Chapter 13
Psychiatry Clerkship

Introduction

The clerkship of the Department of Psychiatry is a six (6) week curriculum designed to help students develop clinical skills and a base of knowledge in psychiatry. The clerkship includes outpatient, inpatient, consultation/liaison and off campus experiences, as well as interactive seminars and lectures. By the end of the clerkship, students should demonstrate the following:

- Ability to perform a comprehensive history and physical examination (when appropriate). This includes performance of a mini-mental status examination.
- Working knowledge of major psychiatric diagnoses on Axes I, II & III of DSM-IV, and the ability to present a reasoned differential diagnosis, including medical disorders.
- Ability to develop a comprehensive treatment plan. This includes an awareness of the biopsychosocial model, and understanding of different therapeutic modalities.
- Knowledge of psychopharmacologic agents, including indications and significant adverse effects.
- Understanding of and basic competence in identifying psychiatric emergencies, and how these should be handled.
- Ability to write clear and thorough psychiatric reports, consult notes and progress notes.
- Demonstrate appropriate professional demeanor and ethics and respect for patients' confidentiality.

Course Description

Inpatient Clinical Work

Patients admitted to the inpatient unit assigned to a medical student will have a complete history and physical and on going psychiatric care participation by that student. The number of patients followed by each student will depend on the patient flow and number of students on the rotation. Assignments will be made by the inpatient director/residents.

When you are evaluating a new admission you should make an effort to obtain as much information as possible from the patient and any other information sources, such as relatives or old records. As complete as possible a history of present illness, past medical history, review of systems, mental status examination, and physical examination should be performed.

The history of present illness and mental status examination should be recorded on the student progress notes. Medical history and physical evaluation should be recorded. A differential diagnosis and plan of evaluation and treatment should also be recorded. An outline of the psychiatric database is included as Appendix 1. This outline is to be followed in a narrative form for oral and written case presentation. When signing your name, please designate your academic status. Practice admitting orders should be written, to be gone over with the resident or attending.

The student should be attentive to the implementation of and modification of the treatment plan (including medications). The medical work-up of each patient should be evaluated and action should be taken as indicated (with the assistance of the patient's attending). A progress note should be entered every time the patient is seen, generally once every day.

With the assistance of the patient’s attending physician, resident and social worker, the student should participate, when possible, in planning for discharge and follow-up care. A student discharge note should be entered in the chart once the attending has communicated in the record that the patient is being discharged.
The discharge note should outline the diagnosis, problems treated, the outcome, and the need for any appropriate modalities of follow-up care. On the inpatient unit patients may not be taken out of community meetings or group therapy. Please check with ward staff for the specific times of these activities. You have the opportunity to participate in these activities after discussion with ward staff. It is expected that most new cases will be seen by the student on-call for the day. The hours of on-call responsibility are from 5:00pm to 10:00pm weekdays and from 8:00am until 12:00 noon or completion of rounds on Saturday and Sunday.

Consultation and Liaison Rotation

The students spend three weeks (half time) on the C/L service. The student rotation consists of:

- Performing consults on C/L under the supervision of the resident and the attending C/L psychiatrist. The student does a history, mental status exam, differential diagnosis, and treatment recommendation. The students learn about depression and anxiety in the medically ill, somatoform disorders, substance abuse, delirium and dementia, trauma victims and the family’s interaction with the above problems. The student present during daily rounds.
- Observation of interviewing technique. The student is observed and given feedback on interviewing patients in the medical setting. The ability to gather data and be empathic is emphasized. Also, the student learns about the emotional impact of disease. This is done at rounds and informal sit down sessions.
- The student learns about the consultative process. The student speaks with the physician who asks for the consult, the nurse on the floor and becomes an integral part of the C/L team. The link between psychiatry and medicine/surgery is learned at interdisciplinary rounds with the trauma service. Consults are done on special units such as ICU, TICU and CCU.
- The student follows-up with patients. The student sees the patient over time and records observations and assessments. The student reports the finding to the resident and attending at meetings prior to bedside rounds. Treatment approaches involving psychotherapy and medication are discussed. Students are “quizzed” during rounds.

Outpatient Clinical Work

- During their C/L rotation, student will spend half their time (usually afternoons) in the Outpatient Clinic in 3 Cooper Plaza. They will interview outpatients who come in for an initial visit, then follow these patients for several weeks. Supervision will be provided by faculty members and residents.

Supplemental Materials

Appendix I: Data Base - Psychiatry

Sample format for oral or written case presentations

The goal of the psychiatric interview is to provide input to the team that other members will not be providing. The perspective should be medical/psychiatric. The following example is intended as a model. All the detail suggested may not be necessary in each case, but all of the main headings must be covered in each psychiatric database.

- IDENTIFYING DATA
  
  Provide brief description of patient including name, age, race, religious preference, marital status, employment status, current or most recent occupation, residence and nature of relationship to patient of those with whom he or she resides.

- CHIEF COMPLAINT
State the reason for the present admission including whenever possible a direct quotation of the patient’s thoughts as to why admission was necessary.

- HISTORY OF PRESENT ILLNESS

Include a detailed description of the history pertinent to the current episode of illness.

PSYCHIATRIC HISTORY

PAST PERSONAL AND SOCIAL HISTORY

PAST MEDICAL/SURGICAL HISTORY

CURRENT MEDICAL STATUS

Current medications, results of physical exam and laboratory tests, drug allergies (list medications and its adverse effects)

- MENTAL STATUS

  - General appearance: gestures, mannerisms, posture, hygiene, grooming, etc.
  - Speech: rate, tone, volume, hesitation, etc.
  - Form of thought: blocking pressure/retardation, nature of associations and thought patterns
  - Thought content:
    - dominant themes and topics, preoccupations
    - hallucinations (auditory/visual)
    - delusions (nature)
    - homicidal/suicidal ideation
  - Affect: quantity, range, relations to content (appropriate or inappropriate) etc.
  - Intellectual abilities:
    - orientation
    - memory (recent and remote)
    - estimate of intelligence range
    - fund of knowledge
    - calculations, abstractions (e.g. proverbs)
  - Insight and judgement

DIAGNOSIS

Diagnosis should be made using DSMIV categories and criteria. Diagnoses should routinely be considered for Axis I, II and III. For your final written presentation, include all five axes as relevant.

Axis I: Major clinical syndrome or condition that is the focus of attention or treatment.

Axis II: Personality Disorders

An Axis II diagnosis of a personality disorder should be made when there are enduring patterns of perceiving, relating to and thinking about the environment and oneself which are exhibited in a wide range of important social and personal contexts. These patterns are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress.

Axis III: General medical conditions

ASSESSMENT

Give a short paragraph, which provides an overall picture of the patient and his current problem. For your final written presentation, include a lengthy assessment that includes
formulations according to all relevant theoretical frameworks (biopsychosocial, behavioral, psychoanalytic, family systems, descriptive, etc.), with appropriate literature references.

- ESTIMATED LENGTH OF STAY
- PROGNOSIS
- PLAN

This discussion of recommended interventions should follow from the diagnosis and assessment.

**Appendix II: Interview Process**

A. INITIATING INTERVIEW - The manner in which the interviewer greets the patient and his ability to cope with the patient's anxiety about the interview, and the method by which he sets the physical arrangement for the interview.

5. Patient given positive acceptance; purpose of interview explained and concerns of patient pursued, disruptive problems corrected.

4. Warm greeting, procedure explained by not purpose, cursory attempt to query patient about concern, cursory attention to physical conditions.

3. Greeting in tone and expression acceptable, but no explanation of procedure, no attempt to query patient about concern, no attention to physical conditions.

2. Brief recognition of patient with no attempt to put patient at ease and/or physical situation not conducive to interview.

1. No attempt to set up interview, launches directly into content.

B. EASE OF INTERVIEWER - The affect and attitude of the interviewer and whether personality characteristics enhance or interfere with the total flow of the interview.

5. Interviewer comfortable and confident, demonstrates empathy and sympathy, makes supportive comments.

**Reading / Learning Activities**

- Textbooks
  
  *Concise Textbook of Psychiatry, Kaplan & Sadock, 9th ed., Williams & Wilkins 2003*  
  .....REQUIRED/PROVIDED

  *DSM - IV, Diagnostic and Statistical Manual of Mental Disorders American Psychiatric Association, 1994*  
  .....SUGGESTED

- Photocopied Articles
  
  You will be given photocopied articles to read in the course of the rotation.

**Seminars/Grand Rounds**

A series of seminars will be given by faculty members every Wednesday. Emphasis in these sessions is an interactional discussion of psychiatric concepts primarily as related to students' clinical experiences. Students should prepare for these seminars through appropriate advance study of textbooks and distributed articles. Psychiatry Grand Rounds take place Tuesdays at 9:30-11:00 AM.
Residency Program at Cooper University Hospital

Cooper University Hospital also has a residency program in Psychiatry.

2008 - 2009 Academic Year - Detailed Schedules, Class of 2011

Rotation #1  July 6, 2009 to August 14, 2009
Rotation #2  August 17, 2009 to September 25, 2009
Rotation #3  September 28, 2009 to November 6, 2009
Rotation #4  November 9, 2009 to December 18, 2009
Rotation #5  January 4, 2010 to February 12, 2010
Rotation #6  February 15, 2010 to March 26, 2010
Rotation #7  March 29, 2010 to May 7, 2010
Rotation #8  May 10, 2010 – June 18, 2010

For more information, contact Viktoria Rile, Clerkship Coordinator at 856-757-7853