A Family Practice Rotation on a Psychiatric Service: The Experiences, The Opportunity, and The Challenge

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There is a considerable range of mutual interests between the disciplines of family practice and psychiatry. Each field has much to offer and receive from collaborative activities in teaching programs, particularly at the level of residency training. This paper describes the goals, content, methods, and initial experience of a one-month family practice rotation on a psychiatric service with a focus on Emergency and Consultation-Liason Psychiatry.

A family practice rotation on a psychiatric consultation service offers a unique educational experience for the resident, a teaching as well as learning opportunity for the psychiatrist, and a chance to integrate the skills, concepts, and perspectives of each discipline.

Family practice and psychiatry have a natural affinity. They share views of treating the whole patient. Both recognize the importance of seeing the entire person rather than an illness or diseased organ. Both appreciate the social and familial aspect of illness. Family doctors have strong interest in psychiatry.[1] Our goal is to develop a "learning alliance."[2]

The Program

There is growing discussion in family practice literature[3,4] concerning the best method of teaching the behavioral sciences during the residency program. Much of the current trend is to develop a comprehensive health "normal" oriented three-year curriculum.[3] This trend has even expanded to encompass university master degree programs.[3] Most of these programs include a significant amount of didactic material. Although all family practice residencies include a one-month psychiatric rotation, there is much less discussion of how best to approach it.

The program at the Maine Medical Center represents a solution to the "rotation." It suggests the importance of an apprenticeship approach to the teaching of psychiatry. But in a broader concept it is an experience designed to enhance, enrich, and expand the behavioral science curriculum. Setting aside the issue of curriculum supervision,[5] the program is an attempt to insert the full range of the psychiatric contribution into the total picture of medical care.

Second year family practice residents spend one month with the Department of Psychiatry at the Maine Medical Center. They work with the Inpatient and the Emergency-Consultation Services. Their work with the latter will be the focus of this paper.

The Emergency-Consultation Service consists of two full-time psychiatrists and three case workers. It is one of the major clinical divisions of the Department of Psychiatry and is an integral part of the Community Mental Health Center. One of its unique features is that the service encompasses Emergency, as well as Consultation Psychiatry. It is responsible for psychiatric evaluations of patients in the Emergency Ward and for consultations of inpatients in the 550-bed general hospital. Such an arrangement presents an added dimension to patient care as quite often a patient seen by the service in the Emergency Ward will be one who the service is later asked to evaluate on the medical-surgical floors. The two interactions with the patient result in a more complete view of him/her than two separate services would permit.

Residents are assigned several consultations each week. In all consultations, the attending psychiatrist first obtains permission from the referring physician to have the patient seen by a resident. The resident interviews the patient, reviews the chart, talks with staff and family, and writes up the consultation. This is reviewed and discussed with one of the attending psychiatrists, who also interviews the patient and writes his own note.

In the Emergency Division, the residents are on first call. After the Emergency Ward physician requests a consultation, the resident interviews the patient and significant others. He/she then writes the case up. At this point, one of the psychiatrists joins the resident and interviews the patient. They discuss the case, a case formulation is made, a diagnosis is determined, and a comprehensive treatment plan is developed and implemented.

In both areas, the emphasis is upon independent first assessment, then review and discussion with the attending psychiatrist, with the latter's personal involvement in the case. Psychiatry can and ought to be taught at the bedside!

In addition to these daily experiences, the service holds two weekly conferences: one on Emergency Psychiatry, and the other on Consultation-Liaison Psychiatry. In the first, the emphasis is on understanding the Emergency Department milieu, reviewing techniques and skills in dealing with psychiatric emergencies, and readings in the psychiatric literature. In the other seminar, an in-depth discussion of each of the consultations is offered. Special attention is given to the referral pattern, the

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diagnosis, staff reactions to the patient, and psychodynamics of the patient. The literature on psychosomatic illness is reviewed. Psychiatric residents participate in both conferences. One result has been the creation of a forum for residents from each discipline to compare and exchange ideas.

A family practice resident interviewed a 36-year-old depressed woman who recently had extensive pelvic surgery. The resident had been on the gynecological service when the surgery was performed. As a result, he was able to explain to the psychiatric residents and attending the nature of the procedure, whereas they were able to explain to him the emotional effects of a hysterectomy.

The Goals for the Family Practice Residents

The rotation presents a teaching and organizational dilemma. On one hand, there is the wealth of psychiatric knowledge, skills, and experiences, and on the other there is time limitation. One solution is to develop a set of objectives or goals for the rotation as follows: (1) To learn to take a complete history and mental status; (2) To appreciate the relationship between physical illness and emotions; (3) To see the possibilities and limitations of psychiatric intervention; (4) To gain facility with psychotropic medications; and (5) To understand the effects of attitudes and interactions between the patient and the health-care team.

The first task and goal is to acquaint and instruct the resident in obtaining a complete psychiatric history and mental status. Often the resident feels he already knows how to do this. In actuality, initial work-ups frequently fall short of being thorough. A complete evaluation begins with the chief complaint and the history of present illness. Particular reference should be made to the precipitant of the psychiatric emergency or the indication for the consultation. This must be followed by an examination of the patient's social, family, religious, educational, sexual, military, vocational, medical, and psychiatric histories. It is important to obtain a developmental history. In these histories, the emphasis is not only on the events, but also on the patient's reactions and associations to them. It is significant not only that the patient lost his mother at seven years of age, but also critical are his recall, perspection, and reaction. Similarly, in obtaining a medical history, the illness must be paired with subjective experience. If this phase of the psychiatric evaluation is successful, a personality will emerge from the "patient" – a person from the "case."

A resident interviewed a 42-year-old woman with chest pain. After completing his work-up, he presented her to his attending psychiatrist. The resident suspected a depression but could not find a cause except "she was in the hospital." The attending psychiatrist then interviewed the patient. She noted the loss of her older brother two months prior to admission, and the impending marriage of her only daughter. She expressed relief at having gotten these things "off my chest." The resident's subsequent histories were more thorough.

The mental status is the other major component of a psychiatric evaluation. It is a key in reaching a diagnosis and deriving a baseline for changes in mentation during treatment. In both the Emergency Ward and on the Consultation Service, the service insists on thoroughly documenting the patient's mental status. One area concerning the mental status often overlooked is the resident's subjective reactions. The resident is encouraged to appreciate his reactions to the patient; his "feelings" can be important clues to the patient's affect.

The second goal is an appreciation for the interplay of emotions and physical illness. Individual consultations demonstrate the relationship. Through selected consultations, three points are made: (1) Emotions can influence and precipitate physical illness, (2) Physical illness has impact upon one's mental health, and (3) Emotional and physical problems can occur together, relatively independently. In the first case, the resident will see patients with ulcerative colitis, asthma, rheumatoid arthritis, and "chest pain." The life-event studies by Rahe[6] are useful to illustrate the influence of emotional and social stresses upon the onset of illness. In the second, residents will work with patients after cardiac surgery, on dialysis, with paraplegia, following amputations, and after a hysterectomy. In the third, residents will interview a number of patients who are depressed, have manic-depressive illness, or schizophrenia, and concomitantly have a physical problem.

In the second situation, where the patient is hospitalized, one can clearly see the impact of medical problems upon the patient's emotions. A family practice resident and the author consulted on a 56-year-old factory worker two days after emergency cardiac surgery. The patient was interviewed in the Intensive Care Unit within 20 minutes after receiving the request. Following a two-day "lucid interval" after surgery, he had become combative and paranoid. He demonstrated a markedly labile affect combined with hallucinations and disorientation. Further history obtained from his wife indicated extensive use of alcohol. The resident and attending recommended chlorpromazine (Thorazine), visited him several times that day, and made daily rounds on him for a week. Later in the week, the Consultation Seminar dealt with post-cardiac surgery psychosis.

The service provides each resident a reading list of the basic consultation-emergency psychiatric literature. Despite the necessity of selection, this augments the residents' program and has been well received. These are the suggested articles:

For Psychiatric Consultation

Abrams HS: The psychiatrist, the treatment of chronic renal failure, and the prolongation of life: II. Am J Psychiatry 126:157, 1969

Chodoff P: The diagnosis of hysteria: An overview. Am J Psychiatry 131:1073, 1974

Hockaday WJ: Experiences of a psychiatrist as a member of a surgical faculty. Am J Psychiatry 117:706, 1961

Krakowski AJ: Doctor-doctor relationship: II: Conscious factors influencing the consultation process. Psychosomatics 13:158, 1972

Lipowski FJ: Consultation-liaison psychiatry: An overview. Am J Psychiatry 131:623, 1974

Schwab JJ, Brown J: Uses and abuses of psychiatric consultation. JAMA 205:55, 1968

In Emergency Psychiatry

Albornoz Ruiz JM: Psychiatric consultations in the emergency room. Md State Med J 21:53, September 1972

Atkins RW: Psychiatric Emergency

Service. Arch Gen Psychiatry 17:176, 1967
Cattell JP: Psychiatric Emergencies in General Practice. NY State J Med 70:2219, 1970
Soreff S: The Suicidal Patient. J Maine Med Assoc 63:225, 1972

The third goal is to show the residents what psychiatric intervention can accomplish and the limitations of that involvement. Cases in the Emergency Ward and Consultation Service offer a spectrum of clinical psychiatry ranging from the "purely" psychiatric patient to the medical crisis presenting as abnormal behavior.

The service, through its extensive involvement within the hospital and its participation in the Community Mental Health Center, is able to provide comprehensive evaluation and treatment. In the patient evaluation process, information is sought from the patient's family and physician, involved community agencies, and nursing staff. Psychological testing when appropriate is available. After complete evaluation, the resident is urged to reach a diagnosis and offer recommendations. The resident has available the full array of treatment options. These range from hospitalization to one-session psychotherapy. He has access to the Day Treatment Program and can make appointments with the Adult and Child Psychiatric Outpatient Department as well as referrals to community mental health resources.

A resident evaluated a 27-year-old mother of two in the Emergency Ward. She had become acutely anxious after viewing a "terror" movie. Although not suicidal, she had been unable to stay alone with the children while her husband was at work. She had had one prior episode. The resident began treatment with appropriate medication, saw her three consecutive days in the Emergency Ward, arranged for a mental health worker to make home visits, involved homemakers in helping to organize the household, and secured an appointment with the Outpatient Division. Within the week the crisis subsided.

It is just as important for the resident to see the limitations of psychiatry as it is for him to experience what psychiatry and the community mental health center *can* provide to patients. Often the situation would develop where the resident would like to do more for the patient than is appropriate. It was tempting for residents to want to have long sessions, up to several hours, with the patient, as well as to desire to control and change substantial aspects of the patient's life.

Maybe the most the rotation can accomplish is as Branch[7] suggests: "Perhaps this is our real – and perhaps our only – contribution to helping physicians see that in many cases there are no crisp cures, that psychiatric principles can make living endurable and functioning possible without demanding the elimination of all pathology." One rather dramatic and occasionally unfortunate limitation has been the recent curtailment of commitment laws. No longer is being mentally ill the sole determinant of certification. The residents shared the frustration of evaluating treatable but not dangerous patients who declined hospitalization.

In the program, psychiatric diagnosis is combined with appropriate medication in the correct dosage. Through "rechecks" to the Emergency Ward and follow-up visits on the consultation, the resident can monitor the effects of the medications. Incidentally, the Emergency Ward is a good location to observe many of the side effects of the medications; akathisia and parkinsonian-like effects are quite commonly detected in patients on phenothiazines, as well as the more acute dystonic reactions including opisthotonus and oculogyric crises.

The fourth goal is for the resident to gain facility with psychotropic medications. Brown[8] has noted this is one of the major purposes of psychiatric consultations. Ketai[9] indicates the importance of this knowledge for the family practitioner.

The fifth goal is to acquaint the residents with the dynamics of the interpersonal milieu surrounding each patient. This includes relationships of physician-patient, physician-consultant, nurse-patient, nurse-physician, and the patient-family. The emphasis is upon the appreciation that staff, patient, and family attitudes, prejudices, and feelings do influence patient care. Beyond the often cited perceptions about alcoholism which color treatment, there are a great number of other feelings which will influence patient care. These range from which shift admits the patient to how long the patient has been in the hospital. A resident interviewed a 22-year-old single woman admitted for a seizure work-up. Her referring physician was not involved directly with the patient on the service and only "consulted" on the case. The house staff felt "they were doing his job." The work-up took nearly three times as long.

Rotation provides experiences which permit the introduction of the concepts of transference and countertransference. Quite often the resident will accept the patient's feelings of love or anger toward himself without realizing the transference phenomenon. A 57-year-old man with extensive alcohol-use history was admitted for pancreatitis. The resident saw him in consultation for the original request "to give him some places to go for alcohol treatment," with the initial interview lasting for two hours. The resident visited the man for one hour each day in the hospital and soon was being called on numerous occasions by nurses because "he said he would leave if you did not see him." The man had a son he had not seen for years and who "was the same age as the resident."

Evaluation

Evaluation is an essential component of a training program. The rotation is examined in three dimensions: the resident, the psychiatric attending, and the program itself.

For the family practice resident, there is an extensive "feedback" system. The first component is the immediate review which both individual case discussion and supervision provide – an informal arrangement permitting an unparalleled opportunity to acquaint the resident with his reactions to patients and staff as well as to advance his psychiatric knowledge and skills. Secondly, in the weekly seminars emphasis is on in-depth examination of the interaction of the patient with his illness, physicians, nurses, family, and psychiatric consultant. Thirdly, at the end of the rotation the psychiatric attendings fill out comprehensive evaluation forms on each resident which assess the resident's skills, knowledge, interest, ability, and relationships with staff and patients.

For the psychiatric attendings the feedback mechanisms are important.

In the spirit of a learning alliance residents are encouraged to express what they are looking for from the program and whether or not the program is meeting their needs. At the end of the rotation each resident formally evaluates his psychiatric attendings. Each attending is rated in the four areas of teaching ability, scholarly attributes, responsibility, and interpersonal relationships. The residents' evaluation of the psychiatric rotation has been uniformly "outstanding."* Most of the residents have elected to spend additional elective time with Consultation and Emergency Service.

For evaluation of the program itself, a follow-up interview is conducted with family practice graduates to examine the effects of the rotation. Was the rotation providing an experience that would be useful to the practitioner as well as the resident? The graduate reports were quite revealing. First, they noted an increased awareness and an earlier sensitivity to psychiatric problems in their practices. Secondly, they felt more willing to engage in counseling with their patients. Thirdly, they reported that they now include spouses and family members early in the therapy process.

*Personal communication from R. True, Chief of Family Practice, Maine Medical Center, Portland, Maine, December, 1976.

Reflections and Conclusion

Such a program offers many satisfactions, frustrations, and challenges. One satisfaction of this rotation is the opportunity to work with the family practice residents. This training venture provides them with some of the essential tools of psychiatry. It deals with *their* issues and exposes them to psychiatric ideas for *their* problems. By focusing on five goals, the rotation covers the "basics." It is rewarding to see the residents come away with "something" about psychiatry. It is exciting to have them participate in the Maine Medical Center's psychiatric training. They add a dimension and perspective to the seminar discussions with the psychiatric residents.

There are frustrations. Often the resident wants to do too many things in one month. It is important to focus his program since it is impossible to teach all of psychiatry in a month.

Finally, there is the challenge of the interface of family practice and psychiatry. Partners in patient care, the goal is alliance in education. Psychiatry has much to offer family practice physicians; in turn, family practice has much to offer and to teach those in psychiatry. A program of individual supervision and case discussions, in which the family physician sees many patients in the Emergency Ward and on the Consultation Service, is a major method in making psychiatric skills available to the family practice physician and resident.

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