

MEDICAL STUDENT NEWSLETTER

A Publication of the American Psychiatric Association Committee on Medical Student Education

Psychiatric Aspects of AIDS

By: Carl Greiner, M.D.

Psychiatrists have an important role in the assessment and treatment of patients with AIDS. The psychiatric consultant usually works in conjunction with a medical team in providing care. The psychiatrist using the biopsychosocial model can provide useful information in the complicated care for AIDS patients. The psychiatrist can provide both primary care for the psychiatric problems and encourage appropriate referrals for social resources.

Let me give an example that is a compilation of several situations. Mr. A is a 40 year old, former teacher who was recently diagnosed as being HIV positive after attempting to donate plasma. When he saw his university internist, he was aware that he had not "felt well" but ascribed this to being homeless for the last four years after his divorce. He noted his risk factors were unprotected sex when he was intoxicated and that he had shared needles with his ex-wife when they had used methamphetamine and heroin. She died a year ago of "unknown causes."

The internist determined that Mr. A's CD4 count was quite low and diagnosed him as having a candida infection of his oral pharynx. His internist discussed with him the diagnosis of AIDS and prescribed a regimen which included the protease inhibitor, ritonavir (a potent CYP2D6 inhibitor). The internist was concerned about the suicidal history and the current despondency and referred Mr. A for psychiatric evaluation.

During his psychiatric interview, he reveals that he has had a past history of depression with a suicidal attempt when his wife left him and took their two children. He had left no forwarding address and no family knew how to reach him. He felt that he had been a neglectful father and poor husband. He had purchased a gun but it misfired when he tried to shoot himself in the chest. Since he had been homeless, he had not carried his gun with him.

Mr. A felt despondent about his new diagnosis and contemplated his current circum-

stances of being estranged from his children, lack of steady work, and fear about future medical bills. He focused on "having fallen through the cracks" and does not even have his old group of friends or his job. He did have some hope in that he is being considered for apartment housing and is comfortable with the quality of care he is receiving from his medical team.

On mental status examination, he was oriented to person, place, and time. His concentration had diminished in that he was unable to perform serial sevens or remember objects after several minutes. He had no indication of psychotic processing, hallucinations, or delusions. He was not actively suicidal but is concerned about "hitting bottom." The psychiatrist asked him what he meant. He responded that he did not want to feel as neglectful as he did in the past. He had no plans of buying a gun.

The psychiatrist identified the following issues:

BIOLOGICAL

He had cognitive changes with a differential diagnosis of a mood disorder with concerns that he may have an opportunistic infection, space-occupying lesion such as an opportunistic lymphoma, minor cognitive-motor disorder, or HIV-1 associated dementia (HAD). The substance abuse was a particularly concerning issue in determining the source of the mental status changes.

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Dr. Greiner is a Professor of Psychiatry, Vice Chair for Education and Assistant Dean for Clinical Affairs at the University of Nebraska. He has been a consultant to the AIDS Clinic at the University of Nebraska for the last eight years.

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Volume 12, Issue 2
Fall 2003

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Psychiatry, Medicine, and the Homeless Mentally III

By: Deborah Field, M.D.

Does choosing psychiatry as your specialty mean hanging up your stethoscope? Beyond internship, will you still have use for all that general medical knowledge you worked so hard to acquire in medical school? Well, I will admit that I do not wear my stethoscope around my neck anymore (I keep it handy in my desk drawer), but I do find that my everyday practice is rich with reminders that psychiatry is a medical specialty.

Brain illnesses cannot be diagnosed or treated in isolation from the rest of the body. Patients with psychiatric illnesses are often also dealing with acute and chronic medical illnesses. Homeless mentally ill adults are a particularly complex and challenging population to treat.

For healthy individuals, the state of homelessness itself poses many health risks. Time spent in crowded shelters and soup kitchens increases the spread of communicable diseases such as influenza, pneumonia, tuberculosis, lice, and scabies. Time spent outdoors increases risk of dehydration, sunburn, heat-stroke, or frostbite. Many shelters for the homeless are only open for meals or overnight shelter.

Potential guests must stand in long lines to get a meal, shower or a bed. Long lines are also common in welfare and social security offices where patients go to seek or renew entitlements. Public libraries and shopping malls are not always tolerant of homeless patrons, so many end up walking the streets in worn-out or ill-fitting shoes. This sets the stage for painful edema, cellulitis, foot ulcers and gangrene. Sleeping on the ground or lugging heavy belongings around all day will aggravate back and joint problems. When you are homeless, a prescription for adequate fluids and bed rest can be impossible to fill.

Homeless persons visiting a medical or mental health clinic will have many

of the same health problems as persons with homes. Street life is so stressful and unpredictable that many homeless persons find it hard to address their healthcare needs. Poverty, lack of health insurance, and lack of transportation are familiar themes. Persons with severe and persistent mental illness may experience additional internal and external barriers to adequate medical care. Paranoia, cognitive impairment, and denial of illness may impede receipt of care.

As a psychiatrist for the homeless, it is essential that I recognize the unmet medical and dental needs of my patients. Diagnostically, what might appear to be major depression might in fact be undiagnosed congestive heart failure, severe anemia, diabetes, pneumonia or cancer. Patients who use drugs or alcohol might present with dementia, liver disease, or skin infection. Many homeless individuals report being victimized. I need to carefully screen for PTSD, traumatic brain injuries, and sexually transmitted diseases. Mental illness itself can be a risk factor for medical illness. Patients with mania may have impulsive sexual encounters resulting in unplanned pregnancy or HIV infection. Patients with schizophrenia have high rates of nicotine dependence, CAD, COPD, and diabetes. Treatment with psychiatric medication further increases a homeless person's risk of orthostasis, heat sensitivity, hyperglycemia, or adverse drug-drug interactions.

How can a psychiatrist respond effectively to this myriad of needs, risk factors, and barriers to care? Working as part of a multidisciplinary team is essential. No one person can address the needs of a homeless mentally ill individual in a comprehensive and sustained manner. Care provided at the intersection of high need and limited resources can be very stressful. The pace of change can be slow and providers need team support to remain sensitive, ener-

getic, and persistent. It may take several years to convince Ms. Jones to have a physical exam. Conversely, Mr. Gonzalez might embrace your advice about dietary change and lower his blood sugar and cholesterol within two months! Both Ms. Jones and Mr. Gonzalez would be poorly served by a burned out practitioner who does not believe change is possible.

Homeless individuals face exclusion every day. They are asked to leave public facilities. Without an address, good credit and references, many are excluded from the rental market. What do you write on a job application that asks for your address and telephone number? Applications for entitlements are often complex and exclusionary. Access to public housing can be denied due to criminal history, bad credit, lack of landlord references, or failure to produce a birth certificate. Health care facilities exclude people who lack health insurance, dual diagnoses, lost ID cards, or artificial geographic boundaries.

For many, the experience of homelessness means becoming invisible and devalued. One homeless gentleman told me, "I used to think I was at the bottom of the barrel, then I realized that I was outside the bottom of the barrel." Many homeless adults report a history of aversive experiences with authority figures: parents, teachers, police, welfare workers, shelter staff, doctors. Exclusion, lack of respect, victimization, and a sense of powerlessness can all profoundly impact the willingness of an individual to trust health care providers.

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Psychiatric Disorders in Primary Care

By: Leah J. Dickstein, M.D., M.S.

A moderately overweight man in his mid-50s walked slowly into a psychiatrist's office for his medication check-up. When asked how he felt, he responded, looking depressed, "I don't know," and gestured with his hand to his lower neck/high anterior and posterior chest areas. Then the psychiatrist asked who his primary care physician was. He responded, "My cardiologist is..." A call was made immediately. When the patient returned to the psychiatrist's office two months later for a medication check, the first thing he said was, "You saved my life. I had bypass surgery the day after my last visit here."

When we ask respectfully with good eye contact, and then allow a few seconds of silence so patients can gather courage to be truthful, we gather information to determine correct etiologies, disorders, lab tests or medical or other referrals to order, and appropriate lifestyle changes. About two-thirds of those who commit suicide have seen their primary care physician within the previous four to six weeks. Most patients with mild to moderate psychiatric disorders seek treatment at primary care sites because they know and deny or don't recognize they have a psychiatric i.e., other medical illness. If we do not ask these medical questions in primary care sites, they become chronic, untreated or mistreated, and endure sad and painful lives. And their primary care physicians experience chronic professional frustrations.

We know patients with psychiatric disorders more often seek care from primary care physicians than from psychiatrists, who remain the focus of stigma by many people. Rather than ask basic questions that can reveal patients' underlying psychiatric illnesses, it is

often faster for a family physician to write a prescription for insomnia, anxiety, or depression.

As medical students, you are probably already interacting with and observing residents, attendings, and community physicians taking patients' medical histories. Despite time pressures, it is mandatory that everyone in medicine, especially in primary care, ask about histories and current symptoms and signs of psychiatric disorders. Especially the most common--anxiety; depression, including suicidal ideation and plans; and substance abuse.

A common symptom for which patients seek treatment is insomnia. Rather than only prescribing a sleep medication, physicians must question patients about mood and anxiety disorders and about prescription, over-the-counter, and illegal drugs they may be taking. Some drugs commonly related to insomnia are stimulating antidepressants, steroids (prescribed and illegal), decongestants (over-the-counter and prescribed), beta blockers, caffeine, alcohol, nicotine, and recreational drugs. Insomnia can also be associated with specific sleep disorders and with stressors.

One major issue and challenge in primary care medicine is obesity. All physicians are well aware of its dangerous cardiovascular and endocrine effects (stroke, heart attack and diabetes). However, we must also consider hypothyroidism (more common in women) and being treated with lithium in the etiology of obesity.

Another example involves mitral valve prolapse. Although most patients with that condition are asymptomatic, others repeatedly go to emergency

rooms complaining that, "I feel as though I'm dying or having a heart attack," when they are having an unrecognized--and therefore undiagnosed--panic attack, a very common unrecognized form of anxiety disorder.

Depression and dementia, particularly in the oldest-old (people aged 85 and older) are common though often not assessed. Thus, misdiagnosed and treated with yet more medications.

Polypharmacy (prescribing multiple, often needless, incorrect, or dangerous medication combinations) particularly to those over age 60, can lead to falls, fractures, and death.

I was asked to make a home visit to a 66-year-old man, still active in his community, living with his wife in a well-kept home. He looked depressed as I had been told he would. When asked "What medicines are you taking and for what reason," he said "a heart pill, one for my lungs--wait," and returned with a shoebox with 23 different prescribed medications. Calls to his cardiologist and pulmonologist led to a conference call with all prescribers to decide a future regimen--since possible drug interactions were impossible to clarify. This resulted in fewer prescriptions and finally, better mood state.

Violence is another medical symptom and sign that must be asked about in the first interview of every patient seen in primary care, regardless of age, sex, socioeconomic status, education, ethnic or racial group, and sexual orientation. Whether the patient is male or female, victim or victimizer, experiencing past or current violence can lead to posttraumatic stress disorder and other anxiety

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"We know patients with psychiatric disorders more often seek care from primary care physicians than from psychiatrists..."

Dr. Leah Dickstein is a Professor Emerita, Department of Psychiatry and Behavioral Science, University of Louisville. She is a member of the APA Committee on Medical Student Education.

“I’m Going Into Psychiatry”

By: Glenda Wrenn Davis, MSIV

It was late in high school when I first expressed a serious interest in becoming a doctor. My career advisor asked me what field I was interested in. I remember saying, “Pediatrics, maybe, or perhaps something surgical—All I know is that I am not going through four years of medical school to be confused with a psychologist!” We shared a chuckle and continued on with our discussion. I did not think about my comment until much later when I entertained my worst fear—that I might be interested in a career in psychiatry.

I recall the day vividly. It was during my second year when we were figuring out the order of our clinical rotations. I was quite distraught that I suddenly had this interest in what I considered a mysterious and secret field that involved understanding the mind. I thought for a moment that this was just a reflection of my days as a child when I told my mom I wanted to be a neurosurgeon. But this involved dissecting the mind in a scar-free, but equally invasive way.

I quickly flagged down a well-known faculty member and requested a meeting. Half hoping to come away relieved to know that this field was not for me instead, I went home perplexed that this seemed to be the best-kept secret in medicine. I did not know there were so many options for career choices from forensics to behavioral neuropsychiatry. I certainly didn’t know the difference between psychodynamic and biological approaches. In fact, I did not know anything beyond what I learned from movies, classroom chatter, or talk shows. I thought psychiatrists were doctors who were not cut out for “real medicine,” who then decided to become pseudo-psychologists. Furthermore, my father is an internist, and I was dreading the moment that I would have to break the news.

Over the next year, I came to know stigma - hated it and tried to avoid it. I tried hard to make it clear that I was good at general medicine, and it frustrated me that on rotations people assumed I was not interested because of my interest in psychiatry. I did not see them treat the students going into surgery that way. My classmates were equally confused by my choice of career, and I would get contorted faces and raised eyebrows as I began to let my secret out. One friend came to me every day for a month with a new alternative suggestion, “What about endocrinology? Neurology? Derm? ENT? GI?” Her expression pleaded with me to choose anything, but psychiatry. My neighbor said, “You are too normal to go into that.” (I still have not figured out if that was a compliment.)

By the middle of my third year, I felt more like I was telling people I was suffering from mental illness than declaring my desire to treat it. Why was I made to feel so ashamed? It reminded me of how people used to think about cancer or AIDS. It did not matter if you were a patient or a caregiver - you were connected to this scary, poorly understood entity that made people uncomfortable.

As a medical student, you have a unique perspective and opportunity to debunk the stigma, generalizations, and ignorance surrounding psychiatry and mental illness. Unlike a practicing psychiatrist, whose defense of the field may be blown-off as self-serving, a medical student that chooses psychiatry is saying, “I could have done anything, but this is what I want to do.” Now, if you are eccentric, somewhat of a loner, or look like the reincarnated Freud, this may not have a surprising effect on the non-psychiatrist. But as a part of the “in-crowd,” a student who picks psychiatry has the opportunity, and sometimes is forced into explaining their choice. I rarely hear an attending ask a

future pediatrician, “Now why did you choose peds?” (with an emphasis on “why” and “peds” and a furrowed brow) But the budding psychiatrist will almost certainly be faced with this situation.

Some people will go to great lengths to understand the reasoning behind these old-fashioned stereotypes and propose vast programs to deflate them. I think the greatest enemy of stigma is information and experience. It reminds me of the view that enlisted soldiers have of civilian doctors who graduate from Health Professionals Services Program, and hold an officer’s rank. They are portrayed as slackers and poor excuses for a soldier; not because they had shorter military training, or were usually there to pay back a debt, but because many of them did not know how to put on a uniform or shine their shoes. They were held to different (lower) standards, and sometimes did not take pride in their military service. But the civilian-turned-officer-doctor who had airborne training, or a crisp salute was usually readily accepted, much like the psychiatrist who does not call an ENT consult for otitis media.

We all have different ways of choosing a career. The most useful advice is to make an informed decision. Do not get too caught up in image and what you think you know. Remember, you will be living that life every day. If you do not know much about psychiatry—find out. There is much more to it than you learn in the first two years of medical school. And the next time someone mistakes you for a psychologist, you might not think it is such a bad thing.

Glenda Davis is a fourth year medical student at the Jefferson Medical College and is the Student National Medical Association representative to the APA.

Scholarship Opportunities for Medical Students

MINORITY MEDICAL STUDENT SUMMER FELLOWSHIP

This new program is intended to identify ethnic minority medical students who have an interest in psychiatric issues and provide experiences to foster this interest.

This program would match a medical student with a mentor based on the following criteria:

- Interest of the medical student and the specialty of the mentor
- Practice setting (i.e. research or clinical)
- Geographic proximity of the mentor to the mentee

What type of support is available?

This program supports the travel expenses of the medical student to go to the work setting of the mentor. The fellowship enables ten minority medical students to spend one month during their summer break with a mentor for a hands-on look at how psychiatrists treat patients. Care will be given to match the student with a mentor in close geographic proximity, although the student is not limited to those close to him/her. This program also supports the actual lodging and meals of the medical student for an entire month (not to exceed \$4,000.)

Who is eligible to apply?

This program is open to all ethnic minority medical students (MS1 to MS1V) currently enrolled in a U.S. medical school. Ethnic minorities are: American-Indian/Alaska Native/Native Hawaiian, Asian American, African American and Hispanic.

For more information, contact Alison Bondurant, APA Department of Minority/National Affairs, 703.907.8639 or abondurant@psych.org. The deadline for applications for the 2004 summer fellowship is **February 13**.

APA/SAMHSA TRAVEL SCHOLARSHIPS FOR MINORITY MEDICAL STUDENTS

The APA is pleased to announce two travel scholarships for minority medical students:

- 2004 Annual Meeting—May 1-6 in New York City
- 2004 Institute on Psychiatric Services (IPS) - October 6-10 in Atlanta, GA.

These scholarships are intended to identify students who have an interest in psychiatric issues in medicine and provide experiences that foster this interest. The scholarships support travel and related costs for minority medical students to attend the APA annual meeting or the Institute on Psychiatric Services (IPS). These scholarships are a part of the APA Minority Fellowships Program and is supported by the Substance Abuse Mental Health Services Administration (SAMHSA).

These scholarships are open to currently enrolled U.S. minority medical students. Applicants must submit the following items:

- An application form is available online at http://www.psych.org/med_ed/cmhs_index.cfm
- A brief statement of interest, not to exceed one typewritten page
- Letter from dean's office indicating you are a student in good standing
- A copy of the medical student's curriculum vitae

Deadlines to Apply:

February 6 for the Annual Meeting and **August 10** for the IPS meeting. For more information contact Marilyn King at 703-907-8653 or at mking@psych.org.

Applications should be mailed to: American Psychiatric Association
Dept of Minority/National Affairs
1000 Wilson Blvd., Suite 1835
Arlington, VA 22209

MINORITY MEDICAL STUDENT FELLOWSHIP IN HIV PSYCHIATRY

This new program is intended to identify minority medical students who have primary interests in services related to HIV/AIDS and substance abuse and its relationship to the mental health or psychological well being of ethnic minorities.

For more information contact:

- Carol Svoboda at (703) 907-8642, csvoboda@psych.org
- Dianne Pennessi at (703) 907-8668, dpennessi@psych.org.

Psychiatric Disorders in Primary Care, continued

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and depressive disorders. Physical signs such as fear, silence, or anger appear during the interview.

Religious and faith issues are also part of a primary care evaluation, because beliefs can influence behaviors and treatment compliance. Neuropsychiatric symptoms (seizures, pain, memory problems, headaches, infections) can impact common primary medical diagnoses or conditions.

Finally, prevention of some general medical and psychiatric illnesses involves assessment for undiagnosed cancer, grief reaction, interest and concern about patients' total lives. A few more minutes to ask on-target questions early in treatment can save days or years of unnecessary, chronic, general medical and psychiatric illnesses and even lives. We must also be alert for somatization disorders, seen differently in women and men by their physicians. Clearly, ongoing and respectful communication between psychiatrists and primary care physicians is basic to ensuring optimal patient care.

Psychiatric Aspects of AIDS, continued

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However, patient denied using illicit drugs over the last six months.

PSYCHOLOGICAL

He had a fear of abandonment after his wife left him. It was hard for him to imagine that the medical and nursing team could care about him. However, he had expressed trust in the considerate and timely work up that he has received in his initial assessment. He had previously been suicidal because of the loss of his marriage and currently felt “useless” and was ashamed of having lost his career as a teacher. His level of estrangement, potential cognitive impairment, and mood disorder placed him at a higher risk. He stated that he was not suicidal because of having a sense of connection with the hospital and the staff. He was willing to call the team if he feels he is in crisis.

SOCIAL

His educational level had been a college degree and he had worked successfully as a teacher prior to his involvement with methamphetamine. At this point, he wanted to change his life and was willing to attend a 12-step program. He wanted to reconnect with his children who were likely in a neighboring state with his ex-wife’s parents. He wanted the assistance from social work to help deal with both the divorce and his losing touch with his children.

In reviewing the AIDS regimen, the psychiatrist prescribed the SSRI antidepressant, sertraline, which had minimal risk of interfering with his AIDS regimen. He avoided bupropion which had a greater risk of further inhibiting CYP2D6. The psychiatrist noted in the chart that usage of benzodiazepines, particularly midazolam would be contraindicated. Fortunately, the MRI examination did not reveal structural lesions of the brain.

After the patient had been on antidepressants for six weeks, the concentration and memory markedly improved. Fuller neuropsychological testing did not reveal

cognitive-motor disorder or HAD. The therapy session initially focused on his coping with his new diagnosis and has more recently allowed him to have a better appreciation of his shame and anger against himself. He was able to appreciate both the times he was an adequate husband and father and relate the downward course of his parenting with the methamphetamine abuse. The repair of his social losses (friends, rewarding work, and family) was the most troubling issue for him. He wanted to see his children again but feared that his prior actions could not be overcome. A gradual approach to contacting his children was developed. The psychiatrist provided supportive therapy in encouraging patience in developing his social support. The

“...developing a biopsychosocial model assisted in making a more comprehensive treatment plan.”

AIDS support group was helpful in finding other men who had experienced similar challenges. A sliding scale clinic for drug abuse treatment and a

Narcotic Anonymous group assisted in his stabilization.

A methamphetamine relapse occurred at three months into treatment when Mr. A felt overwhelmed in trying to make contact with his children and grief that he was not starting off the semester as a teacher. The NA group and psychiatrist were instrumental in focusing on the future and continuing the positive steps that he had taken.

As you will have noted in the above case, the psychiatrist demonstrated a broad perspective in providing care. Providing an appropriate differential diagnosis for the impaired memory and concentration was a significant contribution to the patient’s care in the early stages. The patient was markedly relieved not to have to plan for an early dementing course. Monitoring his suicidal concerns were challenging but an

important contribution to the overall care by the medical team. Although all physicians have a duty to address the potential suicidality of their patients, the psychiatrist was in a fortunate position to have time and training to provide a more “in depth” assessment.

In summary, developing a biopsychosocial model assisted in making a more comprehensive treatment plan. More importantly, the thoughtful clinician will be able to provide a broader grasp of the patient’s illness. Providing psychotherapeutic intervention maximizes the opportunity that the patient will better understand his own strengths and weaknesses. The referral to a drug treatment program can serve as a cornerstone in assisting the patient to a more stable life and improved prescription adherence. In consultation with medical colleagues, the psychiatrist might be the first to discern that the patient is having mental status changes secondary to his AIDS regimen.

The APA has excellent training material available through the Office of HIV Psychiatry. There are also online educational material addressing specific topics such as neuropsychiatric complications. During the APA annual meeting, there are workshops, residency trainings, and AIDS symposia which are open to medical student attendees. For those interested in the history of the AIDS epidemic, Randy Shilts’ book *And the Band Played On* is a valuable resource.

For more information from the Office of HIV Psychiatry please contact Carol Svoboda at 703.907.8642 or visit online at www.psych.org/aids.

Homeless Mentally Ill, continued

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How can you rely on a system of care that allowed you to fall under the safety net?

The treatment team needs to anticipate and remove barriers to care. Be careful to not create an exclusionary intake or referral process. Be sensitive to the context of homelessness. It is hard to receive mail or “call back” for an appointment if you do not have a mailing address or easy access to a telephone. Try to create an atmosphere of respect and autonomy. I try to empower patients to choose appointment times that will not cause them to miss a free meal or the bus that gets them to the shelter in time for bed assignment. A standing appointment time or flexible drop-in hours may work better for patients who work day labor jobs or don’t own a watch. Be flexible. Recognize that psychiatric and medical care may be low on your patient’s current hierarchy of needs. A person focused on finding the next meal, a winter coat, and a safe place to sleep might miss appointments with you or take a while getting that prescription you wrote to a pharmacy. Show enthusiasm and welcome patients when they come in for health care. Make them feel visible and respected. Be courteous and direct patients to the drinking fountain, bathroom, and public telephone. Whenever possible, personally introduce patients to other staff you want assisting in their care. Make referrals to providers you know will be sensitive to their needs (and educate those who are not!).

Close coordination with a medical team is essential. I try to be vigilant for medical issues and work with patients to enhance their understanding and acceptance of medical care. Homeless women with histories of sexual trauma will often refuse mammograms and PAP smears. Building trust with a provider, treating anxiety, and setting sequential goals can help these women get life saving care.

It is important to be “culturally sensitive” when prescribing treatment. Modify your dietary advice to fit into the realities of your patient’s budget or a limited shelter menu. Dose medication once daily if possible. Schedule refills for the early part of the month when entitlement checks arrive and patients will have money for bus fare and co-pays. Develop simple protocols to replace lost or stolen medications.

Help patients keep accurate lists of medications, providers and emergency contacts. Consider costs. Do not force a patient to skip their antipsychotic medication in order to pay for a cardiac medication. Involve patients in their treatment choices. Many patients feel more comfortable taking medications they have had experience taking. I try to respect those preferences. Consider the impact of homelessness on how a patient will manage side effects. Gastrointestinal side effects take on a whole new meaning when you don’t have your own bathroom! Sedation may be intolerable to patients who have to be up at 6 am to comply with shelter rules. Many patients tell me they are afraid to use sleep aids, “if you sleep too deep all your stuff gets stolen”.

Do not try to do too much at once. It is cruel to try to get a complete psychiatric history from someone with a painful dental abscess. Similarly, you cannot expect someone with acute paranoia to see three providers in the same day, and then go to the lab. A complete problem list will help you stay organized. Get back to preventive care issues at every opportunity. Between crises you can work on relapse prevention, HIV counseling, vaccinations, family planning, smoking cessation, weight loss strategies, and rescheduling that Gyn exam. Celebrate small changes. Enhance self-esteem and you will enhance motivation for self care. If you consistently value your patients as individuals, over time they will be more likely to join you in valuing their own physical and mental health.

Every day I am reminded that psychiatrists are doctors of medicine. Our brains are complex. Our treatments are complex. Our society is complex. Some things are simple. People are out there that need good doctors. Whatever kind of doctor you become, I hope you will see the “invisible” patients and try to address their physical and mental healthcare needs. Positive experiences with any healthcare provider will make it easier for a homeless mentally ill person to enter (and stay in) any kind of treatment in the future. If a homeless individual comes to your facility for help, please make them feel welcome and valued.

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FROM THE EDITOR'S DESK

By: Carl Greiner, M.D.
Chair, APA Corresponding Committee on Medical Student Education

Be-coming a psychiatrist can be an intellectually satisfying and emotionally rewarding experience. Glenda Davis notes the challenge and reward of considering psychiatry as a career choice; her thoughts about stigma are worth your consideration.

The psychiatric-medical interface is a featured topic in this newsletter edition. Many students are concerned about "giving up the black bag" in becoming a psychiatrist. However, this does not have to be the case. Working with patients who are homeless, diagnosed with AIDS, or physically ill requires the breadth of skills and knowledge found in medical school training. The articles speak to the diversity of medical assessment and management in contemporary psychiatric practice.

The APA has been in the forefront of teaching about appropriate diagnosis and management of AIDS patients. The clinical issues may encourage you to participate in the AIDS workshops at the annual APA meetings.

If you have story ideas for future issues, please contact me at (402) 595-1483 or Nancy Delanoche at (703) 907-8635.

Carl Greiner, M.D

ANNOUNCEMENT:

A new scholarship is being developed for minority medical students who are interested in substance abuse treatment and prevention.

For more information, contact Marilyn King at 703-907-8653 or by email at mking@psych.org.



As a medical student, you can attend the APA Annual Meeting for free!