INPATIENT PRACTICE

Helping Residents Get 'Inpatient Chops'

"How old are you?" This question, and questions like it ("Where are you from?" "Are you married?" "Where do you live?"), strike fear into the hearts of psychiatry residents everywhere. These new psychiatry residents graduate from medical school with a great deal of knowledge about pharmacology and psychopathology, but with little specific instruction on patient interaction such as how to answer the above questions.

BY MICHAEL C. DULCHIN, M.D.

Since many psychiatry training programs begin with inpatient rotations, it is often the responsibility of the inpatient supervisor to help residents learn to negotiate some of these common and anxiety-producing moments. This month, Dr. Michael C. Dulchin, a psychiatrist who directs an inpatient unit, offers strategies to help supervisors and residents on inpatient units teach and learn these "inpatient chops."

CLINICAL PSYCHIATRY NEWS: How do you begin to help residents understand the dynamics that often develop between physician and patient on inpatient units?
Dr. Dulchin: One of the first things that it is important to help residents understand is that, until proven otherwise, most of the things they find difficult or scary are this way due to the residents' lack of a set of skills and not because of their own character flaws. Residents often worry about this because they are focused on issues of character, personality, and change through psychotherapy in their training, and thus assume that if they were only stronger of character they would not be made anxious by the new training setting. I specifically tell residents that setting limits with patients, for instance, is a learned skill and not an innate ability.

CPN: What kind of general rules do you use with residents to help guide their interactions with patients?
Dr. Dulchin: One rule of thumb I often give residents is that learning the skill of the psychiatric interaction is, essentially, learning to feel comfortable doing clinically what would be considered rude socially. I suggest that, rather than have both parties pretend they are merely having an unusual social interaction, residents call attention to the interventions they make and explain to the patient why the intervention is being made. For instance, trainees often have trouble interrupting patients; teaching them how to do this gracefully can therefore become part of their training. Residents learn to say, "I am going to interrupt you now because I need to get a lot of information from you so that I can best understand what has been going on with you and figure out how to help"—rather than suffering in silence as an overinclusive, tangential, irritable patient with mixed-mania rambles on.

CPN: Often, the patient has more experience on the unit than does the resident. What happens when the patient draws attention to this?
Dr. Dulchin: Beginning residents are constantly aware of their own inexperience. It is every resident's fear that a patient will say something like, "I have been an inpatient 17 times and have been treated by Otto Kernberg himself for years. How long have you been a doctor? Ten minutes? How are you possibly going to treat me? I demand a more experienced doctor to take care of me!" The resident at this point is usually thinking, "Good point!" Luckily, it is only the rare and always personality-disordered patient who will actually say anything like this.

CPN: What is the most effective way to respond to such a patient?
Dr. Dulchin: Here is what I say to the trainee who has just staggered into my office after such an interaction: "Let's take all the humans on the planet and line them up from the least to the most able to help this patient. In that lineup you are so close to the front that for all intents and purposes you are Otto Kernberg."

I also tell the resident that he or she might want to add something along the lines of, "Since you've been in the hospital 17 times, you must know that inpatient doctors are never switched. In that case, it doesn't make sense to say something that might run the risk of making your doctor feel anxious or insecure—a calm and confident doctor is likely to give you the best treatment. I understand your anxiety about being treated by a doctor in training, but I wonder if part of what we can work on together is how to get the most out of an imperfect situation, particularly when it is unlikely to change? I suspect that you have been treated by residents before during your hospitalizations. How did those relationships work out?"

CPN: Have residents taken your advice? What has been the result?
Dr. Dulchin: Rarely does the resident go back to the patient and say any of this. But reframing the problem so that the trainee sees it is the patient's issue rather than his or her own is important. It is essential for patient care that the resident realizes that his or her own inexperience and relative incompetence, while a reality, are beside the point. It is doing the patient a disservice to focus on the minor reality of the resident's inexperience instead of the major reality, and repeated behavioral pattern, of the patient's inability to handle the disappointment of an imperfect world.

CPN: Let's return to the question that opened this column: "How old are you?" How should direct personal questions like that be handled?
Dr. Dulchin: There is no exact right answer for all situations, so I address the issue of the time frame of the resident's response. Before we figure how to answer that question, I have the resident think about what we do as psychiatrists. Our method of effecting change is through what we say, so answering a question like this is best done in one's own time and at one's own pace. Patients do not yell at their surgeons to hurry up and cut faster. I tell residents that they can always say to a patient who has asked a difficult question, "Just a minute; I want to think about how I want to answer that." In fact, a resident can even answer, "I am not sure how to answer that question. As you know, I am a resident, and I know that the question you have asked me is an important one. I want to speak to my supervisor and figure out what is the best answer in this situation."

Again, I know that residents rarely actually say this, but the idea that they are in control of the timing of the interaction is invaluable.

CPN: Are you suggesting that residents not answer personal questions?
Dr. Dulchin: It depends on the situation. In general I suggest an answer like, "How old could I be? I look about my age—somewhere between 20 and 60. Your guess is probably pretty good, but in general psychiatrists tend not to answer questions like that, even though we encourage the questions. I can learn more about you from what you imagine about me than from telling you the actual number."

Sometimes it is reasonable to let a patient know your age but only when it is clinically advisable. Young residents need to learn to avoid simply giving the easiest and least rude-seeming response, since what they are engaged in is not a social but a clinical interaction.

CPN: It sounds like inpatient practice for the resident can prove transforming.
Dr. Dulchin: The task of teaching residents in this setting is that of turning people who are self-diagnosed as character flawed, noninterrupting, insecure, rude 27-year-olds into comfortably anxious, craft-learning, clinically graceful, interview-controlling doctors—who are somewhere between the age of 20 and 60. ■

DR. DULCHIN *is director of inpatient psychiatry at Tisch Hospital, New York University Medical Center, New York. He also serves as an assistant professor of psychiatry at the medical center.*

IOM Report Faults FDA for Lack of Postmarketing Focus

BY ALICIA AULT
Associate Editor, Practice Trends

The Food and Drug Administration should shift its emphasis from the preapproval period to postmarketing, when new drugs pose the greatest risk of safety problems, a sweeping report from the Institute of Medicine recommends.

Many safety-related issues in recent years—including the widely publicized struggles over labeling changes for antidepressants and the recall of Vioxx (rofecoxib)—have led to a lack of confidence in drug development and regulation, according to the 15 experts impaneled by the IOM.

"The credibility of FDA, the industry, the academic research enterprise, and health care providers has become seriously diminished in recent years," the committee said in its report.

The FDA, in particular, has floundered, hampered by a lack of funding and mismanagement that has led to strife and miscues that may have resulted in delays in addressing safety issues, said the panel, made up of academicians, ethicists, and the head of the U.K. Medicines and Healthcare Products Regulatory Agency.

"FDA's reputation has been hurt by a perceived lack of transparency and accountability to the public, a legacy of organizational changes that have not been completed or sustained, and an apparent slowness in addressing lack of sponsor compliance," according to the report, "The Future of Drug Safety: Promoting and Protecting the Health of the Public."

The committee recommended that FDA consider requiring new molecular entities to carry a special caution that the products' true risks and benefits are unknown. The FDA also should consider restricting or banning direct-to-consumer advertising of those products during that early marketing period, the committee said.

After 5 years, the FDA should formally review all the available data on those products and publicize the findings, the panel said. Also, results of phase II-IV clinical trials submitted to the FDA should be published on the Web site www.clinicaltrials.gov.

The FDA should not be given unilateral authority, however, said the panel. "We understand that offering discretion does not mean offering dictatorial power," said R. Alta Charo, a bioethicist at the University of Wisconsin Law School.

Dr. Janet Woodcock, deputy commissioner for operations, said the Center for Drug Evaluation and Research has long recognized many of these issues and has been addressing them by doing things like establishing a drug safety board. The Pharmaceutical Research and Manufacturers of America also defended FDA's recent strides and the industry's safety record. ■