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Family Medicine

BRIEF REPORT

An Innovative Model of Delivering Resident Didactics in Two Family Medicine Residency Programs

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ABSTRACT

Background and Objectives: Didactic training in residency is crucial for competency development. While traditional noon conferences (NCs) are common, challenges exist. The academic half-day (AHD) model has emerged as a promising alternative, showing improved resident engagement and learning outcomes. A hybrid model that blends NCs with AHDs may improve resident learning while minimizing productivity and administrative challenges.

Methods: A 6-month project was implemented and evaluated during the 2023–2024 academic year. The project comprised 3 weeks of traditional NC didactics and 1 week of AHD each month. We assessed didactic quality, resident satisfaction, and attendance, including data from Accreditation Council for Graduate Medical Education (ACGME) surveys. Statistical analyses included paired-samples *t* tests. All tests were two-sided with α set at 0.05. We also analyzed effect sizes.

Results: Resident attendance increased from 60.07%–65.96% overall, with AHD attendance reaching 97.5%. Survey responses indicated significant improvements in engagement (mean 2.46 to 4.46; $P<0.001$), in-depth learning (mean 2.39 to 4.46; $P<0.001$), work-life balance (mean 1.77 to 4.23; $P<0.001$), and wellness (mean 1.92 to 4.39; $P<0.001$). Preferences varied, with 60% of residents favoring weekly AHDs. ACGME surveys showed that compliance for educational balance and protected time increased from 67%–76% and 47%–71%, respectively.

Conclusions: Transitioning to a hybrid AHD model was associated with improved resident engagement, satisfaction, attendance, and educational value compared to the traditional NC model. Continued evaluation is recommended to optimize educational outcomes and resource utilization, while minimizing challenges to productivity and administrative details.

INTRODUCTION

The Accreditation Council for Graduate Medical Education (ACGME) and the American Academy of Family Physicians (AAFP) explicitly mandate that residency programs have a didactics program with certain attributes pertinent to clinical practice.[1,2] A 2000 survey found that most family medicine training programs devoted 4 hours per week to didactics, typically via 60 minute sessions, usually by nonfamily medicine educators.[3] A more recent study (2017) found that most family medicine programs use block formats, devoting more hours on fewer days.[4]

The academic half-day (AHD) model has emerged as an alternative to noon conferences (NCs) because it provides learners with uninterrupted time and promotes attendance, engagement, and clinical knowledge development.[5,6] However, a 2022 scoping review of AHD identified 38 papers from US and Canadian programs showing that more research on AHD in graduate medical education is needed.[7] Early family medicine

training literature (1990 s) conceptualized the AHD model.[3,4,8] However, we found no studies examining the impact of transitioning from NC to AHD in family medicine residencies or of hybrid NC/AHD approaches. Many issues were taken into consideration when making the transition from the NC to the hybrid AHD model, including logistical space availability, potential lost clinical time, financial impact, and residency lost rotation time, all of which are important for programs that may be looking to make such a transition.

ACGME surveys and annual program evaluations in our two programs found the didactics flawed, with frequent absences and interruptions for patient care. In response, we conducted a 6 month pilot study of a hybrid NC/AHD model to evaluate: (a) the quality of didactic teaching, (b) resident attendance and satisfaction, (c) protected learning time, and (d) resident wellness.

METHODS

Participants and Study Settings

Participants included two affiliated family medicine residency programs located in Redding, California. Mercy trains six residents per year, inpatient at Mercy Medical Center and outpatient at Mercy Family Health Center. The second site, Shasta Community Health Center, trains four residents per year and shares didactics, inpatient, and hospital call responsibilities with Mercy. Combined, this study included 27 postgraduate year (PGY) residents: ten PGY-1, nine PGY-2, and eight PGY-3. Both programs are affiliated with the University of California, Davis.

Educational Innovation Implementation

Prior to this project, the programs utilized a traditional NC series with four to five lectures per week during the lunch hour, led by various specialists, family medicine faculty members, and residents. We revised the didactic curriculum to a hybrid model with 3 weeks per month of daily NC and 1 week per month where AHD replaced NC. The pilot project ran from January 1, 2024 to June 30, 2024. During AHD, residents were excused at noon. Inpatient internal medicine and pediatrics services were covered by attendings. The obstetrics service was covered by the senior resident. Each AHD was assigned a theme and included a lecture, a case study, a hands-on workshop, and board review. We evaluated our curriculum and used the AHD sessions to cover important family medicine topics that were not already covered in NC. Attendance was tracked prior to and during project implementation through direct observation by program coordinators.

Program Evaluation

We administered a retrospective pre-post survey electronically to residents. This survey design is a more valid approach than separate pre-post surveys because it prevents response shift bias.[9] Basic demographics were collected, and residents provided feedback on didactics prior to and since AHD hybrid model implementation, including whether the curriculum was engaging, promoted in-depth learning, and supported resident wellness. Variables were rated using 5-point scales. Two open-ended questions captured free-form text responses.

Additionally, we compared selected data from our ACGME 2022–2023 and 2023–2024 surveys for two variables: (a) appropriate balance between education and patient care, and (b) protected time for learning activities. Lastly, we used annual program evaluation surveys to assess didactics quality. Common Spirit Health Research's Institutional Review Board (IRB) reviewed project activities and deemed them to be quality improvement rather than human subjects research (IRB #9715).

Data Analyses

We calculated descriptive statistics, including frequencies, percentiles, means, standard deviations, and ranges using SPSS version 29 (IBM). We used paired samples t tests to assess differences between pre- and post- time periods. We calculated Cohen d to show effect sizes, and all tests were two-tailed with α set at 0.05 for statistical significance. We used classical content analysis to analyze the free-form text survey responses and identify and define emergent themes.[10]

RESULTS

Prior to implementation, didactic attendance was 60.07%, and after implementation of the AHD hybrid model, it was 65.96%. Twenty of 27 residents (74.1%) completed the survey, with 13 of 20 (65%) providing complete responses. Demographics are listed in Table 1.

Residents' ratings of engagement, promotion of in-depth learning, work-life balance, and wellness all showed statistically significant increases between the two time periods (engagement 2.46 to 4.46; $P<0.001$; in-depth learning 2.39 to 4.46; $P<0.001$; work-life balance 1.77 to 4.23; $P<0.001$; and wellness 1.92 to 4.39; $P<0.001$; Table 2). A Cohen d of>0.50 indicates a moderate or meaningful effect size,[11,12] and it ranged from 1.0 to 1.3 in the data we collected.

Residents' rating of didactic quality and protected time also improved between the pre- and post- periods (didactic quality: 2.77 to 4.46; $P<0.001$, and protected time: 1.79 to 4.14; $P<0.001$) with Cohen d at 1.0 for both (Table 2). One survey question asked for residents' preferences moving forward, and 60% (n = 12) reported wanting weekly AHD sessions, and 30% (n = 6) preferred the tested hybrid model. Two residents (10%) preferred an even split of NC and AHD.

The 2022–2023 ACGME survey question regarding "appropriate balance between education and patient care" achieved 67% program compliance. In 2023–2024 this item increased to 76%. The 2022–2023 ACGME survey question on "protected time for learning activities" resulted in 47% compliance, which increased to 71% in 2023–2024.

The response rate to our annual program evaluation was 55% in 2022–2023 and similar in 2023–2024. Responses to the question about didactic quality in 2022–2023 indicated

TABLE 1. Demographic and Training Characteristics of Participants

Characteristics	Value, n (%)
Demographic and training characteristics	
Age categories (years)	
25–29	4 (20.0)
30–34	11 (55.0)
35–39	3 (15.0)
>39	2 (10.0)
Gender identity	
Man	10 (50.0)
Woman	10 (50.0)
Prefer to describe	0
Prefer not to answer	0
Race	
American Indian or Alaska Native	0
Asian	6 (30.0)
Black or African American	1 (5.0)
Native Hawaiian or Pacific Islander	0
White	11 (55.0)
Other/mixed	1 (5.0)
Prefer not to answer	1 (5.0)
Ethnicity (% Yes)	
Hispanic or Latinx	1 (5.0)
Prefer not to answer	1 (5.0)

TABLE 2. Residents' Rating of Training That Occurred Before and as a Result of Implementing Academic Half-Day Didactic Sessions

	Prior to implementing academic half days	*As a result of implementing academic half days*		
The family medicine residency curriculum . . .	**Mean (SD)**	**Mean (SD)**	***P* value**	**Cohen *D***
Was engaging for participants.[a]	2.46 (0.78)	4.46 (0.52)	<0.001	1.0
Range	1–5	4–5		
Promoted in-depth learning.[a]	2.39 (0.77)	4.46 (0.52)	<0.001	1.1
Range	1–5	4–5		
Promoted a healthy work-life balance.[a]	1.77 (0.83)	4.23 (0.73)	<0.001	1.3
Range	1–5	4–5		
Promoted resident wellness.[a]	1.92 (0.95)	4.39 (0.65)	<0.001	1.3
Range	1–5	3–5		
Quality of the didactic sessions?[b]	2.77 (0.83)	4.46 (0.52)	<0.001	1.0
Range	1–4	4–5		
Protected time to participate in structured learning activities?[c]	1.79 (0.89)	4.14 (0.66)	<0.001	1.0
Range	1–5	3–5		

[a]Scale: 1=Not at all; 2=Somewhat; 3=Moderately; 4=Very; 5=Extremely
[b]Scale: 1=Very poor; 2=Poor; 3=Average; 4=Good; 5=Excellent
[c]Scale: 1=Never protected; 2=Rarely protected; 3=Sometimes protected; 4=Often protected; 5=Always protected
Abbreviation: SD, standard deviation

that 30% of residents rated it as below average, 40% as average, and 30% as above average. On the 2023–2024 internal survey, none rated didactics as below average, 33% rated as average, and 66% as above average.

Two emergent themes identified regarding what residents liked best about AHDs were protected time and educational quality (Table 3). Areas of improvement included increasing the topic variety, resident involvement, and engagement.

DISCUSSION

AHD sessions promoted work-life balance and in-depth learning. Our findings align with other studies reported in nonfamily medicine specialties, indicating that transitioning to an AHD format improved resident attendance and satisfaction while contributing to resident wellness.[5,6,13–16]. Studies on the impact of AHD on in-training exam scores

TABLE 3. Emergent Thematic Responses to Open-Ended Survey Questions

Emergent theme	Definition	Exemplars
What residents like best about academic half-day sessions		
Protected time	Residents value having time devoted to their education protected from competing demands; this protected time fosters learning together.	"Huge improvement in engagement and time is actually protected." (*Participant #12*) "Protected time. Deep learning." (*Participant #5*) "The protected time and all the residents learning together." (*Participant #6*)
Educational quality	Several aspects of the program that relate to improved educational quality were appreciated by residents. these included materials provided, structure, and engagement.	"Enhanced preparation of material; improved quality of material." (*Participant #14*) "Huge improvement in engagement." (*Participant #15*) "I really like the way [didactics] are broken down to include education, board review, and procedures." (*Participant #16*)
What would improve academic half-day sessions?		
Increase variety of topics taught	Residents valued increased variety in the clinical content they were taught.	"more variety in lecture content." (*Participant #1*) "more diverse curriculum." (*Participant #2*)
Resident involvement	Residents desired to be more actively involved in the program.	"allow buy-in from residents on topics." (*Participant #7*) "more resident presenters." (Participant #9)
Improve engagement and interaction	Residents desired even more engagement and interaction, and appreciate the inclusion of key staff members.	"make it more interactive." (*Participant #8*) "I appreciate when we bring in specific staff, like the RDs today." (*Participant #19*)

and board scores are mixed,[17-19] which is an area for further research.

One of the greatest benefits of AHD was fully devoting resident time to learning, and many programs have fully transitioned to weekly AHD. However, program directors must ensure program fiscal sustainability, provide needed community services, promote meaningful learning experiences for residents, and assess their well-being. The literature was not clear whether AHD accomplishes these things. We aimed to assess a novel hybrid model of didactic delivery that could provide some of the perceived benefits of AHD (protected time, more time for in-depth/hands-on learning, resident preference) while still meeting clinical and productivity demands. The didactic transition has taken a significant amount of core faculty time (0.1 full-time equivalent). Moving forward, we must decide whether to continue the current AHD hybrid model or expand AHD offerings. One potential pitfall with expanding to a weekly AHD model is that each AHD represents loss of a half-day rotation for the residents; this loss could potentially have a large impact for residents on elective rotations where their time is already limited due to continuity clinic requirements.

Collaboration between programs and survey response rates were strengths of this project. Another strength was our use of Cohen *d* to determine whether the findings were meaningful and not relying solely on *P* values. However, both residency programs exist in the same community, and findings are not generalizable.

CONCLUSIONS

In conclusion, when evaluating the impact of transitioning our didactics model, we found that AHD was well-received and attended by residents with improvements in educational quality and resident well-being.

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