2025, Volume 57, Issue 5, 1-4, e-ISSN 1938-3800

Family Medicine

BRIEF REPORT

Teaching Family-Oriented Patient Care to Family Medicine Residents in Chile

Diego Garcia-Huidobro, MD, PhD[a,b]; Gabriela Soto, MS, MPH[a]; Maria Victoria Rodgriguez, MD[a]; Pamela vonBorries, MD[a]; Solange Rivera, MD, MA[a]

AUTHOR AFFILIATIONS:

[a] Department of Family Medicine, Pontificia Universidad Catolica de Chile, Santiago, Chile

[b] Department of Family Medicine and Community Health, University of Minnesota, Minneapolis, MN, USA

CORRESPONDING AUTHOR:

Diego Garcia-Huidobro, Department of Family Medicine, Pontificia Universidad Catolica de Chile, Santiago, Chile, diego.garciahuidobro@uc.cl

HOW TO CITE: Garcia-Huidobro D, Soto G, Victoria Rodgriguez M, vonBorries P, Rivera S. Teaching Family-Oriented Patient Care to Family Medicine Residents in Chile. *Fam Med.* 2025;57(5):1-4. doi: 10.22454/FamMed.2025.245190

PUBLISHED: 11 April 2025

KEYWORDS: family medicine, medical education, primary care, residents, teaching

ABSTRACT

Background and Objectives: Family-oriented patient care, an approach to involve the patient's family in clinical encounters, is essential to family medicine. The *Pontificia Universidad Católica de Chile* offers a Family-Oriented Patient Care (FOPC) course within its family medicine residency program, aiming to enhance family involvement skills among residents. We present the course and report residents' self-efficacy, satisfaction, and competencies with family-oriented care after the course.

Methods: The FOPC course is an 8-week program using a flipped-classroom model with interactive discussions, role-play with simulated patients, and clinical activities. Evaluation methods include resident-reported self-efficacy, course relevance, satisfaction, clinical supervisors' assessments of family-oriented care competencies, and Observed Structured Clinical Examination (OSCE) scores on simulated scenarios.

Results: Residents reported high self-efficacy in family-oriented practices, with mean scores above 4.0 on a 5-point scale across various domains, including conducting family-oriented clinical visits and using family assessment tools. Course relevance and satisfaction received high ratings, with average scores of 4.7±0.7 on a 1–5 scale for relevance and 6.2±0.8 on a 1–7 scale for satisfaction. Clinical supervisors' evaluations indicated integration of family-oriented skills in patient care. However, OSCE scores suggested partial application of these skills in simulated clinical encounters.

Conclusions: After participating in the FOPC course, residents reported having confidence to apply family-oriented care skills in patient encounters, but OSCE ratings did not confirm clinical translation. Results highlight the need for continued reinforcement to enhance skill application in real clinical contexts, supporting the need for longitudinal training integration throughout residency.

INTRODUCTION

Family-oriented patient care is an approach to involve the patient's family in clinical care.[1] This is a cornerstone skill for family physicians, emphasized in most family medicine residency programs.[2,3] However, no standardized approach currently exists for teaching these competencies.[2] Here we present the Family-Oriented Patient Care (FOPC) course taught at the *Pontificia Universidad Catolica de Chile's* (PUC) family medicine residency as an example of teaching these skills in family medicine.

METHODS

Setting

PUC's family medicine residency is the largest family medicine residency in Chile, with annual cohorts of 20 to 25 residents. The residency has a 3-year program with specializations in child or adult health. Most residents join after several years of general medicine practice. The residency combines clinical practice according to the residents' specialization during 4 full days per week and a common curriculum for 1 full day per week. This longitudinal curriculum includes training on communication, evidence-based medicine, health systems management, health promotion and prevention, and primary care research, among other contents.

Family-Oriented Patient Care Course

The FOPC course is an 8-week course that is part of the common curriculum for first-year residents (postgraduate year 1 [PGY-1]). Table 1 presents the course using the Template for Intervention Description and Replication.[4] The course has

been taught since the creation of the family medicine residency in 1993, training more than 540 residents. Over time, its practical component has been strengthened to become an applied rather than theorical course. The definition of "family" has also evolved, now being considered as the closest emotionally significant social group for patients, regardless of kinship, legal status, or residential or geographical location; and course discussions and application have evolved accordingly.

The current version of the course was developed by Diego Garcia-Huidobro and Gabriela Soto, informed by previous versions, personal training and experiences in family counseling in primary care settings, published resources,[5–10,13] and feedback from Maria Victoria Rodriguez, Pamela vonBorries, and Solange Rivera The course employs a flipped-classroom model,[14,15] where residents study assigned readings before in-person sessions. Class activities focus on discussing content, applying knowledge to clinical scenarios, and practicing skills with simulated patients and families. During role-plays, residents act as physicians according to their residency specialization (children or adults) and observe the simulations of their resident peers. Practical application is emphasized, and Appendix Table A presents guidelines for family interview and engagement skills taught during the course. These guidelines were developed based on the Calgary-Cambridge guides,[16] previous studies and frameworks on family interventions strategies and skills for health consultations,[5–10,13] and the team's experience.

Course Evaluation

Because the course has been taught since the inception of the residency, its evaluation has evolved over time. We present a comprehensive post hoc integration of the most recent ratings used at the PUC's family medicine residency to assess the course and taught skills, including resident-reported outcomes and external evaluations. The PUC's Institutional Review Board approved the anonymous use of these evaluations.

Data Sources

Four data sources were used to inform the FOPC course evaluation.

1. **Postcourse evaluation (n=18 PGY-1 residents, 2019).** Until 2019, residents assessed their self-efficacy to apply the course contents in their clinical practice using 5-point Likert scales at the end of the course. Ratings ranged from "not competent at all" to "totally competent."
2. **Annual family medicine residency evaluation (n=56 PGY-1 residents, 2022–2023 cohorts) .** Before their annual review, residents rate the perceived relevance and their satisfaction with courses taught in the residency's common curriculum. Perceived relevance was rated using a 5-point Likert scale ranging from "completely irrelevant" to "very relevant." Overall satisfaction was rated using a 1–7 scale, commonly used for grading in Chile.
3. **Supervisor evaluations (n=67 PGY-1 to PGY-3 residents, 2023).** Clinical supervisors annually assess residents' CanMEDS competencies[17] [17] using a structured instrument rated using a 5-point Likert scale ranging from "very below expectations" to "excellent." Under the communicator and health advocate CandMEDS domains,[17] the instrument includes items focused on family engagement. Supervisors based their ratings on integrated direct resident observations, patient precepting, and clinical discussions with the supervised residents.
4. **Observed structured clinical examination (n=46 PGY-1 and PGY-2 residents, 2023) .** As part of their evaluation, residents annually complete an Observed Structured Clinical Examination (OSCE) with two or three simulated patients. In these scenarios, family-oriented care competencies are assessed using 3-point scales: complete, partly complete and incomplete.

DATA ANALYSIS

For all measures, we estimated scale means and standard deviations using STATA version 14.2 (StataCorp).

RESULTS

Table 2 presents the FOPC course's evaluation. Residents reported high self-efficacy in applying family-oriented care skills and high satisfaction with the course. Supervisors rated residents favorably on family engagement in patient care. However, OSCE assessments showed only partial application of course skills in simulated clinical scenarios.

DISCUSSION

Here we present a curriculum to teach FOPC, a critical skill for family physicians.[1,2] Despite the recognized importance of this approach, few strategies for teaching family-oriented competencies have been reported.[18] This course addresses this gap, aiming to equip residents with skills to integrate families into patient care. The course's perceived relevance and satisfaction underscore its importance for residents. Postcourse evaluations reflect high confidence in applying course contents and skills. Supervisor evaluations suggest skill translation into practice. However, OSCE results indicate that residents struggle to fully implement taught skills in simulated clinical scenarios. Limited application in the OSCE may be attributed to the nature of the OSCE evaluations (which are designed to assess a wide myriad of clinical competences, not just FOPC), time constraints, residents' focus on medical knowledge and skills, standardized versus real-life variability in which OSCE might not fully replicate real clinical encounters, or lack of learning of FOPC skills.[19] This gap highlights the need to revisit OSCE clinical cases to strengthen the supervised practice of this approach to patient care, offer greater practice with simulated families, and provide longitudinal integration of this content throughout residency.[20]

TABLE 1. Course Description Using the Template for Intervention Description and Replication [4]

1. **Brief name:** Family-Oriented Patient Care
2. **Why:** Family medicine residents are expected to integrate person- and family-centered approaches into their clinical practice to promote a comprehensive understanding and management of patient's health issues. This course aims to enable residents to develop competencies for engaging families in clinical care.
3. **What materials:** Structured asynchronous activities are available through an online learning platform, including readings, family assessment tools, and clinical cases for analysis, among other materials. Course contents include key concepts in family-oriented patient care, [5] Doherty and Baird's levels of family intervention, [3] theoretical frameworks of family functioning and assessment, [6] research for family-oriented health services, techniques for family-oriented interviewing both with and without family members present, [7–10] planning and conducting family conferences, [5] interprofessional collaboration to support patients and their families, and guidelines for comprehensive home visits. [11,12]
4. **What procedures:** Residents attend this course for 8 weeks during their first year of training. Before this course, residents must have completed a clinical communication course. Each course session is led by one or more instructors. Role-play interviews with simulated patients and families are conducted to apply course contents and then are debriefed.
5. **Who provided:** Instructors have changed over time, always including at least a family physician and a family therapist. As the residency has grown, we have expanded the number of instructors to include at least one for every 8 to 10 residents.
6. **How:** Residents attend six face-to-face sessions, perform asynchronous activities through the course's learning portal, and conduct a home visit at their base primary care clinic.
7. **Where:** In-person activities use a large conference room for group discussions and smaller rooms for role plays with 6 to 8 residents. Asynchronous activities are implemented in a location of the residents' convenience.
8. **When and how much:** During the first year of the PUC's family medicine residency, common curriculum for residents in the children and adult specialization is covered. The total course duration is 8 weeks. Residents attend six face-to-face 3-hour sessions at university facilities and two 3-hour synchronous online meetings. In addition, they are expected to dedicate 3 hours per week for asynchronous activities.
9. **Tailoring and modifications:** Over time, the course has been adjusted to enhance its practical dimension and adjust to the teaching context. Since 2023, the course began using a hybrid format, integrating in-person group practical application activities and online self-learning and individual application activities.
10. **How well planned and implemented:** Each year resident feedback is reviewed, and changes are planned and implemented in the next version.

Abbreviation: PUC, *Pontificia Universidad Católica de Chile*

TABLE 2. Course Outcomes of Family Medicine Residents

	Mean (SD)
Resident-reported outcomes	
Self-efficacy to (n=18, PGY-1 residents)	
Integrate a family-oriented approach in my practice.	4.3 (0.7)
Conduct a family-oriented clinical visit when family members are not present.	4.2 (0.6)
Conduct a family-oriented clinical visit when family members are present.	4.3 (0.5)
Plan a family conference.	3.8 (0.7)
Use family assessment instruments.	3.8 (0.5)
Design health plans integrating family perspective.	4.0 (0.5)
Conduct a family-oriented crisis intervention.	3.6 (0.8)
Conduct a comprehensive home visit.	4.0 (0.7)
Course relevance (n=56, PGY-1 residents)	
Perceived relevance for their training	4.7 (0.7)
Satisfaction (n=56, PGY-1 residents)	
Course's global assessment, Scale 1–7	6.2 (0.8)
External evaluations	
Clinical supervisor' s competency assessment (n=67, PGY-1 to PGY-3 residents)	
Involves patients and their family in the development of health plans.	4.5 (0.5)
Promotes healthy behaviors with patients and their families.	4.7 (0.4)
Observed Structured Clinical Examination scores (n=46, PGY-1 and PGY-2 residents), Scale 0–2	1.21 (0.38)

Note: All scores are on Scale 1–5, unless otherwise noted.
Abbreviations: SD, standard deviation; PGY, postgraduate year

LIMITATIONS

Despite the comprehensive evaluation of the presented FOPC course, that the course was developed based on the clinical and teaching experience of participating faculty is important to note. Consensus-based approaches to course development could strengthen its curriculum.[21] Because few reports of FOPC teaching exist,[18] comparative studies also are needed to optimize the teaching of these competencies. Next, the anonymous data and changing evaluation strategies did not allow for a longitudinal course evaluation, which is particularly relevant considering that implementation changes over time. Although no major modifications in content, skills, or learning strategies have occurred, over time the course has changed to enhance learning (eg, changes in simulated interviews, course bibliography). For example, during the COVID-19 pandemic, the course was taught completely online. Despite this temporary change in course delivery, the congruence of the different evaluation methods over time support the course's consistent value. Finally, residents did not complete baseline evaluations prior to the course. In addition, because this course targets PGY-1 residents, no similar control group was used to compare outcomes. We used all available data to describe residents' perceptions of the course, preceptors' evaluation of clinical translation, and OSCE results to report residents' application of FOPC skills. Future evaluations should include baseline assessments to observe skill change and attribute them to the course.

IMPLICATIONS AND CONCLUSIONS

PUC's family medicine residency experience could serve as a model for teaching FOPC in other residency programs. Standardizing this type of training and assessing its outcomes could contribute to greater consistency in teaching family-oriented patient care competencies—a signature clinical approach of family medicine.

REFERENCES

1. Newman MC, Lawless JJ, Gelo F. Family-oriented patient care. *Am Fam Physician.* 2007;75(9):310.
2. Korin EC, Odom AJ, Newman NK, Fletcher J, Lechuga C, Mckee MD. Teaching family in family medicine residency programs: results of a national survey. *Fam Med.* 2014;46(3):209-214.
3. Doherty WJ, Baird MA. Developmental levels in family-centered medical care. *Fam Med.* 1986;18(3):153-156.
4. Hoffmann TC, Glasziou PP, Boutron I. Better reporting of interventions: template for intervention description and replication (TIDieR) checklist and guide. *BMJ.* 2014;348:1687.
5. Mcdaniel SH, Campbell TL, Seaburn DB. *Family-Oriented Primary Care.* 2005.
6. Wright LM, Leahey M. *Nurses and Families: A Guide to Family Assessment and Intervention. F. A. Davis Company.* 2012.
7. Laidsaar-Powell R, Butow P, Boyle F, Juraskova I. Facilitating collaborative and effective family involvement in the cancer setting: guidelines for clinicians (TRIO Guidelines-1). *Patient Educ Couns.* 2018;101(6):970-982.
8. Laidsaar-Powell R, Butow P, Boyle F, Juraskova I. Managing challenging interactions with family caregivers in the cancer setting: guidelines for clinicians (TRIO guidelines-2). *Patient Educ Couns.* 2018;101(6):983-994.
9. Lang F, Marvel K, Sanders D. Interviewing when family members are present. *Am Fam Physician.* 2002;65(7):354.
10. Greenberg G, Ganshorn K, Danilkewich A. Solution-focused therapy. Counseling model for busy family physicians. *Can Fam Physician.* 2001;47(2):295.
11. Rerucha CM, Salinas R, Shook J, M D. House calls. *Am Fam Physician.* 2020;102(4):211-220.
12. Unwin BK, Jerant AF. The home visit. *Am Fam Physician.* 1999;60(5):488.
13. Doherty WJ. Family interventions in health care. *Fam Relat.* 1985;34(1):129-137.
14. Moffett J. Twelve tips for "flipping" the classroom. *Med Teach.* 2015;37(4):331-336.
15. King AM, Gottlieb M, Mitzman J, Dulani T, Schulte SJ, Way DP. Flipping the classroom in graduate medical education: a systematic review. *J Grad Med Educ.* 2019;11(1):18-29.
16. Kurtz S, Silverman J, Benson J, Draper J. Marrying content and process in clinical method teaching: enhancing the Calgary-Cambridge guides. *Acad Med.* 2003;78(8):802-809.
17. Hoyl T, Grez M, Gomes MM, Puschel K, Snell L. Profesionalizar la educación médica de residentes para un mejor cuidado de los pacientes: desarrollo e implementación de la educación por competencias CanMEDS en la UC (Improving residency education for better care: development of competency-based graduate medical education programs at UC). *Ars Med Revista de Ciencias Médicas.* 2022;47(3):62-67.
18. Peck EC, Lebensohn-Chialvo F, Fogarty CT. Teaching family-oriented care to family medicine residents: evaluation of a family skills curriculum. *Fam Syst Health.* 2022;40(1):87-92.
19. Harden RM. Revisiting 'assessment of clinical competence using an objective structured clinical examination (OSCE). ' *Med Educ.* 2016;50(4):376-379.
20. Zeller TA, Beben K, Kong M. Longitudinal interleaved residency training: a consensus definition. *Fam Med.* 2023;55(5):311-316.
21. Humphrey-Murto S, Varpio L, Wood TJ. The use of the Delphi and other consensus group methods in medical education research: a review. *Acad Med.* 2017;92(10):491-492.