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New Developments in Medical Student Education: Opportunities for Child and Adolescent Psychiatrists

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In 1910 the Carnegie Foundation for the Advancement of Teaching published what is known as the Flexner Report. This assessment of medical education in the United States changed the structure of U.S. medical education to the form in which it is today: a focused study of the basic sciences that are the foundation of medicine, followed by a series of supervised clinical apprenticeships. In recognition of the centennial of the Flexner Report, many documents have been published over the past 2 years that present thoughtful recommendations for medical education in the 21st century. This article highlights five documents that present child and adolescent psychiatrists (CAPs) with specific opportunities and challenges, because the recommendations are in areas in which we have significant interest and expertise.

The first of these reports was published in 2010, when the Carnegie Foundation published *Educating Physicians: A Call for Reform of Medical School and Residency*.¹ In this book, Irby et al. made the case that medical education must do a better job of standardizing learning outcomes and individualizing the learning process, promoting multiple forms of integration, incorporating habits of inquiry and improvement, and focusing on the progressive formation of the physician's professional identity. Although many of these principles had been adopted by schools across the United States and Canada, this report marked a change in the expectations of all medical schools by the Liaison Committee for Medication Education, the body jointly authorized by the American Medical Association and the Association of American Medical Colleges (AAMC) to accredit medical schools.

The implications of these new expectations for CAPs became clearer in a series of documents published in 2011. Two came from the AAMC. The first was the Behavioral and Social Science Foundations for Future Physicians, based on the premise that, "A complete medical education must include, alongside physical and biological sciences, the perspective and findings that flow from the behavioral and social sciences" (p. 5).² The report emphasized the need for future physicians to develop self-knowledge, effective therapeutic relationships with patients, respectful alliances with colleagues, and responses to the health needs of populations. The key themes highlighted in this document were the need for a "developmental, life span perspective" and a focus on the social and biological contexts of behavior (p. 10). This 2011 report was commissioned as a complement to a report from the AAMC and the Howard Hughes Medical Institute in 2009, the Scientific Foundations for Future Physicians.³

The second AAMC document in 2011 was MR5: The 5th Comprehensive Update of the Medical College Admissions Test (MCAT).⁴ As of 2015, the MCAT will be lengthened and the content areas changed. There will be four sections, of roughly equal length: biological and biochemical foundation of living systems; chemical and physical foundation of biological systems; psychological, social, and biological foundations of behavior; and critical analysis and reasoning skills. This last section (a version of which has existed before) will ask students to analyze passages from social and behavioral sciences and humanities, including ethics, philosophy, cross-cultural studies, and population health. The section on social and biological foundations of behavior is new for the MCAT. It is described as covering what would be taught in one-semester introductory courses in psychology



An interview with the author is available by podcast at www.jaacap.org.

and sociology. These last two sections are expected to significantly affect undergraduate education for pre-med students even if medical schools do not change their prerequisites, because pre-med students will take courses that prepare them to do well on the MCAT.

A third document of interest in 2011 was the Core Competencies for Interprofessional Collaborative Practice.⁵ This report was sponsored by the Interprofessional Education Collaborative, which includes the American Association of Colleges of Nursing, the American Association of Colleges of Osteopathic Medicine, the American Association of Colleges of Pharmacy, the AAMC, and the Association of Schools of Public Health. The premise of this document is that interprofessional collaboration is essential to safe, high-quality, accessible, patient-centered care. For health professional students to learn the skills of team-based care, the report asserts, core competency should be achieved in the following domains: values and ethics of interprofessional practice, roles and responsibilities, interprofessional communication, and teams and teamwork.

So why do these new publications and directions matter to CAPS? They matter because we, as a group and individually, have a lot to offer to medical schools as these recommendations move toward national implementation. Moreover, they matter because they may mean we will be training future physicians who will be better prepared to treat children, families—and us—the way we think they should.

First, and most obviously, with our focus on development, we can help students to appreciate the “life span perspective” that is emphasized in the AAMC publication Behavioral and Social Science Foundations for Future Physicians (p. 10).² In addition, our appreciation of development allows us to understand how to help medical students, who are often in their 20s and developmentally in late adolescence, to gain the self-knowledge and identity to function as professionals in a doctor–patient interaction and in interactions with other professionals. These are the core skills that are described in different ways in that AAMC document² and in the Core Competencies for Interprofessional Collaborative Practice³ published by the consortium of professional schools.

Interprofessional education and collaboration is familiar to us because it is an essential component of child and adolescent psychiatry. Our

training and practice has always included work on inpatient and outpatient treatment teams or in collaboration with psychiatric nurses, psychologists, speech therapists, social workers, and teachers. We can help medical students (and their teachers) deal with the inevitable power struggles disguised as scope-of-practice debates and the definition of the roles and boundaries with which we are so familiar. Before there was a pediatric medical home, there were child psychiatrists and psychologists working together and providing consultation and liaison services to pediatrics and nursing. CAPs can model and teach skills in interactions in an interprofessional treatment team during the clinical clerkships. This is a valuable contribution to the school and students.

Child and adolescent psychiatrists are also well prepared to teach the skills and knowledge in the social and behavioral sciences that medical schools are required to cover. The topics included are similar to those found in the list of the American Academy of Child and Adolescent Psychiatry committees: culture; family; ethics; spirituality; gay, lesbian, bisexual, and transgender issues; finance; and policy. The skills include the basics of evidence-based treatment in child and adolescent psychiatry: building an alliance that facilitates self-care and adherence to treatment; stress reduction and treatment of anxiety and nonadherence; interprofessional communication; work with families and communities for chronic disease care; and public and social media health education. We have a lot to bring to the medical school curriculum in these areas.

The changes in the MCAT have less direct, but perhaps ultimately even larger, implications for CAPs. The inclusion of a one-semester course each in psychology and sociology as pre-med requirements may not seem like a big change, given the continued emphasis on chemistry, physics, and biology. However, this change in the entrance examination communicates that these topics are important to future doctors. At the least, students will enter medical school better prepared to learn about human behavior, social systems, and development. A new MCAT also offers the possibility that slightly different people will be applying for and getting into medical school.

What are the implications of these recommendations for CAPs? New expectations bring opportunities. One opportunity is for more CAPs to

become actively involved with undergraduate courses, so pre-meds can see us as role models of what doctors can be. This is a largely unexplored area.

Another opportunity is to be more involved in small-group teaching and mentoring in medical schools. The American Academy of Child and Adolescent Psychiatry is currently partnering with the Klingenstein Third Generation Foundation to provide mentorship for medical students starting early in their training. This program is designed primarily for recruiting, to address the need for more people choosing to go into child and adolescent psychiatric training.

However, medical schools also need people who can help their students who do not have the interpersonal skills or the emotional regulation that is needed for empathic, patient-centered care. We bring the skills, knowledge, and com-

mitment that can help realize the big goals set out by these new reports. We agree with the goals. Now we need to let the schools know we are willing and able to help train the next generation of physicians. &

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