*The American Journal of Psychiatry*

# Residents' Journal

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## Editors' Column

We intend to use this space in each issue of this e-publication to guide you to useful features of *The American Journal of Psychiatry*. Residents at this year's APA annual meeting were energized by learning new information about psychiatry presented to them by nationally known experts and also by sharing their own experiences with colleagues in training from across the country. We hope to capture both of these educational benefits in this publication.

The overwhelming majority of physicians report that their preferred source of information for their practice is original articles in the best medical journals. They want to see the latest evidence and to decide for themselves how it should be applied to their practice. Psychiatric researchers who write these articles want all the details of the evidence and methodology, including complex statistical analyses, published in the article to make the paper an archival description of their work. This level of detail necessary for the replication and extension of research findings can obscure their educational value. In the next issue we will initiate a series of articles to increase your understanding of how articles are put together to make details accessible to researchers, without obscuring the overall importance of the article to the general reader. For this month, let us guide you to some of the Journal's features that are intended to make articles more comprehensible.

One of the Journal's features is "In This Issue," which the Journal's editorial staff provides in order to give readers a quick overview of what we feel are the most clinically relevant or scientifically interesting articles in the Journal. It appears in the Journal as the first page before the first editorial, and is always on the left hand side. It's the fastest way to see what you might want to read.

If you decide to read further, you now have two choices. One is to read the article itself, the other is to read the editorial. The editorial is briefer and its goal is to place the article into context. Many of you told us that finding the context for new research, in terms of what is known and not known and what is controversial in the field, is problematic for you when you first begin reading psychiatric literature. The editorial is always written by an expert in the field, often one of the peer reviewers of the manuscript, who is familiar with the context in which it has been written and knows its strengths and limitations. Finally, all editorial authors are asked to provide a specific take home message of either the clinical or scientific importance of the article. The editorial is designed to stand alone so that it can be read before or after the article itself.

Finally you can turn to the article itself. There are several ways to read articles. Often people begin with the abstract for a brief summary. After you have done that, we suggest that you look at three other parts of the article. One is the first paragraph of the discussion section that follows the methods and results. The discussion summarizes what the authors believe they have found. Many beginners look at the methods and try to pick out deficiencies to criticize. You eventually will want to do that, and we will save some of that discussion for a future issue. But before attempting a detailed analysis of the paper, it is best to know what the authors think they have discovered, and they most often will tell us that in the first paragraph of the discussion section. We also try to get the main findings of the paper into figures so that readers can quickly grasp what is most important about the paper. For many clinical studies, Figure 1 is the flow of subjects through the study and Figure 2 is the results. Finally, following each article is a new feature in the Journal called "Patient Perspectives." We ask, whenever possible, that authors provide a description of what patients said, what they felt, and what happened to them as individuals during the study, so that the patient behind the number is not lost for our readers.

Another new feature in the Journal that you may find helpful is the "Treatment in Psychiatry" article in each issue. This feature is designed to address common but difficult clinical problems that are illustrated by a case vignette. The article then reviews the relevant literature regarding the pathophysiology, assessment, and intervention strategy for the condition at hand. The concluding paragraphs summarize what the author believes is best to do, given the available evidence and experience. It is suggested for this feature that the case vignette should have previously been discussed in an academic setting and include a senior expert as an author.

In conclusion, we hope that this information will be useful to you in your training and will form the nexus of a Journal club or teaching experience for you, your fellow residents, and your students.

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# Polypharmacy and Outpatient Psychiatric Care

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TO THE EDITOR: In the recent review on the use of antidepressants in bipolar depression, Dr. El-Mallakh and Dr. Karippot suggest discontinuation of these agents following resolution of an acute episode (1). The paper cites a paucity of evidence to support continued antidepressant treatment in patients with bipolar depression, and the possibility of causing harm with antidepressant-associated chronic dysphoria. Although additional studies are needed to determine conclusive guidelines, the authors' recommendation is helpful in the consolidation of pharmacologic regimens for bipolar patients.

As a third year resident focusing on outpatient psychiatric care, I am cognizant of the different prescribing roles between acute and long-term psychiatric management. As inpatient psychiatrists, we try to stabilize patients as soon as possible before referring them back to outpatient care; this often means adding an acute agent to an existing pharmacologic regimen. In fact, a significant rise in polypharmacy in the treatment of seriously ill psychiatric patients has occurred in recent years (2, 3). However, great caution should be exercised when using drug combinations that are little studied. Inpatient polypharmacy carries the risks of drug interactions, increased adverse effects, and longer hospital stays (4). Several justifications for this practice are given: a.) inpatient treatment, by its nature, deals with the most severe and treatment-resistant cases, b.) refractory symptoms require administration of an initial drug at a maximum dose, and second agents are needed to minimize the side effects of this initial drug, c.) a decrease in length of time of hospital stay requires the most rapid and effective treatments, and d.) improved diagnosis and screening techniques reveal greater comorbidity, which in turn requires further treatment (2, 5).

In contrast, outpatient psychiatrists strive for a pharmacological regimen that is as simple as possible while still adequately managing symptoms. This focus on long-term care minimizes the aforementioned risks while improving compliance and cost savings. Clinicians may hold back from adopting monotherapy due to fears of destabilizing a patient, a stalled cross-titration, or a lack of research-based guidelines as to when or how to taper off medications. Nonetheless, we must aim for monotherapy whenever possible in order to optimize effective and safe treatments for our patients. In the case of bipolar patients, this involves tapering off antidepressants following remission from an acute episode of depression.

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# Research in Residency

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Research has been described as the "inconspicuous, salient pillar of residency" (1). Combining the demands of research with those of training may appear daunting. Others have suggested approaches to help residents confront regulatory, institutional, and personal barriers (2, 3). Nevertheless, research continues to be inadequately explored by many psychiatric residents today (4). Original research is an attainable goal for all residents. The following is a brief guide for exploring research while in residency.

1. Find a mentor with research experience: This step is indispensable. It is nearly impossible to learn research without a mentor who is interested in your topic and is willing to help. A good mentor provides guidance for professional and personal development as well as for research projects and presentations. There are many places to search for mentors. Check with your faculty and peers for references. Consider physicians, Ph.D.s, social workers and others who may be eager to help trainees. Mentors may also be found outside of your organization via psychiatric associations. Impress your potential mentor by reviewing the literature for their contributions prior to your first meeting.
2. Discover your passion: What inspires you? What topic do you want to explore? These are challenging questions. Think about your cases. What patterns have you observed? What drew you into the field of psychiatry in the first place? Read the literature, attend conferences, and chat with peers. Share your ideas and hone your questions. Finding your passion is an evolving experience, so use your resources wisely.
3. Find a project that is already available: Administrators at your facility may be aware of projects already in progress in psychiatry or other fields investigating psychiatric aspects of medical illness. The skills you learn from working with your mentor on a secondary data analysis or literature review will provide an excellent foundation for future projects.
4. The goal: Your goal should be to submit a paper as first author for a peer-reviewed journal. You deserve credit for your work! Make this expectation clear as you share your ideas in order to avoid confusion later. There are many kinds of original work that can result in a first author paper, such as case reports, chart reviews, literature reviews, and secondary data analysis. Your first project should be short, concise, related to your topic of interest, and completed under the close supervision of your research mentor.
5. Plan ahead: Your project may take years to conceptualize and complete. Start early and plan ahead. Many programs offer electives throughout residency which allot time specifically for research. A realistic timeline is essential to maximize your research experience.

6. It takes a village: You are not expected to complete the process on your own. As the first author, you will do the bulk of the writing and literature review, but with a great deal of guidance and support from your mentors and their staff. Most research articles have multiple authors, and most researchers have statisticians to help with data analysis.
7. Keep learning: As your level of sophistication increases, expanding your "resource village" will be essential. Talk to peers and staff who are involved with research. Read books and journal articles to guide your path (1, 5).

Research for residents is an individual journey, and some may choose to continue their experience after residency. The field of psychiatry is always looking for bright clinician researchers, and efforts to recruit physician scientists are imperative (4). Regardless of your eventual goals, the experience alone is worth the effort. So start now, surround yourself with like-minded individuals, and allow your journey to unfold.

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# Focused Medical Assessment of Psychiatric Patients in the Emergency Department: A Very Brief Overview


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Determining the medical stability of psychiatric patients in the emergency department is daunting for both psychiatrists and emergency physicians alike. Severe psychiatric symptoms, substance use, self-injurious behaviors, and underlying medical illness make psychiatric patient evaluations very complex. In this brief article, I address the issues surrounding medical evaluation of psychiatric patients in the emergency department, I suggest some reasons for the difficulties that emergency physicians and psychiatrists frequently encounter, and I discuss one possible way to improve the process. Establishing a dialogue about the challenges of emergency psychiatric patient evaluation is an important step toward the comprehensive care of these uniquely challenging patients.

Psychiatric patients are high utilizers of emergency services (1). High-risk populations such as elderly patients, patients with substance abuse, and patients with preexisting or new medical complaints can be especially challenging (2).

While a variety of medical evaluations can help determine the medical stability of a patient prior to psychiatric admission (including physical exam, blood and urine studies, ECG, and EEG), there is disagreement about whether to perform a variety of standard tests or fewer, more specific, tests (3, 4). As noted in a recent clinical policy statement from the American College of Emergency Physicians, the term "medical clearance" may be inappropriate, "because the term can imply different things to psychiatrists and emergency physicians and because there is no standard process for providing this 'medical clearance'" (2). Instead, the ACEP recommends the term "focused medical assessment" (2). Interestingly, psychiatrists are more likely to request a higher number of laboratory tests than emergency physicians (4). They also are more likely to think testing is necessary prior to psychiatric admission (4).

What contributes to this struggle over the issue of "medical clearance"? I believe it concerns comfort: the comfort of emergency physicians in assessing psychiatric patients, and the comfort of psychiatrists in managing medical illnesses. Psychiatric patients are fascinating, but they also provide unique treatment challenges. They may evoke strong responses in treatment providers, may give incorrect or inconsistent information, and may become violent to themselves or others. Emergency physicians might not be as comfortable with psychiatric patients as they are with other patients, or might tend to dismiss psychiatric patient complaints based on past experience, conflicting information, or the sheer volume of other acutely ill patients needing to be seen. However, electing not to evaluate psychiatric patients or attributing medical complaints to psychiatric illness without a thorough evaluation is extremely risky.

Conversely, psychiatrists often are not comfortable managing acute medical problems. While proficiency in the physical exam is considered essential for all physicians, including psychiatrists (5), managing acute medical illness extends beyond many psychiatrists' domains. Psychiatrists possess other skill sets which are valuable in emergency settings, including evaluating and diagnosing severe mental illness, assessing suicidality (passive, active, and recent attempts) and suicide risk factors, investigating the contribution of drugs and/or alcohol to patient behavior, and remaining cognizant of delirium and other medical comorbidities which would preclude psychiatric admission. Limitations on many inpatient psychiatric units, such as the limited use of interventions like intravenous lines or the lack of cardiac monitoring, necessitate more vigilant evaluation for medical stability prior to admission than is required with many other inpatient services. Psychiatrists are foremost responsible for ensuring the safety of their patients, and may be hesitant to admit patients with unclear medical status, lest their condition deteriorate in the psychiatric unit.

Restructuring inpatient psychiatric units to provide more acute medical treatment may become necessary in the near future. This becomes particularly apparent when one considers current medical/psychiatric issues such as metabolic syndrome, the aging population, and the ever-expanding assortment of legal and illegal substances which can affect patient presentation. Incorporating more medical experience into psychiatry training, and more psychiatric experience into emergency medicine training, may be reasonable as well. However, to continue this article's focus on emergency psychiatric care, I ask what can be done to improve the way psychiatric patients are evaluated, treated, and admitted, and when can these modifications be implemented? In Zun et al., a "medical clearance checklist" was created in order to help guide and document the evaluation of psychiatric patients, and to improve communication between services (3). This checklist directed clinicians' attention to specific issues such as physical and mental status examination findings, laboratory and/or radiological testing, and the presence or absence of substance abuse. It also prompted emergency room staff to document their findings more thoroughly, in order to communicate effectively with psychiatric peers on admitting services. Assessment was patient-specific, which is important, since the very

concept of "focused medical assessment" relies on clinicians using their own judgment about individual cases. Knowing each institution's specific challenges and aims, psychiatrists and emergency physicians around the country could begin collaborating to design their own checklists or algorithms for emergency psychiatric evaluation. This likely could be initiated sooner than other changes (such as modifying the treatment capabilities of inpatient psychiatric wards), and could be educational for residents in both disciplines (even without altering residency training requirements).

Focused medical assessment of psychiatric patients is an intricate issue, and patient safety is of the utmost concern. Establishing a dialogue between emergency physicians and psychiatrists regarding these challenges of emergency psychiatric patient evaluation is an important step towards the goal of comprehensive care for all patients.

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# Psychiatry Training in Light of Uncertainty

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Upon entering medical school, I was told that 50% of what I would learn would sooner or later be proven wrong. When I entered my residency in psychiatry, I was told that making an accurate diagnosis would become increasingly difficult and even close to impossible, the more I knew the patient and about psychiatry. Left with the dilemma of how to obtain good psychiatric training in times of rapidly changing knowledge and opinions, I started my training with great uncertainty about this "truth for now" reality.

Uncertainty about disease etiology, diagnosis, treatment, and prognosis has been prominent since the early days of medicine. Driven by this overwhelming amount of uncertainty, the profession has developed several strategies to deal with this challenge, including research on disease mechanisms, diagnostic techniques, and therapeutics. During my residency I have learned about diagnosis and clinical practice in psychiatry. Initially preoccupied with my personal lack of knowledge, I disregarded many of my questions, attributing them to the result of personal inexperience. For example, it requires on average more than 10 years for 30% of patients with bipolar disorder to receive an accurate diagnosis, after having seen an average of four physicians (1). Statistics such as these made me reevaluate my position. Was it just me, with my lack of clinical experience, who found it difficult to make an accurate diagnosis of bipolar disorder, or was this an issue for psychiatry as a profession, and its diagnostic classification? Further struck by the clinical overlap between bipolar disorder and schizophrenia, I felt more at ease when I learned that molecular genetic studies are challenging Kraepelin's dichotomy, leading to a better understanding that atypical antipsychotics can act as "mood stabilizers" in bipolar patients (2). Uncertainty surrounding diagnosis thus includes personal uncertainty, and the uncertainty of the field's knowledge as a whole (3). Nevertheless, it raises a fundamental question: how is it possible to train a physician when we are uncertain about what we know?

While the paradigm of uncertainty regarding knowledge will remain categorical to science, the field of psychiatry has developed strategies to deal with the anxiety resulting from uncertainty. Professional training attempts to gain control by teaching current knowledge, by providing clinical practice guidelines, and by developing clinical core competencies. Gaining control or a "sense of mastery" in a world of expanding uncertainties and complex realities not only makes one feel more competent, but also plays an important role in the prevention of burn-out syndrome (4). Surveys have indicated that the point of "sense of mastery" differs between medical specialties, with psychiatry reaching this point sooner compared to other specialties (5). Does this mean psychiatry has less uncertainty and thus can be easily mastered, or is psychiatry as a specialty just more comfortable with the unknown? Acknowledgment of our uncertainties while remaining sensitive to complexities in psychiatry will continue to be a lifelong challenge. Although the concept of uncertainty and a "truth for now" reality can be perceived as a weakness in our training and profession, it is the driving force for new research, improved patient care, and ultimately, for hope.

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