

LETTERS

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Reflective and Reflexive Practitioners

To the Editor: I enjoyed the editorial and articles about qualitative research in the July 2008 issue. The tension between qualitative and quantitative methods is heightened because many clinicians and students, in my experience, lack awareness of qualitative methods in the social sciences, especially in psychiatry.

Although the coverage of this issue was illuminating, the Taking Issue editorial (1) makes reference to Schön's "reflexive practitioner," which I found confusing. Benner's "reflexive practitioner" (2) and Schön's "reflective practitioner" (3) are related concepts but are not exactly the same (4). The reflexive practitioner gains experience and, through active observation and reflection, is able to utilize "on-the-spot" experimentation to fulfill the role of "helping expert." This is to be contrasted with the "knee-jerk" reflex approach to health care, which, when dominant, contributes to a one-size-fits-no-one approach (5).

I believe that coexistence of these methodologies and broader aware-

ness of them will be a critical factor in leveraging the enormous technological advances in modern health care so that all patients benefit from them.

Laurence P. Karper, M.D.

Dr. Karper is vice-chair in the Department of Psychiatry, Lehigh Valley Hospital, Bethlehem, Pennsylvania.

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In Reply: First let me express my appreciation to Dr. Karper for such a careful and considered reading of my cramped-for-space editorial. And then let me apologize for the confusing reference to (and misspelling of) Schön's "reflective practitioner." My purpose, ill-advised in retrospect, was to draw ironic attention to the unexpected role of improvisation in the implementation study that Palinkas and colleagues (1) reported on in the same issue. I was especially taken by their discussion of "adaptability" on the part of both participating clinicians and researchers and their joint efforts to arrive at workable amalgams of protocol-driven procedure and experience-based habit and judgment.

True, this is not what Schön (or Benner) meant by the phrase. Nor (and this is what I was awkwardly driving at) was its opposite—the unthinking drone at the wheel of unwavering routine—found to be the case in the implementation study. Instead, it was that all-too-familiar agent juggling a host of competing concerns and hectically trying to do justice to them all. That implementation research too easily assumes otherwise—that it can seem content to train and

test for fidelity and then "black-box" actual performance as roughly what was intended by the original design—is precisely the assumption that Hohmann and Shear meant to challenge with the in-your-face phrase, "noise of real life." What Palinkas and colleagues demonstrated, it seems to me, was not only the operational value of "creativity and compromise" but also the research necessity of documenting it.

On reflection, then, it was Schön's modest subtitle ("How Professionals Think in Action"—in Palinkas and colleagues' study, action was interrupted by a research agenda) that I'd hoped to highlight as an example of the sort of hidden enablements that qualitative research methods are geared to uncover. My thanks, again, to Dr. Karper for the opportunity to clarify this point.

Kim Hopper, Ph.D.

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Smoking Bans on Psychiatric Units: Boundaries and Health Promotion

To the Editor: On January 10, 2005, the Italian government implemented a law that bans smoking in all enclosed places. An emerging body of evidence shows that it is possible to introduce smoking bans in psychiatric units (1,2). However, many psychiatric settings in Italy lack a clear smoking policy.

In this letter we describe the impact on staff and patients of a complete smoking ban that was implemented in a 14-bed psychiatric emergency service that serves primarily an inner-city population in Turin, Italy. The service admits patients from the hospital's emergency department 24 hours per day. Six months before and six months after the ban was implemented, staff members completed a brief questionnaire about their atti-

tudes toward the desirability of the smoking ban and its perceived impact on patients' mental status and the ward milieu. In addition, objective indicators of ward disruption were measured, including rates of aggression, use of PRN medications, need for restraint, elopement, and discharge against medical advice. Chi square tests were used to evaluate the impact of the ban on objective indices of ward functioning. Charts were reviewed for 248 patients discharged from the unit during the six months before the ban and 220 patients discharged during the six months after its implementation. No significant differences in demographic or clinical characteristics were found between the two groups.

Our analyses found no significant differences in objective indicators of ward disruption before and after the ban. Most of the monitored parameters of disruptive behavior remained stable; for other parameters the changes did not reach statistical significance. No changes were noted between the two periods in staff turnover or in problems related to staff illnesses or casualties. Staff members' responses to the questionnaire indicated that they initially disagreed with the new smoking policy. Such early opposition has been found in other studies (3,4). Spontaneous comments were generally negative, reflecting staff members' belief that patients need to smoke in order to relieve the stress and discomfort of their illness and to counter the side effects of drugs. Almost all respondents feared that the smoking ban would increase verbal and physical assaults. Staff members reported that they often used cigarettes to offer support, to manage threatening violence, and to reward appropriate behavior in difficult situations. The prospect of removing this bargaining tool and reward raised concerns that use of restrictive approaches, such as restraint, would increase. Only one respondent offered a positive comment, remarking that the patients and staff who did not smoke would appreciate a smoke-free environment.

Six months after the ban was im-

plemented, questionnaire responses and spontaneous comments indicated that many staff members had changed their minds and appreciated the new policy. Many felt that the old approach was a typically paternalistic one in which cigarettes were used like tokens to keep patients quiet and that such an approach hindered staff from developing insights about patients and good relations with them. Staff reported that the new policy helped them find alternative ways of interacting with patients. Staff noted that when they used a cigarette as a reward, patients demonstrated the desired behavior just to obtain it. With the ban in place, staff found new ways to negotiate with and empower patients. Thus the new environment was not just physically healthier but also mentally healthier.

Smoking bans in institutional settings provide an opportunity for staff to work with patients on boundaries and limits. Staff helped patients manage their smoking behavior when patients were faced with the limitation imposed on their behavior by the ban. The situation provided a basis for staff to work with patients to manage other behaviors and gain insight about other limitations. In addition, helping patients understand limits is a key factor in the deescalation approach to managing psychiatric emergencies.

On the basis of our experience, we conclude that smoking bans in psychiatric settings can lead to better patient care, although such bans are often difficult to implement. Before the ban, it was clear that staff gave little thought to this problem. Some of them even believed that their smoking with patients had therapeutic value (3,5). However, after an initial phase of opposition, both patients and staff adapted to the new policy.

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Acknowledgments and disclosures

The authors report no competing interests.

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Hospital Readmission and Its Correlates Among Psychiatric Patients in Taiwan

To the Editor: A high readmission rate among persons discharged from inpatient psychiatric treatment may reflect the fact that the community lacks adequate accommodations for such patients and can be used as an indicator of inadequacy or inappropriateness of community-based aftercare (1). A wide range of psychiatric readmission rates has been reported in the literature, mainly because studies use various time intervals. Reported rates have ranged from 10% readmission within one month after hospital discharge to as high as 47% within one year (2,3).

Data on readmission of psychiatric patients in Asian societies are limited. We used a registry-based cohort design to estimate the short-term readmission rate—within 60 days—among 1,813 patients discharged from a psychiatric hospital between November 2003 and October 2005 in northwestern Taiwan.

Readmission rates were 6% within 14 days, 9% within 30 days, and 12% within 60 days. Patients who received the scheduled ambulatory follow-up had a significantly higher risk of readmission within 60 days, after adjustment for potential confounders (ad-

justed odds ratio [AOR]=1.89, 95% confidence interval [CI]=1.33–2.69), and those who attended community rehabilitation programs were significantly less likely to be readmitted (AOR=.33, CI=.12–.96). Less impaired patients may be more likely to be referred to rehabilitation programs, which may partly explain the lower readmission rate.

Among patients with schizophrenia, those who had a hospital stay longer than 60 days had significantly increased risk of readmission within 14 days (AOR=1.96, CI=1.06–3.62) and within 30 days (AOR=1.81, CI=1.07–3.09) compared with those whose duration of stay was between 30 and 60 days. Patients who are more impaired may need to stay longer in the hospital, and more impaired patients may be at an increased risk of rehospitalization.

Similar to findings from studies in Western societies, our results indicate that about one-tenth of psychiatric patients in Taiwan were readmitted within one month after discharge (4). The readmission rate increased only slightly (by 3%) by two months after discharge. Our study also showed a

positive association between attending a follow-up ambulatory care visit and readmission, which is consistent with the report by Thompson and colleagues (5), which concluded that patients who attended an initial ambulatory care visit after discharge were likely to seek outpatient care on a regular basis. These patients may either have a poor prognosis or frequent contact with psychiatrists; the closer supervision associated with aftercare may lead to a greater likelihood of rehospitalization.

Although the readmission rate was not substantially high in Taiwan, local clinicians and health policy makers should nevertheless acknowledge the importance of rehospitalization among psychiatric patients. Future investigations should explore specific forms of aftercare and types of services that can ensure that discharged psychiatric patients remain in the community. Moreover, better management of patients with schizophrenia who have longer hospital stays may help to reduce the likelihood of readmission in the first month after discharge.

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The authors report no competing interests.

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