A Day in the Life of a Behavioral Scientist

Anna Pavlov, PhD

It’s days like this that keep me fulfilled as a behavioral scientist. It is 8:30 in the morning, and I have a half hour before I meet one of the second-year residents for a teaching session in the psychiatry and behavioral science rotation. I spend more time than usual with this resident because the psychiatry portion of the rotation was cancelled, and I want her to feel that the rotation is a worthwhile experience with lots of good teaching. So, I double my efforts. As behavioral science faculty, we often have to work harder to demonstrate our relevance. Anecdotally, we behavioral scientists know that it is not until after residency that many residents will appreciate the value of what we taught them.

As we greet each other, I find out about the resident’s weekend. She attended a 2-day EPEC (Education for Physicians on End-of-life Care) Conference. I eagerly listen as she excitedly tells me that she applied what she learned while on call last night with a dying patient. It is rewarding to see a resident enthusiastic about learning, even while performing difficult and emotionally draining work. The resident also tells me that she delivered a baby while on call. I suggest that she write up her call experience, since it exemplified the multiple activities involved in family medicine—from delivering a baby to reviewing code status and assisting a patient to “the well.”

I recently read a fascinating book on bipolar disorder in childhood,1 and I spend time telling the resident what I learned. The resident and I have a lively and productive exchange. We discuss the suggestion that children with bipolar disorder are often misdiagnosed as having ADHD (attention deficit hyperactivity disorder). I feel that we at least scratched the surface on a new development in psychiatry.

After this one-on-one teaching, I get called to the family health center to follow-up with a third-year resident and his 15-year-old patient with ADHD. The resident tells me that he learned from the patient’s therapist that there is a 6-month history of encopresis. While the resident is talking to the patient, I talk with his frustrated mother outside the room when another resident mouths to me, “I need you.”

As I approach, I see that she has the chart of an 8-year-old girl we’ve discussed before. The girl’s mother has brought her in for yet another concern in the genital area and today is reporting a vague complaint. The exam is normal. I investigate the resident’s reason for consulting me and realize she appears hurried and unsure of what to do next. I offer that she can simply make a statement of her observation and go from there: “I see that you have had many concerns about this area of your daughter’s body (her genital area). Do you have any concerns about your daughter that you haven’t mentioned?” I remind her to wait for a response, since many hurried residents forget to do that. I guide the resident through a sequence of questions intended to elicit concerns of abuse. “Do you have any concerns that your daughter has been touched inappropriately in that area?” “Wait for a response. “Do you have any concerns about abuse?” “In response, the mother vehemently denies any concerns. “Whew!” But I caution the resident to also speak to the girl individually.

During this delicate exchange, the mother discloses something new—enuresis. The resident expresses satisfaction that she has unveiled the deeper concern. She schedules another visit that will allow the doctor-patient relationship to develop further, providing other clues as to the reason for the girl’s visits. The resident gratefully acknowledges, “Thanks for your help, Dr Pavlov.” That makes my day—back to being relevant and helpful.

Another resident mentions to me that she just saw a child with encopresis. Is this enuresis/encopresis day? We make a plan to discuss the case later.

I walk into the precepting room where a faculty physician and a resident are reviewing a patient’s case. The faculty physician stops to ask me if I have any pain management contracts. He is recommending use of one for a chronic pain
patient who needs the structure of a formal agreement. I locate them and show him where they are for future use. When I’m busy like this, I’m grateful to assist in a brief way and to know that people actually use the materials in the “Behavioral Science Files” that I keep in the preceptors’ office.

Now it is 12:30 pm, and I attend the weekly continuing medical education presentation for the medical staff. The topic is systemic lupus erythematosus (SLE) in childhood and adolescence. I didn’t realize that 10%–15% of SLE patients are diagnosed in childhood. I walk away feeling more medically enlightened and return to my office to make some phone calls and answer e-mails.

It’s 2 pm, and I meet with my behavioral science resident to de-brief from the extended patient interview she conducted this morning. The resident’s identified goal was to conduct an “interview” with a loquacious patient. Bravo! The resident does a self-assessment of the interview and feels she was successful in assisting the patient to move forward and formulate a plan. She was able to conduct a patient-centered interview without feeling she was “interrupting” the patient. I give her my feedback, including my observation that she implemented aspects of the BATHE Model, which we reviewed recently. Marian Stuart would be as proud as I am.

We then prepare to visit an 83-year-old cachectic nursing home patient with a history of chronic obstructive pulmonary disease (COPD) and a right hip fracture. Two weeks prior, the resident assessed the patient with the Geriatric Depression Scale (GDS) and obtained a score of 14/15. We develop a plan to further assess the patient’s mood and explore her increased isolation. When we see the patient, the bruises on her forearms take us along another path. I’ve never seen a 360-degree forearm bruise on both arms. The resident smirks, “So much for our plan to evaluate depression.” I was thinking the same thing.

The patient reports that a male nursing assistant grabbed her in the groin area. She tells us she told a nurse the same thing. While there is a notation in the chart regarding the bruises, the other information is noticeably absent. While we realize that there could be an alternative explanation, we are compelled to “check it out.” We are shocked to see how defensive nursing staff and administrators react to our inquiries. They would clearly prefer that we not be concerned.

The nurse manager says the patient has at times been confused. She tells us that the patient experienced visual hallucinations awhile back, “seeing kittens on the wall.” Based on our evaluation, the patient is not demented. I ask the resident if it was possible the patient’s mental status had changed. If that was the case, the resident asks why she wasn’t notified about the patient’s confusion. After our assessment of the situation, the resident tells me, “I don’t know if I would have realized how inappropriately the staff behaved. I’m glad you were there and that you said something,” referring to the active protests and declarations as to the patient’s confusion. We learn about the ombudsman system for reporting such patient problems within nursing facilities.

We return to our home base. The resident tells me that she will return to the nursing home to take photographs of the bruises. We imagine her boldly walking in with a camera and joke about putting the camera in a bag. I munch on some leftovers from lunch. I ask the resident if she wants some food. She is clearly interested so I place leftovers in a spot where she can take them to her desk later. She has yet to call the patient’s son and do whatever else remains of the day’s work.

I leave the office at 6 pm and feel satisfied with the day. After I arrive home and briefly reflect on the events of the day, I decide to “practice what I teach.” I follow my earlier suggestion to my behavioral science resident. I write down the events of the day and realize again what a privilege it is to share in the training of family physicians.

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References

