Michigan State University

College of Osteopathic Medicine (COM)

Department of Psychiatry

Psychiatry Clerkship (Core)
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Study Resources/Materials found on the Angel site: angel.msu.edu
  • Study Resources
    o NBME Exam Tips
    o Practice Exams
    o Quizzes for Study Purposes
  • Study Resource
    o Psychiatry Quiz Jeopardy Style
  • Study Resource
    o Psychiatry Teaching Platform with Videos from New Zealand
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Goals

The COM Psychiatry Clerkship is a 4-week rotation. The Psychiatry Clerkship is designed to expose medical students to the contemporary practice of psychiatry.

In the Psychiatry Clerkship, students are required to:

- Attend assigned time at either or both inpatient and outpatient experiences and be assessed on his/her clinical skills as well as his/her interactions with a variety of individuals on the clerkship.
- Complete 100% of the objectives presented in the log book.
- View one video regarding health disparities in mental health and pass a post-test.
- View several required on-line lectures and take a post-test after each lecture.
- Complete a formal mental status exam (MSE) by interviewing, evaluating and presenting on a patient with a mental disorder.
- Prepare an evaluation on one patient and make a 10 minute oral presentation to an attending and peers with a 10 minute question/discussion period after the presentation.
- Pass the NBME Psychiatry Clerkship Shelf Examination.
Learning Objectives

The goal of learning objectives for psychiatry in undergraduate medical education is to provide a well-organized and understandable set of learning opportunities for the Psychiatry Clerkship that are relevant to all medical students regardless of their future specialty career choices. They are categorized into the following four main units:

I. Clinical Skills
II. Psychopathology and Disease Classification
III. Disease Prevention, Management, and Therapeutics
IV. Professionalism, Ethics and the Law

In an effort to continually improve teaching in psychiatry; evidence-based neuroscience forms the foundation of learning in this clerkship.

Unit One: Clinical Skills

A. History, Examination and Medical Interviewing

Rationale: To evaluate and care for any patient, the clinician must be skillful in obtaining relevant historical information and performing a complete examination. Physicians should be able to perform a mental status exam and accurately describe the findings. To be effective, a clinician must have an understanding, ability, and self-awareness to flexibly use a range of empathic interviewing techniques with patients across the lifespan. Medical students are expected to consistently evaluate all patients in regards to cultural issues and health disparities information. They are also expected to demonstrate knowledge of ethical issues related to psychiatry.

Learning Objectives:
CORE
1. Elicit and accurately document a complete psychiatric history, including the identifying data, chief complaint, history of the present illness, past psychiatric history, medications (psychotropic and non-psychotropic), general medical history, review of systems, developmental history, substance abuse history, family history, and social history, use multiple sources of data.
2. Recognize physical signs and symptoms that accompany classic disorders (e.g., tachycardia and hyperventilation in panic disorder) and psychiatric manifestations of medical illness, recognize the possible physical effects of psychotropic drugs (i.e., medications and drugs of abuse).
3. Perform and accurately describe the components of the comprehensive Mental Status Examination (e.g., including general appearance and behavior, motor activity, speech, affect, mood, thought processes, thought content, perception, sensorium and cognition, abstraction, intellect, judgment, and insight with special attention paid to safety, including suicidality and homicidality, and screening for psychotic symptoms, for each category of the Mental Status Exam, list common abnormalities and their common causes, be able to perform common screening exams for common psychiatric disorders (e.g., CAGE, MMSE, etc).
4. Demonstrate an effective repertoire of interviewing skills, including strategies for challenging interviews and sensitivity to the patient, including avoidance of stigmatization, and awareness of cultural differences and health disparities.

VALUABLE
1. Identify strengths and weaknesses in personal interviewing skills and discuss with a colleague or supervisor.
2. Identify verbal and nonverbal expressions of affect in a patient’s responses and apply this information in assessing and treating the patient.

B. **Documentation and Communication**  
*Rationale:* Regardless of the clinical specialty, a physician must be able to properly document clinical findings, diagnostic impressions, and clinical reasoning. The physician must be able to communicate clearly and concisely to other professionals and patients in both written and oral formats.

**Learning Objectives:**

**CORE**  
1. Accurately document a complete psychiatric history and examination and record the components of a comprehensive mental status examination.  
2. Accurately document the daily progress of inpatients and the periodic progress of outpatients.  
3. Demonstrate clear and concise oral presentation of a) a complete psychiatric evaluation including relevant history, mental status findings and diagnostic impressions, and b) the daily progress of patients being treated for psychiatric disorders.

C. **Clinical Reasoning and Differential Diagnosis**  
*Rationale:* Accurately identifying a patient’s problems and the relevant signs and symptoms is basic to establishing a diagnosis in any field of medicine. In psychiatry patients may not always have insight into the problems they are having. To be skillful at discerning signs and symptoms of psychiatric disorders the physician must be knowledgeable about symptom clusters that are suggestive of specific disorders, and able to formulate reasonable diagnostic hypotheses with plans for further evaluation.

**Learning Objectives:**

**CORE**  
1. Use the DSM-IV in identifying specific signs and symptoms that compose a syndrome or disorder and construct diagnoses using the five axes of the DSM-IV.  
2. Formulate a differential diagnosis and plan for assessment of common presenting signs and symptoms of psychiatric disorders.  
3. Know the indications for, how to order, and the limitations of common medical tests for evaluating patients with psychiatric symptoms (e.g., laboratory, imaging, etc.).  
4. Demonstrate the ability to review and integrate the use of new clinical evidence.

D. **Assessment of Psychiatric Emergencies**  
*Rationale:* Psychiatric emergencies may occur in any clinical or non-clinical setting and can be life-threatening. It is important for physicians to be able to perform risk assessments, evaluate patients with altered mental status or behavioral dyscontrol, and recognize signs of potential assaultiveness.

**Learning Objectives:**

**CORE**  
1. Identify and discuss risk factors for suicide across the lifespan.  
2. Be able to conduct clinical diagnostic and risk assessments of a patient with suicidal ideation or behavior and make recommendations for further evaluation and management.
3. Identify risk factors for violence and assaultiveness, understand symptoms of escalating violence and demonstrate safety precautions.

4. Be able to discuss the differential diagnosis and assessment of a patient with potential or active violent behavior or a victim of violence or other trauma and make recommendations for further evaluation and management.

5. Discuss the clinical assessment and differential diagnosis of a patient with psychotic symptoms including perceptual disturbance, bizarre ideation and confusion and make recommendations for further evaluation and management.

6. Discuss the clinical assessment and differential diagnosis of a patient with impaired attention, altered consciousness and/or other cognitive abnormalities and make recommendations for further evaluation and management.

7. Be able to evaluate need for psychiatric hospitalization and understand appropriate level of care.

Unit Two: Psychopathology and Disease Classification

The typical signs and symptoms of common psychiatric disorders as outlined below should be learned and understood for each phase of the life cycle (children, adolescent, adult, and geriatric populations). The clerkship learning experiences should build on an established understanding of basic principles of neurobiology and psychopathology.

A. Cognitive Disorders

Rationale: Cognitive impairment is a presenting sign or symptom for many medical conditions. The student physician should be able to make an initial assessment of cognition with attention to possible emergent underlying conditions, be familiar with the common causes of cognitive impairment, and proceed with or refer patients for further evaluation and management.

Learning Objectives:

CORE
1. Recognize and differentiate the cognitive, psychological and behavioral manifestations of common Cognitive Disorders including Delirium and Dementia syndromes, Traumatic Brain Injury, and Primary Intellectual Deficits.
2. Differentiate the clinical features and course of the common types of Dementia including Alzheimer’s, Vascular, Lewy Body and those syndromes caused by other neurodegenerative and infectious diseases (e.g., Parkinson’s, HIV infection, Huntington’s, Pick’s, Creutzfeldt-Jakob, etc.).
3. Discuss the clinical features and differential diagnosis of a patient with cognitive impairment and make recommendations for evaluation.

VALUABLE
1. Discuss the clinical features, differential diagnosis, and evaluation of Amnestic Disorders due to common general medical conditions including seizure disorders, substance use disorders, and head injuries.
2. Maintain a high index of suspicion that disordered cognition and behavior may have a reversible medical cause.

B. Substance Use Disorders

Rationale: Substance use disorders are prevalent among patients in all clinical settings. There is particularly high co-morbidity between substance use disorders and other psychiatric disorders and medical conditions, which has a negative effect on clinical course and prognosis.
The student will be able to recognize signs and symptoms of possible substance use and abuse disorders; make initial assessment with attention to possible underlying emergent conditions (e.g., withdrawal delirium), and proceed with or refer for further evaluation and management.

Learning Objectives:
CORE
1. Compare and contrast diagnostic criteria for substance use disorders (abuse, dependence, intoxication, withdrawal, and substance-induced disorders).
2. Know the clinical features of intoxication with cocaine, amphetamines, hallucinogens, cannabis, phencyclidine, barbiturates, opiates, caffeine, nicotine, benzodiazepines, alcohol and anabolic steroids.
3. Recognize substance withdrawal from sedative hypnotics including alcohol, benzodiazepines, and barbiturates.
4. Discuss the epidemiology, course of illness, and the medical and psychosocial complications of common substance use disorders.
5. Identify typical presentations of substance use disorders in general medical and psychiatric clinical settings including the co-morbidity of substance use with other psychiatric disorders.
6. Differentiate between primary mood disorder vs. substance induced mood disorder vs. dual diagnosis of substance use disorder and other psychiatric disorders and be able to discuss the prevalence of such co-occurring disorders in the general psychiatric population.

VALUABLE
1. Review the etiology and pathogenesis/pathophysiology of substance abuse and dependence.

C. Psychotic Disorders

Rationale: Psychosis may represent a serious underlying medical condition and/or may be the cause of serious harm to the patient or others. Individuals with chronic psychotic disorders have a high level of medical co-morbidity and completed suicide. The student will need to be able to recognize signs and symptoms of possible psychotic disorders, make initial assessment with attention to possible emergent underlying conditions, and proceed with or refer for further evaluation and management.

Learning Objectives:
CORE
1. Define the term psychosis and be able to discuss the clinical manifestations and presentation of patient with psychotic symptoms, including self harm and suicide risk.
2. Recognize and discuss the importance of a thorough medical evaluation for all patients presenting with signs and symptoms of psychosis to rule out the presence of underlying general medical conditions or substance-induced symptoms.
3. Be able to develop a differential diagnosis and plan for further evaluation for patients presenting with signs and symptoms of psychosis.
4. Compare and contrast the clinical presentation of psychotic disorders for the following patient groups: children, adolescents, adults, the elderly, patients in a general medical practice setting, and the developmentally disabled.
5. Be able to compare and contrast the clinical features and course of common psychiatric disorders that have associated primary (e.g., Delusional Disorder) or secondary (e.g., Mood Disorder) psychotic features.
6. Be able to discuss epidemiology, clinical course, subtypes, and the positive, negative and cognitive symptoms of Schizophrenia.
7. Recognize increased medical co-morbidities that are associated with psychotic disorders.

VALUABLE
1. Discuss the genetic, neurobiological, and environmental theories of etiology and pathophysiology of Schizophrenia and other psychotic disorders.

D. Mood Disorders

Rationale: Mood disorders are pervasive, under-diagnosed, and under-treated despite available and effective treatment of primary mood disorders and mood disorders due to a medical condition. Individuals with mood disorders suffer increased morbidity with other medical conditions, increased risk for self-harm, and challenges to their overall well being and psychosocial functioning.

Learning Objectives:

CORE
1. Discuss the epidemiology of mood disorders with special emphasis on the prevalence of depression in the general population and in non-psychiatric clinical settings among patients with other medical-surgical illness (e.g., cardiovascular disease, cancer, neurological conditions) and the impact of depression on the morbidity and mortality of co-morbid illness. This includes identification of differences throughout the life span.

2. Compare and contrast the features of unipolar and bipolar mood disorders with regard to clinical course, co-morbidity, family history, gender and cultural presentations, prognosis and associated complication (e.g., suicide and development disabilities).

3. Discuss the differential diagnosis for patient presenting with signs and symptoms of mood disorders, including primary mood disorders (e.g., Major Depressive Disorder, Dysthymic Disorder) and mood disorders secondary to other conditions (e.g., substance use, medical-surgical illness, bereavement, adjustment disorder, personality disorders) with regard to clinical course, co-morbidity, family history, prognosis, associated complications (e.g., suicide), and plan for further evaluation.

4. Discuss the subtypes of primary mood disorders including melancholic versus atypical features, psychotic features, seasonal pattern, and postpartum onset.

5. Discuss the high risk of suicide in patients with mood disorders, risk assessment and management strategies (See Unit I D Assessment of Psychiatric Emergencies).

6. Outline mood symptoms associated with menstrual function and child-bearing (such as post-partum depression and PMDD).

VALUABLE
1. Discuss what is currently known about the etiology and pathophysiology of mood disorders (e.g., neurobiology, psychological, genetic).

E. Anxiety Disorders

Rationale: Anxiety disorders are considered to be one of the most prevalent classes of psychiatric disorders and as such are likely to be encountered in all clinical settings. Anxiety disorders bring distress and dysfunction to the individuals and social settings while negatively impacting health care expenditures in the U.S.

Learning Objectives:

CORE
1. Discuss the epidemiology of anxiety disorders with special emphasis on the prevalence of anxiety in the U.S. population.

2. Discuss the differential diagnosis for patients presenting with anxiety, including primary anxiety disorders (e.g., Phobias, Panic Disorder) and anxiety disorders secondary to other conditions (e.g., substance use, endocrinopathy, adjustment disorder, personality...
disorders, somatoform disorders, etc.) with regard to clinical course, co-morbidity, family history, prognosis, associated complications, and plan for further evaluation.

3. Discuss the epidemiology and distinguish the clinical course, co-morbidity, family history and prognosis of Obsessive Compulsive Disorder relative to other anxiety disorders.

4. Discuss the epidemiology and distinguish the clinical course, co-morbidity, family history and prognosis of Acute and Post-traumatic Stress Disorders relative to other anxiety disorders.

**VALUABLE**

1. Discuss what is currently known about the etiology and pathophysiology of anxiety disorders (e.g., neurobiology, psychological, genetic).

**F. Somatoform Disorders, Factitious Disorder and Malingering**

*Rationale:* By their very nature, Somatoform Disorders frequently present in non-psychiatric settings. A physician without sufficient appreciation of the somatoform disorders will likely misdiagnose patients, prescribe unnecessary assessments and interventions, and participate in a dysfunctional patient-physician relationship.

**Learning Objectives:**

**CORE**

1. Compare and contrast the signs, symptoms, clinical characteristics and course, and prognosis of specific Somatoform Disorders including Somatization Disorder, Conversion Disorder, Pain Disorder, Body Dysmorphic Disorder, and Hypochondriasis.

2. Compare and contrast the characteristic features of Factitious Disorder and Malingering and distinguish these disorders from the Somatoform Disorders.

3. Discuss the principles and challenges to physicians of ongoing evaluation and management of patients with Somatoform Disorders, Factitious Disorder and Malingering.

**G. Personality Disorders**

*Rationale:* Individuals with personality disorders often become the difficult to treat or the unsatisfied patient. Physicians with an understanding of personality disorders will be better equipped to treat these patients and support the treatment team in their care.

**Learning Objectives:**

**CORE**

1. Students will be able to name the personality disorders described in the DSM IV, recognize the criteria for each disorder, and describe the general characteristics for Cluster A, B, and C.

2. Students will be able to describe common responses by healthcare providers to individuals with the various personality disorders.

3. Students will be able to describe useful responses and behaviors on the part of care providers as they manage patients with personality disorders.

**H. Disorders in Childhood and Adolescents**

*Rationale:* Recognition of disorders first presenting in childhood will permit timely assessment and intervention. Knowledge of the course of illness/impairment for adults with disorders first presenting in childhood will permit more sensitive assessment and more realistic intervention.

**Learning Objectives:**

**CORE**
1. Students will recognize presentation of the Autism Spectrum in its varying severity and to establish a differential diagnosis.
2. Students will recognize presentation for varying severity of developmental disorders and establish a differential diagnosis.
3. The student will recognize varying presentations of ADD disorders, including gender and age differences and be able to establish a differential diagnosis.
4. Students will recognize presentation of specific learning disorders of varying severity and establish a differential diagnosis.

I. Eating Disorders
   \textbf{Rationale:} Eating Disorders can be primary disorders and can be associated with other disorders such as depression, obsessive-compulsive and other anxiety disorders, substance abuse, and personality disorders. Eating disorders carry significant medical morbidity in addition to psychic distress, social dysfunction, and increased mortality due to suicide.

   \textbf{Learning Objectives:}
   \textbf{CORE}
   1. Discuss the clinical features, course, complications including mortality, and prognosis for anorexia nervosa, bulimia, and other eating disorders.
   2. Propose plans for further evaluation, including criteria for hospitalization.

J. Sexual Disorders
   \textbf{Rationale:} Sexual function contributes to patients’ well-being, exposes patients to risk and both impacts and is impacted by medical and psychiatric disorders.

   \textbf{Learning Objectives:}
   \textbf{CORE}
   1. Outline the differential diagnosis for sexual dysfunction.
   2. Discuss primary versus secondary sexual dysfunction related to other clinical disorders and make recommendation for further evaluation and referral.

K. Impulse Control Disorders
   \textbf{Rationale:} Impulsive action, often resulting in harm, may have many etiologies. Identifying the correct etiology of such behavior can assist the physician in treatment of the patient and protection of the patient and others.

   \textbf{Learning Objectives:}
   \textbf{CORE}
   1. The student will recall the association of impulsive behavior with childhood oppositional defiant disorder and conduct disorder and the adult anti-social disorder.
   2. The student can outline impulsive behavior that may be associated with intoxication, mood disorders, personality disorders, and with traumatic brain injury and with other disorders affecting cognitive functioning.

L. Dissociative Disorders
   \textbf{Rationale:} Accurate diagnosis of adjustment to trauma will help the treatment team provide appropriate intervention and a higher level of care.

   \textbf{Learning Objectives:}
   \textbf{CORE}
   1. Students will be cognizant of the term “dissociation.”
2. Students will discuss the hypothesized role of psychological trauma in the development of disorders characterized by dissociation and altered memory (ex: acute stress disorder, PTSD, Borderline Personality Disorder, Dissociative Identity Disorder, Malingering).

**VALUABLE**

1. Compare and contrast the clinical features of Dissociative Amnesia, Dissociative Fugue, Depersonalization Disorder, and Dissociative Identity Disorder.

**M. Paraphilias**

*Rationale:* Understanding the patient and any practice that may impact the patients’ well-being will permit the physician to provide more effective care.

**Learning Objectives:**

**CORE**

1. The student will be able to outline common paraphilias and any associated disorders.

**N. Special Populations**

*Rationale:* Misunderstanding the needs of special populations often causes persons to leave needed treatment. By familiarizing the student with special populations, utilization of services can increase.

**Learning Objectives:**

**CORE**

1. The student will investigate issues of lesbian, gay, bisexual and transgendered persons.
2. The identification of geropsychiatric issues such as:
   a. Substance use/abuse in the elder.
   b. Possible elder abuse.
   c. Normal cognitive changes versus dementia.

**Unit Three: Disease Prevention, Management and Therapeutics**

**A. Pharmacotherapy**

*Rationale:* Psychopharmacologic agents are a significant part of the therapeutic armamentarium of physicians in both primary care and specialist practice, and have become leaders in sales for pharmaceutical companies. The clerkship in psychiatry provides an opportunity for the student to observe the use of these agents within the frame of clear clinical indications, and to develop the basic elements of good prescribing and practice habits.

**Learning Objectives:**

**CORE**

1. The student will be able to explain the rationale for use, relevant clinical indications, probable mechanisms of action, and possible adverse reactions of each of the following classes of medications:
   a. Antidepressant of the SSRI or SNRI class.
   b. Atypical antipsychotic.
   c. Mood stabilizer.
   d. Anxiolytic.
2. Students will be cognizant of a patient’s ability to be adherent to her/his medication treatment plan, which may include such barriers as cost, cultural factors, religious prohibitions, and transportation.
3. The student will be aware of evidence based information in regards to psychopharmacology.
4. The student will demonstrate the ability to communicate such pertinent information re: medications to the patient and appropriate family.

B. Non-Pharmacologic Somatic Therapies

**Rationale:** While much attention is focused on the use of psychopharmacologic agents in the treatment of mental illness, a variety of non-pharmacologic approaches are helpful, as well, ranging from the much-misunderstood electroconvulsive therapy to diet and exercise.

**Learning Objectives:**

CORE

1. The student will summarize the common indications for electro-convulsive therapy and discuss its appropriateness, and risks and benefits.
2. The student will access evidence from the research literature for peer-reviewed recent studies of the effectiveness of any of the following for common psychiatric disorders:
   a. Vagal nerve stimulation
   b. Nutritional supplements
   c. Light therapy
   d. Exercise
   e. Diet
   f. Acupuncture
   g. Art, music, or dance therapy

C. Psychotherapies

**Rationale:** Even though it is unlikely that a given 3rd year medical student will develop sufficient understanding and skill in performing more advanced approaches to psychotherapy during the course of his or her required clerkship, it is nonetheless important that he/she understand the importance of this extension of the relationship between physician and patient, between helper and the individual in need of help, and the range of modalities possible and their usefulness, and work at pursuing less advanced forms of counseling useful in such things as approaching smoking cessation, treatment for addiction, and the like.

**Learning Objectives:**

CORE

1. The student will demonstrate understanding of the unique relationship between doctor and patient in psychiatric interactions (i.e., transference and counter transference issues).
2. The student will describe general features of common psychotherapies and understand the general effectiveness of these treatments.
3. The student will understand and discuss barriers to treatment experienced by some patients (i.e., availability, cost, transportation, lack of referrals from primary care physicians) and discuss techniques for increasing the likelihood of successful referral for psychotherapy.

D. Prevention

**Rationale:** Prevention is fundamental to medical practice. Physicians must keep in mind the goals of decreasing the occurrence of illness, reducing illness duration, and minimizing the associated disability.

**Learning Objectives:**

CORE

1. The student will recognize and identify signs and symptoms of child sexual and physical abuse and understand psychiatric sequelae of neglect and attachment disorders.
2. The student will recognize signs and symptoms of elder abuse.
3. The student will describe the economic impact and psychosocial burden of chronic mental illness on patients and their families, including the effect of discriminatory insurance coverage.
4. The student will perform a risk assessment of a geriatric patient with diminished capacity for decision-making and self-care and describe possible threats and appropriate interventions, attending to such issues as drug interactions, sedation, falling risks, nutritional issues, and the like.
5. The student will develop a differential diagnosis, and state the principles of management of a personal with potential or active violent behavior.
6. The student will develop a differential diagnosis, and recommend management for a patient exhibiting suicidal thoughts or behavior.

E. Multidisciplinary Collaboration with Consultants

*Rationale:* While the use of multidisciplinary teams is common in medical practice, especially in the hospital setting, its value may be seen more clearly in the psychiatric setting. Physicians must learn to collaborate effectively with other consultants and specialists in treatment of the psychiatric patient. The successful physician will also recognize the importance of collaboration with the patient’s family and significant others to the treatment success of the patient.

Learning Objectives:
CORE
1. The student will demonstrate understanding of the allied healthcare providers and work collaboratively with the professionals.
2. The student will be able to discuss indications for a psychiatric consult and how to request one.

Unit Four: Professionalism, Ethics and the Law

A. Professionalism

*Rationale:* Generally, students must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse patient population. Professionalism is the public face that psychiatry shows to the healthcare system and the public. Specifically in psychiatry, students must develop self awareness and self management skills in order to handle common boundary issues and the use of collegial relationships and established practice guidelines to maintain good practice.

Learning Objectives:
CORE
1. Identify and account for personal emotional responses to patients, including transference and counter transference.
2. Demonstrate respect, empathy, responsiveness, and concern regardless of the patient’s problems or personal characteristics.
3. Demonstrate sensitivity to medical student-patient similarities and differences in gender, ethnic background, sexual orientation, socioeconomic status, educational level, political views, and personality traits.
4. Discuss the prevalence and barriers to recognition of psychiatric illnesses in general medical settings and recognition of general medical conditions in patients with known psychiatric illness (stigma) including barriers involved in cultural backgrounds, economic levels, gender and sexual orientation.
5. Discuss the physician’s role in advocacy for services for the mentally ill.
B. Ethics

*Rationale:* All physicians and psychiatrist in particular confront ethical issues in medical practice. Medical students need to demonstrate a commitment to ethical principles pertaining to provisions or withholding of clinical care, confidentiality of patient information, informed consent and business practices. In caring for patients with altered mental status, physicians must deal with the conflict between beneficence and autonomy. An understanding of the ethical issues of confidentiality, informed consent, the right to refuse treatment, and boundaries in the doctor-patient relationship is critical to appropriate clinical practice.

**Learning Objectives:**

**CORE**

1. Discuss the principles, process and implications of civil commitment and the voluntary versus involuntary status of a patient.
2. Be aware of standards for involuntary commitment.
3. Discuss difference between outpatient and inpatient commitment and adverse consequences of each.
4. The student will understand the increased need for confidentiality rights of the psychiatric patient (HIPPA guidelines, JCAHO).

C. Medical-Legal Issues in Psychiatry

*Rationale:* All physicians must be knowledgeable about the legal obligations associated with medical practice. Important legal obligations for physicians include duty to report, duty to warn, and least restrictive alternative treatments. Particularly relevant in psychiatry are the issues of assessment of competency, seclusion and restraints, and criminal responsibility.

**Learning Objectives:**

**CORE**

1. The student can discuss the risk factors, screening methods and reporting requirements for domestic violence in vulnerable populations including children, adults, and the elderly.
2. The student understands the physician’s role in screening for, diagnosing, reporting and managing victims of abuse. Student will be familiar with State of Michigan requirements.
3. The student can discuss Tarasoff and the duty to protect.
4. The student will define the right to treatment and the right to refuse treatment.
5. The student will describe the process of admission to a psychiatric hospital, specifically a) the implications of voluntary vs. involuntary commitment status; b) the principles of civil commitment; and c) the process for obtaining a voluntary or involuntary commitment and a physician’s role in obtaining it.
6. The student will summarize the elements of informed consent, determination of capacities (e.g., to consent to treatment, to manage funds), and the role of judicial or administrative orders for treatment.

**OPP Objectives for Clinical Clerkships: Psychiatry Specific Objectives:**

1. Describe the osteopathic structural exam, and how structural findings are integrated in the overall workup of the psychiatric patient.
2. Describe the key role of the osteopathic history in the work up of the psychiatric patient.
3. Identify emotional, psychological, and cultural factors and how they may affect disease processes.
4. Describe how somatic dysfunction may affect the psychological and emotional functions of the patient, and how osteopathic manipulative treatment may influence these processes.

5. Demonstrate clinical understanding in psychiatric conditions, considering:
   a. Relevant anatomy and physiology.
   b. Typical manifestations of somatic dysfunction.
   c. Relevant sympathetic and parasympathetic innervation and influence.
   d. Pain and pain behavior.
   e. Venous, lymphatic, and cerebrospinal fluid pathways.
   f. Biomechanical impact.
   g. Supporting the body’s self healing mechanisms.
   h. Psychosocial implications.
   i. Prioritize the above considerations based on the individual patient.

6. Describe the role of somatic dysfunction in the pathophysiology and create an osteopathic manipulative treatment plan.

7. Devise an osteopathic management plan for each of the listed conditions:
   a. Address indications and contraindications for osteopathic manipulative treatment.
   b. Include rationale for osteopathic manipulative treatment in plan.
   c. Recognize the distinctive adaptation of technique necessary in this patient population.
   d. Be able to modify OMT techniques for hospitalized and post-surgical patients.
Medical Student Attire and Etiquette

- Medical students are to wear clean, white, short lab coats during the clerkship unless otherwise instructed by your preceptor. In addition, the student needs to follow the dress code of the institution in which they are placed. (Some hospitals require closed toe shoes, etc.).
- Although the College does not have a “dress code,” tennis shoes, jeans, shorts, short skirts, and “belly” shirts are not considered appropriate attire for hospital/office/clinic settings.
- Students must also wear a hospital ID badge. During orientation, all community campuses will provide information on obtaining your hospital ID badge.
- It is not appropriate to answer your cell phone, text message or pager during lectures, while on inpatient and/or outpatient assignments, rounding, etc. Please turn your cell phone and/or pager to “vibrate” and wait until a more appropriate time to answer.
- As a student, you will come in close contact with patients, physicians, peers and other health care professionals. Good personal hygiene must be practiced. Students must also wash their hands prior to seeing each patient.
- Medical students should introduce themselves to patients and other health care professionals as a medical student, not as a physician.

Student Responsibilities Regarding Patient Supervision

All medical procedures performed by medical students must be supervised by a licensed physician responsible for the care of the patient.

A. No procedure should be attempted by the medical student unless s/he is given permission to do so by a physician responsible for the patient.
B. If a student does not feel capable, then s/he must not undertake performance of the procedure without further instruction and direct supervision.
C. If the student is not known by the patient, the student should properly identify her/himself to the patient as a medical student.
D. If the medical student is not successful in the performance of a procedure within the reasonable amount of time or without undue discomfort to the patient, the medical student must withdraw and notify the supervising physician.
E. It is the responsibility of the medical student to discontinue the performance of any procedure at the direction of any nurse responsible for that patient, if that nurse has reasonable cause to ask the student to stop the procedure. The supervising physician should be notified promptly of any such action.
F. The student has the responsibility to record on the chart that a procedure was undertaken, the reason for the procedure, the outcome of the procedure, the patient’s condition at the conclusion, and plan for post-procedure interval.
G. Medical students must become knowledgeable and abide by Federal HIPPA guidelines.

MSU EMAIL

To facilitate communication from faculty and staff to students, students are required to have a functioning MSU email address. Students are responsible for checking their MSU email accounts daily and maintaining their MSU mailboxes so that messages can be received. Forwarding MSU email to another email account or failure to check email are not valid excuses for missing a deadline or other requirements of the clinical education program.
Clerkship Attendance

Attendance at all scheduled Psychiatry Clerkship activities is mandatory. If a student is unable to be present for scheduled clerkship activities because of extenuating circumstances, the student is required to complete a COM Excused Absence Request form. In all cases except for emergencies and sudden illness, requests for scheduled absences are to be submitted at least 30 days prior to the date(s) of absence. Absences are not approved until the form is signed by the community clerkship director. Once approved, the student is required to notify their preceptor. Failure to complete this form and obtain required signatures will result in an unexcused absence from the clerkship. Unexcused absences are considered unprofessional behaviors and will be noted as a mark of unprofessionalism on the student’s performance evaluation. Unprofessional behavior may lead to failure of the clerkship. Should a student miss more than 2.5 (excused or unexcused) days from the 4 week clerkship, the student may be subject to repeating the clerkship. Absences must be made up by the student unless the absence is a mandatory university activity. Makeup experience will be determined by the clerkship director but could include additional clinical days or written assignments. If a student has an emergency absence, at the time of the absence the student must notify the community clerkship assistant as well as their preceptor. The absence request form must be submitted to the clerkship director upon the students return to the clerkship.

NOTE: Students cannot be absent the first or last calendar day of the Psychiatry Clerkship rotation – requests to be absent will be denied for these days.

Psychiatry Clerkship Orientation

All Psychiatry Clerkships begin with a clerkship orientation. In person attendance at orientation is mandatory for students based in Flint, Kalamazoo, Lansing and Traverse City. Students based in Bay City, Detroit and Grand Rapids are required to do a mandatory on-line orientation. This should be completed prior to the first day of the clerkship. Bay City, Detroit and Grand Rapids students will report on the first day, as directed by your hospital schedules. Any absence from in person attendance or completing the on-line orientation prior to the first day will be considered unprofessional behavior and will result in a mark of unprofessionalism in the student’s clinical performance evaluation. Unprofessional behavior may lead to failure of the clerkship.

Scheduling COMLEX Exams

Students are informed by the COM Clerkship Office during orientation that they should avoid scheduling any of the required COMLEX exams while on the four-week Psychiatry Clerkship rotation. When scheduling COMLEX exams, the students are asked to check their calendars to confirm there are no conflicts with the Psychiatry Clerkship. The student must take every measure to schedule COMLEX exams when they are not on the Psychiatry Clerkship. If, however, the scheduling of COMLEX exams cannot be avoided during Psychiatry, the student must contact the clerkship director prior to scheduling the exam. The Psychiatry Clerkship is an intense full rotation and attendance at all clerkship activities is mandatory. If approval is granted, the student may still not be absent more than 2.5 excused days from the 4-week clerkship.
I. Clinical Performance Evaluation (CPE)

Each student’s clinical performance will be assessed on his/her clinical skills as well as his/her interactions with a variety of individuals on the clerkship. Any information (either in writing or orally) provided by individuals who have interacted with the student on the clerkship (e.g., staff, nurses, residents, patients or their families, etc) may be used in the final clerkship performance evaluation.

The preceptors will evaluate the student’s performance based on four categories, 1) Interactions with Patients, 2) Data Collection and Assessment, 3) Professional Behavior, and 4) Learning and Knowledge. *(A sample evaluation form can be found at the end of this document)*.

**Grading:** Performance will be rated using the following guidelines for each of the four categories listed above:

- Rating of 7 – 9 = “Superior”
- Rating of 4-6 = “At Expected Level”
- Rating Less than 4 = “Unsatisfactory” *(a score below 4 in any area will be investigated and, if substantiated, the student will fail)*.

**Honors Eligibility:** Student must have an overall rating of 7.0 or higher. *(Limited to MSU community approved clerkships).*

**Remediation:** Remediation will be specified by the Clerkship Director and reviewed by the Director of Medical Student Education. If a student has passed all other components of the clerkship, remediation will be limited to the clinical portion of the clerkship.

II. Logbook

The Logbook is one form of evaluation in the Psychiatry Clerkship used to assess expected knowledge and skills. Students must have all items in the Logbook signed by faculty or resident preceptors. The expectation is that all students will complete 100% of the objectives presented in the Logbook. Completion of the Logbook by the end of the clerkship is required. *Students will return the Logbook to the clerkship coordinator or designated staff person at the time of the final examination. (The logbook can be printed out from the Angel site).*

**Grading:** Completion of 100% of objectives presented in the Logbook by the end of the clerkship. Failure to complete the Logbook by the last day of the clerkship may result in an “N” grade for the clerkship.
III. Video and Post-Test on Health Disparities in Mental Health

Given an increasingly diverse population within the U.S., it is critical that physicians develop fundamental knowledge and skills in working with patients from varying cultures and ethnic backgrounds. In all branches of medicine, there are specific bodies of knowledge that are relevant to providing optimal care to patients according to their specific cultural needs. The objectives of this video assignment are threefold:

a) To increase overall understanding of the role of cultural factors in the identification, diagnosis, treatment of mental illness and access to care.
b) To understand specific risk factors and prevalence for various mental illnesses among cultural groups, including underserved minorities.
c) To gain awareness of the varying interpretations of illness/sickness based on cultural norms.

Students are required to view on the following videos regarding health disparities in mental health and pass a post-test no later then one week prior to the end of the clerkship:

1. “A Surgeon General’s Perspective on Cultural Competency: What Is It and How Does It Affect Diagnosis and Treatment of Major Depressive Disorder?”
2. “A Surgeon General’s Perspective on the Impact of Race, Ethnicity and Culture on Mental Illness”

Grading: A minimum score of 70% must be achieved on the post-test.

Remediation: The student must retake the post-test until a minimum score of 70% is achieved.

Instructions for logging on to Angel to complete the video and post-test:

Step 1 Log on to Angel at https://angel.msu.edu
Step 2 Select PSC-608 Psychiatry & Behav Sci Clkshp course for your community
Step 3 Click on “Lessons” at the top of the screen
Step 4 Click on Video and Post Test on Health Disparities in Mental Health
Step 5 Click on one of the following topics:
   1. “A Surgeon General’s Perspective on Cultural Competency: What Is It and How Does It Affect Diagnosis and Treatment of Major Depressive Disorder?”
   2. “A Surgeon General’s Perspective on the Impact of Race, Ethnicity and Culture on Mental Illness”
Step 6 After viewing or listening to a topic, complete the appropriate post-test.
Step 7 The Department of Psychiatry Student Medical Education Office will monitor post-test results and notify Community Clerkship Directors if students have not satisfactorily completed the assignment.
IV. On-line Lectures and Post-Tests

Students are required to view 14 on-line lectures throughout the clerkship and take a post-test after each lecture. A suggested sequence of viewing is included for the student to pace their review of lectures and link their clinical experiences to on-line material.

The following lists the content for our core on-line lectures with a suggested viewing schedule:

Week 1: Psychotic Disorders, Mood Disorders, Suicide, Trauma (PTSD)
Week 2: Personality Disorders, Anxiety Disorders, Substance Use Disorders, Disorders in Childhood and Adolescence
Week 3: Somatoform Disorders, Eating Disorders, Impulse Control Disorders
Week 4: Mental Health Issues in Late Life, Sexual Disorders, Medico-Legal Issues

Grading: Students are not graded on the post-tests and may repeat them until a score of 100% is achieved. Students will not pass the clerkship; however, unless all 14 lectures have been viewed in their entirety and all post-tests have been completed prior to the last day of the clerkship. Verification of lecture viewing will be done to assure students have seen each lecture.

Remediation: The Community Clerkship Director will be contacted and a remedial assignment will be arranged.

Instruction for logging on to Angel to complete the on-line lectures and post-tests:

Step 1 Log on to Angel at https://angel.msu.edu
Step 2 Select PSC-608 Psychiatry & Behav Sci Clkshp for your community
Step 3 Click on “Lessons” at the top of the screen
Step 4 Click on “On-Line Lectures”
Step 5 View lectures each week as recommended above
Step 6 After viewing each lecture, complete the appropriate post-test
Step 7 The Department of Psychiatry Student Medical Education Office will monitor the student’s completion of each of the lectures and post-tests and will notify Community Clerkship Directors if students have not satisfactorily completed the assignment.
V. Performance-Based Assessment (PBA) – Mental Status Exam

The student will be expected to complete a formal mental status exam (MSE) with a patient between the end of the second and fourth weeks of the psychiatry rotation. The MSE will be formally observed and rated by a designated supervisor/evaluator. The MSE will consist of three steps:

1. Communication Skills: The ability to establish rapport, effectively communicate, interview the patient, and manage the session.

2. Data Collection Skills: The formal interview will be completed in approximately 10 minutes without benefit of written guidelines (the student may take notes) and be performed in the presence of an evaluator.

3. Student Presentation and Case Discussion: Presentation is to be completed in approximately 10 minutes. The presentation should review the MSE data collected and integrate the findings from the MSE.

The total time to complete steps 2 and 3 of the MSE is 20 minutes.

The patient selected for the exercise should be unfamiliar to the student, one who the student has not previously examined or interviewed. The rating form can serve as a guide to organization and expectations (sample evaluation form can be found at the end of this document).

Grading: Students must receive a minimum score of 5 (maximum score possible is 9) to pass with no more than one NW (needs work) and no inadequate scores.

Honors: A passing grade on the first attempt is needed to qualify for honors.

Remediation: The exercise may be repeated two additional times (total of three attempts) in order to obtain a pass grade.
VI. Oral Presentation of Patient Information and Selected Topic – Description of Requirements

The student’s grade is also determined by his or her performance on the Oral Presentation of Patient Information and Selected Topic. Students will demonstrate basic competence in their ability to:

- Elicit information from the patients and collateral sources
- Organize and synthesize the information
- Evaluate the information to reach reasonable conclusions
- Review pertinent literature, and
- Communicate the information orally.

To demonstrate this competence, students will:

- Prepare an evaluation on one patient. The evaluation will include four parts:
  - Part I: Basic Oral Communication Skills
  - Part II: Presentation of Data
  - Part III: Conclusion and Recommendations
  - Part IV: Discussion of Selected Topic which includes a review of a topic pertinent to the understanding of the patient with support from the literature, choosing one of the following topics:
    - Differential Diagnosis
    - Neurobiological Basis of Disorder
    - Diversity
    - Access to Care
- Make an Oral Presentation to your peers and attending on the patient and topic. The presentation will be 10 minutes and then there will be about a 10 minute question/discussion period.

Grading: The student must demonstrate competency in all rated areas of the oral presentation: Part I: Basic Oral Communication Skills, Part II: Presentation of Data, Part III: Conclusion and Recommendation, and Part IV: Discussion of Selected Topic, in order to receive a pass. The student’s performance for each section will be rated either 3=Excellent, 2=Competent, 1=Needs Work, or 0=Inadequate. A Passing score is 30 (tabulated is the sum of all sections of the oral presentation). The maximum possible score is 45.

Honors: A passing grade on the first attempt is needed to qualify for honors.

Remediation: Students will be asked to re-present any component that does not obtain a rating of “2=competent” until all rated sections obtain a rating of “competent.” Demonstration of competency in all sections of the oral presentation will be required to pass.

The patients chosen for this assignment may be well known to the student. Patient confidentiality must be maintained at all times. This can be achieved by using an alias, limiting identifying information to age, sex, and ethnicity, and adjusting other potentially identifying information to maintain the patients’ privacy. The rating form can serve as a guide to organization and expectations (sample evaluation form can be found at the end of this document).

The oral presentations should be scheduled prior to week three of the clerkship to permit timely review and remediation as necessary within the timeframe of the clerkship.
Oral Presentation of Patient Information and Selected Topic – Guidelines

The outline given below will assist students to prepare the oral presentation of patient information, including mental status, conclusions and discussion of topic relevant to the patient and supported by the literatures

Presentation of Supporting Data Including Mental Status

A. Identifying Information and Chief Complaint
   Including impact on functioning and quality of life

B. Relevant Present Illness
   Current Symptoms: considers depression, anxiety, mania, psychosis profiles
   Onset/duration/variation: ex: daily, diurnal, seasonal variation, menstrually-related, post-partum, episodic
   Severity: subjective impairment of function, hopelessness/helplessness/worthlessness, suicidal/homicidal ideation, history of suicide/violence toward others
   Contributing factors: ex: genetic or other biological predisposition, medical illness, medication side effect, substance use
   Psychosocial Precipitants/Meaning: work/school, financial, family/primary relationship, physical/sexual abuse, legal, other

C. Relevant Past Psychiatric and Medical History
   Biological: heredity, medical problems (past), medications (past), substance abuse (past)
   Medications Tried: names, dose, duration, benefits, side effects
   Psychotherapy History: with whom or category of professional providing care, type, duration, benefit, compliance history
   Self Help Efforts: support groups, alternative care, exercise, etc.

D. Brief Relevant Social and Family History
   Current: age, marital status, significant other, number of children, living arrangements, work, interests, supports, coping skills, etc.
   Background: history of significant relationship or marriage, family/living relationships, remarkable child developmental features, work, etc.

E. Mental Status Exam
   Presented in standard order, all areas included, good descriptors, correct use of terms
   Appearance, Behavior and Attitude: general description, distinguishing features, dress, hygiene, grooming, general motor activity, abnormal movements, eye contact, cooperation, etc.
   Affect: present emotional responsiveness including range of expressive behavior and degree of congruence with mood (ex: characterized as normal constricted, blunted, flat, etc.).
   Mood: pervasive and sustained emotional state (e.g. depressed, irritable, anxious, angry, expansive euthymic, labile, etc.).
Speech and Language: articulation, fluency, grammar use, pace and volume.
Thought Content and Process (form of thought): coherence, organization and goal directedness (ex: circumstantiality, loosening of associations, flight of ideas, racing thoughts, blocking, tangentiality, hallucinations, delusions, preoccupations, distressing ideation and suicidal/homicidal ideation).
Insight and Judgment: awareness of illnesses, need for care, role of stresses, ability to manage decisions and conduct, etc.
Cognitive: orientation, attention/concentration, memory, calculations, language function, abstraction.

F. Pertinent Physical Examination and Lab Data

CONCLUSIONS AND RECOMMENDATIONS INCLUDING BIO-PSYCHO-SOCIAL STATEMENT, DIAGNOSIS, COURSE OF TREATMENT AND RECOMMENDATIONS
A. Summary Statement of Biological, Psychological, and Social Factors
   Contributing to patient’s illness at this time

B. Diagnosis (5 axis)
   5 axis format, all relevant diagnoses, differential diagnostic considerations, conclusions fit data.

C. Course of Treatment (Treatment Rendered and Results)
   Medical: psychotropic medications (dose, benefit, side effects), medical problems diagnosed and treated, results of medical consultations.
   Non-Medication Intervention: individual, group, milieu therapy, etc.

D. Discharge Recommendation/Consultant Recommendation
   Medical: psychotropic medications, treatment and/or further evaluation for medical condition.
   Non-Medical: psychotherapy, support groups, community resources, family support/involvement, etc.
   Follow-up: persons/agencies recommended to provide follow-up care, dates of appointments, etc.

DISCUSSION OF SELECTED TOPIC PERTINENT TO PATIENT
Topic Choices:
1. Differential Diagnosis
2. Neurobiological Basis of Disorder
3. Diversity
4. Access to Care
VII. NBME Psychiatry Clerkship Shelf Examination

The Department of Psychiatry core clerkship uses the National Board of Medical Examiners (NBME) shelf exam for the final examination on the last day of the clerkship to measure knowledge gained during the clerkship experience. The NBME final examination is a standardized, board-style exam with 100 multiple-choice questions that is returned to the NBME for scoring.

After instructions are given, students are given 2 hours and 30 minutes to complete the exam. Exam scores are provided approximately 10 business days following the end of the clerkship.

In the psychiatry clerkship welcome letter email, students are notified of the date, time and location of the final exam. This information is reiterated verbally during clerkship orientation. Any room or scheduling changes will be communicated to students in writing as they occur. All final written exams will be administered in all communities on the last day of the clerkship, starting no later than 9:00 a.m.

The starting time of the examination will be strictly adhered to, and all students must be seated in the exam location by the announced starting time for the exam. Admission to the exam will not be allowed after this time.

The examination will start on time and begin with the reading of directions for the examination, and admission to the exam will not be allowed during the reading of directions. Students may not request to be absent on the last day of the clerkship. Should an absence occur, documented extenuating circumstances will be considered by the Department of Psychiatry Director of Medical Student Education on a case-by-case basis.

Any unexcused absence from the scheduled NBME shelf exam or make-up exam will result in an automatic “N” grade for the clerkship. Additionally, students with an unexcused absence for a scheduled NBME shelf exam or make-up exam will be required to pay any additional fees associated with ordering another NBME exam. Once a makeup examination date is scheduled, it cannot be revised by the student.

Grading: A score of 62 is required to pass.

Honors: A score of 80 is required to be eligible for honors.

Remediation: Students scoring below 62 will be allowed to retake the NBME exam. A score of 62 on the make-up exam is required to earn a PASS mark. Students who fail their second attempt on the NBME shelf exam will be given an oral examination (see description below). Should a student fail the oral examination, he/she will receive an “N” grade and be required to repeat the entire four-week psychiatry clerkship.
Psychiatry Oral Examination
(Only for students who fail the second attempt on the written NBME shelf exam)

The oral examination is coordinated by the community clerkship director and administered by faculty (or clinical faculty) from the MSU Department of Psychiatry.

The student will be presented with three cases to read and will be asked questions about each case. The questions will vary depending upon the case content, but the student can expect questions focusing upon: (1) DSM-IV TR diagnosis (Axis I-V), (2) DSM-IV TR differential diagnosis: what other diagnoses should be considered?, (3) Epidemiology of mental illness: how often can we expect to see this disorder?, (4) Psychiatric treatment for the patient described in the clinical scenario: hospitalization, medications-type, dosage, efficacy, side effects, etc; other treatment possibilities-psychotherapy-what type, what goals, prognosis? Students should be aware of the names/classes of psychotropic medications, average dosing and medication side effects. The student will be given 20 minutes per case, which includes time for the student to review the case, take notes and present the case.

The cases will be taken directly from the DSM-IV-TR Casebook. While cases with a variety of diagnoses and features may be chosen, typical cases might include features of schizophrenia, affective disorders, anxiety disorders, substance abuse, eating disorders, ADHD, personality disorders and organic mental disorders. Review of the DSM-IV TR and Casebook is strongly recommended prior to the psychiatry oral examination.

There will be two examiners. The examiners may give the option to read all the cases at once in the beginning of the hour and then present them, or the option to read and present each case separately. The total exam time is one hour regardless of which option is chosen.

Students are required to be on time to allow for adequate administration of this examination.

**Grading:** Each component area of the case is scored as either “satisfactory” or “unsatisfactory.” If the student receives more than one “unsatisfactory” score for each case, the student fails the case. **In order to pass the oral examination, the student must pass two out of the three cases.** Following the exam the student will be given immediate feedback regarding his/her performance. A No Pass score requires repeating the entire four-week Psychiatry Clerkship. A summary of the performance will be prepared by the examiner and sent to the Clerkship Program Coordinator in the MSU Department of Psychiatry Medical Student Education Office.

An unexcused absence and/or failure to give at least one week notice to change a confirmed oral examination date/time will result in an automatic failure and an N grade will be processed. The student will be required to repeat the entire four-week psychiatry clerkship. Documented extenuating circumstances will be considered by the Department of Psychiatry Director of Medical Student Education on a case-by-case basis.
Criteria for Passing the Psychiatry Clerkship

- Successful completion of all portions of the required clerkship.
- Satisfactory numerical ratings between 4.0 – 6.0 on the Clinical Performance Evaluation (CPE).
- Completes 100% of objectives presented in the logbook in a timely manner.
- Completion of video on health disparities in mental health and successful passage of post-test.
- Completion of all on-line lectures and all post-tests.
- Successful completion of the Oral Presentation.
- Successful completion of the Performance-Based Assessment (PBA).
- Receives a score of 62 or better on the NBME shelf examination.

Criteria for Honoring the Psychiatry Clerkship

The Psychiatry Clerkship will award an Honors designation (H) for outstanding performance. Although the Honors designation is awarded in the clerkship, this is not an official University grade and therefore will not be reflected on the student’s Michigan State University transcript. The student will be sent an Honor’s letter from the MSU Department of Psychiatry Chairperson at the end of the clerkship after review of Honor’s criteria. The letter will also be kept in the student’s permanent academic file. Criteria for Honors Includes:

- Students must meet all criteria for passing as outlined above plus:
- Attain an average numerical rating of 7.0 or above on the Clinical Performance Evaluation (CPE).
- Pass the Oral Presentation on the first attempt.
- Pass the Performance-Based Assessment (PBA) on the first attempt.
- Receive a score of 80 or better on the NBME shelf examination.

Suggested Study Resources and Recommended Text


Recommended Websites:

1. [http://i3cme.com](http://i3cme.com)
2. [http://psychiacomp.com](http://psychiacomp.com)
3. [http://www.nbme.org](http://www.nbme.org)
4. [www.mghcme.org](http://www.mghcme.org)
5. [www.neiglobal.com](http://www.neiglobal.com)

Students can download free complete medical texts for handheld computers at: [http://ccspublishing.com/library/palm_ce_library.htm](http://ccspublishing.com/library/palm_ce_library.htm)
Grading Criteria

The Psychiatry Clerkship grades are assigned in accordance with established College policy. Upon completion of the scheduled clerkship the student will be assigned a grade of Pass (P), No Pass (N), Extension (ET), or No Grade Reported (NGR).

1. **Pass (P) Grade**

   The Pass grade (P) is given when the student has met or exceeded all of the criteria of the course.

2. **No Pass (N) Grade**

   The No Pass (N) grade is given when the student fails to meet all the criteria of the course.

3. **Extended (ET) Marker**

   The University-approved Extended (ET) marker is given to students only in courses specifically approved by the University Committee on Curriculum. Approval requires specification of the time period within which work must be completed. Courses that involve field experience or thesis work and courses in which work normally extends beyond one semester are the types of courses normally considered.

4. **No Grade Reported (NGR) Marker**

   The No Grade Reported (NGR) marker: The NGR (No Grade Reported) marker is automatically recorded by the University records system when student grades are not reported within five days of the end of the course. As soon as grades are submitted and recorded by the department, the NGR marker is erased and does not appear in the updated student record or on printed transcripts. Because the process of compiling the Final Clerkship Evaluation typically takes 3-4 weeks after the end of the clerkship, most students will receive a temporary NGR marker until their Final Clerkship Evaluation is prepared and final grade reported.

A student’s grade will be determined by his/her performance in the following areas and as described above. **Please note: It is the student’s responsibility to see that all clerkship requirements are completed by the last day of the clerkship. Should a student need to remediate any clerkship requirement, remediation must be done or arranged within four months after the clerkship rotation ends or the student could receive an N grade and have to repeat the clerkship rotation.**
Statement of Professionalism

Academic Honesty

“The goal of the College of Osteopathic Medicine (COM) should be to create individual professionals; physicians who can access and examine critically, a reliable and extensive fund of knowledge and apply it consistently to maximize the clinical benefit of patients. COM students are expected to demonstrate academic professionalism and honesty, and to maintain the highest standards of integrity according to a code of honor that embodies a spirit of mutual trust and intellectual honesty. Michigan State University’s Medical Student Rights and Responsibilities (MSRR) document has established that medical students have certain rights and responsibilities, and affirmed that students are a party to the social trust shared by all in the university community. COM supports the policies and procedures described in this MSRR document.”

“COM recognizes that a code of professional behavior cannot encompass all potential issues of conduct that may arise, and that judgments regarding professional behavior are subjective thereby making it impossible to specify all behaviors deemed to be unprofessional. Students are expected to hold themselves and their peers to professional standards of behavior throughout their course of study. Included among these standards are five fundamental values of academic integrity including honesty, trust, fairness, respect and personal accountability. Codes of professional conduct as outlined in the MSRR document should be provided to COM students at the time of their enrollment in medical school and these principles should be reinforced throughout the curriculum. Students shall also be bound by the precepts of professional behavior contained within the AOA code of ethics and the institutions where they complete medical rotations.”

Professionalism

“Principles of professionalism are not rules that specify behaviors, but guidelines that provide direction in identifying appropriate conduct. These principles include the safety and welfare of patients, competence in knowledge and skills, responsibility for consequences of actions, professional communication, confidentiality, and lifelong learning for maintenance of professional skills and judgments. Professionalism and professional ethics are terms that signify certain scholastic, interpersonal and behavioral expectations. Among the characteristics included in this context are the knowledge, competence, demeanor, attitude, appearance, mannerisms, integrity and morals displayed by the student to faculty, peers, patients and colleagues in other health care professions. Students are expected to conduct themselves at all times in a professional manner and to exhibit characteristics of a professional student.”

Students Rights and Responsibilities

“Each individual student is responsible for their behavior and is expected to maintain standards of academic honesty. Students share the responsibility with faculty for creating an environment that supports academic honesty and principles of professionalism. Proper relationship between faculty and student are fundamental to the college’s function and this should be built on mutual respect and understanding together with shared dedication to the education process. It is a fundamental belief that each student is worthy of trust and that each student has the right to live in an academic environment that is free of injustice caused by dishonesty. While students have an obligation to assist their fellow students in meeting the common goals of their education, students have an equal obligation to maintain the highest standards of personal integrity.”

Please refer to this site for further, detailed information: http://ap.com.msu.edu/MSRR-Official-Document-Final.pdf
Department Regulations Regarding Unprofessionalism

If a student is involved in one unprofessional incident during the four-week Psychiatry Clerkship rotation, the Director of Psychiatric Medical Education (DME) will be immediately notified by the Clerkship Director. If the incident is considered valid, the student will be notified immediately by the local Clerkship Director. The student will be told that they are receiving an unprofessional behavior citation that will be noted on the student’s clinical performance evaluation, a part of the student’s permanent file. The local clerkship director will explain the reasons for the unprofessional behavior citation and immediately work with the student to improve any behaviors considered unprofessional. Should a student receive more than one unprofessional behavior citation, the DME and Clerkship Director will discuss immediately. If the citations are appropriate, the student will be notified immediately that the student will receive an N grade for the entire rotation. Students who receive an N grade must successfully repeat the entire clerkship including all clerkship clinical work, assignments and exams in order to pass the rotation.
Appendix A

The Mental Status Examination – Definition
Developed at the University of Rochester, School of Medicine and Dentistry

The complete examination and study of any patient must include the examination of the patient’s mental status. The Mental Status Examination (MSE) is designed to test the functions of the mental apparatus. It yields an estimate of the gross effectiveness and integrity, quantitatively and qualitatively, of a broad spectrum of functions at the psychological level of organization. When administered properly, the MSE elicits evidence of dysfunction or malfunction of the mental apparatus. It aids in the detection and identification of psychopathology and may point to etiological factors.

While the MSE is performed on every patient, the psychiatric examination, especially of psychotic patients and of children, must include data from other sources also. Information directly elicited from the patient is supplemented by data obtained from relatives, neighbors, ministers, or social workers. The patient is part of a social system each member of which, as a result of his idiosyncratic perception of the system, affects the behavior of the patient and is in turn, affected by the patient’s behavior. The comprehension of the patient’s problems, therefore, requires the utilization of as many sources of information in the patient’s immediate environment as can practically be tapped. Whenever possible such ancillary informants should be called upon at the time the patient is admitted. The yield from such interviews is often amazingly rich. Errors, discrepancies, and omissions in the patient’s own history are thus corrected and an early, clear definition of the patient’s problems is facilitated.

A single interview with the same or with different members of the family often is not sufficient. Any one member of the family or social unit of which the patient is a part may need to be seen a number of times before we are able to understand the structure of the family, the life-style, the life experiences of the patient and the place of these factors in the pathogenesis of the patient’s presenting illness. The psychotic patient’s own productions may seem to be unintelligible at first. They should nevertheless be recorded with as much precision as possible. When combined with other information and increasing quantities of direct observations, even the most psychotic productions often begin to make sense.

Mental illness frequently arouses resentment, fear, guilt, shame, and anxiety in patients and relatives. These may manifest themselves by attitudes of defensiveness, anger, or by bewilderment. The doctor should be aware of this and attempt to make each interview an exercise in psychotherapy. In addition, to obtaining much information from family members, the interviews should orient the family members, allay some of their anxiety and give them a better understanding of the causes of emotional illness. The members of the family should be encouraged through their interest in the patient to share as much information as possible with the student or house officer. They can also be told in general terms about some of the problems the patient is facing. With better understanding on the part of the relatives, they will be able to be more cooperative in following through recommendations for further care or hospitalization, changes in the home, and attitudes toward the patient. Discussions with the relatives should avoid the extremes of alarmism or undue optimism. In speaking to them, language should be used which is understandable in terms of their own culture pattern. Special care should be exercised to protect the patient’s interests and not give information to the relatives that could be used against him or that could be misinterpreted by the family. After the initial interview, the family should be seen whenever necessary or at their request. They should be kept informed of the patient’s progress. Any communication with the family members or with others concerned with the patient’s welfare should be undertaken with the full knowledge of the patient. There must be no question in the patient’s mind about the confidentiality of what transpires between him and his physician. In instances in which further information is needed from social, health, and judicial agencies in the community, medical students and house officers will not make direct inquiries to these agencies but will refer such matters to the psychiatric social worker. Inquiries, in any detail about the patient from individuals, or from other third parties (agencies, etc.) are responded to only
with written permission of the patient. The only exceptions to this rule are inquiries from other physicians or from other hospitals.

Evaluating the material obtained from the patient and from the informants and piecing it together to obtain a comprehensive view of all the facts requires judgment, objectivity, and knowledge not only of a clinical psychiatry but in a broader sense, of persons living in a social group. It is sometimes difficult to determine the validity of the patient’s statements. In addition to possible sources of confirmatory or contradictory data from the informants, the MSE will help the examiner to detect slight or marked abnormalities in the thought processes and actual experiences of the patient.

It is particularly important to remember that patients should not be accosted directly with information obtained from second-hand sources. The MSE is not a legal inquiry but an outline to help the examiner learn the nature of the patient’s problems and to note the pertinent aspects of the patient’s behavior.

**Indications for the Mental Status Examination**

A record of the patient’s mental status is part of every completely recorded history of illness. In the form here suggested, it follows the record of the Physical Examination. How much of the complete MSE is administered and at what point or points in the total relationship with the patient this is done, depends on each individual case. In many instances, as will be elaborated below, much necessary minimum information can be elicited in the course of taking the patient’s history and during the physical examination. This may be sufficient to give adequate data for an estimate of the status of the patient’s mental functioning and may provide adequate material for a useful record. In instances where no further formal examination may be necessary a number of areas of mental functioning will have been found to be grossly intact in the course of history-taking and other initial contacts with the patient. These might include the formal headings of:

- Appearance and Behavior
- Speech
- Mood
- Thought Content
- Perception
- Orientation as to time space and person

A patient may be too ill to be subjected to a prolonged MSE. Here again, many pertinent data can be obtained during the necessary initial contact with the patient and more formal examination, if deemed indicated, may be postponed.

The fact of the patient’s refusal to cooperate in some of the more specific areas of the MSE is not in itself a contraindication to pursuing the examination further. Such refusal needs to be understood on its own terms and may be an important datum towards establishing, for instance, the presence of a sensorial defect. The patient in this case may be reacting to his anxiety about the presence of such a defeat by refusal to participate in its demonstration. The skillful examiner then seeks other avenues through his developing relationship to the patient to obtain the needed confirmation.

When, early in the course of examination of the patient, defects are detected in some of the areas mentioned above (or in others elaborated below), more formal and detailed examination is in order. This is also almost always the case in any patient whose complaints when first seen are primarily in the area of mental functioning.

A written record of the MSE should always be made regardless of factors limiting the extent of the examination itself. No matter how scattered the sources from which the information has been gathered in the course of the total contact with the patient, the accumulated data should be recorded in an organized fashion. One possible form of organizing them is suggested below.
The Technique of Performing the Mental Status Examination

Much of the success and validity of this examination will depend on the way the examiner approaches the patient. All aspects of the patient’s behavior are data, including his reaction to the examination itself. Much depends on the examiner’s attitude towards this part of the total examination of the patient. The patient senses quickly if the examiner considers his task in this area a routine, which has to be performed for the sake of “completeness” of the record. Perfunctoriness on the part of the examiner, lack of understanding of the purpose of the examination, defensiveness about administering various parts of the examination—all these are reflected in the test results and their validity. As many as possible of the items enumerated below should be obtained during the course of general history taking. Those parts of the MSE, which require specific questioning, should be done with thorough knowledge of their purpose. This should be done in the same matter-of-fact manner as one examines those areas of the body which often are invested with special significance by the patient, but the thorough examination of which are usually accepted by the patient as a matter of necessity. By the time MSE is begun, after initial history-taking, certain background facts about the patient will be known which will, to some extent, determine the choice of some of the specific items in the examination (e.g., in the area of “general information”). These background facts include education, occupation, socioeconomic status, age, sex and marital status. Conditions, at the time of examination, also have a great potential influence on the results and their validity. These conditions should be established and later recorded (e.g., patient’s experiences with regard to drugs, alcohol, recent sleep disturbances, acuteness of present illness, time of day of the examination, and the physical surroundings in which it was given—on the hospital division, in the physician’s office, etc.).

The Content of the Mental Status Examination

I. Observations of Examiner (not in response to questions):

A. Initial Appearance and Behavior
   Dress – neat, untidy, eccentric, etc.
   Posture – relaxed, rigid, tense, erect, recumbent, etc.
   Facial Expression – mobil, fixed, bland, angry, etc.
   Motor Activity – immobile, restless, dystonic, graceful, clumsy, etc.
   Physical Characteristics – body configuration
   Mood – (objective observation) calm, elated, anxious, irritable, etc. Is mood divergent from or contradictory to content of thought? Is it changeable during interview? If so, with what topics? At various times of the day?

B. Speech
   Quality of speech – tone, inflection, loudness, pronunciation (clear or slurred, defects, lisp), continuity (slow, rapid, halting), blocking, stuttering, etc., free verbalization, monosyllabic answers, pressure of speech, etc.
   Organization of speech – coherent, logical, relevant, circumstantial, disorganized, flight of ideas, work salad, rhyming, punning, etc.

II. Patient’s own subjective evaluation of his emotional reaction and mood (in response to questions by examiner, or in spontaneously offered communication). In the following, a number of questions are suggested to elicit the information desired under this heading. These questions are best asked in relation to certain topics as they arise in the course of interviewing the patient. Do not suggest feelings to patients but ask for them in an open-ended way.

A. How do you (did you feel…when such and such happens (happened))? Also used as a general question.

B. Mood fluctuation – diurnal, longer periods, during interview – What part of the day is most difficult? Most pleasant? How is this? Do you know why? Now, at the end of the interview, do
you feel the same as you did in the beginning? Did you notice any swings in mood at some time during the interview?

C. It is often important in the early contact with a patient to establish the presence of suicidal tendencies. Often the patient will offer either a direct or indirect clue in this area, which can be followed up with more questions. When you feel this way, does it seem at times that you just can’t go on? Have you thought when you are in such a mood that you might hurt yourself? Do away with yourself?

D. Feelings of unreality often come out spontaneously in the course of interviewing when the patient reports that he seems to feel strange, detached, in a fog, in a dream, unreal, without life, etc. At other times they must be elicited through judicious questioning. Again, it is better that this be done in context of the rest of the history than in a separate questioning period.

III. Content of Thought

It is necessary to repeat that this is an artificial division, made for the purpose of recording the results of the MSE, but that much of the material in any of these numbered categories will have emerged during the history-taking interview or may come out while the interviewer is questioning the patient on matters having to do with the previous or subsequent categories—or any other enumerated here. The purpose of the order suggested here is to organize the total material relevant to mental status which will have been obtained in various places at various times and even from various persons other than the patient.

The above is true particularly in this category. The patient’s content of thought may be his chief complaint: “I have a recurring thought that I will hurt my children.” The patient’s content of thought may be the chief complaint and the interviewer may not find it out until he has known the patient for some time—for example: a frightening hallucination, an obscene obsessive thought, an overwhelming preoccupation with some fearful or shameful thought, feeling, or act of behavior.

In eliciting details about the content of thought or searching for specific information (presence or absence of hallucinations) special skill is required and also a reasonable control of the examiner’s own anxiety about the material which may be in the offering. To begin with, the open-ended question is, as usual, the best: “What do you think about when you are upset like this?” (Or “depressed like this,” etc.). “Sometimes people who are upset (or depressed, etc.) have other upsetting (painful, frightening, unusual) thoughts.” “Sometimes they hear things or see things that are upsetting.” “Sometimes they have recurring thoughts that don’t want to go away,” etc. Directness, when timed properly, when supported by a good relationship with the patient, or when coupled with the kind of reassurance indicated above, need not be traumatic. At times the patient may sense correctly, or assume erroneously, that the doctor is beating around the bush, is being indirect because of his own anxiety, or his disapproval or fear of the patient’s symptom, thought, or hallucination.

At the end of the completed MSE, the examiner should have obtained information or have the knowledge of the presence or absence of the following items, listed usually under the heading of content of thought.

A. Symptomatology Involving Thoughts:
   1. Compulsions: repetitive acts which the patient feels driven to do (hand-washing, counting, etc.).
   2. Obsessions: repetitive thoughts which enter the patient’s mind unbidden and which he seems unable to control (thoughts of aggression, sexual thoughts, etc.).
3. Ruminations: repetitive or continuous speculation. Often circular, about abstract matters, interfering with all other thought processes.
4. Doubting and Indecision: excessively time-consuming uncertainties about which dress to wear, which tie to wear, what to eat, what to do, what to think, etc.
5. Phobic Thoughts: irrational fears – of heights, crowds, closed spaces, certain animals, etc.
6. Free-floating Anxiety: sense of dread and/or impending doom.
7. Feelings of Unreality: things seem in a fog, dim, distant, as if in a dream, unreal, remote. The solid objects in the environment somehow look different; shapes and colors are flat or changed, etc.
8. Depersonalization: a loss of sense of identity; the person feels different, changed, empty.
9. Feelings of Persecution: this heading includes the patient’s perception of relationships with people – does he feel that everyone is against him; that he is friendless, disliked, scorned, persecuted and plotted against? Are there suspicions of people’s motives; is he feeling wronged, annoyed, poisoned? How does he account for these events?
10. Feelings of Influence: are others working on him without his control? Is there a feeling of being controlled, influenced or manipulated, etc?
11. Feelings of Reference: sensations and feelings that events in the outside world are in some way all related to patient. This may include newspapers, radio and television programs beamed at him, commenting about him. Car horns may toot for him and street lights shine in a certain way to deliver certain messages.

B. Somatic Preoccupations (These include ideas about the patient’s body. The patient may believe that his body has changed or is changing, that his senses, his eliminative functions, his sexual functions and digestion, operate in a different, strange, extreme way; that the size of an organ or organs has changed; that internal changes are going on of a strange, different, or bizarre nature).

C. Symptomatology Affecting the Perceptions
1. Illusions: (particularly important in delirious patients). Does the patient misinterpret sensory data, shadows, noises, odors, bodily sensations? Are these misinterpretations more severe and/or upsetting to patients at certain times of the day, under certain conditions, e.g., in the dark, or in shadowed or subdued lighting.
2. Hallucinations: These are subjective sensory perceptions, which may occur in any of the sensory modalities. Often the patient will volunteer information regarding the presence of distressing voices, which he hears; at other times their presence is inferred from the patient’s behavior. Sometimes there is no outward indication of the presence of hallucinations but the patient may respond affirmatively and in some detail to specific questions regarding the presence of noises, odors, voices, visions, pictures, etc.

Auditory hallucinations are most frequently experienced in the form of voices. The content may be fragmentary or structured. The voices may be single or multiple and may be threatening, accusatory, persecutory, obscene, seductive, terrifying, or reassuring. Men’s, women’s, children’s voice may be identified.

Visual hallucinations are much less common. They, too, may appear in a great variety of different forms, from fleeting images of varying emotional impact, to well-defined, vivid pictures or scenes. (For example, monkeys with red hats and red coats in a patient with delirium tremens, are so real to the patient that he could chase them, describe their antics, etc.).

Gustatory hallucinations include odd or unpleasant tastes. (rare)
Olfactory hallucinations include odd or unpleasant smells. (rare)

Tactile hallucinations include sensations of being touched, fornication, insects on and under the skin, painful sensations, etc.

Of the above items, III A (1-6) are more frequently associated with neurotic distress; the rest more likely with psychotic conditions.

In any of the above it is important to establish exactly the circumstances surrounding the occurrence of these experiences (time, place, content, frequency, and constancy of occurrence. When, how and how often, what time of day, what relation to sleep or walking—all are pertinent questions).

D. Other Unclassified Types of Experiences

1. Dreams: Does the patient dream? How often; how vividly? Are there repetitive dreams? Are there nightmares? What is the content?

2. Hypnagogic and Hypnopompic Phenomena: These are dreamlike experiences often having a quality akin to hallucinations, occurring in the twilight states, between falling asleep and sleep, and between sleep and waking up. They may have special, repetitive content and specific affective components.

3. Déjà vu and similar sensations: This is a group of phenomena in which the patient may have the sensation of having been in a similar or same situation as the one in which he finds himself at the time. It may be an acute sensation of “having heard this same thing once before: (déjà entendu). This feeling may involve any of the sensory modalities, and may be very strong and vivid, with uncanny sense of great familiarity with a new situation or sensation.

IV. Examination of the Cognitive Functions

This part of the MSE is somewhat different from the rest in that it consists of more formal test questions. The methods and materials of this part of the examination are borrowed from more structured psychological tests. If these abbreviated procedures are not sufficient, or if they lead to data that are equivocal, a more detailed study with more elaborate and sensitive psychological tests is indicated.

Not every patient requires even the amount of cognitive testing here outlined. The most important problems in which these tests are indicated is in the distinction between organic brain disease and functional psychogenic illnesses; in the diagnosis of epilepsy, fugue states, delirium and dementia, and in the estimation of intelligence in patients in whom there is a question of mental deficiency.

Here more than in any of the other sections of the MSE it is important to be aware of the patient’s reactions to being given such test questions, which may often be interpreted as threatening, humiliating, annoying, or insulting. Again, certain sections of the following (orientation, memory) may be elicited casually, informally, during other interviews with the patient. Those questions, which involve actual testing (serial sevens), should be explained and introduced to the patient so that he can understand their purpose. To explain these tests as a necessary baseline—these and other preliminary statements may help considerably in obtaining the patient’s full cooperation. It is important also to remember that it is necessary to proceed slowly with questions with patients in whom a deficit in the cognitive functions is suspected. The test questions used should take into consideration the patient’s age, cultural background, and educational level. Easy questions should be asked first, followed by more difficult ones until the patient is unable to respond correctly. At this point it is often reassuring to the patient to return again to a question, which he is able to handle correctly.
As a rule, a patient should not be given the correct answers to questions on which he has failed. Giving such answers would, obviously influence the patient’s performance on any subsequent examination, should one be necessary.

For testing the cognitive function, the following subsections are suggested:

- Orientation
- Level of Attention-Concentration
- Memory (recent, past)
- Information and Vocabulary
- Abstract Reasoning
- Judgment
- Perception and Coordination, Psychomotor Speed

A. Orientation (This may have been established in the course of history-taking). Can the patient place himself in time? In space? As to his identity, who is he? Where is he? When? Does he recognize the function and identity of those around him (physicians, nurses, students)? When you ask a patient for the date, it is useful to remember to ask for the complete date—a patient may appear to be oriented fairly well to the approximate day and exact month, but when asked about the year, may prove to be mistaken.

B. Attention and Concentration

1. The Digit Span test consists of asking a patient to repeat a series of digits read to him by the examiner. Patients should first be tested on retention of digits forward. When the upper range of this is determined, retention for digits in reverse order should then be tested separately. For both parts, digits should be given at the rate of one per second and should not be grouped. The pitch of the examiner’s voice should be allowed to drop with the last digit of each series. If the patient fails on first trial at any digit series, a second trial of that length series should then be given. Stop after two failures at any given series length. The following are suggested as digit series to be used:

**Digits Forward**

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<th>Digits Forward</th>
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<tbody>
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<td>3,8,6</td>
<td>5,1,7,4,2,3,8</td>
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<tr>
<td>6,1,2</td>
<td>9,8,5,2,1,6,3</td>
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<tr>
<td>3,4,1,7</td>
<td>1,6,4,5,9,7,6,3</td>
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<tr>
<td>6,1,5,8</td>
<td>2,9,7,6,3,1,5,4</td>
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<tr>
<td>8,4,2,3,9</td>
<td>5,3,8,7,1,2,4,6,9</td>
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<tr>
<td>5,2,1,8,6</td>
<td>4,2,6,9,1,7,8,3,5</td>
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<tr>
<td>3,8,9,1,7,4</td>
<td>2,5</td>
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<tr>
<td>7,6,9,4,8,3</td>
<td>1,6,5,2,9,8</td>
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**Digits Backward**

<table>
<thead>
<tr>
<th>Digits Backward</th>
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<tr>
<td>2,5</td>
<td>1,6,5,2,9,8</td>
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<tr>
<td>6,3</td>
<td>3,6,7,1,9,4</td>
</tr>
<tr>
<td>5,7,4</td>
<td>8,5,9,2,3,4,2</td>
</tr>
<tr>
<td>2,5,9</td>
<td>4,5,7,9,2,8,1</td>
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The average expected level is from 5 to 8 digits correct forward and from 4 to 6 correct backward, less than 5 forward or less than 3 backward should be considered below average performance. A slight decrease in score after age 65 is considered normal. At any age a discrepancy between digit span forward and backward of more than 3 points is unusual.

2. Serial 7’s or Serial 3’s
This is a test of concentration in which the patient is asked to subtract sevens (or threes) from 100 in serial fashion audibly and as fast as he can. Attention should be paid to the manner in which the test is performed. It is not only a test of arithmetical ability. Serial subtraction, which taxes continuously and repeatedly the ability to attend and to concentrate, is one of the most valuable tests in detecting slight changes in attention produced by delirium. Long before arithmetical error may be manifested, the patient may betray his decreasing ability to perform the task by heightened effort, preservation, increase in total time of the test, frequent hesitation or questioning, requesting a new start, or becoming irritable, depreciating the test and the examiner. Average time for serial 7 subtractions is up to ninety seconds. Four or more errors is considered marginal, and seven or more errors is considered quite poor performance. For repeated examinations, examiner should use 102, 101, 99, or 98 as starting points in order to minimize learning effects. If the patient is unable to do this, “counting backward” is of a lesser degree of difficulty and, finally, “counting forward” may be used. One may also ask the patient to recite the alphabet forward as fast as he can as a similar test with a lower degree of difficulty.

C. Memory
Both recent and past memory may be tested and estimated during the regular history taking. Recent memory includes recall of events since patient’s hospitalization – meals he has taken, dates of hospitalization, of hospital procedures, events of hospital day, patient’s home address, telephone number, names and birth dates of relatives, current news events. In helping to determine whether the patient is confabulating, some of the above should be checked more than once with the patient and, if possible, with outside sources. In this regard, the question: “Have you seen me before?” may be helpful. The patient who confabulates will often answer in the affirmative, fabricating details of a previous meeting with the examiner that did not take place.

D. Information
The patient’s fund of information and vocabulary are the two best indicators of his general level of intelligence, and are particularly useful because of their relative insensitivity to the effects of any but the relatively most severe forms of psychopathology. That is, they are particularly helpful in determining “The pre-morbid” level of intellectual functioning, when there is impairment in other functioning, when there is impairment in other functions as the result of a disease process. Some suggested items are as follows:
1. How many days are there in a week?
2. What must you do to water to make it boil?
3. How many things are there in a dozen?
4. Name the four seasons of the year.
5. What do we celebrate on the 4th of July?
6. How many pounds are there in a ton?
7. What does the stomach do?
8. What is the capital of Greece?
9. Where does the sun set?
10. Who invented the airplane?
11. Why does oil float on water?
12. What do we get turpentine from?
13. When is Labor Day?
14. How far is it from New York to Chicago?
15. What is a hieroglyphic?
16. What is a barometer?
17. Who wrote “Paradise Lost”?
18. What is a prime number?
19. What is Habeas Corpus?
20. Who discovered the South Pole?

Individuals of average intellectual ability should be able to answer correctly from 8 to 13 of these items. Fewer than 8 correct answers is suggestive of below average intelligence, and correct answers to more than 13 of these items suggests above average intellectual ability.

E. Vocabulary

The patient's vocabulary is probably the best indicator of his general intellectual level. This is an attribute, which can be observed and evaluated throughout the interview with the patient, but is can be more specifically tested through presentation of a number of words from the following list, in order of difficulty.

2. Donkey 14. Stanza
3. Diamond 15. Guillotine
5. Join 17. Seclude
7. Shilling 19. Recede
8. Bacon 20. Affliction
10. Armory 22. Dilatory
11. Fable 23. Flout

Patients must be able to give a reasonable definition or in any other way indicate they understand the meaning of the word. Using the word correctly and appropriately in a sentence also indicates an understanding of the meaning. Persons of average intellectual ability should be able to answer correctly from 8 to 16 of these items. Fewer than 8 correct answers indicate below average intellectual ability.

F. Abstraction

We are interested in the patient’s capacity to reason abstractly. This is a particularly important aspect of the patient’s intellectual function because of its vulnerability to the effects of organic disturbances, and because of its impairment in certain psychotic states, particularly schizophrenia. We are concerned with the patient’s capacity to generalize, to think in terms of classes of objects and of events, and to understand the meaning and implication of symbols. The
capacity for abstraction can be tested in a number of ways, two of which are the use of proverbs and similarities. The use of proverbs for this purpose is subject to some criticism because of the varying familiarity of patients with various proverbs and because of the possibility of patients responding correctly on the basis of “stereotyped” or “habitual” responses, rather than the capacity to perform the reasoning function at the time the proverb is presented. That is, in testing capacity for abstraction, we are interested in the patient’s ability to perform this function at the time the proverb is presented. That is, in testing capacity for abstraction, we are interested in the patient’s ability to perform this function at the time of the examination rather than a demonstration of having possessed this capacity in the past. The test can be presented in the following way: “You know what a proverb is, don’t you?” A proverb is a saying. What do people generally mean when they say…” Some proverbs that may be used are as follows:

1. Don’t count your chickens before they are hatched.
2. There is no use crying over spilt milk.
3. The wheel that does the squeaking is the wheel that gets the grease.
4. A stitch in time saves nine.
5. As the twig is bent so is the tree inclined.
6. You can catch more flies with honey than with vinegar.
7. It’s an ill wind that blows nobody good.
8. The restless sleeper blames the couch.
9. The tongue is the enemy of the neck.
10. The mouse that has but one hole is soon caught.

Persons of average intellectual ability should be able to give adequate responses to at least 4 or 5 items from this list of proverbs.

The testing of the capacity to give similarities is another method of assessing the patient’s ability to reason abstractly. Here we are concerned with the patient’s capacity to see objects and concepts in terms of “abstract or general classes.” The test may be administered in the following way: “I am going to name some things which are the same or alike in certain ways. I want you to tell me in what way they are the same or alike. For example, in what ways are the plum and a peach alike?” Other similarities are as follows:

1. A plum and a peach 7. Scissors and copper pan
2. Beer and wine 8. Mountain and lake
3. Cat and mouse 9. First and last
4. Piano and violin 10. Salt and water
5. Paper and coal 11. Liberty and justice
6. Pound and yard 12. The numbers 49 and 121

Persons of average intellectual ability should be able to answer correctly from 5 to 8 of these. Five adequate responses or less suggest below average intellectual functioning, more than 8 adequate responses suggests above average intellectual functioning.

Note that the patient’s response to similarities may be more or less concrete or abstract. For example, recognizing that a plum and a peach both “can be eaten” or “are round” or “have skins” are all correct in the sense that these are all accurate similarities. However, there are somewhat less abstract responses that recognizing that a plum and a peach are both fruits, i.e., they are members of a class of objects called “fruits.”

G. Judgment and Comprehension
As part of the examination of the patient’s intellectual function, we are concerned with the extent to which the patient has been able to acquire an understanding of common modes of behavior in
society, and an understanding of common social mores and conventions. The extent to which a patient can perform well in this area may be an index of the extent to which he is a socially conforming individual who responds in terms of good judgment. The patient may be asking the following questions:

1. What is the thing to do if you lose a book belonging to the library?
2. Why is it better to build a house with brick than of wood?
3. What should you do if you see a train approaching a broken track?
4. Why is it generally better to give money to an organized charity than to a street beggar?
5. What is the thing to do if a very good friend asks you for something that you don’t have?
6. Why are criminals locked up or put in prison?
7. Why should most government positions be filled through Civil Service Examinations?
8. Why does the United States require that a person wait at least two years from the time he makes application until the time he receives his final citizen papers?
9. Why is cotton used in making cloth?
10. Why should a promise be kept?

Persons of average intellectual ability should be able to answer correctly from 4 to 7 of these items. Less than 4 correct responses suggests below average intellectual functioning, while correct answers to 8 or more suggests above average intellectual functioning.

H. Perception and Coordination

The examination should contain at least a brief examination of the patient’s perceptual and visual motor functioning. To this end the patient can be asked to:

1. Write his name (observe the speed and coordination the patient displays; observe the size of the letters, their accuracy, the presence or absence of tremor, etc.) on a sheet of blank paper.
2. Copy a simple circle drawn by the examiner on a sheet of blank paper.
3. Copy a simple cross, drawn by the examiner on a sheet of blank paper.
4. In a similar fashion, the patient is asked to copy a square, a diamond, a row of dots.

In each case we are concerned with the patient’s capacity to accurately reproduce the design drawn by the examiner and to do this with a reasonable degree of coordination and speed. Aberrations in the quality of design in terms of the capacity to reproduce angles, corners, circles, and to draw crossing lines, all point toward impairment of the visual, motor, and perceptual processes. All of the above tasks are so simple that one would expect an individual of average intelligence to be reasonably accurate in the performance. Inability to perform may be suggestive of brain damage or of mental deficiency.

Summary and Conclusion

The above is an outline of a comprehensive mental status examination. It is neither complete nor is it minimal. If further information is needed to establish the patient’s mental status, formal psychological testing is in order. Often it will be the judgment of the examiner that not all of the above outlined tests need to be performed. Often it will not be possible to do all of the examination. For the beginner the rule should be that, in this instance, it is better to do more than necessary than to do less than is needful for a clear picture of the patient’s mental functioning. On whatever service the patient, who is examined, finds himself, the record of a history, which does not include some ordered statement of the patient’s mental status is incomplete. The outline presented above is one way of ordering the data.
Appendix B

Terms Used in the Mental Status Examination

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Association</td>
<td>Relationship between ideas or emotions by contiguity, continuity, or by similarities.</td>
</tr>
<tr>
<td>Confabulation</td>
<td>The more or less unconscious, defensive “filling in” of actual memory gaps by imaginary or fantastic experiences, often complex, that are recounted in a detailed and plausible way as though they were factual.</td>
</tr>
<tr>
<td>Neologism</td>
<td>In psychiatry, a new word or condensed combination of several words coined by a patient to express a highly complex meaning related to his conflicts; not readily understood by others; common in schizophrenia.</td>
</tr>
<tr>
<td>Blocking</td>
<td>Difficulty in recollection, or interruption of a train of thought or speech, due to emotional factors usually unconscious.</td>
</tr>
<tr>
<td>Dissociation</td>
<td>A psychological separation or splitting off; an intra-psychic defensive process which operates automatically and unconsciously. Through its operation, emotional significance and affect are separated and detached from an idea, situation, or object. Dissociation may unconsciously defer or postpone experiencing the emotional impact as for example, in selective amnesia.</td>
</tr>
<tr>
<td>Clang Association</td>
<td>Associations that are governed by rhyming sounds, rather than meaning, e.g., “This is what I thought, bought, knot, caught, rot sought.”</td>
</tr>
<tr>
<td>Flight of Ideas</td>
<td>Verbal skipping from one idea to another before the last one has been concluded; the ideas appear to be continuous, but are fragmentary and determined by chance associations.</td>
</tr>
<tr>
<td>Loss of Goal</td>
<td>Failure to follow a chain of thought to a logical conclusion – usually elicited by asking a question which the patient starts to answer, then he seems to wander off the subject.</td>
</tr>
<tr>
<td>Circumstantial</td>
<td>A characteristic of conversation that proceeds indirectly to its goal idea, with many tedious details and parenthetical and irrelevant additions.</td>
</tr>
<tr>
<td>Autism (autistic thinking)</td>
<td>A form of thinking which attempts to gratify unfulfilled desires without due regard for reality. Objective facts are distorted, obscured, or excluded in varying degree.</td>
</tr>
<tr>
<td>Euphoria</td>
<td>An exaggerated feeling of physical and emotional well-being not consonant with apparent stimuli or events; usually of psychologic origin, but also seen in organic brain disease and toxic states.</td>
</tr>
<tr>
<td>Depression</td>
<td>Psychiatically, a morbid sadness, dejection or melancholy; to be differentiated from grief, which is realistic and proportionate to what has been lost. A depression may vary in depth from neurosis to psychosis.</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Apprehension, tension or uneasiness which stems from the anticipation of danger, the source of which is largely unknown or unrecognized. Anxiety is primarily of intra-psychic origin, in distinction to fear, which is the emotional response to a consciously recognized and usually external threat or danger. Anxiety and fear are accompanied by similar physiologic changes. Anxiety may be regarded as pathologic when it is present to such extent as to interfere with effectiveness in living; the achievement of desired realistic goals or satisfactions, or reasonable emotional comfort.</td>
</tr>
<tr>
<td>Apathetic</td>
<td>Showing lack of interest, indifference, or lacking feeling.</td>
</tr>
<tr>
<td>Flattened Affect</td>
<td>Displaying an abnormally small range of emotional expression.</td>
</tr>
<tr>
<td>Labile Affect</td>
<td>Rapidly shifting emotions, seen in extreme form in brain syndromes.</td>
</tr>
<tr>
<td>Inappropriate Affect</td>
<td>Emotional expressions that are not in accord with the situation, or what is being said, e.g., giggling when talking about the death of a parent.</td>
</tr>
<tr>
<td>Delusion</td>
<td>A false belief out of keeping with the individual’s level of knowledge and his cultural group. The belief is maintained against logical argument and despite objective contradictory evidence. Common delusions include: Delusions of Grandeur: Exaggerated ideas of one’s importance or identity. Delusions of Persecution: Ideas that one has been singled out for persecution. Delusions of Reference: Incorrect assumption that certain casual or unrelated remarks or the behavior of others applies to oneself.</td>
</tr>
<tr>
<td>Illusion</td>
<td>The misinterpretation of a real, external sensory experience.</td>
</tr>
<tr>
<td>Hallucination</td>
<td>A false sensory perception in the absence of an actual external stimulus. May be of emotional or chemical (drugs, alcohol, etc.) origin, and may occur in any of the five senses.</td>
</tr>
<tr>
<td>Phobia</td>
<td>An obsessive, persistent, unrealistic fear of an external object or situation such as heights, open spaces, dirt, and animals. The fear is believed to arise through a process of displacing an internal (unconscious) conflict to an external object symbolically related to the conflict.</td>
</tr>
</tbody>
</table>
| Compulsion            | An insistent, repetitive, intrusive, and unwanted urge to perform an act which is contrary to the person’s ordinary conscious wishes or standards. A defensive substitute for hidden and still
more unacceptable ideas and wishes. Anxiety results from failure to perform the compulsive act.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obsession</td>
<td>Persistent, unwanted idea or impulse that cannot be eliminated by logic or reasoning.</td>
</tr>
<tr>
<td>Sensorium</td>
<td>Roughly approximates consciousness. Includes the special sensory perspective powers and their central correlation and integration in the brain. A clear sensorium conveys the presence of a reasonably accurate memory together with a correct orientation for time, place and person.</td>
</tr>
<tr>
<td>Orientation</td>
<td>Awareness of oneself in relation to time, place and person.</td>
</tr>
<tr>
<td>Perseveration (stereotype)</td>
<td>Persistent, mechanical repetition of an activity, common in schizophrenia.</td>
</tr>
<tr>
<td>Insight</td>
<td>Self-understanding; a major goal of psychotherapy; the extent of the individual’s understanding of the origin, nature, and mechanisms of his attitudes and behavior. More superficially, recognition by patient that he is mentally ill.</td>
</tr>
<tr>
<td>De-personalization</td>
<td>Feelings of unreality or strangeness concerning either the environment or the self.</td>
</tr>
</tbody>
</table>
Michigan State University  
College of Osteopathic Medicine (COM)  
Psychiatry Clerkship  
Clinical Performance Evaluation (CPE)

STUDENT___________________________________________  SEMESTER: Fall Spring Summer YEAR:___________
COMMUNITY (circle) Detroit Flint Grand Rapids Kalamazoo Lansing Traverse City
If Alternative Site (non-MSU) please list hospital/facility______________________________________________________________
CLERKSHIP DATES_______________________  to  ____________________________________________________
FACULTY EVALUATOR_____________________________________________________________________________________

FACULTY INSTRUCTIONS: Based on your interactions and observations, please evaluate the student’s performance in the four categories below. Behaviors listed would be expected of our students; thus the majority of students should be rated between 4 and 6. PLEASE CIRCLE NUMBER TO INDICATE YOUR RATING. Comments on all ratings are strongly encouraged. If an item is not relevant to your contact with this student, mark N/A.

### INTERACTIONS WITH PATIENTS

**EXPECTED BEHAVIORS INCLUDE BUT ARE NOT LIMITED TO:**

- Is respectful of patients and their needs.
- Establishes cooperative working relationships appropriate to patient age and cultural background.
- Assesses patient understanding.
- Informs patient clearly without jargon.
- Listens effectively.
- Adheres to all aspects of the Osteopathic Tenants (holistic medicine, health promotion, comprehensive treatment).

<table>
<thead>
<tr>
<th>UNSATISFACTORY</th>
<th>AT EXPECTED LEVEL OF PERFORMANCE</th>
<th>SUPERIOR</th>
<th>NOT ASSESSED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

**COMMENTS:**

### DATA COLLECTION AND ASSESSMENT

**EXPECTED BEHAVIORS INCLUDE BUT ARE NOT LIMITED TO:**

- An accurate and appropriate history and physical examination.
- Creates relevant master problem list, including psychosocial problems.
- Organizes and synthesizes available data.
- Generates an appropriate assessment, including differential diagnosis.
- Writes timely and appropriate chart notes.
- Incorporates patient assessment into routine verbal and written work.
- Appropriately monitors therapeutic plans.
- Applies fund of knowledge to clinical situations.

<table>
<thead>
<tr>
<th>UNSATISFACTORY</th>
<th>AT EXPECTED LEVEL OF PERFORMANCE</th>
<th>SUPERIOR</th>
<th>NOT ASSESSED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>
PROFESSIONAL BEHAVIOR

EXPECTED BEHAVIORS INCLUDE BUT ARE NOT LIMITED TO:

- Cooperates and works effectively with other health care professionals.
- Accepts responsibility for own actions/decisions.
- Is punctual, available and reliable.
- Demonstrates honesty and trustworthiness.

LEARNING/KNOWLEDGE

EXPECTED BEHAVIORS INCLUDE BUT ARE NOT LIMITED TO:

- Takes initiative and acquires new information on assigned cases.
- Seeks advice/input from other health professionals.
- Accepts and incorporates constructive feedback.
- Communicates and applies knowledge learned about patients.

PLEASE ADD ANY COMMENTS THAT FURTHER DESCRIBES THIS STUDENT'S PERFORMANCE:

Signature of Evaluator

Date

For this evaluation, I spent approximately _________ hours interacting directly with this student.

COMPLETE AND RETURN this form to the student OR Fax to 517-884-6860, OR mail it directly no later then 2 weeks after the clerkship ends:

Sarah McVoy
Michigan State University
Department of Psychiatry
965 Fee Road, Room A233B
East Lansing, MI 48824-1316.
The student will be expected to complete a formal mental status exam (MSE) with a patient between the end of the second and fourth weeks of the psychiatry rotation. The MSE will be formally observed and rated by a designated supervisor/evaluator. The MSE will consist of three steps:

1. **Communication Skills:** The ability to establish rapport, effectively communicate, interview the patient, and manage the session.
2. **Data Collection Skills:** The formal interview will be completed in approximately 10 minutes without benefit of written guidelines (the student may take notes) and be performed in the presence of an evaluator.
3. **Student Presentation and Case Discussion:** Presentation is to be completed in approximately 10 minutes. The presentation should review the MSE data collected and integrate the findings from the MSE. The total time to complete steps 2 and 3 of the MSE is 20 minutes.

The patient selected for the exercise should be unfamiliar to the student, one who the student has not previously examined or interviewed.

**GRADING:** Students must receive a minimum score of 5 (maximum score possible is 9) to pass with no more than one NW (needs work) and no inadequate scores.

**HONORS:** A passing grade on the first attempt is needed to qualify for honors.

**REMEDICATION:** The exercise may be repeated two additional times (total of three attempts) in order to obtain a pass grade.

<table>
<thead>
<tr>
<th>1st attempt</th>
<th>2nd attempt</th>
<th>3rd attempt</th>
</tr>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

**COMMUNICATION SKILLS**
Rapport/interviewing skills

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Competent</th>
<th>Needs Work</th>
<th>Inadequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

**DATA COLLECTION SKILLS**
___Appearance, ___Orientation, ___Attention, ___Memory, ___Language, ___Abstraction, ___Visual-Spatial, ___Mood, ___Affect, ___Judgment, ___Insight, ___Suicidal homicidal lethality assessment

| 3 | 2 | 1 | 0 |

**STUDENT PRESENTATION AND CASE DISCUSSION**
Concise, organized summary with appropriate discussion of the possible meaning of the results, diagnostic hypotheses and implications, need for further evaluation.

| 3 | 2 | 1 | 0 |

**TOTAL SCORE, SECTION III**
MENTAL STATUS SUMMARY

<table>
<thead>
<tr>
<th>Maximum Score</th>
<th>Score</th>
<th>Minimum Score to Pass</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td></td>
<td>5*</td>
</tr>
</tbody>
</table>

**Pass** Yes/No

**COMMENTS:**
**INSTRUCTIONS:**  Students will prepare an evaluation on one patient. The evaluation will include four parts as listed below. Students will make an oral presentation to peers and attending on the patient and topic. The presentation will be 10 minutes followed by a 10 minute question/discussion period.

**GRADING:**  Students must demonstrate competency in all rated areas of the oral presentation, Part I: Basic Oral Communication Skills, Part II: Presentation of Data, Part III: Conclusion and Recommendation, and Part IV: Discussion of Selected Topic, in order to receive a pass. The students performance for each section will be rated either 3=Excellent, 2=Competent, 1=Needs Work or 0=Inadequate. A passing score is 30 (tabulated is the sum of all sections). The maximum possible score is 45.

**HONORS:**  A passing grade on the first attempt is needed to qualify for honors.

**REMEDICATION:**  Students will be asked to re-present any component that does not obtain a rating of “2=Competent” until all rated sections obtain a rating of “competent.” Demonstration of competency in all sections of the oral presentation will be required to pass.

<table>
<thead>
<tr>
<th>TOTAL SCORES</th>
<th>Maximum Score</th>
<th>Score</th>
<th>Minimum Score to Pass</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PART I: BASIC ORAL COMMUNICATION SKILLS</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Organization and delivery</td>
<td>3</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Content</td>
<td>3</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Ability to expand on relevant information</td>
<td>3</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td><strong>PART II: PRESENTATION OF DATA</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifying data and chief complaint</td>
<td>3</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Relevant present illness</td>
<td>3</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Relevant past psychiatric and medical history</td>
<td>3</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Pertinent social and family history</td>
<td>3</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Mental status examination</td>
<td>3</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td><strong>PART III: CONCLUSION AND RECOMMENDATIONS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bio-psycho-social statement</td>
<td>3</td>
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<td>2</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>3</td>
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<tr>
<td>Treatment</td>
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<td>2</td>
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<tr>
<td>Recommendations</td>
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<td></td>
<td>2</td>
</tr>
<tr>
<td><strong>PART IV: DISCUSSION OF SELECTED TOPIC</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarity</td>
<td>3</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Scientific merit</td>
<td>3</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Relevance to patient</td>
<td>3</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>45</td>
<td></td>
<td>30</td>
</tr>
</tbody>
</table>

**COMMENTS:**
Michigan State University  
College of Osteopathic Medicine (COM)  
Psychiatry Clerkship  
Absence Request Form

Attendance at all scheduled Psychiatry Clerkship activities is mandatory. If a student is unable to be present for scheduled clerkship activities because of extenuating circumstances, the student is required to complete a COM Excused Absence Request form. In all cases except for emergencies and sudden illness, requests for scheduled absences are to be submitted at least 30 days prior to the date(s) of absence. Absences are not approved until the form is signed by the community clerkship director. Once approved, the student is required to notify their preceptor. Failure to complete this form and obtain required signatures will result in an unexcused absence from the clerkship. Unexcused absences are considered unprofessional behaviors and will be noted as a mark of unprofessionalism on the student’s performance evaluation. Unprofessional behavior may lead to failure of the clerkship. Should a student miss more than 2.5 (excused or unexcused) days from the 4 week clerkship, the student may be subject to repeating the clerkship. Absences must be made up by the student unless the absence is a mandatory university activity. Makeup experience will be determined by the clerkship director but could include additional clinical days or written assignments. If a student has an emergency absence, at the time of the absence the student must notify the community clerkship assistant as well as their preceptor. The absence request form must be submitted to the clerkship director upon the students return to the clerkship.

NOTE: *Students cannot be absent the first or last calendar day of the Psychiatry Clerkship rotation – requests to be absent will be denied for these days.*

<table>
<thead>
<tr>
<th>Student Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dates requesting to be absent:</td>
</tr>
<tr>
<td>Reason for absence (please be specific):</td>
</tr>
<tr>
<td>Student Signature:_________________________ Date:__________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clerkship Directors/Coordinators: State below the remediation plan as discussed and agreed upon with the student.</th>
</tr>
</thead>
<tbody>
<tr>
<td>____________________________________________________________________________________________________________</td>
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<td>____________________________________________________________________________________________________________</td>
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<table>
<thead>
<tr>
<th>Approved by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clerkship Director: ___________________________ Date:<strong>/</strong>/__</td>
</tr>
<tr>
<td>Psychiatry Clerkship Office: _________________________ Date:<strong>/</strong>/__</td>
</tr>
</tbody>
</table>