Transitions to Practice

Navigating the Transition to Practice

Catherine Hickey, PGY5

Dalhousie University, Halifax, Nova Scotia

Abstract: The transition to staff is a time of great turmoil for many residents. It is a developmental stage not unlike any other and should be marked as a rite of passage. Unfortunately, postgraduate programs do not seem to give it the attention it deserves, and termination of the relationship between residents and faculty is neglected. As the phase of "benign neglect" endures, many residents have symptoms of anxiety and depression. Many are unprepared to successfully pursue the business and contractual aspects of securing employment upon graduation, and many are preoccupied with the technical and logistical aspects of the transition. However, the true transition is marked by the learning that accompanies independent and autonomous decision-making.

Résumé : Traverser la transition à la pratique

La transition à la pratique est une période de grand tumulte pour nombre de résidents. C'est une phase du développement semblable à toute autre qui devrait être désignée rite de passage. Malheureusement, les programmes d'études post-doctorales ne semblent pas y porter l'attention qu'elle mérite, et la fin de la relation entre les résidents et le corps enseignant est négligée. Bien des résidents qui subissent la phase de « négligence bénigne » ont des symptômes d'anxiété et de dépression. Nombre d'entre eux ne sont pas préparés à transiger à bon escient avec les aspects commerciaux et contractuels de trouver un emploi après avoir obtenu leur diplôme, et ils sont nombreux à se préoccuper des aspects techniques et logistiques de la transition. Toutefois, la véritable transition est caractérisée par l'apprentissage qui va de pair avec un processus décisionnel indépendant et autonome.

Key Words: transition, practice, residency

The Prelude to the Transition

The final year of residency can be challenging. Since the Royal College Exam changed its format, fifth-year residents have a written and an oral exam occurring within a shorter period of time. While some residents clearly favour the change to a more focused exam, others do not. Regardless of how one views the change, this newly condensed year of study has a tremendous impact on senior residents.

During this year of strenuous study, senior residents must also navigate the task of separating and individuating from their (often) well-loved postgraduate psychiatry programs. Many secure attachments must be disrupted. The literature describes well this separation crisis in various residency programs (1). To smooth the transition, senior residents often go through well-defined, albeit subtle and unconscious, developmental phases. For example, when leaving their resident colleagues and the collegial and cohesive spirit inherent in years of shared camaradarie, senior residents often find ways to make the old environment seem less becoming. They may be hypercritical of attending staff, and they sometimes grow aloof and distant from the more junior residents. This can lead to a "we–they" schism that serves a clear purpose in making the old environment less comforting and nurturing, so that the ominous environment lurking in the future seems less threatening and anxiety-provoking. Unless the separation crisis is recognized, appreciated and effectively dealt with, it can have deleterious effects on residents and staff alike. The separation crisis must be treated like any other rite of passage. The crucial elements of dealing with it include normalizing the experience for residents and encouraging expression of affect associated with the experience. This is often best accomplished in the group setting (1).

The Inadequacy of Education and the Phase of Benign Neglect

Early in the final years of training, residents begin to accept that they must soon leave sheltered environments and assume careers as independent clinicians and entrepreneurs. Associated with this is a developmental phase. What should naturally accompany this time of personal development is a time of professional development. Intuitively, one would expect numerous professional development programs and seminars at the postgraduate level throughout the country. Such seminars would offer "real life" advice to senior residents embarking on the journey of transition. Yet the lack of such programs is astounding. Borus developed a "Transition to Practice Seminar" and commented on the lack of similar programs in the United States:

> There have been many hypotheses about why there have not been more organized faculty attempts to facilitate residents' transition to practice. Some suggest that the annual loss of highly cathected professional progeny is such a painful event for faculty that they deny or minimize the importance of this transition for the residents. Others suggest that since graduating residents are clearly competent adult professionals, any attempt by faculty to intervene in their decision making would be inappropriately intrusive and parental. At the opposite end of the spectrum is the suggestion that because residents

> become practitioners at the end of training, they pose a competitive threat to faculty members with whom they will be competing for a variety of limited practice resources (e.g. patient referrals, research monies, and academic and institutional positions) and that in areas that are overpopulated with psychiatrists faculty are not eager to aid their more recently trained competition (2).

The attitude of some faculty toward transition issues is one of benign neglect. Given the importance psychiatry places on termination of relationships, it behooves us to examine what drives the indifference permeating this issue. While we must acknowledge benign neglect from faculty, we must also acknowledge apathetic acceptance from residents.

The Reality of the Transition: Affectively, Logistically and in the Real World

In the final years of training, many residents experience various emotions, symptoms and even disorders as they try to assimilate what it means to be a psychiatrist. After residents navigate the tasks of separating, they individuate and become clinicians. Often, this is based on role models encountered in the academic environment. Such role models have been called "triple-threat psychiatrists" in reference to their roles as clinicians, teachers and researchers (3). Many (likely most) residents feel unable to live up to this standard. Many residents feel confusion, anxiety and depressive symptoms when they approach the task of deciding on their professional identity. This is not unlike Eriksson's developmental stage of identity vs. role confusion. Looney and colleagues found that, during the transition period, 73% of psychiatric residents experience anxiety that ranges from moderate to incapacitating and that 58% experience depression to a similar degree (4). Many residents must balance the demands of family and other personal obligations. Compromise and sacrifices are frequently made.

Residents making the transition to practice have many variables to consider. There are numerous logistical decisions to be made. For example, they must choose the type of practice, the acceptable level of income, the frequency of call, expected teaching responsibilities and hospital privileges that they would expect in a practice. Many feel that psychiatric training prepared them well for psychiatric practice but very few feel prepared to manage its practical aspects (3).

Having invested a significant amount of time and money in the process leading to Royal College Specialty recognition, many residents feel that the process will end once the exam is completed. However, the steps required to choose the right practice (or fellowship) can be just as onerous as the various other rites of passage. Negotiations with potential employers can be arduous. Few residents have considered the intricacies of thorough contract negotiation. In this age of alternate funding plans, where contracts contain complexities beyond the imaginations of even the most seasoned of our mentors, many of us are simply unprepared to consider just how complicated our professional lives will become.

Much of the growth arising from the transition to practice does not come from the responsibility we learn as we assume the roles of manager and professional. It comes from the tribulation of independent and autonomous decision-making. As senior residents, we memorize lists and tables of good prognostic factors, but at the end of the day, we must acknowledge that we are often unable to predict prognosis. Our patients are often rational individuals who leave our offices and make choices for themselves. As much as we would like to believe in our abilities to predict and protect, we inevitably encounter the patient who escapes our abilities to do so and makes a decision we could not have predicted. As residents, no matter how bad the outcome, we can always document that every assessment was discussed with an attending staff person. When we become that staff person, we assume a whole new level of accountability.

Physicians are taught to be protectors. As residents make the transition to staff, many become more hypervigiliant and cautious. Somewhere among the volumes of text and hours of lectures, it was instilled in our psyches that we must not only provide care but that we must also protect. In other areas of medicine, the onus is on the physician to treat the illness only. But psychiatry is unique in that we often treat not only the illness but, more holistically, the person. Psychiatrists treat major mental illnesses and personality disorders, and with that come expectations from patients and family members alike. Unlike the surgeon who simply removes the inflamed appendix, we psychiatric clinicians must assess complex and abstract entities; we must decide when a patient is impaired and incapable of ensuring safety. When a bad outcome has occurred and we are forced to question our assessment, having no staff "back-up" is a startling experience. However, experiences such as these are at the heart of the emotional and maturational transition.

As we make the transition to staff, we must assume this dubious responsibility of knowing when and when not to protect. Like all other aspects of this enormous transition, we have been poorly educated about it. Some argue that this skill transcends teaching. Yet, this single responsibility can be the most overwhelming, disturbing and meaningful aspect of the metamorphosis itself.

Who Does Well?

Given the enormity of the challenge, are there any ways to predict who will do well with the transition to practice? Some residents do report a smooth and fairly effortless evolution. Looney and colleagues found that residents expressed feelings of growth, mastery and confidence if they had "solid personal anchors of stable, nurturing relationships with friends and loved ones" (4). Psychiatrists who had a difficult time with the transition had difficulties in other areas of their lives, were more isolated and were unable to seek out support from others.

Continued on p 14

Conclusion

Clearly, the task of transition is considerable. Residents must demand, and staff must establish, programs. Faculty, both senior and junior, must formally demystify the process of becoming an independent psychiatrist. First, however, we must acknowledge the affect that accompanies the loss. We must normalize the experience for ourselves, for the faculty and for the residents who must bear the repeated loss of well-respected friends and colleagues. We must accept the denial that is inherent in our coping and move on to make this a stage of growth, rather than a pattern of indifferent disregard.

References

1. Merkel WT, Walbroehl GS. The annual third-year resident rampage: a separation crisis of manageable proportions. J Med Educ 1980;55:366–7.
2. Borus JF. The transition to practice seminar. Am J Psychiatry 1978;135:1513–6.
3. Cavanaugh JL. Career decisions in the early post residency years. Am J Psychiatry 1975;132:277–80.
4. Looney JG, Harding RK, Blocky MJ, Barnhart FD. Psychiatrists' transition from training to career: stress and mastery. Am J Psychiatry 1980;137:32–6.