

Medical trainees and their encounters with first episode patients in the emergency- room setting: A Qualitative Approach

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Calgary Psychiatric Emergency Services

Catchment area - 1.3 Million people



Abstract

- Qualitative methods are increasingly being used in medical education research, particularly when the topic of investigation centers on attitudes and beliefs, areas which have been referred to as the “grey zone”, because they are often neglected in educational studies that use quantitative methods. This presentation will provide the results of a grounded theory study of psychiatry resident attitudes towards patient care in the emergency department, with particular focus on the resident experience with first episode psychosis patients. A review of the focus group transcript data will demonstrate the richness of the qualitative approach in exploring the trainee experience with first episode patients, and will also provide a glimpse into the experience of the ER visit for the patients themselves.

Presentation Objectives

- To demonstrate a qualitative methods investigation that provided a sense of the resident experience with the FEP patient in the ER
- To theorize on factors that influence resident perceptions of the FEP patient
- To comment on training issues related to an FEP curriculum in residency

Background

- Calgary Psychiatry Residents On-Call

- May 2004 CPA Position Paper
 - Emergency Room as a rich training ground for residents

- But the residents were not happy

Calgary PES in context

- “Largest ER in Canada”

- Calgary and Alberta population boom
 - Alberta's two Census Metropolitan Areas CMAs, Calgary and Edmonton, experienced vigorous growth since 2001. Calgary's population grew by 13.4% between 2001 and 2006, the second-highest growth rate among CMAs. Edmonton was the fourth fastest-growing CMA in the country (+10.4%).
 - Calgary had the highest rate of in-migration of any Canadian city for 2006-2007

Study Objectives

- Qualitative study of the attitudes and perceptions held by the University of Calgary psychiatry residents towards the role that the PES plays in their psychiatric training
- Grounded theory approach
- Objective was to generate a hypothesis to explain resident attitudes towards the PES

Research Questions:

- What role do psychiatry residents in Calgary believe that the psychiatric emergency service plays in their overall psychiatric education?
- The Canadian Psychiatric Association has expressed a clear appreciation of education in the emergency room, yet evidence from both the literature and personal experience, suggests that trainees do not share this opinion. Why is there such a discrepancy?
- What are the barriers to effective resident education in the psychiatric emergency service?

Data source: The residents

- University of Calgary Psychiatry Residents
- 2004 – 2006 academic years
- Focus groups determined by years of training
- Yielded 167-pages of transcript data

Unexpected theme:

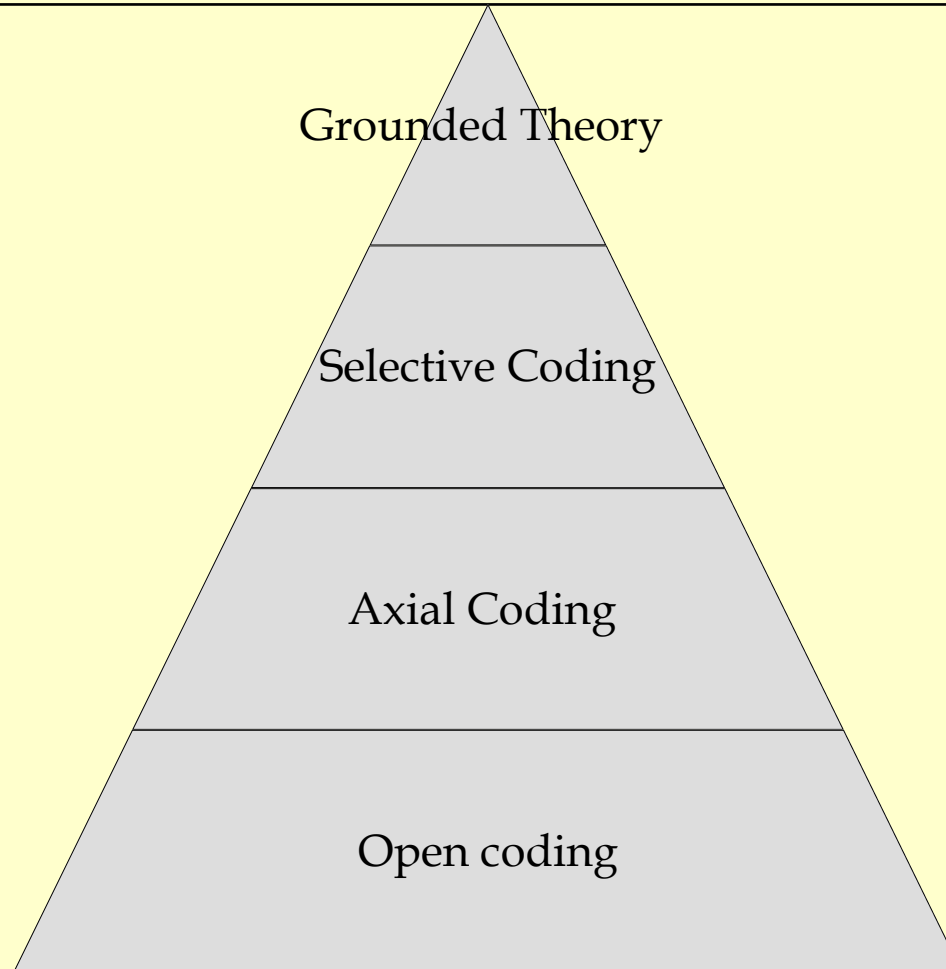
- Resident encounters with FEP patients
 - Fortunate results
 - ER studies and ethics approval
- Unexpected because of the demographics of the psychiatric emergency services patient base...

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- Of the top 10 most common psychiatric diagnostic presentations to the Calgary psychiatric emergency services, “psychosis” ranks at #5 and schizophrenia at #7 (6 – 10%)
 1. Substance Use Disorders (25%)
 2. Adjustment Disorders (23%)
 3. Depression/dysthymia (19%)
 4. Personality Disorders (12%)

Back to the data...

- Why did FEP patients stand out so clearly as a theme in this larger study?
- Key question: What are the factors that influence resident attitudes towards these patients?

Coding Process



Open Coding

- “What is going on here?”
- Consider and describe all data
 - Level 1 – each piece considered for “incidents”
 - Level 2 – condense level 1 into mutually exclusive categories
 - Level 3 – constructs

- Initial sense of resident experiences with FEP patients

Axial Codes (AC)



- Describe “What is going on in each construct or category”
- Causality, context, contingency, consequences, covariance, conditions for development of perceptions

Axial Codes

1. Resident's value the FEP-ER encounters
2. Lessons learned from the FEP-ER patient
3. Lines in the Sand
4. FEP-ER families
5. Impact of the FEP-ER patient on the resident

Residents value the FEP- ER encounters

(in stark contrast to other experiences...)

Resident learn from FEP-ER cases



“I think the psyche emerg has the potential to be an incredible place for learning because that’s where you see the acuity, right? You see people when they’re psychotic...prior to receiving any kind of treatment. So, I think, it is an ideal place to learn...”

FEP as the reason to be in the ER

“I find there are nights when you seem to get all of these cases that are really complicated and really messy and not really that psychiatric, and then there are other nights when you get someone presenting for the first time with catatonia or something truly psychotic that you’ve never seen before... Those nights you don’t mind staying up to do that.”

Residents in defence of the FEP ER patients



“It’s an issue of triage. If diagnosed with schizophrenia, and it’s the first psychiatric visit and the patient goes to Emergency with any other problems, they are sent directly to the psychiatrist, instead of being seen first by the general ER doctor. Patients shouldn’t be labelled like that.”

Compared to other populations:

“I guess another thing that influences as well is the type of patient. I found working at the [PES], just seeing so many in a row, cocaine, crack, crack, crack, crack...I just became so cynical, so fast; I couldn't believe how fast I lost empathy and just was irritated at every consult. It was again this kind of onslaught of the same type of patient again and again.”

Comment



- There is something special about the FEP-ER patient in the minds of the resident.
- These are desirable patients, worth “staying up” for.

Lessons learned from the
FEP – ER patient.

Patient spectrum - Easy

...the sicker the patient, the easier it is to make decisions. Whereas, the less sick they seem to appear, the harder it is, which is so different from other conditions. If they are very sick, you know exactly what to do in psychiatry, they need to be admitted, they need to be started on this or that treatment. But in other conditions, the sicker they are, the more you second guess yourself, you are always wondering if you did the right treatment for medically unstable patients.

Patient spectrum – complex



“And the patients can be difficult. You may have aggressive patients and agitated patients, with multiple social issues...and you have to have security there and the nursing staff’s all up at arms and can’t handle it and, yeah, I mean, some of the patients are really difficult.”

Learning about FEP experience with the system



“I think there’s a ton to learn from patients. As they enter the system, they have a variety of experiences, some good, some not so good, and so if you’re sort of open to hearing about their experiences, I think, there’s a lot to be learned there about... And even just being able to ask patients about what they’ve found helpful in the past and what they haven’t found helpful is very useful for our learning.”

Residents learn to advocate for psychotic patients



“One of the things that really struck me was when I was trying to advocate for a patient. We decided we were going to send her home and I was trying to negotiate to get a taxi chit for this woman and the ER staff said, “We’re not here just to give hand-outs.” It’s interesting because you do learn a lot about your role as a mental health advocate and you get a sense through those experiences as to how the medical system can butt up and prevent progress for people who have certain deficits. So, I’ve definitely felt that way, that I was in the role of advocate and that somehow the rest of the Emerge environment was against me, in that.”

Development of empathy



“I don’t know if that helps in terms of self-definition as a psychiatrist but certainly it’s come up a few times; even just calling around to get somebody into a shelter or whatnot. Well, you know, there are all these rules and regulations, and you realize that it’s not an easy thing to negotiate and it gives you a lot more empathy for people who have to do this themselves.”

Skill needed for the FEP-ER patient



“We anticipate going in for this pretty intensive experience where not only does the patient have to be capable of tolerating what we’re asking but we also have to be able to have the resiliency and the fortitude, at three o’clock in the morning, to tactfully and sensitively ask them incredibly personal questions and then, on top of it, occasionally have to make decisions that the patient is not going to like, like removing their rights and admitting them to hospital. It’s an incredibly intense, difficult thing. I know it is really hard and it takes a lot of energy and a lot focus and it’s draining.”

Lines in the Sand

ER-Psychiatry Resident perceptions of FEP

FEP as a diagnostic line in the sand



“Sometimes, the story you get from the family may be a lot different than the story you’re getting from the patient. You may start off thinking about one diagnosis, and then you’re wondering, “Is this something acutely psychotic here?””

FEP as a test for a novice

- *“It’s [exposure to the FEP patient] is such an important thing. Even if you’re not going to be a psychiatrist, you need to be able to go and assess a patient who presents with psychosis and not be scared, to dispel illusions that non-psychiatrists have about mental illness. It’s all about that comfort zone. That’s why when working with medical students, I’ll give them a week or so and encourage them to get doing it on their own.*”

Psychosis and the admission threshold



“I think your learning experience varies according to time of day, too. People are more keen on teaching and guiding you if it is earlier. If it is later, it is about “do you need to go the hospital or not”, and that is pretty much it. The psychiatrists don’t want to hear the personal history at three in the morning. They want to know, “are they actively psychotic or not, admit or discharge”.

FEP as a specialty



“When you are on-call, they [psychiatrists] kind of function as a general psychiatrist. There will be very few who would be specialized in, let's say, early psychosis.”

FEP-Families

ER-Psychiatry Resident experiences with...

Complexities of FEP-ER families

“Families makes the situation more complicated, because they bring their expectations of what should be done. Often times, there are things that you are not able to do, and when you explain that, the family is angry, and there are more things to handle there. It tells you why the patient is sick, or the attention the patient gets when sick. A lot of it depends on what the family wants. It is really interesting, and makes it more complex.”

FEP-ER family response to crisis

“You learn about how different people respond to different supports, because you get one patient coming with family members saying, they are there for the patient, even while they are crying; then, you see others whose family boots them to be all alone in the ER while they are acutely psychotic, and this person is very sick with no support. So, you see this variety of support, and how people deal with it.”

Resident provide FEP psychosis education



“Things are so much more acute in the emergency room. Patients are so much more worried and frazzled and it makes us more sensitive to the realization that these families are going through a whole lot. Half the time, they don't even know what psychosis is, so you really do have to take the time to explain it to them and be sensitive to that fact.”

FEP-ER confidentiality challenges



“It is hard, because there are a lot of privacy violations going on with family members. You need collateral, but sometimes patients won’t allow you to talk to family. So, the nurse would go ahead and talk to family and get the information that I thought I couldn’t get, and I just didn’t know what I could say and what I couldn’t say, and if I could even contact the family if the patient said no. Those are weird situations.”

Impact of the FEP-ER patient on the resident

Impact of the FEP-ER case



“When a psychotic patient presents, most often times, that’s the textbook instances, when you’re on-call and see someone like that. Probably the strongest memories that a lot of us have of different patients or different situations would be in the emergency room. Regardless of all the things we’ve complained about. Think about the interesting cases that you’ve seen or cool experiences. A lot of that’s in the emergency room.”

Job Satisfaction and the FEP-ER patient



“The comfort zone that you wind up pushing is a totally different comfort zone than the rest of medicine or the rest of your life. You’re dealing with people that might be unpleasant or there’s a stigma around. It’s not only an interesting area but it’s rewarding, as well. That’s something I’ve really learned, is that blossoming of how much I enjoy the experience, actually, of these people and getting into people’s lives and seeing if you can help them in some way. And it is totally different than going to your first surgery and cutting your first person open and that sort of thing. I won’t say that I did not enjoy that... (laughter) But, again, it’s pushing your comfort zone and seeing what’s out there.”

Making sense of the data...

Selective Coding



- Advance beyond describing the data, and move to theorizing about the data

- Answer questions:
 1. What is going on in the data?
 2. What are these data a study of?
 3. What is the basic psychological problem with which these people must deal?
 4. What basic psychosocial process helps them cope with the problem, and how does it work?

What is going on in the data?

- Residents are encountering a syndrome that presents with a wide variance in terms of acuity and complexity.
- Residents are describing FEP patients as the reason to be in the ER, or, the reason that being on-call is “worth it”.

Basic psychological problem with which these people must deal?



- These are trainees, making “line in the sand” decisions about acutely ill patients, presenting for the first time to emergency mental health services.
- Immediate basic problem: uncertainty, fear, anxiety
- Long term basic problem: trainees are trying to transition from “student” to “consultant”

...

- Through advocacy and development of skills and empathy, residents cope with 1) their anxiety about these patients, and 2) their developing identity as “psychiatrist”, and in the process, develop:
 - Enthusiasm
 - Job satisfaction
 - Respect
 - General appreciation for FEP patients in the ER



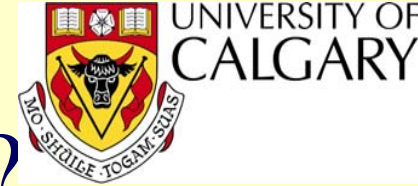
The key to residency is:

- becoming a psychiatrist
 - (knowledge, skills, attitudes)

- practicing/adopting roles

- feeling familiar

Factors that influence resident perception of the FEP-ER patient?



- The acuity is comforting – “the sicker the patient, the easier the decision”

- Role clarity is comforting– resident knows what to do (lines in the sand; resident as teacher; resident as advocate)
 - Crucial when you are very junior and scared
 - Crucial when you are senior, and ready to fly

Implications



- Importance of longitudinal exposure to FEP outpatients
 - Changes at the Royal College



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Importance of longitudinal exposure



- *I think sometimes the best learning you can get from patients is after the fact. We learn about the acute presentation of psychosis, but talking to them, once they're stabilized, about what that was like for them and what they were experiencing and how they experienced the nursing staff and the security and you. I think that's huge; And it kind of gives you more information when you're seeing patients in that acute environment.*

Future Direction



- Focussed investigation currently underway to better understand the resident experience with the FEP patient in an outpatient training setting.

Questions and Comments
