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ORIGINAL ARTICLE

Roles and Relationships Between Family Medicine Faculty and Residents

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ABSTRACT

Background and Objectives: Family medicine residency faculty occupy multiple roles with residents, including teacher, adviser, evaluator, and supervisor. Faculty also might fill noncurricular roles in social settings and in providing health care services to residents. These overlapping responsibilities create potential for dual relationships that may blur boundaries and cause ethical concerns. While national guidelines prohibit overtly inappropriate relationships, little guidance exists for common noncurricular interactions. This study examined the prevalence, types, and consequences of faculty–resident dual relationships and assessed faculty awareness of related policies.

Methods: We conducted a convergent mixed-methods survey of US family medicine faculty that included demographic items, questions about specific dual relationships and policy awareness, and an open-ended prompt concerning boundary crossings. Quantitative data were analyzed using descriptive statistics and χ^2 tests; qualitative responses underwent thematic analysis.

Results: We received 213 responses. Frequently reported dual relationships included social comingling (68%), provision of minor medical or behavioral services (54%), and personal relationships (36%); financial or contractual ties were rare (≤3%). We observed significant differences by faculty type: Behavioral health faculty were more likely to provide minor services (P = 0.004), while physician faculty more often provided intensive services (P = 0.011). Awareness of residency policies was low. Qualitative responses highlighted boundary crossings with negative impacts on residents, faculty, and programs.

Conclusions: Dual relationships are common in family medicine residencies, yet policy guidance is limited. Stronger institutional and professional guidelines would support resident wellness, faculty objectivity, and professional boundaries.

> *Like all boundary crossing problems, it's not just one instance with this faculty member. It's the global lax boundaries with things like medical favors, favoritism for residents that they hang out with socially, disrupting the feedback procedures by talking outside with residents and "running interference" for them before they talk to the PD, advocating for exceptions for standard leave of absence and pay and not reporting it for preferred residents, and creating a culture of in groups versus out groups. It's not the big stuff like financial dual relationships but the slidey-slimy-can't-quite-get-your-hands-on-it stuff that makes us fellow faculty members uncomfortable.*
>
> –Quote From Survey Respondent

Family medicine residency faculty fill multiple roles in the lives of residents. Primary (curricular) roles have been described as role model, adviser, teacher, supervisor, and evaluator.[1] These roles often are maintained alongside other secondary (noncurricular) roles, such as friend, personal clinician, and contracted service provider.[1]

Increasingly, faculty also are called upon to promote wellness among residents. For example, the most current Accreditation Council for Graduate Medical Education (ACGME) common program requirements mandate: "Programs, in partnership with their Sponsoring Institutions, have the same

responsibility to address well-being as other aspects of resident competence."[2] This ACGME requirement puts resident wellness on a par with ensuring medical competence. It involves faculty in wellness issues of individual learners.

These role conflicts exist in a power hierarchy, described by Larkin and Mello: "There are obvious asymmetries in power and position within the academic medical ecosystem that create the potential for mistreatment, abuse, and even sexual trespass between mentor and mentee."[3]

Currently, in medical education, the core requirements regarding these issues are general, lacking specific details about many problematic situations to avoid. All major medical organizations that we are aware of prohibit sexual relations between faculty and residents. For example, the American Medical Association (AMA) *Code of Medical Ethics* states, "Sexual relationships between medical supervisors and trainees are not acceptable, even if consensual."[4] Similarly, the Society of Teachers of Family Medicine's (STFM's) Ethics and Conduct Policy prohibits sexual harassment from its staff and members.[5] ACGME core requirements on professionalism mandate a training environment "that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff."[2]

Faculty providing health care services to residents receive little discussion in the professional literature. AMA's *Code of Medical Ethics* does not specifically address the situation of faculty treating trainees. Indeed, AMA's *Code* promotes mostly unchecked physician autonomy in deciding 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."[6] AMA Opinion 1.2.1 on "Treating Self or Family" does provide some potential guardrails on this type of care provision relationship, especially in extraordinary circumstances.[7]

Researchers have studied boundary issues from the perspective of residents and medical students. Recupero *et al.* researched supervisor-trainee relationship boundaries, soliciting feedback from residents across several residencies at a single institution. Residents reported significant boundary crossing behaviors, including problems with academic/professional boundaries, personal boundaries, and dating boundaries.[8] Other researchers queried medical students about boundary crossings with faculty, resulting in concerns about favoritism, inappropriate self-disclosure, and dating/sexual interactions.[9]

Our research sought to clarify ethical questions by reaching out directly to family medicine residency faculty, requesting that they describe the nature of their noncurricular relationships with residents, including whether their programs have policies in place that would guide social, health care, and financial relationships between faculty and residents.

METHODS

Our study used a mixed-methods design that collected both quantitative and qualitative survey data.[10] All research was granted exempt status from the Colorado Multiple Institutional Review Board (#23–2558).

Sampling and Collecting Data

We used convenience sampling via email sent through three different channels, with the intent of representing a broad swath of residency faculty:

- Individual email to the family medicine residency program directors who were listed on AMA's FREIDA website;
- List serv email to STFM's Families and Behavioral Health Collaborative; and
- List serv email to STFM's Pharmacy Collaborative.

Each email included a brief description of the purpose of the study, inclusion criteria, and a link to the study's survey on a secure online survey platform. The STFM email messages requested that the recipient complete the survey, whereas the email messages to program directors requested that the recipient both complete it themselves and send it along to their faculty. The survey included four sections: (a) basic demographic information about the respondents and their residencies, (b) questions about activities involving faculty and residents, (c) presence of residency policies regarding faculty and resident relationships, and (d) a qualitative question requesting an example of a concerning boundary crossing between a faculty member and resident(s) from their program (Table 1).

Data Analysis

Our study used a convergent mixed-methods design,[11] where both quantitative and qualitative data were collected concurrently, analyzed independently, and findings then integrated during interpretation to comprehensively examine faculty-resident dual relationships. We used descriptive statistics to summarize and describe the sample. We ran frequencies, correlations, and χ^2 tests to assess for significant differences among the Yes/No answers between the type and location of residencies and faculty type.

For an in-depth exploration of residency faculty and their views on dual relationships, we analyzed the open-ended question using thematic synthesis.[12] Through this process, we parsed out analytical themes from incidents of inappropriate dual relationships and the faculty's thoughts about those incidents. The three authors, analyzing the data separately, defined descriptive themes from the extracted data and then defined analytical themes in relation to the data and research questions. The group discussed themes emerging from the extracted data to avoid bias toward a certain outcome. Through this coding method, the authors were able to quantify and bring to light further implications for dual relationships within family medicine residency programs.

TABLE 1. Survey Questions, Based on the Roles Described in Reitz et al[1]

#	Question
1	As faculty, I comingle with residents at casual activities such as picnics, sporting events, and game nights outside of the medical setting and formal curriculum.
2	As faculty, I have personal relationships with residents (eg, both sharing personal matters such as relationship concerns, major life transitions, secrets, etc.).
3	As faculty, I interact with residents through social media (eg, Facebook, Instagram, Snapchat, etc).
4	As faculty, I have provided minor medical services to residents that are outside the curriculum structure: Medical faculty (eg, prescribing an antibiotic, removing a wart, ordering imaging, etc.); Behavioral health faculty (eg, informal counseling, facilitating a support group or "Balint" group, coaching on test taking anxiety, etc).
5	As faculty, I have provided more intensive medical services to residents that are outside the curriculum structure: Medical faculty (eg, prescribing a chronic medication, delivering a baby, acting as primary care physician, etc.); Behavioral faculty (eg, ongoing therapy, formal psychiatric diagnosis, family therapy, etc).
6	As faculty, I have had residents provide (paid or unpaid) services for me (eg, house-sitting, dog-walking, house projects, moving assistance, etc.).
7	As faculty, I have rented a home or apartment to a resident.
8	As faculty, I have contracted with a resident to provide patient services in a setting that is outside of the residency curriculum (eg, the resident "moonlights" with the faculty, etc.).
9	Our residency program has written policies that govern the relationship between residents and faculty regarding the following (check all that apply): 1. Personal relationships 2. Medical/behavioral services relationships 3. Financial/contractual relationships
10	Many residencies will have examples of a faculty member who crossed a boundary with a resident (socially, clinically, or financially). Please briefly describe a faculty crossing boundaries from your program that was especially concerning for you.

RESULTS

Sample

Of the 740 email messages originally sent to program directors, 90 were undeliverable, leaving 650 viable email recipients. The listservs for the Families and Behavioral Health Collaborative and the Pharmacist Collaborative included 320 members and 57 members, respectively. All told, we received 213 survey responses, resulting in approximately a 21% response rate. Among respondents, the most frequent demographic descriptions were female (64.8%), Caucasian (85.4%), and physician faculty (69.5%). Residencies in urban settings (43.7%) and community-based programs (43.7%) constituted the largest proportion of respondents. Most programs (60.9%) accepted two to eight residents per year. See Table 2 for detailed demographic information.

Dual Relationships Between Faculty and Residents

The most frequently reported dual relationships included social comingling (68%), providing minor medical or behavioral services (54%), and maintaining personal relationships (36%; Table 3).

TABLE 2. Demographics

Demographic variables	n (%)
Gender (*N* = 213)	
Female	138 (64.8)
Male	73 (34.3)
Prefer not to say	1(0.5)
Race/ethnicity (*N* = 213)	
White	182 (85.4)
Asian/Pacific Islander	10 (4.7)
Hispanic/Latino/a	8 (3.8)
African american/Black	5 (2.3)
Middle eastern or north african	3 (1.4)
American indian/Alaskan	1 (0.5)
Native	1 (0.5)
Type of faculty (*N* = 212)	
Physician faculty	148 (69.5)
Behavioral health	58 (27.2)
Pharmacy	7 (3.3)
Location residency (*N* = 213)	
Urban	93 (43.7%)
Suburban	78 (36.3%)
Rural	40 (18.8%)
Type of residency (*N* = 213)	
Community-based	93 (43.7%)
University-based	65 (30.5%)
Hospital-based	55 (25.8%)
Number of residents accepted per year (*N* = 212)	
2–8	129 (60.9%)
9–16	71 (33.5%)
16+	12 (.6%)

The least commonly reported dual relationships included obtaining favors or services from residents (3.3%), engaging in moonlighting contracts with residents (1.4%), and renting housing to residents (0.5%). These findings suggest that informal and routine interactions (eg, comingling and providing minor services to residents) are more prevalent than formal or resource-based relationships.

We conducted χ^2 analyses to examine potential differences across demographic and program variables, including gender, race/ethnicity, faculty type, residency location, residency type, and number of residents accepted per year. We found significant differences only by faculty type. When comparing physician faculty and behavioral faculty, the only significant associations (Table 4) we found were for two items related to offering services to residents. Question 4 (minor medical/behavioral services provided to residents) resulted in a χ^2 of 13.252 (P = 0.004, V = 0.25). This finding indicates that behavioral faculty were significantly more likely to report providing minor medical/behavioral services, as evidenced by the higher-than-expected "yes" responses (41 observed vs 30 expected; standardized residual=+2.01). Question 5 (intensive

TABLE 3. Dual Relationships

Dual relationship	% Yes	Location			Type			Physicians	Faculty
	Total (*N* = 213), n (%)	Urban (*N* = 93), n (%)	Suburban (*N* = 78), n (%)	Rural (*N* = 40), n (%)	Community based (*N* = 93), n (%)	University based (*N* = 65), n (%)	Hospital based (*N* = 55), n (%)	Physicians (*N* = 145), n (%)	Behavioral health (*N* = 56), n (%)
Comingling	144 (68)	68 (73)	48 (62)	26 (65)	66 (71)	44 (68)	34 (62)	98 (68)	38 (68)
Personal relationships	76 (36)	27 (29)	31 (40)	17 (42.5)	34 (37)	17 (26)	25 (45)	57 (39)	14 (25)
Social media relationships	51 (24)	24 (26)	15 (19.2)	10 (25)	20 (21.5)	18 (28)	13 (24)	30 (21)	16 (29)
Minor medical/ behavioral services provided to residents	114 (54)	52 (56)	42 (54)	18 (45)	51 (55)	36 (55.4)	27 (49.1)	68 (47)	41 (73)
Intensive medical/ behavioral services provided to residents	29 (14)	10 (11)	16 (20.5)	3 (7.5)	15 (16)	7 (11)	7 (13)	28 (19)	1 (1.8)
Services from residents (eg, house-sitting, dog-walking, house projects, moving assistance)	7 (3.3)	2 (2.2)	3 (4)	2 (5)	4 (4.3)	1 (1.5)	2 (3.6)	6 (4)	0
Rented home or apartment to resident	1 (0.5)	0	0	1 (2.5)	0	0	1 (2)	1 (0.6)	0
Moonlighting contract	3 (1.4)	2 (2.2)	1 (1.3)	0%	1 (1.1)	1 (1.5)	1 (2)	3 (2)	0

medical/behavioral services provided to residents) resulted in a χ^2 of 11.081 (P = 0.011, V = 0.26). This finding indicates that behavioral health faculty were significantly less likely to report providing intensive services, as shown by the lower-than-expected "yes" responses (8 observed vs 13 expected; standardized residual=-2.08).

Residency Policies on Dual Relationships

Faculty reported a lack of awareness of policies governing dual relationships. Only 23.9% described awareness of policies addressing personal relationships, 22.3% were aware of policies related to medical/behavioral services, while 17% reported policies covering financial/contractual relationships. Of concern, 59% of respondents reported not being aware of any policies on these topics.

Qualitative Question

Seventy respondents (33%) provided examples of "concerning boundary crossings" between a faculty and a resident. These examples can be divided into three categories: 71% described a social boundary crossing, 36% described health care provision, and 11% described financial or contractual concerns (Table 5). The respondents also described some antecedents that predicted or explained the boundary crossings, and they described the problematic outcomes that boundary crossings caused for the faculty member and/or their colleagues.

TABLE 4. Significant χ^2 Results Comparing Faculty Roles on Dual Relationship Survey Items

Survey question	Groups compared	χ^2 (*df*)	*P* value	Cramer's V
Q4. minor medical/ behavioral services	Behavioral health vs others	13.252 (1)	.004	.25
Q5. intensive medical/ behavioral services	Physician faculty vs others	11.081 (1)	.001	.26

Note: χ^2 tests of independence were conducted to examine differences in responses by faculty type. Only statistically significant results (P<.05) are presented. Cramer's V is reported as a measure of effect size, where values of .10, .30, and .50 are interpreted as small, medium, and large effects, respectively.
Abbreviations: Q, question; df, degrees of freedom

DISCUSSION

Our study had four important findings.

Informal Dual Relationships Were More Common Than Formal, Intense, and Resource-Related Dual Relationships

Dual relationships such as social comingling, providing minor medical or behavioral services, and maintaining personal relationships were among the most frequently reported interactions. These types of relationships reflect the informal, day-to-day interactions that are likely to occur in residency programs. Interestingly, the least commonly reported dual relationships—such as favors or services from residents, or renting housing—suggest that faculty are less inclined to engage in more formal or contractual relationships with residents. These findings may indicate that faculty are more comfortable navigating informal or collegial interactions than navigating more clearly defined or transactional relationships.

Behavioral health faculty, in particular, were more likely to engage in minor health care services (eg, facilitating support groups, assisting with test-taking anxiety), which may align with their training and the supportive roles they play within residency programs. Of note, family medicine residencies are required to provide wellness services to residents, and activities such as facilitating support groups are frequently part of the formal job descriptions of behavioral faculty. However, behavioral health faculty were less likely to provide intensive services, suggesting that these faculty maintain clear professional boundaries regarding more formalized therapeutic relationships. Conversely, physician faculty were more likely to provide intensive services, potentially reflecting their broader scope of practice and the tradition of physicians providing services to all in their community and workplace.

No Significant Differences Were Observed Between Residencies Based on Type, Location, and Size

We were surprised to discover the absence of statistically significant differences between larger and smaller residencies, residencies in urban areas and rural areas, and university-based residencies and community-based residencies. In each of these cases, we had assumed that the latter would be more informal and family-like than the former.

Awareness of Policies Related to Dual Relationships Was Very Low

Only 42% of respondents described awareness of institutional policies to guide faculty in creating social, clinical, and resource-related relationships with residents. Possibly that limited awareness of policies at the faculty level does not equate with lack of policies at the institutional level. However, our literature review also demonstrated few policies at the level of the major institutions that guide medical education (eg, ACGME, Liaison Committee on Medical Education [LCME], AMA, and STFM). The absence of clear guidelines leaves faculty to navigate these complex dynamics without institutional support, increasing the risk of boundary crossings and unintended consequences for both faculty and residents. Given the well-documented challenges of balancing mentorship, wellness support, and evaluation roles, this lack of policy could represent a significant concern.

Many faculty can identify "concerning boundary crossings" between faculty and residents

We intentionally left this question open-ended so that faculty would not be influenced by how we would define "concerning boundary crossings." The responses they provided varied widely, from partying with residents, romantic/sexual relationships, stalking, providing primary care services to residents, requesting medical services from residents, requesting paid or unpaid support services from residents (eg, pet care), and renting homes to residents. Faculty described how these interactions caused difficulty for the residents, the faculty members, and the residency as a whole. They also described contextual and personal characteristics that helped to explain why crossings would have occurred (eg, with early career faculty, in earlier times when policies were less stringent, and in resource-limited areas). These crossings highlight the need for policies and residency cultures that reinforce ethical and clear boundaries between faculty and residents.

Implications

Based on our literature review, we found general guidance from professional organizations about faculty/resident relationships, but not specific guidance on the various types of nebulous professional interactions between faculty and trainees. Our findings suggest that residencies and faculty members would benefit from more specific guidance about best practices. Residencies and faculty members frequently lack guidance about best practices for managing noncurricular roles with residents and the impact that these relationships can have on residents, faculty, and the program. This lack of guidance could lead to different experiences and expectations for faculty and residents. Other professions have more specific ethical guidelines and recommendations than medical residencies in this regard.

Our data and the broader professional literature provide a sense that expectations are changing for residencies. These changes pull residencies in two different directions. That is, residencies might be limiting the provision of health care services between faculty and residents but, at the same time, are being asked to ensure wellness for residents. We are not aware of any data that suggest this tension impacts the wellness of residents.

Limitations

While our sampling strategy aimed to capture a range of residency types and faculty roles, our findings reflect only the perspectives of those who responded and should not be assumed to represent all US family medicine residency programs. Overall, the participation rate in our survey was low, and our respondents might overrepresent female faculty. As a result, our data possibly reflect a subset of faculty and

do not reflect the beliefs and experiences of the broader community of family medicine educators. Our data collection relied on participant recall and awareness of residency policies, both of which might not be reliable.

We are concerned that our question regarding minor clinical roles for behavioral faculty might have confused participants. The question was about providing services *outside the curriculum structure*, but respondents then gave as examples "support groups or Balint groups," which are frequently part of the curriculum and part of the job description for behavioral health faculty. That said, a concern is that some faculty are required to provide a curricular element that could also be described as a health care service. While we provided definitions and examples for "minor" and "intensive" services across both medical and behavioral health contexts, differences in clinical training may have led to variation in how respondents interpreted these categories.

Additionally, our survey design set certain boundaries that shaped how specific faculty-resident interactions were described. For example, our study did not distinguish between residency-sponsored social events (eg, formal gatherings where all residents are invited) and informal or *ad hoc* events involving select residents and faculty. The survey item on comingling was intentionally broad, capturing the general presence of social interaction outside of the formal curriculum rather than evaluating the structure or inclusivity of specific events. While we acknowledge that the context and inclusivity of social interactions may influence the perception and impact of dual relationships—particularly around issues like favoritism, exclusivity, or blurred boundaries—that level of detail was beyond the scope of our current survey design. This generalization represents a deliberate delimitation of the study: Our aim was to map general patterns of dual relationships rather than to evaluate the nuanced quality of each interaction. Future research would benefit from more granular distinctions between types of social engagement.

The composition of our sample also reflects certain limitations in our recruitment strategy. Our initial outreach through the FREIDA database—targeting program directors—could have contributed to a higher proportion of physician faculty and faculty in leadership roles. To increase representation from nonphysician disciplines, we supplemented recruitment through targeted STFM listservs, specifically the Families and Behavioral Health Collaborative and the Pharmacy Collaborative. While we considered broader STFM membership outreach, we prioritized these specialized groups

TABLE 5. Analysis of Qualitative Responses

Type/subtype	%	Exemplar quote
Social		
Romantic or sexual	71	"We had a faculty date a resident. he had to be removed from any supervision of the resident." "We had a faculty stalk a resident."
Personal/confidante		"Faculty known to gossip with a resident about other residents, including personal issues and remediation issues."
Alcohol-related		"Faculty drink to excess with residents."
Clinical		
Informal vs formal	36	"A faculty prescribed antidepressants for a resident—unsure if charted." "Our residents are empaneled to the clinic, so I have provided care, but not outside the patient/physician relationship."
Bidirectional		"There are two MD faculty who regularly request that DO residents perform OMT on them. Can the residents say no? What if the residents cause harm?"
Financial/contractual		
Financial	11	"This faculty asks residents to dog-,sit and paid for a house payment when the resident couldn't."
Contractual		"A faculty member rents her house to residents."
Antecedents		
Early career	14	"One young faculty member was very chummy with residents as he had recently been a resident himself."
Previous era		"I've been a faculty for over 30 years. Some of the boundaries that exist now regarding clinical care didn't exist back then."
Convenience-related		"Faculty acting as a PCP for residents due to residents having difficulty scheduling appointment with PCP on their schedule."
Difficult outcomes		
Unpredictable	33	"Faculty too involved in helping a resident with alcohol addiction and was personally upset when patient relapsed and then didn't want to work with them clinically."
Problems for colleagues		"One faculty member developed personal relationships with residents, but then left the program disgruntled, which caused conflict between residents and faculty."
Compromised teaching role		"They develop a friend-based relationship rather than a mentor/coach/teacher relationship, making it difficult to give necessary corrective feedback that is critical to resident development."
Perceived favoritism		"I heard from a resident that they perceived that as giving special treatment."

to ensure the inclusion of interdisciplinary faculty whose roles in residency education might otherwise be underrepresented. Nonetheless, the resulting sample may not fully reflect the diversity of faculty roles across all family medicine residency programs. Future studies could expand recruitment through more general listservs and national faculty databases to further enhance representativeness.

RECOMMENDATIONS AND CONCLUSIONS

Managing these tensions and amorphous boundaries requires broader adoption of, and adherence to, policies regarding relationships between residents and faculty. These policies and ethical guidelines could be adopted at the clinic, medical school, and professional association levels. At the broadest level, AMA could update its current *Code of Medical Ethics* to provide more guardrails for faculty and trainee provision of health care. ACGME and LCME could assist by adopting ethical guidelines and promoting model policies for residencies and medical schools. STFM and the Association of Family Medicine Residency Directors could develop model policies, workshops, and web-based curricula with specific scenarios to provide ongoing faculty development on this topic.

Researchers could further investigate roles and relationships between faculty and residents:

- Replicating this and other similar research from the perspective of residents. What are their experiences, preferences, and concerns?.
- Analyzing the policy documents that exist in residencies and medical schools.
- Studying the impacts that these multiple role relationships have on residents, faculty, and programs.
- Comparing multiple role relationships at residencies of the various medical specialties.
- Investigating residency support groups and how these might put faculty who run them in formalized dual role relationships with residents.
- The qualitative question introduced themes about antecedents and outcomes of boundary crossings. These themes could be studied as hypotheses in future research.

PRESENTATION

Roles and Relationships Between Residents and Faculty: Choosing the Appropriate Hat to Wear. Presentation at the Society of Teachers of Family Medicine Annual Conference, Salt Lake City, Utah, May 4, 2025.

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