

What residents should know before starting inpatient psychiatry?

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Abstract. Most psychiatry residencies begin clinical training assigned to an inpatient service. This exposes residents to acute, hospitalized mental health crises cases and teaches them teamwork in collaboration with a variety of healthcare professionals. Faculty and staff can facilitate resident transition to hospital practice by orienting them ahead of time with an introduction to clinical and documentation procedures. International medical graduates might benefit from extra training about the American health care system and culture. Once on service, resident guidance by faculty includes educational supervision about interviewing skills, making diagnoses, and clinical management. A self-guided study plan with appropriate literature can initiate a practice of independent learning.

Key words: Adjusting to the inpatient setting, hospital exposure, inpatient education, inpatient training, psychiatry residents, residency training

1. Introduction

Resident exposure to the inpatient setting is important for their education. Hospital service training usually occurs in the first post-graduate year. The Accreditation Council of Graduate Medical Education (ACGME) requires at least six months and no more than 16 months of inpatient experience during a psychiatry residency (1). As training begins, there is an initial clinical and administrative orientation session. These meetings are especially helpful to doctors who completed medical school in another facility.

Close supervision and monitoring by attending faculty during this rotation is essential. Observing and treating acutely ill patients while assessing

their status provides an educational opportunity to monitor clinical progress. Managing individuals in the inpatient setting also teaches information about the appropriateness of when to ask for a consultation and/or when to accept or refer patients to other medical services. Shared decision making for patient evaluation and treatment, in consultation with hospital staff and various sub-specialty physicians, provides patient safety and improves trainee education. Exposure to a wide variety of treatment modalities that includes group psychotherapy and electroconvulsive therapy offers a good quality learning experience. Residents should begin the process of educating themselves through reading and by attending conferences and lectures. They also are responsible to supervise and train medical students.

2. Before starting

It is important to obtain state medical licensure before starting the residency; hospital personnel usually provide guidance. Most residents are relocating and need to secure housing; many programs help this transition by making accommodation lists available. Some international medical graduates face further challenges in having to obtain a work permit or

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Received: 12.07.2011
Accepted: 30.05.2012

visa (2), a social security number, and driver's license. Most residencies begin the orientation sessions and host a get-acquainted social event before the first day of the residency. All trainees should have an office for personal use.

3. Orientation

Hospital administration, in collaboration with each of the departments, conducts orientation sessions for new incoming residents. These discussions review hospital policies, safety training, and infection control. Basic and advanced life support training is also provided. Administrative matters, documentation requirements, and rules about seclusion and/or restraint are clarified. Self defense is taught for personal and patient safety (3); such classes are mandated by some state boards. Becoming familiar with the emergency procedures at calling for help should be part of the initial orientation. Any resident with a language barrier is advised to start remedial English language classes.

Orientation sessions should impart beginning residents with an understanding about acute emergency issues that they will be facing. Crises with patients are often seen while on call, with less experienced personnel there for assistance. This prepares them about how to handle dangerous events independently. It includes skill training about assaultive or aggressive behaviors and about people with overt suicidal intent. Also, it focuses on learning about intoxicated individuals and on management of alcohol and drug withdrawal syndromes.

4. Day Structure

Residents start their day by individually rounding on their assigned patients. This is followed by a formal morning report, in which staff members review and discuss cases. The meeting attendees include nurses, social workers, medical students, residents, psychologists, recreational or other therapists, and attending physicians, etc.

Some facilities assess their patients as a team, while others round individually, followed by resident/attending meetings. Educational feedback by the supervisors is a part of training. New admissions are initially assigned to medical students and residents for evaluation; the workup includes a complete case review and presentation to the team. Residents and faculty doctors document their own notes. Resident and social worker responsibilities include obtaining collateral information from families, emergency services, and referral organizations. Doctors are

responsible for a detailed interview with a completed evaluation done on the day of patient's admission. Previous hospitalization records and recent test results or medication trials are often requested from other facilities.

It is important for new residents to get familiarized with charting. Progress notes and orders differ from one hospital to another; some use paper charts while others use electronic medical records, with the latter increasingly becoming the standard of care in America. Some adjustment may be required to get accustomed to the change from the metric to the English system of measurements. Residents should understand the formally documented treatment plans required for charting on all patients.

The departmental educational program includes attending grand rounds, didactic classes, and journal clubs, etc. Educational reading is essential to learning psychiatry. Everyone should be familiar with the medical library and with medical online internet search engines for accessing journals and other literature.

5. Books

Residents are encouraged to obtain a synopsis textbook of psychiatry and to begin an independent reading plan (4). A handbook, such as *Pharmacopeia*, is also advised as a quick reference and is convenient to carry. A copy of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*, the *Physician Desk Reference*, and/or similar books should be available (5,6). *Epocrates*, an electronic medical reference guide, is popular on handheld devices and cell phones (7).

6. Interviewing

Residents should interview patients in a private area, but not in their own room since meeting there may allow some individuals to regress or fall asleep. The Health Insurance Portability and Accountability Act (HIPPA) protects the privacy of patient health information. Confidential data that is collected but not needed, should be disposed of by shredding. Evaluations done in the presence of a nurse, yield comfort for some patients and provides staff safety from allegations of improper behavior. This is especially important between genders, with a same-sex-as-the-patient person being present at such times, particularly for those with a personality disorder. Aggressive or angry individuals should also be examined with at least two people present in the room.

Residents must learn to do a complete case presentation; a bio-psycho-social formulation should be taught. During rounds, the attending psychiatrist may inquire about any additional details and discuss the case and its treatment. Supervising physicians should monitor and

comment on residents' ability to conduct an interview. In child or adolescent cases, a parent should ideally be present during and/or after the interview to give collateral information and to sign consent forms.

Table 1. Case presentations

Identifying information: race, gender, marital status, living situation, and voluntary versus involuntary admission status

Chief complaints: complaints in the patient's own words

History of present illness: why the patient was hospitalized and progression of the most recent problem. Prominent symptoms are documented.

Past psychiatric history: onset of mental illness and circumstances; its progression including previous inpatient, outpatient, and/or partial hospitalization treatment. Medication trials and effects; inquiries about electroconvulsive therapy and/or specialized treatments are elicited. Suicidal aspects and other problems are recorded.

Alcohol and drug history: which substance(s), when started, last use, amounts, and consequences. The longest periods of sobriety are listed. History of inpatient, intensive outpatient, and/or chemical dependence treatment groups. Nicotine and caffeine usage should also be documented.

History of any physical, sexual abuse, or neglect: post-traumatic symptoms should be enumerated. Involvement of a minor, cognitively limited, and/or geriatric patient requires reporting to appropriate authorities.

Past medical history: medical, surgical, medication, allergy, sexually transmitted disease, and head injury histories are recorded.

Family medical and psychiatric history: this includes alcohol or drug abuse, mental illness, medical disorders, and suicidal or homicidal histories.

Social history: living situations, marital status, children, parents, siblings, education, employment, military, legal, and religious data.

Developmental history: pre-and post-natal development or schooling information is noted, especially in treating child or adolescent cases.

7. Safety

Consider personal safety when conducting a patient interview. The doctor should be close to the door of the interview room. Means to visualize inside the room by a window or a television monitor simplifies hospital staff observation for dangerousness and to minimize inappropriate behaviors. Some hospitals provide a signaling and/or rescue method through whistles, panic buttons, or other means. Self defense training is important and periodically updated. For self-protection, some facilities suggest that staff not wear ties or necklaces, but such advice is not universally followed.

8. Initial Evaluations

On the day of admission always document the history and a physical examination that includes a neurological assessment. Basic laboratory studies should include a comprehensive metabolic panel, a complete blood count, a thyroid profile, urinalysis, and consider a drug screen. A serum

test for pregnancy is performed in females of child bearing age. Screening for sexually transmitted disease is ordered when indicated. All major medical issues should be handled; consultation with other medical specialty services may be required. Brain imaging scans are requested when specific indications exist. An electroencephalogram is considered when seizures or delirium are in the differential diagnosis. Thyroid and kidney function tests are always monitored when prescribing lithium. Liver function tests are especially important when utilizing hepatotoxic medicines or for persons with drug abuse (8). Repeated blood counts, with cell differentials, are mandated with clozapine prescribing or in other concerns about bone marrow suppression (9). An electrocardiogram is recorded in patients with cardiac issues and when prescribing medicine with the potential to induce cardiac conduction or rhythm disturbances. Use clinical judgment about whether to re-order laboratory tests in cases of a

recent discharge or when fresh laboratory results are available from another source.

9. Case presentation

Clear, concise case presentations require training and practice. Table-1 reviews the required information. The mental status examination is presented in Table-2. The patient formulation is taught and practiced early in training. There are two common methods: the 4 P's system and the biopsychosocial model. The "P" system includes predisposing, precipitating, perpetuating, and protective factors for the presence of mental illness or dysfunction. The biopsychosocial model includes three parts: biological, psychological, and social. Faculty provides guidance at learning these systems.

10. Charting

An admission note begins with identifying information and demographics. Chief complaints in the patient's own words should be recorded. The history of present illness, family history, past

psychiatric and medical history, allergies, and alcohol or drug usage are documented. A review of systems is expected in all cases. The social history details educational, military, religious, legal, marital, personal, family, and employment data. The mental status, physical examination data, and laboratory results are enumerated. Include information about suicide or behavioral concerns. In a hospital discharge note, usually the previous information is briefly reviewed, with current data about diagnosis, medication changes, adverse events, and patient compliance or behavior. These summaries must be kept to a concise and not too long length. The hospitalization dates and duration are made evident. Family meetings are described. Discussion of treatment plans and referral appointments is made explicit and includes the discharge medications, follow up laboratory tests, and clinic appointments. Place copies of forms, work releases, and similar papers in the chart to document these transactions.

Table 2. Mental Status Examination

General appearance: age, gender, race, body habitus, grooming, and dress
Face and body: hair, dentition, skin, scars, movement disorders, gait, etc.
Engagement, alertness, cooperativeness, and eye contact
Mood, affect, and suicidal or homicidal concerns
Thought disturbance, contents, and perceptions or excitability
Speech expression, form, and fluency
Cognitive tests: mini-mental status examination or similar assessment tools
Judgment and insight

11. Commitment court

Mental health court is performed periodically in the hospital. Each state has its own policies for commitment, which differs in terminology and procedure. Attendance at judicial proceedings is an educational opportunity. Presentation of information to the court is done by various staff, but such duties can be a resident responsibility, on their cases. Prioritize data about why the patient was hospitalized and about safety concerns. Collateral history and testimony from court petitioners must be included at the hearing.

12. Progress notes

Legibility is important; some programs encourage or even mandate typing the records. The "SOAP" note is a popular way of charting and is documented daily; it includes: (S) subjective statements of what patients say in their

own words, (O) objective information about observed behavior or test results, (A) assessment data of examinations or diagnoses, and (P) a recording of planned treatment. Incorporate vital signs and laboratory results each day. The date, time, and the duration of each visit are recorded. Clinical information from staff about patient behavior or problems and collateral information is included.

13. Consents

Written consent should be obtained before talking to others, even referral agencies. There are limited situations where consents are not needed; in cases of legal warrants, they are not required for discussion with appropriate authorities. Rules about informed consent documentation for medication administration vary widely, especially as pertain to child psychiatry. In children, written consent for

treatment by a parent is mandatory and they are always informed about behavioral problems and their management. In some states, however, adolescents older than 14 years of age are able to consent for treatment without parental consent or knowledge.

14. Groups

In hospital settings, groups are usually conducted on the unit. It is advisable for residents to familiarize themselves with different groups and participate in staffing them. The methods of group psychotherapy encompass cognitive behavioral therapy, psychoanalytic techniques, music, recreation or art therapy, anger management, and/or Alcoholics Anonymous or related means to treat substance abuse.

15. On call

In the first postgraduate year one is expected to have several on call rotations each month. It is advisable for new residents initially to perform “shadow calls” with a more experienced colleague to get familiarized with procedures. Faculty must provide backup and each hospital has its own way to supervise and monitor case management. Residents also need to know the practical rules of maximum working hour allowances. Sometimes problems occur between residents due to on call issues (10).

16. Education

Residents are offered a variety of teaching options. In some programs, the on call resident must present cases seen to an attending physician that night or the following morning. Seminar series attendance is an expectation for all residents. Grand round is a required weekly session for the entire medical staff. A selection of other conferences is also offered; these include journal clubs, morbidity conferences, and other special focused teaching opportunities. Some programs provide films to educate trainees about uncommon syndromes. This allows residents and their supervisors to interact in discussion of cases in a less formal environment. Faculty leadership in the educational process is important (11). Sometimes additional training may be required on an individualized basis to improve communication skills (12). The inpatient experience prepares trainees for their outpatient rotation (13).

17. Teaching

Beyond formal teaching to residents, education also comes through involvement at teaching

medical students. This includes supervising students clinically, guidance at documentation skills, and answering questions. Learning is enhanced by resident presentations of clinical topics for general discussion to students, peers, and faculty or at departmental grand rounds.

18. International medical graduates

Approximately 30% of psychiatry residents and 25% of faculty physicians are trained outside of America; they face adjustment challenges upon coming to this country (14). These doctors add to our cultural diversity, and we all should recognize their unique professional and personal experiences (15). Special attention with faculty feedback is sometimes required to improve cultural understanding. Educational films on American life are available if needed (16).

19. Conclusion

The inpatient rotation is an integral part of training and residents spend a substantial amount of time there. They face a predictable variety of clinical and educational challenges, made easier by orientation sessions. Faculty guided adjustment to the new setting ahead of the starting date is important. Once on service, a consistent approach to new learning facilitates education and good clinical care. A self-guided reading plan and attending all educational activities is important. Exposure to a wide range of treatment modalities and consulting with other physicians and staff improves patient management and safety. Residents also serve as educational mentors to medical students.

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