The Emergence of Family Medicine Identity Among First-Year Residents:
A Qualitative Study

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BACKGROUND AND OBJECTIVES: As part of a national pilot, the Lehigh Valley Family Medicine Residency Program implemented curricular changes to emphasize family medicine identity. These changes included limiting first-year inpatient experiences, adding "interval" outpatient weeks, and increasing family physician mentorship. This study explores how postgraduate learners describe their professional identities within the context of their chosen specialty, as defined by Family Medicine for America's Health (FMAHealth).

METHODS: This qualitative study approached family medicine identity formation from a social constructionist framework using evolved grounded theory. We performed a thematic analysis of focus groups conducted over 12 years with first-year residents (n=73). Then, utilizing a matrix analysis, articulations about professional identity were compared with structural components of the FMAHealth definition of the specialty. Three cohort groups (Preimplementation, Implementation, and Postimplementation) were defined to conduct a longitudinal comparison.

RESULTS: Six unique biosketches synthesizing the analyses emerged. Expansion in ability to articulate professional identity was evident not only across, but also within cohort groups. The Preimplementation cohort entered and left their first year identifying as relationship-centered generalists desiring guidance from role models. The Implementation learners used more FMAHealth language to describe their practice, later recognizing the potential it held for patient care. Similarly, the Postimplementation cohort entered with a broader view of family medicine and exited wondering how to help advance its reach.

CONCLUSIONS: Curricular changes placing interns within specialty-relevant learning settings coincide with thematic differences in articulations in professional identity. These findings suggest that experiential learning and role modeling contribute to professional identity formation among graduate medical learners.

Like their colleagues entering other medical specialties, family medicine interns will spend time during residency establishing a professional identity within their chosen field. What first-year residents are able to articulate about themselves in these new roles emerges from explicit influences (eg, personal experiences and academic lessons) as well as implicit guideposts (eg, the hidden curriculum of medical education[1,2] or organizational culture). Interactions with peers, faculty, and professionals within family medicine as well as those in other specialties "create, maintain, and reproduce" ideas about professional identity.[3]

While extensive theoretical literature exists on identity formation,[4-9] the majority of the research about medical professional identity focuses on undergraduate transitions[10] or development of clinical competency skills.[11,12] We seek to better understand the stages through which family medicine residents progress toward "thinking, acting, and feeling like a physician."[13] A set of quantitative constructs exists for measuring family medicine identity,[14] and this qualitative study seeks to utilize a nationally accepted definition of the specialty to operationalize a qualitative means of describing how family medicine residents articulate professional identity.

Redefining Family Medicine Education

Sixteen years ago at the Keystone III conference, a core group of family medicine organizations collaborated to develop "a strategy to transform and renew the specialty of family practice to meet the needs of people and society in a changing environment."[15] Educational changes such as the Preparing the Personal Physician for Practice (P4) national demonstration project[16,17] were a part of the Future of Family Medicine (FFM) 1.0 project's restructuring

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plan. The P4 project challenged residency programs "to create a new context for education"[18] that would better prepare family medicine graduates to deliver the model of care envisioned at Keystone III. In 2013, the FFM consortium members reconvened to provide a clearer definition of the role of family physicians in the 21st century. Considering the triple aim,[19] the FMAHealth project intended to set family medicine's identity development[20] back on course (Figure 1).

Residency Innovations

In the fall of 2007, as one of the 14 P4 pilot sites, the Lehigh Valley Family Medicine Residency Program (hereafter referred to as "the residency")—a large, multicampus, tertiary care health network in southeastern Pennsylvania—began its 5-year educational redesign. The curricular changes increased mentorship time with family physician role models, placing greater emphasis on outpatient care. The revised first-year inpatient curriculum was limited to first-contact care specialty rotations, including family medicine service, emergency medicine, pediatrics, and newborn nursery/labor and delivery. Inpatient rotations in other specialties (eg, intensive care unit [ICU]) were moved into the second and third years of residency. First-year schedules were restructured to feature interval training, which alternates inpatient weeks with outpatient weeks to encourage earlier establishment of continuity relationships in their family practice sites.

Research Objective

This retrospective qualitative research study is designed to explore how new family medicine practitioners understand what it means to be members of this specialty. We performed a secondary analysis of first-year resident focus groups to explore changes in articulations of family medicine professional identity. Our network's Institutional Review Board granted approval for this study, certifying that it met the

Figure 1: Constructs for Operationalization of Family Medicine Identity, Based on FMAHealth Role Definition[20]

1. Family physicians are personal doctors for people of all ages and health conditions.
2. They are reliable first contact for health concerns and directly address most health care needs.
3. Through enduring partnerships, family physicians help patients prevent, understand, and manage illness, navigate the health system, and set health goals.
4. Family physicians and their staff adapt their care to the unique needs of their patients and their communities.
5. They use data to monitor and manage their patient population and use best science to prioritize services most likely to benefit health.
6. They are ideal leaders of health care systems and partners for public health.

federal requirements for exemption as per 45 CFR 46.101(b).

Methods

Approaching the topic from a social constructionist theoretical framework,[21] this study considers how first-year residents described their membership within the family medicine discipline and how this changed after embedding themselves within a specialty-focused graduate medical education program. Evolved grounded theory[22] was used to perform a thematic analysis[23] of focus group transcripts collected before, during, and after the implementation of curricular changes designed to emphasize family medicine practice.

Data Collection

The dually-accredited residency houses a traditional 6-6-6 cohort structure. As part of the residency's program evaluation process, each cohort participates in annual focus groups, which are audio recorded and then transcribed. The first-year class participates in two focus groups—one immediately after the orientation period (T-1) to capture baseline perceptions and feedback on these initial activities before they are conflated with other first-year experiences, and the other at the end of the academic year (T-2). The standardized question set includes specific questions about professional identity (Table 2). This study examines transcripts of focus groups conducted with first-year residents between July 2002 and June 2014.

Sample

The deidentified data set represents the 73 individuals enrolled as first-year residents during the study period (Table 1). The 26 focus group transcripts were divided into three cohort groups—Preimplementation (July 2002-June 2007), Implementation (July 2007-June 2012), and Postimplementation (July 2012-July 2014)—with Implementation representing the period the residency participated in the P4 national demonstration project.[16,17] The cohort groups were subdivided into T-1 (postorientation) and T-2 (end of intern year), for a total of six cohort subsets (Table 2).

Role of Researchers

The research team members have various roles within the residency: two (S.M., J.D.) are family medicine physician faculty, and two (S.H., N.B.) are interprofessional faculty members who lead the residency's program evaluation efforts, which includes facilitation of resident cohort focus groups. The fourth author (J.D.) also served as residency program director for the majority of the time period covered by this study, and was thus recused from primary data analysis, instead serving in a member-checking role. This is one of several study design considerations made to reduce bias and ensure quality of research. The research team includes individuals who were part of the original P4 evaluation design team (N.B., J.D.) as well as those who were not (S.H., S.M.).

Table 1: Demographic Detail of Focus Group Participants

	Preimplementation (July 2002–June 2007)	Implementation (July 2007–June 2012)	Postimplementation (July 2012–June 2014)
Interns enrolled	30	32	11
% Female	73.33%	65.63%	63.64%
% MD	56.67%	56.25%	45.45%
% US medical school graduates	83.33%	59.38%	90.91%
Mean age (SD)	30.0 (3.5)	31.5 (6.3)	29.9 (3.7)

Abbreviations: SD, standard deviation.

Table 2: Sample and Data Collection Detail

	Preimplementation (July 2002–June 2007)	Implementation (July 2007–June 2012)	Postimplementation (July 2012–June 2014)
Number of transcripts	12	10	4
T-1 focus group questions (postorientation)	• What is your model of a family doctor? • What are your hopes, fears, and expectations for the rest of your internship year (personal and professional)?		
T-2 focus group questions (end of intern year)	• What is your model of a family doctor now? • Do you still want to be a family doctor? • How do you see your individual identity as family doctor? • What are your hopes for this upcoming year, on a personal and professional level?		

Analysis

Analysis of the data set occurred in several stages.[24] The process began with verbatim transcription of all focus groups conducted between July 2002 and June 2014. Using NVivo 10 software (QSR International Pty Ltd, Doncaster, Victoria, Australia). A seven-member data analysis team (S.H., N.B., S.M., and four others named in the Acknowledgments section of this paper) coded the complete transcripts using an a priori coding scheme representing the residency P4 project's five overarching areas of inquiry: (1) Adult Learning, (2) Relationship-Centered Clinical Practice, (3) Family Medicine Identity, (4) Satisfaction With Life, and (5) General Program Feedback. The sections coded to the Family Medicine Identity node were extracted for secondary analysis.

Three authors (S.H., S.M., N.B.) independently reviewed the coded transcripts, separated into six cohort subsets (Table 2), to identify emergent themes. The group reconvened to compare thematic findings and, by consensus, to identify exemplar quotes. This was an iterative process; each cohort subset was revisited to ensure saturation. The final themes for each cohort subset were sent to

the last author (J.D.) for member checking from a programmatic perspective.

The third stage of data analysis involved the creation of a matrix utilizing the six components of the FMAHealth definition[20] (Figure 1) as constructs to operationalize family medicine identity. The emergent themes and companion quotations extracted from the focus group transcripts were matched to related components of the FMAHealth definition.

Results

To capture the unique family medicine identities that emerged for each cohort group at T-1 and T-2, the authors synthesized the matrix analysis described above into six biographical sketches (Table 3) highlighting the most pervasive themes. The articulations illustrate some notable differences between the cohorts, which are outlined below.

- *FFM Construct 1—"Personal Doctors":* While all three cohort groups at T-1 noted care across the lifespan, each cohort emphasized a different aspect of this role. Preimplementation speakers focused on the

personal relationships formed with families: "The family doctor is … a patient's friend, confidante, and healer rolled up in one" (T-1, July 2003); and "They are totally mixed with the family at the basic level" (T-1, August 2002). The Implementation cohort members spoke more pragmatically, pointing to the family physician as a "generalist, who meets their patients at their point of need" (T-1, September 2011) who is "taking into consideration that whole person … all aspects of their health, mental, physical, social, um, spiritual" (T-1, September 2009). The Postimplementation cohort exhibited self-awareness as the foundation for patient care: "I think just acknowledging your own emotions and how it plays a role … how you practice and how you are as a physician" (T-1, October 2012).

- *FFM Construct 2—"First Contact":* All three cohorts at T-1 referenced this aspect of family medicine practice, focusing on a need for "broader-based knowledge" (Postimplementation, T-1, October 2012) to provide first-contact care: "We are

Table 3: Syntheses of Six Cohort Subset Articulations of Family Medicine Identity

Time Period	Preimplementation (July 2002–June 2007)	Implementation (July 2007–June 2012)	Postimplementation (July 2012–June 2014)
T-1 (postorientation)	We value personal connections with patients and aspire to be "humble" and "graceful" in practice. We seek to be like our family doctor role models who knew their patients' stories and cared for whole families while also being visible in their communities. We are still uncertain about our roles as leaders. At this time, we envision family doctors as those who care for patients of all ages with a variety of medical conditions. We see our future selves as well educated and generous in sharing the knowledge we have gained with time and experience.	We value teamwork with our professional colleagues and in the community to make sure that our patients receive the most appropriate care for all of their medical conditions. We believe in treating the whole person, which means paying attention to the physical, mental and social aspects of health as part of our patient care. As front-line clinicians, we recognize that family practitioners need "to know a little bit about everything" and expect to gain this knowledge through "lifelong learning." Even if the acuity of a particular problem requires a referral to a specialist, we intend to maintain continuity of care with our patients. We are empowered to be patient advocates and expect to become leaders in our communities, and we acknowledged that the demands of this job can be stressful. We recognize the importance of wellness for ourselves and our patients, but are not sure how that will play out in the context of our role as family physicians.	We use emotional language such as "compassion" and "trust" to describe ourselves and our practice. We see family physicians as having a broad base of knowledge and working in teams. We strive to be adaptable in our practice, recognizing that effective communication and awareness of self enables doctors to make relevant and meaningful connections with patients. And while we are aware that family medicine is an evolving profession, we struggle to understand how family medicine can have a leadership role in the changing landscape.
T-2 (end of intern year)	We consider family physicians to be good communicators with an "intellectually diverse" knowledge base. We crave stronger family medicine role models within in our different learning environments. We noticed a mutual lack of respect between family medicine and the specialists who educated us during traditional hospital rotations and "hope that our program can make a voice for itself." When we see a need for change, we are uncertain of what our role is or how to effect change. We are unclear about the need for some of our educational rotations. But we do recognize our growing confidence even if we do not yet understand the full scope of our chosen profession.	We own our titles as "Doctor" as we articulate what it means to be a family physician. We value whole person care and use models such as the Clinical Hand[36] to help us remember to how to engage in relationship-centered care. Family doctors adapt to their care within the context of their geography, medical setting and patient's biopsychosocial needs. On a systems-based level, we are starting to understand our role as being a "gatekeeper" and recognize that a change is coming as it relates to the "medical home" by referencing terms such as continuity.	We recognize patient needs, including deficits in insurance coverage, access to specialists, and connection to community resources and how these impact the care we provide. We see family doctors as filling the gaps in a flawed healthcare system. We crave more continuity with patients, emphasizing the need for a breadth of knowledge as the "front line" physicians for all ages and conditions. As rising second-year residents, we desire to be role models to the next class of interns.

the initial caregivers. And we assess at that time" (Implementation, T-1, August 2007), to "a wide variety of patients" (Preimplementation, T-1, July 2003). However, at T-2, differences between the cohorts were apparent. The Preimplementation

cohort saw their strengths as having the "interpersonal skills" (Preimplementation, T-2, June 2005) to "talk to a family in a better manner than the other department doctors" (Preimplementation, T-2, June 2004). The Implementation cohort

embraced their growing adaptability and competencies: "You're comfortable with kids. You're comfortable with cultural issues … comfortable with working in the community … with different hospital staff" (T-2, June 2008). The Postimplementation

cohort noted how family medicine "front-line care" fills gaps in the health care system: "At times it feels a family doctor, uh, can be a cardiologist to the patients that can't quite afford or can't get in with the cardiologist, or psychologist, or neurologist. You know, we're the safety net of the medical community" (T-2, May 2013).

- *FFM Construct 3—"Enduring Partnerships"*: The Preimplementation cohort referred to continuity as "long-forming relationships" (T-1, July 2004) for multiple members of a single family. "You could draw a connecting line from each one of them to a single-family practitioner and, with that, comes a lot of insight and opportunity to not only treat while ill but treat while healthy" (T-1, July 2003). The Implementation and Postimplementation cohorts agreed, and added that at the bounds of their knowledge: "We're not expected to know the huge in-depth portions of all those different subjects" (Implementation, T-1, August 2007), was the option to enlist "help from specialists" (Postimplementation, T-1, September 2013).

    However, at T-2, the cohorts diverged on this construct. Preimplementation learners described hits to their "self-worth and … worth in the whole medical field" (T-1, June 2004), based on perceived lack of respect from inpatient colleagues in other specialties. While the Implementation cohort noted similar concerns about the reputation of family medicine: "I don't think we're well respected as we should be" (T-2, June 2008), this didn't dissuade them from seeking more continuity with patients.

- *FFM Construct 6—"Leaders/ Partners"*: The cohorts perceived the idea of family physician leadership in vastly different

ways. The Preimplementation cohort saw family physicians as "well respected … community leaders" (T-1, July 2004). The Implementation learners were focused on how their generation might be responsible for reclaiming respect for the specialty ("Family medicine … we are the leaders. … I think, um, we may not have been in that position the last several years, but it's time" (T-1, September 2010); and "I see it as, again, the gatekeeper of healthcare. And, um, the medical home … We're kind of like the forerunners in that also" (T-2, April 2011). The Postimplementation cohort pondered the shifting health care landscape more generally: "With the way that health care goes now, my views are kind of changing, and I can see the positives of patient-centered medical home" (T-1, September 2013), and the more immediate demands on them as rising senior residents: "I would like to be a, a good role model for the next class" (T-2, 2014).

A few themes outside of the FMA-Health definition[20] emerged. They are noted below as evidence of the varied voices and stages of identity development:

- *Flexibility in Schedule*: Some respondents stated that they appreciated the choices that their specialty offered in terms of when and where they could practice family medicine. "You can be, you know, part time, full time, see patients in the hospital or just strictly outpatient…" (Preimplementation, T-1, September 2006).

- *Role Clarification*: At the end of the internship year, the Preimplementation cohort members expressed a need for family medicine role models: "This year really hadn't afforded me the opportunity to be just a family doctor. I had to be the internist, the

OB, um, be the pediatrician" (T-2, June 2007). By contrast, the Implementation period cohorts had begun to embrace their role as family physicians: "I was afraid to be addressed as 'doctor' for probably the first half of my intern year … but now I'm like, I'm owning it" (T-2, April 2007); and "[I want] to know what it is that my niche is inside family medicine" (T-2, June 2010).

- *Relevance of Curricular Elements*: Preimplementation learners questioned the value of some inpatient specialty rotations: "I would say for me OB is entirely irrelevant … Surgery also isn't particularly relevant" (T-2, June/September 2006). Implementation learners made connections between inpatient rotations and outpatient work: "After the last two weeks of hospital service I found that coming back to the office, I started seeing my complex chronic patients and noticing more certain symptoms that were presenting repeatedly in the hospital and being able to help them much better" (T-2, June 2009).

Discussion

Differences occurred between T-1 and T-2 in each cohort, indicating expanding ability to articulate family medicine identity over time, as would be expected from added exposure to family medicine as a discipline. In addition, we noted more frequent and more complex conceptualizations of identity within the Implementation and Postimplementation groups. The Implementation and Postimplementation cohorts articulated many more of the components of the FMAHealth definition, undoubtedly influenced by exposure to similar concepts in the patient-centered medical home (PCMH) teachings that had emerged in undergraduate medical education.

The Preimplementation cohort entered with a desire to be relationship-centered clinicians, and by the end of the first year of training found

themselves with a clearer picture of what clinical competency entails, but without strong guideposts for how to translate their newfound medical knowledge into the practice of family medicine. The Implementation cohort shifted from viewing themselves as solely front-line generalists to gatekeepers for health care who recognize the PCMH model of care's potential to serve their complex patient panels. The already self-aware Postimplementation cohort saw themselves as family physician leaders who enable continuity of care by coordinating care for patients who seek interventions from a variety of settings. Our opinion is that these shifts were influenced by the experiences the residents had during their first year of family medicine training.

This study revealed a disconnect felt by first-year residents from the family medicine specialty in the Preimplementation years. Part of the decision to join the P4 demonstration project[16] was to ensure that residents were exposed to family medicine role models by moving away from the traditional rotational internship schedule. The richness of the resident cohorts' articulations about being family physicians expanded during the time period of the curricular changes.

The impact of exposing residents to family medicine role models earlier in their training is supported in the literature. A meta-analysis of 73 studies of undergraduate medical students found that early experience in medical settings

> could teach them about clinicians' roles, responsibilities and position in society; about public health and how the health care system can improve it; and about the impact of disease on patients.[10]

Family medicine identity development was studied by Senf et al,[25] who found that added exposure of medical students to family medicine physicians increased understanding and positive perceptions of the specialty. Moreover, our restructuring

of schedules, placing residents in learning environments emphasizing primary care practice with family medicine role models, follows Swanwick's[26] assertion that informal learning occurs most effectively through "situations, not subjects." In other words, doing the work of family physicians is more likely to influence professional identity than talking, reading, or listening to lectures about it. This embraces the concept that learning is a sociocultural process of "becoming"[27,28] that transcends cognitive acquisition of skills and knowledge through participation in the "developmental space" that results from the workplace culture, personal and professional interactions, and emotional engagement of the learner.[29] Monrouxe[30] emphasizes the role curriculum plays in professional identity formation:

> identity and identification issues affect medical education in terms of students' relationships with patients, with doctors and with themselves and thus are of central importance to the conception and development of medical curricula. . . . Medical education is as much about learning to talk and act like a doctor as it is about learning the content of the medical curriculum.

We contend that this phenomenon occurred within the resident cohorts (Implementation and Postimplementation) who were exposed to the curricular changes that placed first-year residents in family medicine mentorship relationships, thus expanding their identification with the specialty.

Limitations
The primary limitation is that the Postimplementation cohort contained only two classes of residents, as compared with five in each of the other groupings, so identified themes might be an overrepresentation of individual experiences. Another limitation pertains to the nature of focus groups as a data collection method, in that there is no guarantee all perspectives are heard, because

participants may choose not to respond to any or all questions. Also of note is that the questions asked in the focus groups were not contrived with this specific study in mind; therefore, some of the key components of the FMAHealth identity definition[20] might be underrepresented in resident responses.

While the timing of the focus groups data collection allowed us to examine articulations about family medicine identity over the same time period as our curricular innovations were implemented, there is no way to fully attribute the differences between the results to curricular changes alone. We acknowledge that in any social science study, cause-and-effect claims are unreasonable. Finally, as a result of academic innovations during P4,[31] the residency's recruiting message changed to highlight our P4 participation as well as our curricular focus on adult learning, integrated care, and PCMH principals. The residency saw an increase in applicants during our period of innovation, a phenomenon experienced by other P4 sites.[32] Therefore, both the Implementation and Postimplementation cohorts may have contained individuals with a broader sense of the FMAHealth concepts than the Preimplementation cohort.

Implications
We concur with the observations of Miller and Dostal[33] that immersing residents in other specialty inpatient rotations during the formative first year stunts the development of family medicine professional identity of those new to the field:

> This structure also promotes a reductionist framework of thinking that is problematic in the primary care setting, where whole person, community, and population frameworks are essential.[33]

Family medicine doctors will need to clarify for themselves and their patients which roles they perform in the ever-expanding health care diaspora.[34] FMAHealth offers

a holistic definition to remind family physicians of their identity amid the trends of fragmentation of care, increase in specialization, more narrowly defined scope of practice, and gatekeeper roles in managing increasingly complex patient panels.

Conclusion

Expansion in ability to articulate professional identification as a family medicine physician was evident not only longitudinally, but also within cohort groups from the beginning to the end of the first year of training, albeit to differing degrees. Gaining access to strong role models in the first year of residency through curricular innovations such as those described here gives learners more opportunities to become socialized into their chosen profession through the informal learning of the everyday routine[35] of practicing alongside family physicians.

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