TD Introduction And Patient Assessment Podcast

MODERATOR: The information provided herein is based upon the healthcare provider's clinical judgment and personal experience. With us today we have Dr. Craig Chepke from North Carolina. Craig, tell us a little bit about your practice.
DR. CRAIG CHEPKE: Sure. So I have a solo private practice. I'm the sole psychiatrist, actually in the practice with my wife, who's a social worker and does therapy for us. And so I see patients 18 and older, I do see a significant portion of geriatric patients. And in the past couple of years, I've kind of sub-specialized in patients with movement disorders. So tardive dyskinesia being one, but also Parkinson's disease and Huntington's disease and other neurological issues as well.
MODERATOR: Fantastic. Well let's jump right in then, when it comes to drug-induced movement disorders in your patients, so outpatient, private practice psychiatric patients, what kinds of things do you look for?
DR. CRAIG CHEPKE: So really just from the time I get the patient from the waiting room, watching them walk, what does their gait look like? Looking at their arm swing, do you see any dyskinetic movements? Especially with a lot of drug-induced movement disorders, patients will be self-conscious of them and when they're anxious, they might lock up and you don't see them.
So really instead of waiting until I do a formal motor exam when I'm staring at them and I might not see everything, just really when I call them from the waiting room and watching them in the 10 seconds that it takes to get them to my office, I can catch a lot of information right there. I just have to be careful not to be staring at paperwork or other things, and really just focus on looking at the patient.
MODERATOR: So looking at the patient?
DR. CRAIG CHEPKE: Yeah, imagine that, right?
MODERATOR: What a concept. Most of us in psychiatry weren't really taught to do that. We were taught to listen to people.
DR. CRAIG CHEPKE: Yeah, great point. Exactly. In the Freudian style not being able to see each other but yeah, and I had noticed that I caught myself looking at paperwork, shuffling through, signing this and that, and I realized, wow, I'm really missing out on a wealth of information in just a short period of time that I might not even be able to get when I did go to actually look for it.
MODERATOR: Yeah. So Craig, when you actually do do an exam for movement disorders, what kinds of things do you do?
DR. CRAIG CHEPKE: Sure. So we definitely have to look at the whole patient as one thing. Whenever I'm looking at any particular part of the body, I always try and keep my peripheral vision open because while I'm looking at someone's face, I want to be able to see if their hands are moving or-- and that's a good skill for the entire interview actually if I'm making eye contact with someone, I still want to be able to detect some motion if they are having a marching movement with their legs or with their fingers and then I can kind of glance down.
So really just being perceptive of the whole patient and looking for something that sticks out. That we've all looked at patients and other humans for so long that if we actually are proactive in thinking about it, I

think our brain will naturally start to notice like well, wait a minute, that movement isn't supposed to be there. And then from there narrowing it down, is it that they're nervous and they're shuffling around and tapping their foot anxiously, quickly, or impatiently? Or is it another characteristic of a tremor or dyskinesia or some other type of movement?

MODERATOR: So do you do this on all your patients or just people that you think might be at risk for movement disorders?

DR. CRAIG CHEPKE: Well, when I started off, I did have to be very intentional because I was not in the habit of doing it. And now I've started to look for it in pretty much every patient because there's been a lot of attention and press recently on tardive dyskinesia, which is generally caused by doping blocking meds like the antipsychotics but there are a number of different meds that can cause movement disorders. For instance, many antidepressants like the SSRIs can cause akathisia, so there's mood stabilizers like lithium, Depakote. So many, many of the meds that we prescribe in psychiatry can cause movement disorders. So I really think we should be looking at it in all of our patients.

MODERATOR: Does it take extra time to do that?

DR. CRAIG CHEPKE: Honestly, not a whole lot of extra time. But just extra mental effort just to remember it. Just like trying to break down a bad habit and get rid of it, building up a new good habit took me a lot of time too. So I had to be very intentional about really thinking, OK, I've got to look for this, I've got to look for this.

And then even sometimes I'd put sticky notes on my sheets for patients saying, look for movements because it wasn't something I was used to doing. And so to build that good habit really did take a lot of effort. But then once I did, it really doesn't add any time to the time that I spend with the patient, doesn't detract from the time that I take with the patient or the quality of the time. Now that I am used to doing it it's really just kind of muscle memory that I just am looking for it and then attending to what I see.

MODERATOR: So it's become just part of your routine?

DR. CRAIG CHEPKE: Yeah, absolutely. I've made that as an integral part of my mental status exam as I would assessing for eye contact or the rate of speech or the volume of speech and things that we as psychiatrists do every day. I just tried to work that in and make it part of my exam that at this point, it doesn't feel burdensome at all, it's not any extra time. Once we build it in, then it's really no more than anything else that we're assessing for throughout any interview.

MODERATOR: How do the patients react to it?

DR. CRAIG CHEPKE: Well, for the-- just my kind of passive scans, then I don't know that anyone's really perceived it or noticed it. When I do get a little bit more in-depth and focused-- for instance, like in the AIMS exam when we're supposed to hold-- [INAUDIBLE] someone's face, we're supposed to look for 15 seconds. And so I'll usually make a joke or that's saying, hey, it gets real awkward pretty fast staring at- making eye contact for 15 whole seconds doesn't it? And then that can diffuse the tension. But I think that's actually a key point is that we've got to manage our own anxiety because it does get awkward without breaking eye contact for 15 seconds with somebody and if we're looking at someone's face and we get an awkward feeling and look away after three seconds, four seconds thinking that that's long enough, we could very easily miss some movements that could be critical.

MODERATOR: What about patients that may have a tinge or more than a tinge of paranoia, does that get extra uncomfortable?

DR. CRAIG CHEPKE: Well, I think it's all about just making sure that you have a good relationship with the patient. And if they trust you, then that's going to help you a little bit. But also just being very straightforward and upfront with them and saying if you notice that I seem to be staring, I'm just assessing for any potential side effects that your medications might have. And I think that kind of technique is just being upfront with them.

The patients appreciate that, that you're looking out for them, you're doing your job as a physician and making sure that you're monitoring everything. And if they have that underlying baseline trust of you and you put in the work to build the relationship, then I think that is manageable. Maybe a little bit more of a challenge with some patients but nothing that can't be overcome. And certainly, they deserve it.

MODERATOR: You explain it and then it doesn't feel so creepy?

DR. CRAIG CHEPKE: Right. Exactly. Yeah.

MODERATOR: Otherwise it could be pretty creepy, right?

DR. CRAIG CHEPKE: Yeah. Similar to when we learned how to do a physical exam. OK, I'm going to press on your abdomen now. Let them know what you're doing and that it's part of an exam and then they know hey, he's just doing his job.

MODERATOR: Great. Great. Well, I so much appreciate your time. I know how busy you are.

DR. CRAIG CHEPKE: You're welcome. Thanks for having me.