Hidden in Plain Sight: 
Residency Coordinators’ Social Support of Residents in Family Medicine Residency Programs

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BACKGROUND AND OBJECTIVES: Social support resources for family medicine residents have increased over the years in response to the challenges of residency training and Accreditation Council for Graduate Medical Education (ACGME) requirements. In all of the discussions of social support, the role of residency coordinators (RCs) has been overlooked. A national survey was conducted to expose and explore the contribution of RCs to the social support of family medicine residents.

METHODS: A questionnaire was developed to identify the specific contributions to social support RCs might make and the amount of time dedicated to social support activities. The questionnaire was mailed to RCs at 459 US family medicine residencies, with a response rate of 69% (n=316).

RESULTS: RCs report devoting on average approximately 6 hours a week (14% full-time equivalents) to the social support of residents. They provide ideas for solving personal and professional problems, opportunities for residents to express feelings, and emotional support. They frequently discuss resident issues with the residency director and others and often play a role in progress evaluations.

CONCLUSIONS: RCs in family medicine residencies report playing an important yet often unacknowledged role in the social support of family medicine residents and often serving as a conduit for information between residents and the administration. This role raises issues concerning the recruitment, supervision, training, and job expectations of RCs.

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The challenges and stresses of residency education have been well-delineated. In response, the Accreditation Council for Graduate Medical Education (ACGME) requires that residency training programs provide resources for residents to moderate the impact of these stresses and to help prepare them to manage the stresses of the postgraduate practice of medicine. The ACGME states that programs must attend to the promotion of physician well-being and the prevention of impairment by monitoring resident stress and mental or emotional conditions inhibiting performance or learning, supplying group support, and making confidential counseling and psychological support services available to residents.

Surveys of psychosocial support services in family medicine residencies have shown that the availability of social support resources has increased over the years. Many programs have incorporated in their curricula a variety of educational activities that may contribute to resident coping skills and resiliency. Though many interpersonal resources are mentioned as important to the social support of residents, one obvious and common source is strikingly absent.

Anyone who has spent time observing the day-to-day operation of residency training programs recognizes the central role that many residency coordinators (RCs) play in the social support of residents. At graduation ceremonies the residents routinely express their deep appreciation for the contribution of the RC to their personal and professional success. Yet when previous surveys of social support available to residents were conducted, RCs have not been included on the list of possible resources. RCs appear to be a major unacknowledged source of social support for residents during residency training.

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If this is the case, many important questions are raised concerning the recruitment, training, supervision, and job expectations of RCs. The first step in exploring these questions is to get a clearer picture of the social support provided by RCs.

**Social Support**

The positive contribution of social support to physical and mental health and coping abilities in response to life events has been well explored and well established. Social support refers to the resources provided by others and the quality of those resources. Antonucci and Akita have advanced a model that recognizes the interactive influences of the characteristics of the person, the properties of the situation, the broader social network, specific social support, and the quality of that support. Our study focused specifically on the social support activities of RCs, recognizing that there are many other variables that might modify or amplify the impact of social support on residents. The three-part distinction of social support activities is commonly used and captures the full range of possible RCs behaviors: (1) Emotional—verbal and nonverbal communication of caring and concern, (2) Informational—the provision of information used to guide or advise, and (3) Instrumental—the provision of material goods (eg, transportation, money, or physical assistance).

**Methods**

**Instrument**

The authors developed a questionnaire that operationalized observed social support activities of RCs. A literature review was conducted to study the most frequently used social support measurements to help specify activities that had previously been defined as socially supportive. The first draft of the questionnaire was based on the literature review, observations of activities of residency coordinators in multiple residencies, and the experience of the residency coordinator at the Wake Forest Department of Family and Community Medicine. This draft was reviewed by three of our research staff with significant experience in survey research for feedback on the general questionnaire format and the wording of specific questions. The questionnaire was revised based on their input. This version was completed by 11 RCs at the 2007 Residency Program Solutions conference in Kansas City, MO, and they gave feedback about content and construction. For each question, the RCs had the opportunity to answer “other” and include any comments. The 11 RCs suggested no modifications and found the questionnaire clear and complete.

**Design and Sample**

A cross-sectional study design was used. The protocol was reviewed and approved by the Wake Forest University Health Sciences Institutional Review Board. Cover letters describing the purpose of the survey and explaining confidentiality and consent along with the questionnaires was sent to all residency coordinators at the 459 US allopathic family medicine residency programs active in 2007. If there was no response in 3 weeks, a postcard was mailed as a reminder. Nonrespondents at 8 weeks were mailed a second cover letter and questionnaire.

**Results**

A total of 459 questionnaires were mailed and 316 (69%) returned. Ninety-five percent of respondents reported that they provide regular or very frequent social support (Table 4). Eighty-nine percent of the RCs reported that they provide emotional support (verbal and nonverbal communication) regularly or very frequently. Approximately 25% of RCs reported that they regularly or very frequently provide social support to residents during their second Mom and that residents “pretty much tell me everything,” and “vent about almost everything.”

The second question asked specific information related to social support activities (Table 4). Eighty-nine percent of the RCs reported that they regularly or very frequently provide residents an opportunity to express their input. This version was completed by 11 RCs at the 2007 Residency Program Solutions conference in Kansas City, MO, and they gave feedback about content and construction. For each question, the RCs had the opportunity to answer “other” and include any comments. The 11 RCs suggested no modifications and found the questionnaire clear and complete.

**Table 1: Respondents**

<table>
<thead>
<tr>
<th>Questionnaires</th>
<th>Mailed=459</th>
<th>Returned=316 (69%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Female=95%</td>
<td>Male=5%</td>
</tr>
<tr>
<td>Age of RC</td>
<td>X=46</td>
<td>Range=23–77</td>
</tr>
<tr>
<td># of Years as RC</td>
<td>X=8.8</td>
<td>Range=1–36</td>
</tr>
</tbody>
</table>

RC—residency coordinator

SD—standard deviation
I decide the discussion should be shared.”

One of the more striking outcomes of the survey is how often RCs are asked to report information about the residents (Table 6). They are asked for information by the residency director, faculty advisors, other faculty, chief residents, the behavioral science faculty, and even other residents and the chair. How much of this is just checking

**Table 2: Self-reported Time Spent by RCs Providing Social Support**

| How many hours per week do you spend providing social support to residents? |
|-----------------------------|-----------------------------|-----------------------------|
| Mean=5.85 hours | Maximum=25 hours | Minimum=0 hours |

| What percent of your time on an average weekly basis is spent providing social support? |
|-----------------------------|-----------------------------|-----------------------------|
| Mean=13.92% | Maximum=50% | Minimum=0% |

RCs—residency coordinators

**Table 3: Family Medicine Residency Coordinator Survey—Question #1**

<table>
<thead>
<tr>
<th>How often do the residents talk to you about:</th>
<th>Regularly/Very Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily events</td>
<td>73%</td>
</tr>
<tr>
<td>General problems in residency</td>
<td>73%</td>
</tr>
<tr>
<td>Their personal life</td>
<td>54%</td>
</tr>
<tr>
<td>Interpersonal problems in the residency</td>
<td>44%</td>
</tr>
<tr>
<td>Their personal problems</td>
<td>32%</td>
</tr>
<tr>
<td>Finding help for professional problems</td>
<td>27%</td>
</tr>
<tr>
<td>Finding help for personal problems</td>
<td>17%</td>
</tr>
</tbody>
</table>

Conduit of Communication

A major role that RCs report playing is the sharing of information between the residents and residency administration (Table 5). Almost half of RCs report sharing information regularly or very frequently with the residency director, and 26%, 23%, and 14% share with faculty advisors, chief resident, and the behavioral science faculty, respectively. Although much less frequently, RCs report discussing residents’ issues or concerns with other RCs, other staff, the chair of the department, and even a resident’s friend or spouse (9%; 6%). This reflects one RCs description of her role as “point guard” distributing information to the appropriate person but only if there is “danger or significant impact on performance” or “impairment that might affect patient care.” Several RCs emphasized the confidential nature of the conversations with residents. One said I share “only with permission. If speaking in confidence I keep it to myself” and another said “I always inform the resident when
in or part of a more formal evaluation is unclear. What is clear is that RCs consider themselves a significant source of information about residents’ personal and professional status. Sixty percent of RCs attend residency progress review meetings, and 92% share information that contributes to the residents’ progress assessment whether they attend the meeting or not.

**Limitations**

One must recognize limitations of the accuracy of data gathered by questionnaire. Established measures of social support address multiple resources that may provide social support in a variety of settings. The questionnaire developed for this survey focused on the activities of an individual provider of social support in a specific setting. Though many of the items on the questionnaire reflect similar activities included in more established measures of social support, this questionnaire’s reliability and validity was not established. Though there was an unusually high response rate, the activities of the nonrespondents may not be reflected in these outcomes. Finally, all data is based on self-report, which can be unreliable. For example, the report by one RC of 25 hours per week and another of 50% of the work week dedicated to social support is unlikely given the other job requirements of RCs and may reflect a misunderstanding of the definition of social support activities.

In recognition of potential limitations, we closely collaborated with research professionals on the construction and content of the questionnaire and field tested it on a small sample of RCs. The high response rate suggests that these data may serve as a reasonable reflection of the RCs’ perspective on their social support activities in many family medicine residencies.

**Discussion/Conclusions**

The challenge and stresses of residency training can be an impediment to the physical and psychological health of residents and their professional performance. The seriousness of the problem and the positive impact of social support are underscored by the ACGME expectation that residency programs provide a variety of social support options for residents. Social support contributes significantly to an individual’s ability to contend with a variety of challenging circumstances and contributes to resilience.

The RCs participating in our survey report spending approximately 6 hours of their work week providing informational, emotional, and instrumental social support to family medicine residents. They describe regularly or frequently talking with residents about the resident’s personal and professional lives and problems. They say that they frequently triage issues, judge confidentiality, and share information with residency administration to help residents, support the program, or contribute to the assessment of resident’s progress.

From the reports of this survey, it is clear that many residency coordinators see themselves as a major on-site source of social support for residents both in terms of the time and the range of support that they provide. Further, they describe playing an important role in the triage and transfer of information about residents that contributes to the functioning of the residency training.
program. This role has been unrecognized in previous reviews of social support resources.

It is important to get multiple perspectives on the RCs’ support activities. Similar surveys of residency directors, residents, and faculty would contribute to our understanding of RC support for residents. It would also be useful to survey other residencies, for example, surgery, obstetrics and gynecology, pediatrics, internal medicine, and psychiatry to explore possible differences and similarities in the RC support role.

If further research supports the extent of social support provided by RCs, many questions are raised about the job qualifications, recruitment, training, supervision, and job expectations of residency coordinators. When hiring a new RC, should specific social support skills be included in the job description and explicitly assessed during the interview process? After hiring, should the program provide training to cultivate social support skills and schedule formal ongoing supervision to assist RCs with both the predictable and unexpected personal and professional dilemmas residents may share with them?

The prevalence and importance of the social support provided by RCs to family medicine residents has not been thoroughly explored, and their contribution to the gathering and dissemination of information related to residents’ professional and personal status within the program is often unacknowledged. With the average historical turnover of residency directors at about 3–5 years, the role of the RC as an institutional historian and database for established procedures and processes becomes more important. There is a growing recognition that the RC position has become more of a managerial role than administrative support, which may obviate opportunities for social support activities. In light of the information gathered from this survey, more research is needed to fully understand the contribution of RCs to the social support of residents and the implications for residency education and administration.

ACKNOWLEDGMENTS: Results of the survey were presented at the 2007 Residency Program Solutions Conference, Kansas City, MO; the 2010 Behavioral Science Forum, Chicago; and the 2008 Family Medicine Residency Program Administrators/Coordinators Workshop, San Antonio.

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References