions, comments, personal articles, and helpful information to **sor_cfpc@yahoo.ca**. *(Note to third-year program directors and secretaries: please begin submitting information [contact names, e-mail and website addresses, phone numbers, fax numbers, deadlines, etc] for 2002 applications. The end of April is the deadline for the annual July Residents' Page listing family medicine residency programs.)*

once. Given the material these rotations offer and their applicability to our learning needs, the benefit of challenging programs in other disciplines is debatable. Residents fear being labeled as troublemakers; they want to avoid the possibility of a negative evaluation as a result of not being a "team player." Some departments have unclear expectations of them and will default to lower expectations than those required of their own residents. Family medicine residents also lack a defined rotation through which other residents move, and this further alienates them from their peers.

As Dr Katz recently pointed out,[1] the greatest challenge facing us today is defining who we are and what we do. He suggests that, because of the confusion surrounding our identity, medical students do not become interested in family medicine as a discipline. I would add that the problem is not so much lack of an identity to which medical students can relate as their observation that family medicine residents are passive, quiescent, and complacent in shared environments that show a lack of respect for, understanding of, and attention to, individual learning needs. These are the very real consequences of our lack of identity.

For family medicine to have a strong identity, residents must be able to find and maintain contact with mentors who can share their wisdom and experience in a true apprenticeship. Family medicine residents need to bring to each department they visit learning objectives that are congruent with their personal interests and future professional needs. Setting goals and objectives is an exercise in futility, however, unless senior faculty members validate and reinforce their importance administratively and politically. Faculty members need to be willing to challenge programs. They need to be willing to defend family medicine residents or even withdraw them from departments that abuse them or fail to meet their learning needs (service-oriented vs learning-oriented rotations).

A strong identity requires direction and vision on the part of resident leaders and program directors. Today's family medicine residents need to be able to assert their identity throughout hospitals, knowing that their departments will stand behind them. We also need to take leadership and management roles within our own department and to support others in these roles, so that we can re-establish our collective identity within the discipline and with our peers. We are holistic practitioners; we have a unique role; and we have the privilege of providing longitudinal care to our patients. We owe it to ourselves, our mentors, up-and-coming medical students, and the profession as a whole to remember this.

Dr Hotson *is a first-year resident at the University of Manitoba in Winnipeg.*

Reference

1. Katz A. Definition lacks clarity [letter]. *Can Fam Physician* 2001;47:1721.

Stressful results

Dorothée Garant, MD

Did you know that a recent descriptive cross-sectional study found that the prevalence of psychological distress among medical residents was 53%? Even if we are pressed for time, Dr Langlois' findings are one good reason to stop and give the matter some thought.

Problem

Unpredictable schedules, performance objectives, and punishing study hours offer great challenges to residents. We are supposed to model the principle of a healthy mind in a healthy body, but achieving balance is next to impossible. We enrol in an activity, only to miss a third of it because of our on-call responsibilities!

We might have no control over our schedules, but we can change one important stress factor: lack of support from our supervisors. It is easy to find fault with supervisors, and yet how many of us are guilty of being negative and demanding when it comes to junior residents and even externs? In a survey, 77% of us reported that our supervisors had not expressed any interest in our well-being over the previous 4 months. But are we looking after the well-being

of our junior residents and externs? If we are too stressed out to do this, maybe our supervisors are, too. Maybe this is why they adopt an intimidating stance, always goading us into working harder, without the support and instruction we need (and, hence, any real educational gain).

Solution

Is there a solution to this problem? Of course there is! First, let us learn how to talk to each other. When we feel weighed down by personal or other problems, let us dare to talk about them with our supervisor (or residents). Let us tell them that, today, we need a little extra support. Instead of being a victim of our stress, that person will probably help us and feel good in the process.

Second, let us use the options provided under our collective agreements: sick leave, vacation, provisions for the day after on-call stints, lieu time for working statutory holidays, and so on. Most of us never use these options.

Instead of waiting for stressed-out residents to quote the collective agreement in support of a request for some well-deserved rest, supervisors themselves could suggest a break. Capitalizing on a resident's sense of guilt or reluctance to stand up for his or her rights is nothing short of intimidation. Supervisors should show respect for residents who request leave without pay. They need to remember that our choice of the field of medicine means we are hard-working and put extraordinary demands on ourselves. If we say that we need to stop, it is because we really need to stop! I don't understand supervisors who refuse requests for leave without pay, on the grounds that there is no medical justification for it. For goodness sake! They are doctors, which means that they should understand the importance of prevention. They must take the time to sit down with us to work out an alternative.

Dr Garant *represents the Association des Médecins Résidents et résidentes de Sherbrooke on the Comité sur le bien-être des résidents du Québec [Quebec Residents' Well-being Committee].*