Balancing the Roles of a Family Medicine Residency Faculty: A Grounded Theory Study

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BACKGROUND AND OBJECTIVES: Great variety exists in the roles that family medicine residency faculty fill in the lives of their residents. A family medicine-specific model has never been created to describe and promote effective training relationships. This research aims to create a consensus model for faculty development, ethics education, and policy creation.

METHODS: Using a modified grounded theory methods, researchers conducted phone interviews with 22 key informants from US family medicine residencies. Data were analyzed to delineate faculty roles, common role conflicts, and ethical principles for avoiding and managing role conflicts. Key informants were asked to apply their experience and preferences to adapt an existing model to fit with family medicine residency settings.

RESULTS: The primary result of this research is the creation of a family medicine-specific model that describes faculty roles and provides insight into how to manage role conflicts with residents. Primary faculty roles include Role Model, Advisor, Teacher, Supervisor, and Evaluator. Secondary faculty roles include Friendly Colleague, Wellness Supporter, and Helping Hand. The secondary roles exist on a continuum from disengaged to enmeshed. When not balanced, the secondary roles can detract from the primary roles. Differences were found between role expectations of physician versus behavioral science faculty and larger/university/urban residencies versus smaller/community/rural residencies.

CONCLUSIONS: Diversity of opinion exists related to the types of roles that are appropriate for family medicine faculty to maintain with residents. This new model is a first attempt to build consensus in the field and has application to faculty development, ethics education, and policy creation.

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Faculty members in health care education settings fill many roles in the lives of their trainees. As described in the literature, formal faculty roles include advisor, teacher, and evaluator. Other non-educational roles are also ubiquitous. For example, 63% of medical students report seeking informal consultation for health problems from their faculty. However, maintaining multiple roles in the life of a trainee can conflict with the relationship. Perhaps it is for this reason that 50% of medical students report choosing not to be patients at their training institutions out of concern that it would affect their relationship with faculty. And, more formally, the Liaison Committee on Medical Education (LCME) prohibits health professionals from providing psychological or psychiatric services for students they evaluate or matriculate.

Compared to other health care disciplines, medicine has far fewer specific guidelines for managing multiple roles, and this topic receives scant attention in the medical literature. For example, the American Medical Association Code of Medical Ethics places a premium on physician autonomy in choosing who to treat: “A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care” (Preamble VI). Similarly, sexual relationships are the only specific prohibitions between medical supervisors and trainees (Opinion 3.08).

One of the authors of this article (RR) was primary author of a conceptual article that proposed an ethical model for multiple role relationships in health care education broadly. This publication proposed the following model to distinguish and maintain balance between...
faculty roles and other roles that faculty fill in the lives of trainees (Figure 1).

As a specialty, family medicine presents numerous potential role conflicts. Family medicine residencies are more likely to be outside the formalized confines of university settings, more likely based in rural settings that present fewer health care and social options, and more likely to include provision of services relevant to any person, regardless of age and wellness. However, despite the heightened need for clarity related to multiple role relationships, the American Academy of Family Physicians (AAFP) and the Society of Teachers of Family Medicine (STFM) have no formal statements on this topic (Personal email communication with Stacy Brungardt, executive director of the Society of Teachers of Family Medicine, March 2, 2015).

The purposes of the current research were to study the roles that family medicine faculty fill in the lives of their residents and to use these data to create a family medicine-specific model by adapting a trans-disciplinary model that had previously been created by one of the study authors (RR). The central question of this inquiry was: What are the roles that are created between family medicine educators and residents? Sub-questions include the questions: (1) Which roles are primary and secondary? (2) What types of conflicts arise between these roles? (3) How can balance be maintained between primary and secondary roles?

Methods

This project was reviewed by the IRB of the St Mary’s Regional Medical Center, which awarded the research an IRB exemption.

We used a modified grounded theory method to answer our research questions. Grounded theory is an inductive methodology through which qualitative researchers create a new theory or model. The result is the creation of a new hypothesis, rather than testing of an existing hypothesis. Like in many other qualitative traditions, a grounded theory researcher typically collects data through interviewing people from a particular setting or activity. The interviews elucidate the perspectives of these people related to a specific dilemma or circumstance. We modified this methodology by collecting data from key informants to improve upon an existing model rather than to create a new model sui generis.

We recruited family medicine educators from across the United States. Recruitment occurred through two emails: the first to the members of the Family Medicine Residency program director’s listserve, the second to the members of the Society of Teachers of Family Medicine’s Family and Behavioral Health listserve. The survey collected residency program data (ie, location, size, and

Figure 1: Initial Model

The interviews were digitally recorded and transcribed by two graduate research assistants.

We followed a four-step modified grounded theory process in evaluating the interview transcripts and creating our model:

(1) The transcripts were printed on paper and coded for themes. Each transcript was coded by three different researchers, with the first three transcripts being coded simultaneously so we could refine our method.

In coding, we paid special attention to (a) mentions of primary family medicine educator roles, (b) secondary roles that were not directly related to being a faculty member but were common among our participants, (c) descriptions of how roles varied based on individual and contextual factors, (d) managing role conflicts, and (e) feedback on our previously created model.

(2) The transcripts were uploaded to N’Vivo software (a computerized tool for organizing qualitative research) and digitally marked with the codes from step one.

(3) Queries were created within N’Vivo to batch the codes for deeper analysis and identification of themes.

(4) We updated our original model based on the themes of our analysis.

A final step in grounded theory is “member checking”\textsuperscript{10} to ensure that the created model is considered viable by the study participants and the broader population that the model purports to represent. We edited our model three times based on feedback we received by different groups of key informants: (1) during the initial interviews, (2) via data collection cards that were provided to attendees at a presentation on our model at the 2014 Society of Teachers of Family Medicine Annual Spring Conference, and (3) through an online survey that we emailed to our initial 22 participants at the end of the research. At each phase we solicited quantitative and qualitative input regarding the model’s understandability, accuracy, and applicability.

Results
A total of 121 family medicine educators completed the online recruitment survey. We conducted a review of the individual demographics and residency characteristics to subsample 30 key informants. The subsampled educators were invited to participate in a phone interview, of which 22 completed the interview (Table 1).

Roles That Faculty Fill
Interview participants were asked to describe the primary (or official) roles faculty fill in the lives of residents. Responses included teacher,
Table 2: Primary Roles of Family Medicine Educators

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<th>Primary Roles</th>
<th>Definition</th>
<th>Sample Interview Quotation</th>
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<tr>
<td>Role model</td>
<td>An advanced clinician whose professional and life activities are imitated by</td>
<td>“The role model focuses on not only developing their skills in residency, but helping them figure out how they’re going to function in the future. How will they obtain their career goals? Maybe they spend time outside of residency talking about these things and helping the resident create that vision for themselves.”</td>
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<td>Advisor</td>
<td>An identified faculty member with a formal role to advise a resident on professional matters and their progress in the program.</td>
<td>“In our program we have a faculty advisor who is assigned to each resident for academic and knowledge facilitation, but also coping with issues inside and outside of residency. It’s done formally through a faculty advisor program.”</td>
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<td>Teacher</td>
<td>Teacher of the knowledge base and conventions of the profession.</td>
<td>“The main role is educator. We disseminate information to the residents that allows them to be adequately trained as physicians. We engage them in a way that allows them to utilize their basic medical school knowledge and apply it clinically.”</td>
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<td>Supervisor</td>
<td>Clinical overseer of patient care and other duties.</td>
<td>“We supervise their care, making sure that the care is appropriate, that it is safe for the patient.”</td>
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<tr>
<td>Evaluator</td>
<td>Provider of formative and summative feedback that guides decisions related to competency and matriculation.</td>
<td>“We’re supposed to monitor the residents’ progress and make decisions whether to promote to next year.”</td>
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We evaluated these responses and categorized the secondary roles as Friendly Colleague, Wellness Supporter, and Helping Hand (Table 3).

Setting Characteristics
Faculty in our sample described that the size of town and residency impacted the experience of faculty with secondary roles (i.e., friendly colleague, wellness supporter, and helping hand). Specifically, it was perceived that faculty in smaller towns and smaller residencies were more likely to become highly invested in secondary roles than faculty from larger residencies and/or larger cities.

Regarding small towns, some faculty stated that residents had fewer opportunities for clinical services and friendship than in urban areas. So, it was common for residents to run into faculty outside work and to look to faculty to meet their secondary role needs. As highlighted in these interview quotes, this was described as both inevitable, and problematic:

“I’m going to run into people from church or I’m going to run into people that I work with at the hospital. Because we live in a town that is like that, this probably will result in more blurring of the professional and the social within the residency setting.”

“So the multiple roles can be difficult to avoid and it’s a matter of managing them the best you can, really. So I might end up going to the gym with one of my residents so we kind of have this outside relationship and that’s just a product of being a small city.”

“A larger city provides for more opportunities to not be engaged in those interpersonal, friendship, or other roles in the community.”

Regarding program size, smaller residencies were described as more intimate environments that naturally promoted multiple role relationships. Faculty from small residencies typically viewed this as added value, asserting that it amplified their impact in their primary faculty roles:

“I think we get to know each one a lot better than some of the larger residencies. We know when they’re struggling or not.”

Alternatively, faculty in larger residencies reflected that this setting tended to reinforce their primary roles (at the expense of secondary roles) with some or all of the residents:

“I think that there are numerous personalities and people and interests that they can find amongst the group. It may be not as small, intimate, and close, so that’s kind of a
good-bad thing. Maybe in a smaller program everyone might know everyone’s business and there might be a little bit more of that. And there might be a lot more interaction with the same people so you can develop stronger friendships and associations and ours is bigger, broader, we have the opportunity to meet a bigger group of people and find someone that matches your interests and likes a little bit more.”

Personal Characteristics
In considering how demographics influence these beliefs and practices, we did not find any differences based on age, years as a faculty member, or ethnicity/race. However, participants did describe broad differences between physician faculty and behavioral science faculty. That is, both types of faculty observed that physicians were more likely to rely on experience (rather than explicit policy) as an ethical compass:

Physician: “Well, I’m obviously not a behavioral scientist, although I could probably play one on TV. I guess I’ve had plenty of time to feel comfortable in my own skin and in my own abilities and my roles. So, it doesn’t bother me being fluid about boundaries and roles and stuff. I have a pretty good sense of what’s inappropriate and where the difficulties are.”

Behavioral Scientist: “I think that it’s actually ingrained in my discipline—it’s in my code of ethics that we don’t have dual relationships with our clients and with our trainees.”

Member Checking
We received feedback on the original model during the interviews with the 22 initial participants, from 18 participants at the 2014 STFM conference and from 15 of the initial participants who responded to our online survey. We made major revisions after the initial interviews and minor revisions based on the feedback from the conference and online survey.

Based on feedback from the phone interviews, we edited the model to better reflect the perspectives and preferences of our participants, ie, we changed the category of roles from “faculty roles” and “other roles” to “primary roles” and “secondary roles.”

• With the primary roles, we changed “Mentor” to “Role Model” and split it out from “Advisor.” We removed “Gatekeeper” and added “Supervisor.”

• We simplified the secondary roles so that they did not look more prominent or important than the primary roles.

• We added hooks to the simplified secondary roles and created weights labeled “Disengaged” and “Enmeshed” that could be hung on the hooks. Our intent was to indicate that a disengaged or enmeshed approach with a resident would take the relationship out of balance.

• We changed “Health Advisor” to “Wellness Supporter,” as this was in-line with how a majority of participants believed enmeshment would be avoided in this role.

Figure 2 portrays the faculty roles as a balance between primary roles (see Table 2) and secondary roles (see Table 3). The model illustrates how the secondary roles exist on a spectrum from Disengaged to Balanced to Enmeshed. A balanced approach to the secondary roles is most likely to maintain the principal status of the primary roles, whereas a disengaged or enmeshed approach can weigh down the relationship and relegate the primary roles to secondary status.

Key informant feedback regarding the utility and application of the model was quite positive. The only repeated recommendations were to define the terms “disengaged” and “enmeshed” and to clarify that ethically minded faculty from different types of residencies can appropriately engage residents in varying degrees of the secondary roles based on their personal characteristics and experiences.

### Table 3: Secondary Roles of Family Medicine Educators

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<tr>
<th>Secondary Roles</th>
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<tr>
<td>Friendly Colleague</td>
<td>A co-worker with friendly interaction in clinical and social settings.</td>
<td>“We have offsite events such as retreats and conferences where we interact with spouses, partners, and children. Even though we are a larger program, we still have a very familial feel. I, as program director, know the families of residents and vise versa.”</td>
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<td>Wellness Supporter</td>
<td>One who is attentive to resident wellness needs, often offering support, or a referral.</td>
<td>“We provide informal support for the things that sometimes get in the way of their training and learning, which have to do with their life. We counsel in that area, but not as a therapist or a medical provider.”</td>
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<tr>
<td>Helping Hand</td>
<td>Someone aware of, and helpful with, resident needs for goods and resources.</td>
<td>“It’s about discussing who’s cutting your hair, who’s taking care of your teeth and where do you get your own vaccinations and medical care.”</td>
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on their context. In addition, participants recommended using the model to orient new faculty and residents and for ongoing faculty development. Participants suggested that the model provides a vocabulary to discuss the abstract concepts of faculty roles.

**Discussion**

We believe that the final product of this modified grounded theory process is a useful model for residency programs and decision-makers. Most research participants were able to explain the model without explanatory text or discussion, and they provided valuable information to improve the content and presentation of the model. In creating the model, we attempted to balance the needs for the model to be simple, elegant, and self-explanatory. We also attempted to create a model that would have universal appeal and utility. As such, the model does not specifically prescribe or proscribe any particular roles. Rather it suggests that faculty seek a moderate approach that is neither “enmeshed” nor “disengaged.”

Suggested usages come from our research participants, our own experience in presenting the model in multiple settings, and through communication with colleagues who have used the various iterations of the model in faculty development activities. Perhaps the most ready usage is for self-reflection and faculty group reflection. The model contains principles that can be used to assess whether our own roles are in balance and if our residency cultures promote role balance. Our participants recommend that this occur in faculty development sessions and orientation for new faculty and residents.

We hope the model will be useful in guiding policy discussions at the residency, association, and governmental levels. For example, as a residency, how can policy and procedure guide faculty members in creating relationships with residents that will promote their professional development and maintain focus on primary faculty roles while not discouraging other roles that bring richness to residency life? What are our own standards for social media,
friendships, intimate partnerships, health care provision, and financial agreements?

At the association and governmental levels, how can decision makers guide the activity of residencies? Would there be benefit from adopting the ethical standards from other disciplines and from literature on education? Or, is medicine a unique field in which the autonomy of the individual clinician and educator should maintain primacy?

While there is limited empirical research investigating family medicine educator roles, a number of possibilities exist for expanding this knowledge basis:

- Are there faculty roles and activities that demonstrably improve or distract from the outcomes of resident education?
- Are faculty disengagement and/or enmeshment detrimental to resident education?
- Are there broad differences in role expectations and activities between: (1) physicians and behavioral science faculty? (2) early career and later career faculty? (3) rural and urban programs? (4) university- and community-based programs? (5) large and small programs?
- Do faculty development activities related to faculty roles change faculty behavior?

We encourage faculty and administrators to use this model in their settings and to investigate these research questions using qualitative and quantitative research methods. We hope that this scholarship will result in advocacy for ethical guidelines at the local, state, and national levels.

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References