

Emerging Trends in Undergraduate Medical Education: Implications for Geriatric Psychiatry

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Despite the demographics of aging and the prevalence of psychiatric disorders, the pipeline of geriatric specialty-trained physicians, including geriatric psychiatrists, remains woefully inadequate. In response to this shortfall, the Institute of Medicine has recommended the development of core competencies in geriatric mental health and substance use for all healthcare providers.¹ Despite this compelling mandate, many medical students receive little geriatric psychiatry education. A survey of psychiatry clerkship directors at 110 U.S. medical schools found that 21% of responding clerkships lacked any specific instruction or clinical experience focused on the mental health needs of older patients.² The amount of geriatric psychiatry teaching in non-psychiatric clerkships is unknown, but is likely even less.

A work group of the American Association for Geriatric Psychiatry (AAGP)'s Teaching and Training Committee aimed to help ameliorate this training gap by developing geriatric psychiatry learning objectives for all medical students to attain prior to graduation.³ Lehmann et al. identified six key domains of geriatric psychiatry essential in preparing medical students to deliver competent and safe care to their older patients: normal aging, mental health assessment of the older adult, psychopharmacology, depression, dementia, and delirium. The group has presented these learning objectives nationally to clinicians and educators at annual meetings of the AAGP, the Association for Directors of Medical Student Education

in Psychiatry, and the Association of American Medical Colleges. Although audience members appreciated that these objectives constitute a fundamental educational framework, some expressed concerns about incorporating additional content into an already full and ever-evolving undergraduate medical curriculum. Indeed, in 2012, data from the Association of American Medical Colleges suggested that over 94% of all medical schools would be involved in curricular change in the following 5 years.⁴ In this paper, we explore these emerging changes in undergraduate medical education and discuss implications for geriatric psychiatry.

INTEGRATION AND INNOVATION: EMERGING TRENDS IN UNDERGRADUATE MEDICAL EDUCATION

The traditional model of undergraduate medical education (UME) dates back to the early 20th century, when Abraham Flexner's historic report recommended sweeping changes in the way physicians were educated. An educator, not a physician, Flexner investigated 155 medical schools in the United States and Canada and ultimately developed a conceptual model of UME that included a standardized "2 + 2" curriculum (2 years of basic science followed by 2 years of clinical experience), salaried faculty in both basic and clinical

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science, and access to hospitals for active participation in patient care.⁵ In addition, Flexner recommended that medical schools select applicants with a basic science background prior to entering medical school. With this historic report, Flexner shaped modern medical education as it was known in the 20th century.

In 2010, the Carnegie Foundation for the Advancement of Teaching identified several challenges with the current structure and composition of UME.⁶ The traditional model of education was criticized for being too long, not learner-centered, and not outcomes-based. They cited a poor connection between formal knowledge and experiential learning, and noted inadequate attention to teamwork skills, scientific inquiry, population health, and health promotion. These concerns developed amid a revolution of biomedical research and technology. Not unlike Flexner before them, the Carnegie Foundation made several recommendations for UME in the 21st century. Among others, these included calls to individualize the learning process, to increase the focus on teamwork and interprofessional education, and to integrate basic, clinical, and social sciences. The timing and integration of basic and clinical sciences education have been identified as key pressing issues facing medical education,⁷ even though best practices have not been identified.⁸ Educators strive for “vertical integration” by incorporation of clinical experiences earlier in the pre-clerkship curriculum and revisiting basic sciences in the clinical years. Meanwhile, “horizontal integration” aims to integrate educational material between courses and clerkships during the same academic year. For example, in the first year, disciplines that share common scientific foundations, such as anatomy and physiology, are often integrated. In the clerkship year, clinical disciplines sharing similar settings of care, patient populations, or approaches to patient care are frequently integrated.

In addition to evolving changes in UME organization, emerging trends have also been seen in pedagogy. Educators have increasingly shifted away from passive learning modalities such as lectures in favor of active learning strategies geared toward adult learners, such as team-based learning, interactive case conferences, “flipped curricula”, and use of technology (e.g., online learning modules, mannequin-based simulation). To prepare students for the multidisciplinary teams they will join in healthcare systems of the 21st century, many active learning pedagogies involve teams of medical,

nursing, and physician assistant students learning and solving clinical problems together.

GERIATRIC PSYCHIATRY EDUCATION: OPPORTUNITIES AND BARRIERS IN AN EVOLVING CURRICULUM

Educational endeavors of this magnitude require significant medical school administrative support to assure success. Administrative challenges abound as curricular change takes hold across the country.⁹ These challenges include increasing class sizes, incorporating distance learning, and providing adequate clinical training sites as student numbers expand. To support physician shortage claims, many medical schools have expanded their class size, stretching financial, faculty, and administrative resources. The trend towards increasing class size has occurred in concert with curricular change. Overlapping groups of students participating in new and legacy curricula increase competition for clinical training sites. Increased reliance on distance-learning video technologies commonly occurs as medical schools take on multiple campus locations. Additional financial and faculty resources are needed to support active learning exercises such as Objective Structured Clinical Examinations.

Opportunities for geriatric psychiatry education have arisen in conjunction with medical school curricular change. The opportunity for cross-departmental collaboration and more effective use of faculty has prompted academicians to think creatively about introducing geriatric psychiatry content throughout the entire medical school curriculum. Silos of discipline-specific learning are crumbling as integrated curriculum development requires specialties such as internal medicine, neurology, and psychiatry to work together. Collaboration is not new for geriatric psychiatry, however. Because our field naturally requires us to work jointly with other specialists to meet patient needs, we are well suited to contribute to curricular change.¹⁰

Barriers to geriatric psychiatry education also abound. Geriatric psychiatry may not be seen as a curricular priority area, especially if there is no faculty content expert to advocate for older-adult learning experiences. As integration occurs, faculty may experience a loss of content control as individual courses disintegrate and content is partitioned across the curriculum. Faculty resources may be taxed as active learning may

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