

# The Roots of Discontent: Understanding the Pressures of Psychiatric Emergency Training

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## Introduction

McIlwrick and Lockyer's fascinating inquiry into the unique challenges inherent in emergency training for psychiatry residents in this issue of *JGME* stresses a number of important points well worthy of further consideration.

In this qualitative study, researchers at the University of Calgary found that despite the rapid pace, clinical challenges, and onerous and intense workload characteristic of emergency room call for psychiatry residents, some of the most compelling and troubling issues for residents were more often intensely interpersonal. Identified challenges to a more positive and useful experience included a perceived lack of education and support for residents from attending psychiatric physicians, a perceived inconsistency in the availability of the psychiatric emergency services team, and a sense that nonpsychiatric physicians within emergency departments treated both psychiatric patients and psychiatric residents with significant negative bias and stigma.

In other words, while residents were clearly mindful of the strenuous tasks implicit in caring for psychiatric patients in the most severe and extreme circumstances, the study found that trainees noted most commonly the lack of camaraderie and team cohesion as the key correlates with negative and counterproductive emergency psychiatry experiences. Interestingly, these findings were consistent across all levels of training for residents, suggesting that these challenges are not simply indicators of novice or less-experienced practitioners. Finally, the article notes that attending physicians often failed to appreciate the severity of the emotional and cognitive duress that can be experienced by residents thrust into such extreme circumstances. Given that the very same attending psychiatrists without question had similar experiences

during their own training, one cannot help but wonder what creates such a seemingly short memory for what residents often experience as a profoundly unsettling but also often immensely rewarding rotation. Clearly, there are many levels at which one can address these complex and nuanced issues.

## The Importance of Respect for and Utilization of the Team

As medicine becomes more and more complex, the importance of team cohesion among all those involved in the delivery of care cannot be overemphasized. Studies<sup>1</sup> continually show that when health care workers function cooperatively, patients do better, outcomes improve, and doctor satisfaction is higher. Conversely, when teams are inconsistent in their approach, when responsibilities are not clearly delineated, and when members of any given team show a lack of respect for the importance of each other, the experience for patient and health care workers is universally worse.<sup>1</sup> It is noteworthy that the residents in this study reported that the potential benefits of the learning experience in the emergency department (ED) far outweighed the stress of managing difficult, at times abusive, patients; the inherent liabilities in the system of care; and even the long work hours. What was missing, however, was the infrastructure to support their education, training, and emotional burdens in such a challenging clinical setting.

The forces that conspire against team cohesion are myriad in the ED, and these counterproductive influences are perhaps most likely in psychiatric emergencies. Diagnoses are not always clear, there is often significant ambiguity in dispositional decisions, and systems of care are often poorly defined to even the most advanced ED workers. This can lead to the sense among residents that no one is really in charge. Because psychiatric residents are long accustomed to assuming care in situations where it is unclear who shares responsibilities for unaccounted-for care, it is very possible that residents in the ED find themselves quickly responsible for not only the "medical" aspects of the care but also for the byzantine systems available for safe and satisfactory disposition.

There are without question differences in the means by which care is delivered and accessed in the United States and Canada, and it is worth noting that the seemingly constantly changing nature of psychiatric service delivery in the United States poses yet an additional and significant stressor for US residents.<sup>2,3</sup> It would be very interesting in fact to do this

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very study at a demographically matched institution in the United States to discover whether these findings become even more pronounced.

### The Importance of Attending Psychiatrists in Emergency Training

The study suggests that residents experience poor support, empathy, and understanding of psychiatric emergencies from on-call attending psychiatrists. Residents therefore are left worrying alone even after they call for help and advice. Because most institutions do not have designated emergency psychiatry attendings, the on-call attending is often not specifically trained in the ever-changing milieu of the emergency room.

This might in part explain the sense among some of the study participants that attending psychiatrists seemed somewhat nonchalant about the intensity of the experience of the psychiatry resident in the emergency room. If an attending psychiatrist is only responsible as backup coverage 3 or 4 times a year, then there is little incentive to understand more fully the particulars of psychiatric emergencies. There is additional evidence in the United States that poor reimbursement for psychiatric emergency room care also limits greater interest among attending psychiatrists for emergency services work.<sup>3</sup> To the extent that residents often emulate their mentors, the relative dearth of emergency room psychiatrists suggests that we will continue for some time with psychiatric emergency coverage provided by general psychiatrists who have not had special training other than residency training in psychiatric emergency room care. As with team coherence, better education among all involved in psychiatric emergency rooms will be a potent remedy to some of these shortcomings.

### The Always-Present Need to Address the Ever-Present Stigma

Stigmatization of patients with mental health problems has shown ongoing improvement. At the same time, as this and countless other studies have shown, nonpsychiatric physicians continue to devalue psychiatric disease, psychiatric patients, and psychiatrists themselves. The irony, of course, is that the Cartesian dualism that allows us to separate mind and body as altogether different aspects of the human condition is virtually nonexistent in basic science and epistemological inquiries into psychiatric illness. The emergency room psychiatry resident therefore inherits the difficult task of combating stigma for the patient and for the discipline itself in an often-harried, nonempathic, judgmental, and biased setting. This is a societal issue that must be grappled with at all levels of our culture. In particular, it is very likely that the curriculum for psychiatric training among nonpsychiatry residents who deliver emergency care will need to change in order to accommodate the realities of modern medicine.<sup>4,5</sup>

### The Need for Improved Psychiatric Emergency Educational Experiences

While the authors of the study expected to hear complaints about fatigue and long duty hours particularly in the ED, these did not emerge. To the contrary, residents seemed more concerned with the nature of “shift work” that did not allow for a number of important clinical and educational experiences. The authors make valuable suggestions to improve ED training, for example, morning rounds, continuity of care, and review of handoffs; in-depth discussions of cases with senior attendings and in team meetings; teaching and support from senior residents; didactic experiences for the multidisciplinary team, including critical incident reviews; and perhaps most importantly, on-site observed interviews of challenging patients.

Paradoxically, for the ED residents, the new restriction on duty hours, in its effort to combat fatigue and ensure patient safety, may in the current system actually negatively affect quality of care by reducing opportunities for learning, team building, improving the quality of handoffs, and longitudinal case management. Clearly, the educational system, particularly in the busy ED, must be able to accommodate the clinical needs of patients as well as the educational needs of residents.

### Conclusion

Psychiatric emergencies will without doubt become more common. More people are receiving care, and more people need care in this particular setting.<sup>6,7</sup> The role of the emergency room in caring for these patients is crucial, and it is therefore equally crucial that every effort is made toward optimizing what is otherwise an easily disenfranchised setting that is ironically central to our delivery of ensuring the well-being of all patients.

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