The Limitations Of Questionnaires As A Method Of Defining Residency Content

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Assessing residency performance through alumni questionnaires has a distinguished tradition. Hansen,[1] Pfundt,[2] and North[3] in pediatrics; Ciriacy, et al.,[4] Mayo, et al.,[5] Geyman, et al.,[6] and Gaede, et al.[7] in family practice; and Kern, et al.[8] in internal medicine have all found residency validation in alumni contentment.

The Northridge Hospital Medical Center Family Practice Residency Program asked its alumni to compare their residency curriculum to the demands of their subsequent practices in 1985. A list of 96 subjects was generated from the medical and surgical specialties, supplemented by selected hospital procedures, office procedures, and doctoring skills. No new ground was broken, but analysis of the responses prompted some caveats regarding the polling process as a guide to residency design and stimulated further consideration of residency purpose itself.

Three-quarters of the alumni of this community hospital program responded to the questionnaire. Their assessments of how much emphasis each item on the list received in residency and how important each item was in practice were collated. The message to be distilled from these responses is inherently ambiguous. For instance, alumni report history taking, physical examination, diagnosis/problem definition, and interpersonal skills heavily emphasized in residency and unequivocally important in practice. However, one would find it hard to confess that these items would be taken lightly. Moreover, is the close correlation between residency emphasis and practice importance in over 70 percent of the questionnaire subjects occasion for pedagogical self-congratulation? Or does the residency/practice disparity noted in the almost 30 percent demand curricular change?

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Residency deficits are perceived by alumni to be among the surgical specialties. Are these a call for more procedural experience? Perhaps. Proctology and flexible sigmoidoscopy residency experience are found deficient in equal measure. Is this also a call for more procedural experience? Perhaps not. The shortage in orthopedics instruction is not matched by a shortage in fracture immobilization, and the deficit in otolaryngology education is not matched by one in indirect laryngoscopy. Concept may be wanting rather than technique.

What, in fact, abstractions like otolaryngology mean to respondents is not defined by questionnaire instruments. Does the high practice importance given this item by our alumni refer to head and neck tumors or sore throats? Does the importance of ophthalmology mean retinal detachment or pink eye? Or both?

The Shortcoming of "Topics"

Assessing family practice education as the sum of its parts is inherently contradictory. Family practice professions of comprehensiveness are belied by reductive analysis into required "subjects." The resident dutifully attending lectures, seminars, and clinics in every questionnaire topic listed, in time-slots perfectly proportioned to future practice importance, may still become no more than the jack-of-all-trades that skeptics aver. And how many other omitted concepts and procedures, excluded from surveys in obedience to the law of diminishing questionnaire returns, remain to be crammed into the comprehensive curriculum?

The ability to integrate makes credible the universalist claims of family practice. It demands more than being informed in many specialties, being conversant with many skills. But if otolaryngology eludes definition, how are diagnosis, interpersonal skills, or ethics defined and taught? Are slide-shows on patient education, CPCs on physician impairment the way to go?

Must our humanities/psychiatry department fractionate man into pigeonholes such as alcoholism, substance abuse, or neuroleptic deficiency as our questionnaire did? Existence of specific expertise in these maladies is accepted by our respondents; attainment of specific expertise in their management seems wanted for their practices. School health and occupational health residency experience did not match the practice importance assigned to them by alumni; school physicals, employment exams, and back-to-work notes scribbled in the family practice center are not enough. Our preventive medicine teaching efforts were found inadequate in proportion to practice need. Are the deficiencies peculiar to our residency?

The Elusiveness of Fulfillment

Family practice commitment to preventive medicine is a universal piety, certainly accepted here. Our residents recommend infant car seats to all. They immunize. They "manage" risk factors daily. They develop screening protocols for their own collective use. Still, residency is short and prevention long. The results of one's anticipatory guidance are for others, if any, to know. Arterial plaques unformed, bronchial metaplasia not developed, are not easily documented in the resident's procedure diary, nor do they validate hospital privileges often challenged. The satisfactions of the job well done, and reflected on as well by alumni, are not as accessible in prevention as in diagnosis or therapeutics.

How do we in residency education remedy the reported shortfall in our adolescent medicine instruction? Absolute shortage of patients is certainly a part of this problem, but the captive patient whose trusted physician may be one from an evening free clinic challenges our one-doctor-for-the-whole-family paradigm. Treating the alienated adolescent without dressing or acting like one confounds even experienced faculty. For the resident, an adolescent professional in his/her own right, the issues of dependence and autonomy are often too painful to engage effectively. Specific maladaptations of the young can be expounded upon didactically for three years, but learning to be physician to youth may have to await the doctor's postresidency development.

Teaching the Unwanted

Can practice management and administration be well taught in residency? These are the slowest-moving items in our curricular inventory; our seminars sell only in the last nine months of the third year. Among the junior proletariat immersed in clinical concerns, management and administration evoke not only resistance, but the hostility reserved for the uncouth. Management experience through group family practice center governance is offered subliminally, but it is not reflected in a postgraduate sense of administrative competence.

Should alumni practice define the portion that obstetrics deserves in the residency enterprise? Our survey affirmed the obvious: for alumni who still do it, this program's heavy emphasis was proportionate; for those who do not, not. We do not attach value solely to doing (see below), but will there be a place for family practice participation and for family practice residency education in whatever brave new world slouches toward the OR to be born? The questionnaire didn't say.

Alone among the medical specialties, dermatology instruction fell short; all graduates want more external medicine. As consistently, our experience in critical care medicine, ventilator management, and cardiopulmonary resuscitation is seen as excessive. Should these be reduced or eliminated, as some of our intensivist faculty prefer? Indeed, if the residency is a three-year, zero-sum experience, the time spent in the intensive care units might more profitably be invested in pondering acne. Such an exchange would imply that the quintessential lessons of the ICU can be applied there alone, that physiology learned from the critically ill is not applicable to the ambulatory office patient. Procedures excepted, the program does not accept this as true and here resists the guidance of its graduates.

Beyond Vocational Training

Ultimately, with what fidelity the curriculum should be tailored to its alumni practice patterns depends upon the extent to which a residency is conceived by its members as a vocational training scheme. If it be only preparation for the practice to come, one more link in each resident's nursery-school-onward chain of delayed gratification, a residency would be well designed to reflect the real world its alumni describe or the surveyed consensus thereof.

If the residency aspires to be more than its questionnaire, it will offer learning opportunities that are not easily scored in the 1-2-3-4-5 format—for

example, office procedures that include tolerating uncertainty, doctoring skills such as reading history, and medical specialties like epistemology and hermeneutics. Marching in the flexible sigmoidoscopy parade, the residency will provide as well study in why half a colon is better than all, will assess the proportionality of means to ends. Pursuit of the can-do will be tempered with reflection on the what-is. Screening mammography protocol will be taught as will the history of the community mobile chest x-ray, normal-pressure hydrocephalus with the shade of status thymicolymphaticus. The resident may learn to balance the dictates of reality with those of authority. He or she will peruse the cost of "rule-out," the feasibility of "make-sure." Accepting its continuity with undergraduate algorithmic instruction, anticipating the postgraduates' needs to keep themselves current with an evolving standard-of-care, the residency will yet accommodate each individual's immediate effort to define for himself the space between impotence and omnipotence and will provide instruction circumscribed neither by the dead hand of tradition nor the iron demand of relevance to some putative future, determined by public opinion poll.

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