Resident Training in the Psychiatric Emergency Service: Duty Hours Tell Only Part of the Story

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Abstract

Background Psychiatry residents in North America are generally required to work on-call on the psychiatric emergency service (PES) during training. Resident discontent with the long hours, onerous case loads, and lack of on-call teaching has been reported as a barrier to PES training. Given that the PES is a longitudinal and important experience, we sought to develop a better understanding of this service from the resident perspective and identify factors that affect residents as they work and train in this area.

Methods In this grounded theory qualitative study, we collected data from focus groups with psychiatry residents. We analyzed data according to grounded theory methodology to develop an enhanced understanding of the resident experience on the PES.

Results Three major themes emerged from data analysis: (1) challenges residents face in the PES are complex and attributable to more than simply long duty hours, (2) the PES offers unique learning opportunities for residents, and (3) resident satisfaction with the PES depends on a good relationship with the team.

Conclusions This study highlights important topics for any residency programs that require residents to work on a PES team. Although much attention has been paid to addressing challenges inherent to the on-call experience, such as limiting the amount of on-call hours and call frequency, equal attention should be paid to team dynamics. Like prior work on physician contentment and multidisciplinary team functioning, our study found that physicians will tolerate stressful workplace factors, so long as there is a supportive and healthy team dynamic. It is important for program directors to identify problems with team dynamics in the PES in light of their potential impact on residents.

Background

The psychiatric emergency service (PES) refers to a model of care that focuses on rapid assessment and management of patients presenting with emergent mental state changes, most commonly in the emergency department.[1] The PES developed in the early 1980s in response to deinstitutionalization that saw chronic mental health patients being moved from long-term care psychiatric facilities into the community and outpatient setting. The PES became a key provider of mental health care to this displaced patient population and is currently considered to be both the entry point for many patients who are new to the mental health system and the primary source of treatment for many with chronic mental illness. During the past several decades, the PES care model has evolved to include the provision of comprehensive mental-state assessments and treatment recommendations by a multidisciplinary team of nurses, physicians, and other clinicians, including resident physicians.[1] The PES has been described as "an ideal training ground for health professionals"[2] including psychiatry residents,[3–5] for whom a PES curriculum and learning objectives have been developed in both the United States and Canada.[6–8] At the same time, resident discontent with the long on-call hours, onerous case loads, and lack of on-call teaching has been reported as a barrier to training on the PES.[9–14] Additionally, a 2002 Task Force Report on Psychiatric Emergency Services described the "haphazard" nature by which PESs are planned and organized and noted the poorly specified and "generally lower" standards applied to the PES compared with other psychiatric services.[1] Despite the challenges associated with the PES, emergency psychiatry is a longitudinal and important training experience for residents. Therefore, the purpose of our qualitative study was to explore the PES from the residents' perspective to identify factors that affect residents as they work and train in this area.

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Methods

We designed a qualitative study to generate an understanding of the response of a group (psychiatry residents) to phenomena (the PES).[15–19] Unlike quantitative research, which requires statistical power to reject or accept a hypothesis, grounded theory qualitative research requires data sampling and analysis to proceed concurrently. By using constant comparison analysis, every piece of data was compared and considered, leading to the generation of theory to explain the relationship between themes in the data.[17–19] The project was approved by the University of Calgary Conjoint Health Research Ethics Board.

Participants and Setting

All 26 residents enrolled in postgraduate year-1 (PGY-1) to 5 years of the accredited residency training program were eligible to participate in the study. We identified a criterion-based, purposeful pool of study participants,[17,20] including only those residents that had worked in the PES. Participants were recruited by e-mail invitation. All participants had worked on-call to the emergency room (ER) approximately once per week (one 16- to 24-hour shift) during the course of their residency. The PGY-1 residents worked an additional mandatory 1-month dedicated daytime shift in the PES. Two of the senior residents had completed elective daytime PES rotations. Participation in this study was voluntary, and participants received a $25 honorarium.

Data Collection

Residents participated in 1 of 5 focus group discussions about their experiences in the PES. Focus groups were separated according to level of training. Semistructured focus group interviews were conducted by an experienced focus group leader who had no relationship to the participants. Participants in focus groups 1 through 4 were asked the following questions: Tell me about the kind of learning experiences you have in the emergency room? How have the people (nurses, medical students, etc) in the PES influenced your education/learning? When you think about the learning that occurs when you are on-call, what do you think works well? What doesn't work well? How does the learning experience in the PES compare to the learning in other settings in your residency? An additional fifth focus group was convened to check the theoretical constructs under development as a way of enhancing the credibility of the results of this study.[17,18] No personal demographic data were collected. Focus group conversations were audiotaped and transcribed verbatim. The transcripts were entered into an NVivo7 database and analyzed following a systematic multiphasic coding process.

Data Analysis

A PES psychiatrist and a PhD medical educator created the primary coding structure, which was subsequently reviewed by a PhD nurse and a second psychiatrist. The coders independently read the transcripts and developed an initial open coding scheme that consisted of main themes and subthemes. A preliminary coding structure was agreed upon, and the coding structure was subsequently reviewed and revised, as needed, each time additional focus group data were added. Each transcript was fully coded. Once thematic saturation[17,18] was achieved, the coding team proceeded with preliminary axial coding of the data collected from focus groups 1 through 4. The data from the fifth focus group was reviewed to ensure that all possible thematic categories were established and supported. Once data collection and analysis was complete from all focus groups, the axial coding process was finalized by the coding team meeting 4 times during a 6-month period to discuss the relationships between the emerging themes and the core variable. These discussions led to the generation of the grounded theory.

Results

All 26 residents in the program agreed to participate in the study, but due to scheduling conflicts only 23 residents participated (4 PGY-1, 6 PGY-2, 4 PGY-3, 4 PGY-4, and 5 mixed group participants, including 2 PGY-5 residents). Focus group transcripts yielded 167 pages of text for qualitative analysis. Topics raised by residents were consistent across all focus groups, and no differences were noted in resident responses according to year of training. Three main themes emerged during transcript analysis: (1) challenges residents face in the PES are complex and attributable to more than simply long duty hours, (2) the PES offers unique learning opportunities for residents, and (3) resident satisfaction with the PES depends on good relationships with the team. The major themes and subthemes are supported by the following data.

Theme 1: The Challenges Residents Face in the PES Are Complex and Attributable to More Than Simply Long Duty Hours

Across all groups, and regardless of year of training, a prominent theme raised by residents related to the difficulties they encounter when working in the PES. Resident descriptions of the difficulties associated with work in the PES were categorized according to 4 major subthemes:

1. Residents in all groups described the difficulties associated with the *hectic pace and workload* of the PES: "We are being overwhelmed when we are on-call, and we don't have the support to deal with it ... just the quantity, everyone is just getting completely slammed on call. How do you handle that safely, and not compromise patient care?"
2. Residents described the *clinical challenges* associated with the need to manage critically ill patients in

unpredictable situations: "The things that I find that we are expected to predict or estimate are so much more significant than some other specialties. We are predicting complex behaviors, such as, is this person going to go out, after they have been screaming at you, 'if you discharge me, I am going to step in front of a bus,' and you are thinking, 'Is this guy actually going to do it?'"

3. Residents portrayed an environment in which they felt *disrespected and misunderstood* by the ER doctors and nurses: "I went to a ... talk on how we advocate for ourselves as psychiatrists, and I think that is an issue in the ER, because of the issue of respect. I think if it got to a point where there was less respect than there is now for psychiatry by the ER docs and nurses, I think that would be quite discouraging, and make it an even less attractive place to work."
4. Residents described the difficulties associated with the 24-hour PES shift requirement in *safety and risk*: "There are so many things that are unsafe about [24-hour shifts]. You are probably not going to deal appropriately with a more violent or aggressive patient. Your judgment might be off if you haven't had any sleep. I know that I make mistakes and I tell myself, well, so as long as I didn't get a call that the patient died. That is not very good job satisfaction."

Theme 2: There Are Unique Learning Opportunities in the PES

Despite vivid descriptions of the difficulties associated with the PES, residents in this study also described the educational benefits associated with PES shifts. Residents identified the PES as a *unique source of lessons* that are not found in other areas of training. For example:

> The comfort zone that you wind up pushing is a totally different comfort zone than the rest of medicine or the rest of your life. You're dealing with people that are often unpleasant or there's a stigma around. It's not only an interesting area but it's rewarding, as well. That's something I've really learned, is that blossoming of how much I enjoy the experience, actually, of these people and getting into people's lives and seeing if you can help them in some way.

Similarly, residents recognized the PES as a place in which they may *develop skills* to manage difficult patient care decisions:

> We anticipate going in for this pretty intensive experience, where not only does the patient have to be capable of tolerating what we're asking, but we also have to be able to have the resiliency and the fortitude, at three o'clock in the morning, to tactfully and sensitively ask them incredibly personal questions and then, on top of it, occasionally have to make decisions that the patient is not going to like, like removing their rights and admitting them to hospital. It's an incredibly intense, difficult thing.

Theme 3: Resident Satisfaction With the PES Is Dependent Upon Good Relationships With the Team

The data included extensive detail from the residents regarding the multidisciplinary PES team, which consists of the residents, psychiatrists, nurses, mental health clinicians, and medical students. All focus groups discussed the importance of establishing good relationships with all members of the PES team. Residents described the quality of the relationships with the PES team members as highly variable and unpredictable. For example, residents described a spectrum of relationships with the psychiatrists, ranging from collaborative and instructive ("I think that the best nights that I've had for learning is when the psychiatrist has come in and is enthusiastic and sees the patient with you. When I just think over the years and what nights I've learned the most, it's definitely when the psychiatrist was in there") to remote, with infrequent contact from their preceptors ("You're left to yourself, when you're having all these difficult cases, and you go home afterwards and there's really no feedback about that night. Some nights you don't really learn very much and just figure it's just an inevitable thing and you begrudgingly go to the next time you're on-call."). Residents described complex interactions with the PES nurses, whom they perceived as supportive, but potentially threatening:

> I feel a lot of pressure sometimes from the nurses. If you want to hear about a topic from a psychiatrist, for example, the nurses are kind of like, 'OK, move it along,' and you don't have the time to learn. That influences your learning, because if it is a little more relaxed, then you might take the time to ask questions. You have to get along with the nursing staff. You work too closely with them, and they can make your life horrible, or they can make it very easy for you. You don't want to be ticking them off.

Residents spoke to the rewarding and frustrating relationships they had with medical students, depending upon whether the resident could teach and mentor, or felt disrespected and burdened by the medical student:

> I think if you have medical students who are co-operative and interested in learning something, then it can be a positive experience. But sometimes you have the medical students who are not that terribly interested in learning anything and there is this perception that psychiatry call is slack, and so there's this resentment, which makes it kind of tough to teach them.

Discussion

Our study used qualitative methods to explore psychiatry resident experiences in the PES. Residents in this study observed the clinical and environmental challenges associated with the PES and appeared to embrace the learning opportunities that resulted from them. However, residents were critical of the lack of regularly available support and supervision from the veteran nurses and physicians on the team. In fact, the theme that emerged most clearly in all of the focus groups was related to the importance that residents place upon professional relationships with the members of the PES team. In explaining the predominance of this particular theme, it was theorized that residents accept that the PES is a difficult place in which to work, and they rely upon relationships with the team to cope with the complexities of the PES. However, residents often described a remote and unsatisfying relationship with the supervising psychiatrists:

> I remember one of my first nights as a second year and there was this patient with [her] mom and they were [threatening] to sue me. I kind of got the sort of superficial support from the psychiatrist ... telling me to document [what happened] and that was basically it. I went home a bit traumatized afterwards. It would have been a bit more helpful if [the psychiatrist] supported me a bit more, whether coming in or just talking to me a little bit more about than just a couple of minutes and saying what you have to write down.

Similarly, residents described a system in which the nurses and nonphysician members (who, on many teams, are the veterans in the PES) are variably available to the resident as a source of support in difficult situations. Residents in this study appeared to be willing to tolerate the clinical variability of the PES, but only if they could rely upon the support from the veteran members of the team. However, given that the minimum contact recommended by the American Psychiatric Association (APA) is that the consultant psychiatrist be available by phone at all times,[1] it would appear that the needs and expectations of residents are not always congruent with the reality of the PES structure. The question this raises is how to enrich the collaborations between residents and other members of the PES. We suggest that support provided to residents may take many forms. The traditional telephone supervision that usually occurs between the resident and the on-call psychiatrist is a critical educational and medicolegal aspect of the on-call experience that must be incorporated into every on-call experience. Resident relationships with the PES team can be enhanced in many ways, including:

1. Use of morning handover rounds, during which the outgoing PES shift reviews cases with the incoming PES team; making senior psychiatry residents available to supervise and support junior and off-service residents.
2. Encouraging all members of the PES team to participate in regular journal clubs, staff meetings, and critical incident reviews.
3. Encouraging PES teams to jointly present Grand Rounds or Morbidity and Mortality Rounds topics.
4. Encouraging residents to take the lead in organizing a medical student lecture series in PES topics; recruiting veteran members of the PES teams to supervise residents in achievable quality improvement PES research projects.

There may be obstacles to the strengthening of PES team relationships. Limits on duty hours mean that residents leave postcall, and it may be 24 hours or longer before the resident is again available for further discussion with a supervisor, a team member, or another resident. Residents at the end of an on-call shift will not necessarily be alert enough to benefit from postcall debrief or handover rounds. Because all departmental psychiatrists generally take on-call shifts, the on-call psychiatrist is not necessarily dedicated to the PES, making it difficult for residents to access their supervisor for postcall teaching sessions in the following days after the resident has had time to get some sleep. The nonphysician PES team members are not reliably available for interdisciplinary activities due to the shift-based nature of the working hours. Finally, because the focus and attention in recent years has been on duty-hour limitation,[21,22] other more subtle aspects of the resident experience in the PES might have been forgotten in the discussions. Nevertheless, we suggest that it is critically important that attention is paid to the experience and role of the resident on the PES team. The number of patients presenting with acute psychiatric emergencies has been increasing since the early 1990s,[23] and it is now estimated that 1 of every 20 of the 115 million patients presenting in the emergency department is in need of psychiatric emergency assessment and management.[24] Residents are generally the front-line physicians in the management of psychiatric patients in acute stages of illness, and residents are most often managing these patients during the night, when it has been suggested that psychiatric disorders present with greater severity.[25] Residents must be supported by the PES team in a way that ensures not only the quality of their education but their ability to provide quality care that is safe, effective, timely, efficient, equitable, and patient-centered.[26]

Given the interest during the past few years in duty hours for trainees,[22] we anticipated that residents would discuss long hours and fatigue as key aspects of their on-call experiences. However, this theme did not emerge in any substantial way. We believe the PES experience in our institution is typical of that found in any large North American city, and the weak emergence of this theme during focus group discussions, therefore, is not believed to be due to the absence of difficult environmental factors in our PES. Rather, the data in this study supported the hypothesis that

residents are willing to accept the inherent challenges associated with the PES because of the value of the lessons that are learned in the PES. As stated by a resident:

> It's often much more stressful being on-call to your body and, the potential number of hours, the uncertainty of it all, the driving time. So, you just have to prepare yourself in that way. But when you do get some great cases, some of those days really, really make it worthwhile. It's tremendously rewarding and they don't happen that often but when they do, it makes it all worthwhile being on-call.

This article describes the findings from 1 residency training program in North America, raising the question regarding the generalizability of these results to other programs. Although the data in this study were well triangulated, the design rigorous,[27] and the conclusions credible, an important limitation to this study is that the development of workplace relationships is assumed to be a multifactorial process that could not be explored within the confines of this study.

Conclusions

Our study highlights important topics for any residency programs that require residents to work on a PES team. Although much attention has been paid to addressing challenges inherent to the on-call experience, such as limiting the amount of on-call hours and call frequency,[21,22] we suggest that equal attention needs to be paid to team dynamics in the PES. Work has been published in other areas related to physician contentment and multidisciplinary team functioning,[28] suggesting physicians are willing to tolerate stressful workplace factors, so long as a supportive and healthy team dynamic was in place. It is important for program directors to identify and address problematic team dynamics in the PES in light of the potential impact on trainees and patient care.

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