INPATIENT PRACTICE

How Much Training Is Best for Residents?

The Accreditation Council for Graduate Medical Education has reduced the amount of inpatient training necessary for psychiatry residents from a minimum of 9 months to a minimum of 6 months.

At least two psychiatrists who supervise residents say this reduction, which took place in July, "threatens to seriously undermine the quality of training for psychiatry residents." In a commentary, Dr. Sabina Lim and Dr. Robert Rohrbaugh argue that inpatient training helps foster the development of psychiatry's fundamental skills in indispensable ways, and they note that other specialties appear to place great value on inpatient training (Academic Psychiatry 2007;31:266-9).

They also cite a study of residents, in which those who had an inpatient rotation during the year immediately following their internship (e.g., their second year), were compared with those who had an outpatient experience their second year and then spent their third year on the inpatient unit. According to evaluations taken during the residents' inpatient year, those whose inpatient training was delayed until their third year were more likely to underestimate the severity of patient symptoms and to misinterpret symptoms of Axis I disorders as Axis II psychopathology. Those residents also were more hesitant to prescribe psychotropic drugs, had difficulty making rapid decisions and interventions, and had greater difficulty developing a professional identity (Academic Psychiatry 1991;15:204-7). That study reflects just how central the inpatient experience is to producing general medical competency in psychiatry, Dr. Lim and Dr. Rohrbaugh said.

This month, CLINICAL PSYCHIATRY NEWS speaks with Dr. Lim, an associate residency director at Yale University, New Haven, about her commentary.

Clinical Psychiatry News: You mention in your commentary that you pursued inpatient practice because you had positive experiences during your own residency. What were some of those experiences?
Dr. Lim: I had some excellent inpatient mentors and I learned so much from them—not just from their direct supervision, but because of the modeling they did on the unit. I also found it the most thrilling environment. There are immediate changes you can make for patients. It is hard to say if those are longlasting changes, but it is rewarding to see an acutely psychotic patient transformed within a few days.

Or, often you see someone who has been through many hospitalizations. It is challenging to try and take a fresh look at someone who has been through the rigors of a hospitalization again and again.

CPN: Was there one experience that helped shape your view of inpatient work?
Dr. Lim: I do remember one formative experience during my second postgraduate year that showed me what inpatient practice could be. There was a patient who had bipolar disorder, possibly schizoaffective disorder. She had very little insight into her illness. The pharmacologic management of this patient was straightforward enough. But there were so many facets to understanding why she had such trouble with the need for treatment and her diagnosis. There was intense individual and family work, and the legal system got involved, too.

Only because it was an inpatient setting could I fully appreciate the complexities of this patient's illness and treatment.

CPN: You note in your commentary that residents who did an inpatient rotation early appeared to develop important skills better than residents whose first inpatient experience was delayed. Why would timing make a difference if both ultimately got the same experience?
Dr. Lim: I think some of the skills that were seen to be relatively lacking were the making of diagnostic assessments, having a full biopsychosocial understanding of psychopathology, and having confidence in making clinical decisions. I'm guessing that part of the reason is that in inpatient rotations, supervisors are immediately available to residents throughout the rotation, right when the most teachable moments usually occur.

Traditionally, outpatient work is much more independent. There is an assumption that residents are familiar with the basics of psychiatric interviewing, diagnostic assessment, and typical treatment, so that they can make these decisions on their own and then go to the supervisor.

'I think the most important thing is not to just take any sort of training experience away.'

DR. LIM

But if they don't have these initial formative experiences, I can imagine that those sorts of skills are not quite as solidified, and residents may not be quite so confident. There may be something about intensive immersion, with daily feedback, that helps create a foundation that should be built upon by the more independent nature of outpatient work.

CPN: You say that patients in inpatient units tend to have more classic and florid presentations, and that it is important for residents to be exposed to those presentations. Can you explain why that would be so important?
Dr. Lim: So much of what we go by as psychiatrists to diagnose illnesses is what is in the DSM. That is our nosology. You see those patients who fit the classic presentations that fit the models described in the DSM, and you learn to understand those illnesses. However, the thing about inpatient rotations is that you also often see patients who do not fit into these models. I think that is a great opportunity for residents to discuss those cases with their supervisors and to learn what the limitations of the DSM are.

CPN: You mention that inpatient training provides a better chance to learn basic skills of self-reflection in addition to the management of strong emotions. Why does that occur more in the inpatient setting?
Dr. Lim: In the inpatient unit, you often see your supervisor immediately during or after an encounter with a patient. In some outpatient clinics, you do not see the supervisor until later, when both the objective and subjective experiences of the encounter are not as fresh. The immediate access to a supervisor allows residents to process strong emotional responses to patients right when they occur.

CPN: Since you submitted your commentary, the ACGME has taken the action they had proposed and reduced the inpatient requirement. Do you anticipate that most programs will cut back inpatient hours? Would you like to see it changed back to more time? And, how much more time do you think would be optimal?
Dr. Lim: I don't know. I think a lot of programs are thinking about this. But there haven't been studies to actually say that a certain amount of time is necessary. So we don't really know whether 6 months, 9 months, 15 months, is adequate.

I think the most important thing is not to just take any sort of training experience away. Residents often think of their inpatient rotation as their most difficult rotation. But this is a chance for those of us running training programs to take a closer look at inpatient training. For some programs, it may be more useful to decrease the amount of inpatient time, depending on their resources. For other programs, it might be different. Some programs may have their greatest training opportunities in inpatient units.

I am sure there are people with many different opinions. I think I may be in the minority, actually. Regardless, I think this change can serve as a crucial opportunity for training programs to scrutinize their inpatient training sites. They should carefully consider whether the unique educational and professional experiences of inpatient rotations can really be effectively distilled down to only half a year. ■

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Residency Duty-Hour Changes Tied to Mortality Reductions

BY DEBRA L. BECK
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TORONTO — In the second year after the new Accreditation Council for Graduate Medical Education duty-hours rules became effective, mortality in patients hospitalized for four common medical conditions—acute myocardial infarction, heart failure, gastrointestinal bleeding, and stroke—were significantly reduced at more-teaching-intensive hospitals, compared with less-teaching-intensive hospitals.

This apparent survival benefit was not seen for surgical patients. No changes in mortality were seen in surgical patients during either the first or second year post reform, Dr. Kevin Volpp and his colleagues at the Philadelphia VA Medical Center and the University of Pennsylvania, Philadelphia, reported at the annual meeting of the Society of General Internal Medicine.

The Accreditation Council for Graduate Medical Education (ACGME) duty-hour reform policy went into effect in July 2003. Designed to improve patient safety, the rules limit the number of hours residents can work to 80 per week, with a minimum of 10 hours of time off between shifts.

The study cohort included all unique patients (n=320,685) admitted to acute-care VA hospitals between July 2000 and June 2005 with principal diagnoses of acute myocardial infarction (AMI), heart failure, gastrointestinal bleeding, stroke, or Diagnosis-Related Group classification of general, orthopedic, or vascular surgery.

In the first year after duty-hour reform, no significant relative changes in death rates were reported for either the medical or surgical patients. In the second year, a significant 26% reduction in mortality risk was seen at the more-teaching-intensive hospitals for patients with any of the four medical conditions. That change was predominantly driven by a highly significant 52% relative reduction in mortality risk in AMI patients.

For patients in hospitals in the 75th percentile of teaching intensity, mortality improved from prereform year 1 to postreform year 2 by 0.70 percentage points—or a relative improvement of 11.1% for medical patients—compared with patients in hospitals in the 25th percentile of teaching intensity, Dr. Volpp said.

At hospitals in the 90th percentile of teaching intensity, the improvement in mortality was even greater: about 0.88 percentage points, or a relative improvement of about 14%, compared with hospitals in the 10th percentile of teaching intensity.

VA hospitals are the largest single site for residency training in the United States, Dr. Volpp noted. The study was funded by the VA Health Services Research and Development Service. ■