University of Pittsburgh Medical Center, Geriatric Psychiatry Clerkship

의대 4 학년 김시원

My interest in psychiatry increasingly grew as I learned more about medicine, because brain has many fascinating functions and interesting clinical consequences. After completing 5-week psychiatry clerkship in my third year at my home school, Seoul National University College of Medicine, I wanted to make an opportunity for a deeper involvement in the intriguing world of psychiatry. And there came an elective that gave me freedom to pursue my interest, and I chose to do a psychiatry clerkship abroad.

I participated in Geriatric psychiatry clerkship at University of Pittsburgh Medical Center (UPMC) for four weeks in July. Before the clerkship began, I met with the director, who thankfully designed the well-balanced schedule for me, and got instructions on my upcoming schedule and multiple hospital locations where I would do my clerkship. I had a different schedule each day, which consisted of inpatient care, outpatient clinic, nursing home, consultation and liaison, intensive adult program, journal club, and a few interesting lectures.

My morning agenda was always inpatient care at Western Psychiatric Institute and Clinic (WPIC), which was a large free-standing building for solely psychiatric care. I mostly did the work at 12th floor, which was a geriatric psychiatry ward with more than 30 beds across three different wings. All geriatric psychiatry health care practitioners including physicians, nurses, physician assistants, psychologists, and pharmacologists met up at 8 45 in the conference room, and listened to the nurse making reports on what happened to each patient last night. After the report, each team visited its patients for daily care. I joined Green team, which included an attending physician as well as two second-year residents and two medical students besides me. My first day at morning round came as a surprise to me, because new incoming patients received our care for a long time, which sometimes went over 30 minutes. When the interview ended, the whole team gathered up in the attending's office and discussed the interview, possible diagnoses, and the most ideal treatment plan. The atmosphere was relaxed, and anyone in the room freely contributed to the discussion. Sometimes social workers and pharmacologists joined. After all the new incoming patients were taken care of, we then visited patients who had been staying in the hospital and conducted a relatively shorter interview with each one. Then, we went to the attending's office again and discussed each one's progress. During the first week, I took up one patient as my responsibility, conducting an interview and writing a daily progress report myself. While I was a bit unskillful when talking to a patient at first, I practiced interviewing under the supervision of the attending and the resident. Therefore, I was able to receive feedback from them and improve my skills based on what I learned each day. I also had multiple occasions, in which I went over my progress report with the attending and the resident and received feedback on my writing as well.

My first patient whom I took during my first week had late-onset depression. He had several symptoms of depression, including feelings of depression, anhedonia, insomnia, and

decreased appetite as well as concentration. He had been suffering from Parkinson's disease for several years and its worsening progress affected him much. For instance, he could not do what he could have easily done before such as exercising. I had trouble understanding him because he mumbled a lot and had little facial expression due to Parkinson's disease. However, I did my best to understand him and focused on the help I could provide him. For instance, he had a bad habit of stopping medication without consulting with physicians. Therefore, I went into one of the patient-friendly official psychiatry websites, and printed out the information on drugs that he was taking. The information sheet had a sentence that said the patient should not stop taking medicine on his own because sudden stop of medicine without tapering can not only compromise the effects that we are aiming to bring with the drug, but also can cause concerning side effects. But I must admit that as much as I hoped this print-out could touch and help him, I was also a bit dubious. Thankfully, he carefully listened to what I said about the mechanism of drug and the danger of noncompliance thereof, and even decided to keep the information sheet in his room. From this experience, I learned that communication between patient and clinician is important even if the subject of discussion may seem trivial to the clinician. While I heard during my medicine classes and clerkship hundreds of times that noncompliance is a fast way to ruin your health, I almost forgot that it might not be so obvious to patients. My effort to communicate with the patient also benefited my studies as it was an effective way to learn about medication, which should always be emphasized as psychiatrist's main responsibility. In the end, I could explain what paroxetine and mirtazapine are, that paroxetine is notorious for anti-cholinergic side effects, and that mirtazapine is effective in increasing sleep and appetite.

There was one another grateful experience helping him, and it was practicing mindful breathing. The patient was starting to take anti-anxiety medicine whenever he felt anxious, and we were concerned that he might develop addiction to it. Therefore, since the patient had no knowledge on dialectical behavior therapy (DBT), I borrowed DBT book from the attending and went over the whole instruction on mindful breathing with the patient. While I felt nervous again that he might find this useless, again, he seemed to like it, even showing some smile that was mild but nonetheless emerged from the masked face. I recommended that he practice breathing before he considers taking medicine. He nodded in agreement. This was my first time providing the therapy that I witnessed as effective, and I was grateful that I could be that helpful provider. While I learned during classes and clerkship that psychological therapies are useful in psychiatric treatment, I did not have much chance to experience them firsthand. Along with my own experience with the patient, I also had multiple opportunities to observe physicians, psychologists, and social workers who productively made use of psychological techniques. Therefore, I was able to learn psychological treatment such as cognitive behavior therapy (CBT) and DBT and appreciate them more than before in addition to building expertise on medication. Towards discharge, I conducted Montreal Cognitive Assessment (MoCA), which is one of the most commonly used cognitive tests on psychiatry ward, on him, in order to confirm that his cognition was intact. And in the meantime as I spoke with the patient every day, I started to understand him better and I was already feeling confident conducting an interview.

My second patient whom I took during my third week had late-onset psychosis, a paranoia type. She was very different from my previous patient in that while she had a perfect pronunciation, she stayed guarded and barely spoke. Since she mostly answered with either yes or no, I had trouble continuing a communication with her. In order to solve this problem, I went over interview technique guidelines, one that I found online and another that my colleague copied for me. I also told my difficulties to the attending and the resident, and they recommended me some interview techniques that I could use with her. From literature and personal advice, I learned that I could probe more aggressively using phrases like "why is that?" "what do you mean by that?" Next day, while the patient avoided eye contact and kept looking elsewhere, I looked right into the patient's eyes and asked direct questions. I first started out with softer topics, such as her worries about living at home after discharge from the hospital, so that she could start talking. Then when the topic came across with her child, I asked what concerns she has about her child, why she harmed herself, and how that might be related to her concern. She seemed overwhelmed at first, but as I asked direct and detailed questions, she nonetheless answered and started to open up. Previously during my psychiatry clerkship, I mostly focused on empathizing with patient and maintaining a soft role. Therefore, this experience was my first time helping someone to open up by taking a strong stand. It felt a bit new, but having observed during the first two weeks my colleagues, residents, physicians, and social workers talking with confidence definitely helped. In the end, I ensured the patient that this hospital is a safe place for her, and we would make sure that she stays safe with the guard checking on her every five minute. And I added that since she harmed herself, it would be wise to start medication. She agreed. Besides the resistance to talk, one other difficulty I had with her was a need to not open up entirely. For instance, my previous patient with depression had no misconception about his symptoms and we could talk freely about how little he could eat or sleep. However, for patients like her with psychosis, I could not entirely come forthcoming about her paranoia and say that that is the reason she needs medication. I had to phrase my talking in a way that I would not worsen her paranoia and still build rapport and suggest the help she needed. It was a challenging skill, but nonetheless I managed to develop it and I came to hope that I enhance it further through future training.

My last patient whom I took during the last week had a history of bipolar disorder. He was extremely aggressive and had to be heavily sedated with Ativan multiple times a day. I visited him only when he was sedated enough. Most difficulty I had with him was his random talking. He diverted from my questions and often brought up unrealistic topics such as him being dead and born again. During the first visit, I got trapped into his fanciful story and failed to ask important questions. During the next visit, I reminded myself the questions that I need to ask despite his diversion, and I got some answers for a few, though he failed to concentrate on our talk soon after. This pattern continued for several days, and I had to patiently wait until medication kicks in. Then my last day came before he could bring his cognition back to normal.

From inpatient care training, I learned several lessons. First, I learned that taking time to explain to patients about their symptoms, diagnosis, and treatment are critical for patient compliance and also for my own studies. Second, psychological treatment is an important part of psychiatric care and that I have a responsibility to make use of them if I intend to become a

psychiatrist. Third, patient with psychosis is challenging to treat and that interview techniques are especially important when talking to them. Lastly, sometimes medication is the only option to help patients with severe psychiatric disorder and patience is the key. In addition, by working in an environment where students are encouraged to speak up and try out, I asked and answered many questions. If I got the right answer, I felt good, and if I got the wrong answer, I simply opened the book and studied to find the right one. This interactive training immensely nurtured my curiosity about medicine and motivated me to study in depth. I intend to remember this feeling of satisfaction and continue the active mindset and study style that I as I continue my clinical training.

During the afternoon, I visited different places each day. On Monday, I visited nursing home, where patients with chronic disease or disorders stayed and received care from multiple specialties. During the first week, I observed the physician doing consultation on patients. Then on consequent weeks, I conducted an interview on my own, discussed with the physician for symptoms, possible diagnoses, and treatment plans. Most patients had depression, anxiety, cognitive impairment and sometimes psychosis. On Tuesday, I observed the physician at UPMC Shadyside hospital for consultation on patients with complicated medical problems. We mostly did psychiatric assessment for depression and cognitive impairment. Among many, one patient had a stroke and subsequently depression, another had a heart surgery and then depression, and another had severe heart and kidney problems along with depression and chronic delirium. On Wednesday, I observed the physician at Benedum geriatric center doing outpatient clinic care. Patients who allowed me to observe were those with depression and cognitive impairment including Alzheimer's disease and frontotemporal dementia. On Thursday, I observed intensive outpatient clinic, which is a place where many patients right after inpatient discharge go to for a half-day care. First two hours consist of group behavioral therapy, sharing one's own symptoms, thoughts, and worries with the rest of the group. A psychologist is in charge of the care, providing feedback on patients and bringing up topics that patients could discuss. Next two hours consist of outpatient clinic, where the physician did an interview with each patient and make adjustment of treatment accordingly. I had a chance to talk about what I thought about the interview, suggest possible diagnosis or progress, and review the treatment. On Friday, I attended geriatric lecture, where mostly geriatric psychiatry or geriatric medicine fellows attended. Topics were introduction to geriatrics, delirium, and MoCA assessment. Introduction to geriatrics lecture was helpful because I did not heavily study geriatrics before, delirium lecture was interesting in that it explained how organic the disease is and how severe consequences are afterwards, and MoCA assessment lecture was interesting because it explained a lot more than what was written on the instruction. And lastly, one night I went to a journal club meeting and had a chance to discuss about the paper on recent stroke research.

Overall, my schedule was well-balanced in that I could experience in-depth inpatient care, while I had opportunities to expose myself to a variety of places such as nursing home and outpatient clinics where psychiatry is practiced. I am thankful for my school and the scholarship committee for giving me this wonderful opportunity as a part of school curriculum, and also for staff at UPMC, who were always friendly and helpful.