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EDITORIAL

Future Frontiers in Medical Education

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Psychiatry is many things; it is listening deeply to patients, understanding brain chemistry, and acknowledging the role that family and social structures interplay with all in the health and functioning of patients. Psychiatrists are often asked—like the queen in Lewis Carroll's *Alice's Adventures in Wonderland* [1]—to hold many beliefs in their heads before breakfast. Psychiatry is simultaneously subjective and objective. This special topical collection of articles on US Medical School Curriculum Reform Effects on Education in Psychiatry speaks to some of the ways psychiatry education has grappled with this complexity in recent years.

In the pre-clerkship era of medical training, psychiatry educators present to students the aspects of the brain and human behavior that are important for every future physician to know. In the clerkship era, they provide trainees with exposure to the care of patients with psychiatric illness in a variety of care settings. And in the post-clerkship era, they identify and reinforce what core psychiatric skills are needed to transition from medical student to resident physician. As psychiatry educators move trainees through these systems, they use varied assessments to verify that medical students are ready for the next step in training.

The article by Klapheke et al. [2] focuses on using workplace-based assessments already in place [3] to better assess learners' preparedness for resident training. These assessments consist of direct observation of a learner's skills followed by focused feedback; the mini-CEX adopted by the American Board of Internal Medicine is one such example [4]. Klapheke et al.'s work provides another step toward competency-based medical education, defined as an outcomes-based approach to the design, implementation, and assessment of learners, and the evaluation of medical education programs, using an organizing framework of competencies [5]. The Association of American Medical Colleges has invested much into this process, and psychiatry educators should be encouraged to identify the existing elements of their own assessment processes that could be part of this larger conversation [6].

In parallel to the need for knowledge and skill acquisition, psychiatry educators need to identify students who are interested in psychiatry and cultivate their growth. What ancillary experiences should be offered and considered? How do psychiatry educators teach not only that psychiatry is a branch of medicine but that psychiatry is cool? How do psychiatry educators talk about the relevant societal topics of our time and bring them into psychiatry? Psychiatry student interest groups and elective courses in medical humanities do some of this work. Volunteer experiences also allow exposure to patients with mental health challenges. But there are opportunities beyond these traditional avenues, such as having psychiatry student interest groups partner with other student interest groups for a deeper discussion. Some examples could be partnering with the obstetrics and gynecology interest group to discuss postpartum depression or volunteering with the Black medical student group at local fairs doing screenings for depression.

So much of medical education is focused on teaching to the exam that psychiatry educators must take the time to remind learners that the ultimate goal of their education is to be ready to care for patients. MacKinnon and Frosch's [7] article on "A Role for Personalized Medicine in Psychiatry" speaks to the importance of incorporating psychiatric concepts into the greater medical school curriculum. I would encourage readers to think about their involvement not only in psychiatry but in all areas of the curriculum. Where can there be integration of psychiatry with other specialties? Consider clinical experiences in collaborative care spaces, such as situations in which the psychiatry department provides the consultant physician to patients who have complicated pregnancies or are receiving cancer treatment. The impact of the COVID-19 pandemic on the mental health of both patients and health care providers is another topic of curriculum exploration.

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A discussion on curriculum reform would be remiss not to talk about the ongoing conversations in the USA about race and racism. Hafferty [8] spoke of the importance of addressing the "hidden curriculum" in medical education in 1998, and it is as relevant now as it was then. At all levels of medical education, we must tackle systemic racism. The article by McLaughlin et al. [9] provides an example of medical students working to create a more nuanced curriculum in a pre-clerkship course. The authors noted that while their fellow student learners appreciated the work done, they also recognized when faculty did not fully understand the social determinants of mental health that might be impacting certain diagnoses. It is amazing that trainees are taking this initiative, and psychiatry educators would benefit from their interest and energy.

In addition to thinking about the importance of diversity, inclusion, and equity in the medical school and its curriculum, psychiatry educators must also think about the equity of medical school education. Cotton et al. [10] speak to the need for equity in access for medical students. Training at a Historically Black College and University, with a predominantly Black student population, the authors found striking disparities in financial availability. Ensuring that all students have access to high-quality online materials can serve to mitigate some of the challenges.

The pandemic has required a rapid shift in teaching modalities. Questions for educators moving forward will also include where they teach. Will there be a return to large lecture hallways and small group instructions? Many faculty members speak to the frustration of teaching "into the void" [11], and there are concerns about the impact of isolation on students' overall mental health [12]. Educators will benefit from taking stock of the last few years, assessing what has worked well in remote settings compared to what needs to be taught in person. This assessment could allow for opportunities for asynchronous learning followed by small group discussions and skills training.

This topical collection of articles on curriculum reform is only a small sampling of the various ways our colleagues are shaping psychiatric education. I encourage my fellow educators to continue innovating, changing, and growing. Curriculum reform is many things all at once; it is delivering high-quality content in innovating and engaging ways, providing new knowledge to learners to help them better take care of their future patients, and identifying tools to help students become more self-directed in their careers as lifelong learners.

Declarations

Disclosures The author states that there is no conflict of interest.

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