



Psychiatric Training During Clerkship: Specific Recommendations for Reform—Part 1, Teaching and Learning

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Introduction

The psychiatry clerkship is a significant component of the core curriculum of medical schools worldwide. It provides an ideal opportunity for learning and gaining clinical and theoretical experiences.¹ The clerkship experience provides students with practical and realistic experiences with psychiatric patients, compared to the nonclinical exposure in pre-clerkship. These experiences can be important factors in residency choice.² Psychiatric education during clerkship may influence students' attitudes towards mental illness, stigma and psychiatric patients in a positive way.³ The clerkship may also contribute to psychological development, future resilience and well-being; but negative development is also possible.^{4,5}

Studies examining the relative growth in knowledge show that the level of knowledge amongst students at the end of the clerkship is not equal, even if it was equal at the start of the clerkship. These findings suggest that the learning environment influences learning outcomes.⁶

Clerkship rotations are usually carried out at different sites with several supervisors. There are variations in patient populations and clinical education.⁷

Some studies suggest that students may experience variations in patients' length of stay, patient volume, types of diagnoses and quality of supervision. There is evidence in the literature regarding the importance of clinical supervision on student learning. The variations extend to the clinical competence demonstrated by the student, general attitude towards clinical practice, the quality of the student's interaction with patients and staff, the amount of student's available knowledge, the student's competence in taking and presenting a case history, and the student's general clinical competence. Clinical competence also may be assessed during practical examination, professional performance and theoretical examination.

A survey of graduating US students identified several elements of an excellent psychiatry clerkship experience. The elements included clear communication of expectations, transparent grading, integration in the team, meaningful clinical work, organization, valuing student time, a good clinical environment, inpatient experience, timely faculty feedback, faculty teaching, a diversity of clinical experiences and quality outpatient experience.⁸

The variation of students' clinical experiences has frequently been identified as a problem worldwide with a need for reform, structure and uniformity.^{6,7} Canadian medical schools report significant variations in most aspects of clerkship.

A third-year psychiatry clerkship is a core (mandatory) rotation of six weeks in duration in the majority of Canadian medical schools. Several schools split the experience into two blocks of three weeks. Clerkship is intended to be a structured clinical experience under the direct supervision of staff psychiatrists who assume the responsibility for patient care. The psychiatry clerkship uses a variety of clinical settings including adult, geriatric, outpatient units, psychotherapy clinics, ambulatory clinics, consultation-liaison teams, emergency settings, and child and adolescent outpatient and inpatient settings. For most students, clerkship will be their only supervised learning experience in psychiatry. In such a short time, all of psychiatry cannot be covered. Clerkship should provide students with the psychiatric competencies required for them to continue on to generalist or specialist postgraduate training.

This paper aims to:

- (i) Provide specific recommendations on the core competencies to be met during psychiatry clerkship.
- (ii) Describe best practices in teaching during clerkship.
- (iii) Discuss and explore the methods that shape the delivery of teaching.
- (iv) Describe the emerging, innovative approaches to clerkship teaching practice.
- (v) List specific recommendations for areas of teaching during clerkship.

Undergraduate clerkship directors from across Canada met with representatives from the CPA Education Committee and concluded that a position paper was required to reform the undergraduate psychiatry clerkship in Canada. A general framework was designed to combine a literature review with expert opinion to produce a hybrid review and make recommendations on clerkship reform in Canada. An initial comprehensive search was conducted in Medline and irrelevant articles were excluded. A narrative review to synthesize the empirical literature was combined with expert consensus to provide a comprehensive understanding of core competencies, teaching and assessment. Psychiatry clerkship assessment will be the subject of a future paper.

Identified Psychiatry Clerkship Objectives

The following psychiatry clerkship objectives were identified through the above process:

General Objectives

- (1) Conduct and document a complete psychiatric diagnostic evaluation including a complete history, relevant collateral history, mental status examination and appropriate physical exam in an accurate, organized and systematic manner.
- (2) Demonstrate how to screen for and diagnose the major categories of psychiatric disorders using the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Text Revision criteria (DSM-5-TR) and other diagnostic and functional assessment tools.
- (3) Discuss the importance of comorbidity of psychiatric and medical illness and evaluate and manage this with appropriate use of targeted physical examination, investigation and consultation.
- (4) Integrate information obtained in the assessment to develop a working and differential diagnosis using the DSM-5-TR. Describe the etiology of the diagnosis within a biopsychosocial framework relevant to the patient.
- (5) Develop and carry out (under supervision) a biopsychosocial management plan that considers immediate, short-term and long-term treatment goals using available resources. This includes assessment of suicide/homicidal risk and taking appropriate action where necessary.
- (6) Communicate effectively, both orally and in writing, to patients, families and health-care professionals. This includes medical record documentation, case presentations, medication orders under supervision, referrals, and patient and family interviews.
- (7) Work collaboratively within a multidisciplinary team.
- (8) Describe the structure of the mental health system, relevant legal issues and ethical issues pertinent to the care of psychiatric patients in both general medical and psychiatric settings, including (a) respect for patient autonomy and confidentiality, (b) the implications and principles of civil commitment and (c) the process of obtaining a voluntary or involuntary commitment.
- (9) Demonstrate commitment to lifelong learning, including the development of self-assessment skills and the use of evidence-based resources to direct patient care.
- (10) Demonstrate the attitudes and behaviours necessary to optimize the care of the patient presenting with psychiatric symptoms. Emphasis should be placed on recognizing the components of a therapeutic relationship, professional boundaries, stress management and work–life balance.
- (11) Discuss the role of stigma as a potential barrier to accessing mental health care and explore and manage one’s own preconceptions or reactions to patients with psychiatric symptoms.
- (12) Demonstrate knowledge of the epidemiology, course and prognosis for the major DSM-5-TR diagnostic categories.

Specific Objectives

- (1) Psychopharmacology and neurostimulation treatments:
 - (i) Determine indications, basic mechanism of action, common side effects and important drug interactions and starting doses for commonly used psychotropic medications.
 - (ii) Determine how to appropriately monitor patients on antidepressants, mood stabilizers, antipsychotics and benzodiazepines.
 - (iii) Apply knowledge of benzodiazepine pharmacology to the management of alcohol withdrawal.
 - (iv) Describe extrapyramidal side effects and their management.
 - (v) Describe the symptoms and initial management of serotonin syndrome and neuroleptic malignant syndrome.
 - (vi) Describe the indications, contraindications, process and side effects of electroconvulsive therapy and repetitive transcranial magnetic stimulation.
- (2) Emergency psychiatry:
 - (i) Identify signs and symptoms of an agitated patient and describe nonpharmacological and pharmacological management approaches.
 - (ii) Demonstrate suicide risk assessment and management of this risk.
 - (iii) Describe the different legal forms for involuntary assessment and admission.
 - (iv) Discuss capacity assessment.
 - (v) Discuss the indications for psychiatric hospitalization.
- (3) Anxiety disorders and obsessive-compulsive and related disorders:
 - (i) List the DSM-5-TR diagnostic criteria of the common anxiety disorders and describe basic psychological and pharmacological management approaches.
 - (ii) Differentiate between the following disorders in terms of presenting symptoms, epidemiology, course, prognosis and family history: panic

- disorder, generalized anxiety disorder and social phobia.
- (4) Mood disorders:
 - (i) List the DSM-5-TR criteria for bipolar I, bipolar II and major depressive disorder.
 - (ii) Describe the first-line psychotherapeutic and pharmacological management for bipolar I, bipolar II and major depressive disorder.
 - (iii) Review the differential diagnosis and investigations in a patient presenting with mood symptoms.
 - (iv) Distinguish major depressive disorder from normal grief.
 - (v) Identify features of depressive disorders across the lifespan.
 - (5) Eating disorders:
 - (i) Describe the DSM-5-TR criteria for anorexia nervosa, bulimia nervosa and binge eating disorder.
 - (ii) Identify common comorbidities of eating disorders.
 - (iii) Describe basic pharmacological and nonpharmacological management approaches for eating disorders.
 - (6) Child and adolescent:
 - (i) Describe the core features of attention-deficit/hyperactivity disorder, oppositional defiant disorder, conduct disorder, disruptive mood dysregulation disorder, autism spectrum disorders, anxiety disorders and obsessive-compulsive disorders.
 - (ii) Describe basic pharmacological and nonpharmacological management approaches for the above conditions in the child and adolescent population.
 - (7) Psychotic disorders:
 - (i) List the DSM-5-TR criteria and clinical presentations for schizophrenia, delusional disorder, substance-induced psychotic disorder, brief psychotic disorder, schizophreniform disorder and schizoaffective disorder.
 - (ii) List first-line pharmacotherapy strategies for the management of psychotic disorders.
 - (iii) List evidence-based nonpharmacological interventions for psychotic disorders.
 - (8) Somatic symptoms and related disorders:
 - (i) Describe the main categories of DSM-5-TR somatic symptoms and related disorders.
 - (ii) Describe a management approach for a patient with somatic complaints.
 - (9) Neurocognitive disorders:
 - (i) Describe the basic pathophysiology of neurocognitive disorders and their risk factors.
 - (ii) Describe the clinical features and progression of common neurocognitive disorders.
 - (iii) Identify impairments in activities of daily living and instrumental activities of daily living arising from neurocognitive disorders.
 - (iv) Describe investigations that should be done in neurocognitive disorders.
 - (v) Differentiate delirium from neurocognitive disorders.
 - (vi) Describe pharmacological and nonpharmacological management strategies for delirium and major neurocognitive disorders.
 - (vii) Perform cognitive screening assessments using a standardized tool (e.g., Folstein Mini-Mental State Examination and Montreal Cognitive Assessment).
 - (10) Personality disorders:
 - (i) Define a personality disorder according to DSM-5-TR.
 - (ii) Describe the key features of each DSM-5-TR personality disorder.
 - (iii) Describe the elements of dialectical behaviour therapy and its indications.
 - (11) Stress and trauma-related disorders:
 - (i) Discuss the concept of stress, including the stress response curve and the possible impact of trauma on child development (e.g., adverse childhood experiences).
 - (ii) List defining characteristics of acute stress disorder and posttraumatic stress disorder and identify their common comorbidities.
 - (12) Substance and alcohol use disorders:
 - (i) Describe the clinical features of the alcohol and substance use and related disorders listed in DSM-5-TR.
 - (ii) Demonstrate appropriate alcohol and substance use history-taking skills.
 - (iii) Describe common laboratory findings in individuals with an alcohol use disorder.
 - (iv) Recognize the manifestations of alcohol and substance intoxication and withdrawal.
 - (v) Outline treatment and monitoring approaches for alcohol and opiate intoxication and withdrawal.
 - (vi) Define concepts of addiction, dependence, tolerance, withdrawal, rebound, and relapse.
 - (13) Psychotherapy:
 - (i) Describe the principles, indications and general techniques of the following therapies:
 - (a) Cognitive behavioural therapy.

- (b) Interpersonal therapy.
- (c) Dialectical behavioural therapy.
- (d) Behavioural activation.
- (e) Motivational interviewing.

Clerkship Teaching

Teaching Standards

The teaching component of the psychiatry clerkship is driven by the learning needs of students in hands-on clinical placements, and as such, may take many different forms, both informal and formal. More informal teaching may be **bedside or impromptu educational opportunities** initiated by students, resident teachers or supervisors. This teaching is often **case-driven**, though not always case-based, and is a pivotal part of any student's clerkship experience. More formal teaching should be considered to enhance clinical learning and be grounded in the **objectives outlined by the Medical Council of Canada (MCC)** that govern the licensing of medical students after their training.⁹

The MCC provides a framework that is extensively used in Canada and recognized worldwide. Their approach offers overarching objectives based on the **Canadian Medical Education Directives for Specialists (CanMEDS) roles**: communicator, collaborator, health advocate, leader/manager, scholar, professional and medical expert. It is the work of each Canadian medical school to determine how best these objectives will be met through curriculum development across all clerkship rotations.¹⁰

For psychiatry clerkship teaching, under the medical expert role, MCC identifies 17 clinical presentations/diagnoses that apply most directly to psychiatry practice (Table 1). As there may be overlap with other clerkship rotations (i.e., pediatrics or care of the elderly), each medical school must decide which clerkship will be primarily responsible. Consideration should be given to the following for psychiatry teaching:

It is important to note that some of these topics may have been covered in the pre-clerkship teaching for psychiatry. It is essential to **coordinate psychiatry pre-clerkship and clerkship teaching** to ensure that there is no curricular redundancy.¹¹ In addition, teaching content may be selected to reflect the assessments used by the course. There is value in ensuring that content reflects assessment, but it is recommended to create teaching opportunities that reflect national standards, prepare students for postgraduate training and support societal needs.

Table 1. Clinical Presentation/Diagnoses That Apply to Psychiatry Practice as Identified by the Medical Council of Canada (MCC).

Attention, learning and school problems
Developmental delay
Anxiety
Personality disorders
Psychosis
Sleep-wake disorders
Substance use or addictive disorders
Suicidal behaviour
Weight loss/eating disorders/anorexia
Substance withdrawal
Adults with developmental disabilities
Mania/hypomania
Depressed mood
Dementia (major/mild neurocognitive disorders)
Delirium
Obsessive-compulsive and related disorders
Somatic symptoms and related disorders

Adapted from MCC (2024).⁹

The formats or methods adopted for formal clerkship teaching are variable. They must take into consideration how best to teach this content given the resources, curricular objectives and preferences of each university site.^{12,13} Certainly, the movement towards integrated and longitudinal clerkship experiences also challenges delivery methods, as students may be at remote sites with access to different patient populations and resources compared to urban sites. This shift has invited more asynchronous and virtual methods of teaching delivery to allow students to access teaching when possible.

Delivery Methods

In the effective delivery of clerkship education, a combination of learning strategies is generally recommended. The 2016 Survey of the Association of Directors of Medical Student Education in Psychiatry in the US demonstrated that psychiatry clerkship programs use the following modalities for teaching: case-based learning (23.4 per cent), small group discussions (22.5 per cent), formative observed structured clinical examinations or standardized assessments (15.02 per cent), team-based learning (14.7 per cent), interactive computer teaching modules (11.8 per cent), and problem-based learning (10.7 per cent).¹⁴

Asynchronous learning involves students being provided learning material to be used in a self-directed manner with clear learning goals. This material can include interactive videos,¹⁵ case-based materials,¹⁶ reflective writing assignments¹⁷ and even comics to

engage students to review core concepts.¹⁸

Self-assessment, which is a recommended component of asynchronous learning, could include multiple-choice and clinical decision-making questions with automated feedback.

Synchronous learning can include case conferences and group-based learning. This provides students with an opportunity to review results from their self-study and reflect on their learning through peer and faculty interactions.¹⁶

Active learning which combines intentional engagement, purposeful observation and critical reflection is evidenced as leading to superior student academic performance both in pre-clerkship and clerkship assessments. Examples of active learning include problem-based learning and clinical simulation. This should be preferred over more passive learning strategies where students receive information in traditional lecture-style sessions.¹⁹ **The flipped classroom**, where students learn key concepts on their own using guided material and then use the classroom time to engage with peers and the teacher to practice application of knowledge, is a widely used example of active learning.²⁰

The amount of **independent studying** students engage in outside of protected, in-classroom time during clerkship is worthy of consideration when designing a clerkship curriculum. On average, students spend 11 to 20 hours per week studying independently.¹⁹ This is a significantly larger amount of time than is spent in designated classroom time. Planned and intentional self-directed study resources to supplement what students learn in their clinical encounters and designated classroom learning activities need to be considered.¹⁹

There is a clear need for **high-quality web-based resources** in psychiatry education. Surveys involving psychiatry clerks suggest that 90 per cent want more educational smartphone apps and that only a minority currently use printed material. The applications of technology in clerkship learning are instrumental, rather than supplemental.²¹ Nearly 55 per cent of the clerkship directors in the US reported using digital technology in their clerkship teaching.¹⁴

Given that a significant number of medical schools use clerkship settings outside the academic hospitals, web-based learning activities appear to be a feasible and satisfactory way to ensure didactic comparability across sites.²²

In the delivery of an effective clerkship, the role of the teacher can be distributed among many potential

candidates. In addition to staff psychiatrists, students can learn from other mental health professionals as well as resident physicians and peers.

Literature suggests that incorporating **residents as educators** both augments resident training and enhances the medical student experience and performance. Medical students spend substantial time with residents, placing them in a prime position to serve as educators. They are able to build rapport more readily and create a safe space that encourages student engagement, given the proximity in age and training to clerks.^{23–25}

Peer teaching is supported by research to be noninferior compared to faculty teachers in the clerkship setting. Near-peer teaching, where the near-peer teacher is on the same level of medical training but one or more years senior, is gaining momentum in medical education.²⁶

Interprofessional education is a collaborative educational approach whereby students of two or more health professions learn interactively together with the aim of providing high-quality, patient-centred care. Interprofessional learning events can be particularly useful in clerkship as students work in teams during their rotations. Topics pertaining to geriatric psychiatry have shown to be effectively taught in interprofessional learning activities.²⁰

In summary, delivery modes of clerkship learning are varied. One method cannot be recommended above others. Adopting a variety of teaching methods could maximize the impact on students with different learning styles and minimize faculty burden. The selection of teaching methods should consider the resources available at each medical school and sociocultural factors.²⁷

Innovation in Delivery

While the aim of any psychiatry clerkship course is to ensure learners meet core competencies in psychiatry, no matter the specialty they choose, innovation in teaching practice is invited and encouraged. Discussion in this paper focuses on the medical expert CanMEDS role with delineation of core presentations and diagnoses. There certainly has been a movement towards incorporating other CanMEDS roles into psychiatry teaching in ways that reflect the unique strengths that psychiatrists hold as advocates, collaborators and communicators while working in a variety of settings with individuals with mental illness.

Standardized patients (SPs) are now widely used to create opportunities to build communication and

interview skills.²⁸ SPs are individuals who have been trained to present specific clinical material in a consistent and reliable manner. There is extensive literature documenting the fidelity and reproducibility of SPs' performance. The educational method uses active, experiential learning with immediate individual verbal or written feedback from the SP and faculty for each student.²⁸

Students rank SP experience as useful learning experiences in the clerkship. Students highlight the exposure to different patients as valuable, providing them with the opportunity to become more comfortable interviewing, receiving feedback and watching their videotapes with faculty.^{29,30}

In one study, 42 per cent of students assigned to an outpatient site evaluated a patient with bipolar illness, 25 per cent saw a patient with schizophrenia, and 15 per cent evaluated a patient with dementia. Given the limitations of clinical exposure based on individual rotations, SPs can be a useful supplementary resource to expose all clerks to essential psychopathology.^{28,31}

More than 90 per cent of Liaison Committee on Medical Education-accredited medical schools in the US use SPs in their educational curriculum. Students who had conducted a comprehensive psychiatric interview of an SP during their psychiatry clerkship demonstrated significant improvement in data gathering, safety assessment and professional demeanour during the psychiatric component of the fourth-year standardized patient examination.^{32,33}

There are also increasing opportunities to use **simulation** as a core component of teaching.^{29,34} This more novel approach to teaching is becoming more mainstream and several schools across Canada are using simulation in their teaching. Simulation-based approaches are particularly powerful when teaching subjects like the management of the agitated patient.^{35,36} With challenges to delivery, web-based lectures as well as e-modules have also become more common and there is evidence to suggest that these approaches offer equal outcomes on standardized assessment tools.^{14,22,28} Certainly during the COVID-19 pandemic, there has been a sense that virtual teaching methods are a good way to ensure that learners can engage in sessions regardless of their location or health status. There has also been discussion about exposure to telepsychiatry approaches and the potential learning through virtual rotations.^{31,32}

Clinical topics such as psychotherapy and neurostimulation have not historically been considered a mandatory part of the clerkship curriculum in Canada.^{37,38} At present, exposure is variable in clerkship courses across Canada.

This may reflect issues with access and resources. Exposure to these topics is encouraged but cannot be standardized across Canada.

In addition to the teaching interventions listed above, some schools have experimented with incorporating approaches to teaching skills that have previously been considered traits and thus not directly taught. One example of this is teaching strategies to improve empathy as a skill in medical students using interactive video technology.¹⁵

Recommendations

The teaching component of the psychiatry clerkship curriculum is integral to meeting the learning needs of our students, regardless of the opportunities and limitations at the location where they have been placed. Based on the literature review conducted, as well as discussions with key psychiatry clerkship stakeholders across Canada,²¹ the primary recommendations for psychiatry clerkship teaching are as follows:

- (1) Coordination with pre-clerkship curriculum is essential to ensure that all mandatory presentations, as outlined by the MCC, are met.
- (2) Given the movement in Canada towards using both regional site selection and integrated models of clerkship delivery, consideration of teaching methods that are accessible to all students should be prioritized. This may include use of high-quality, web-based resources as well as asynchronous modules or simulations. There should be a movement away from paper-based teaching resources where possible.
- (3) When possible, protected time for formal asynchronous teaching should be considered to ensure that students are able to complete these opportunities in a fair and equitable manner. This may also include protected time for completion of self-directed learning activities with a clear delineation of mandatory versus optional components.
- (4) Given the evidence to support using residents as teachers, incorporation of resident teaching for students is recommended. This will also support resident development of teaching skills as part of the transition to practice entrustable professional activities.
- (5) Opportunities for collaboration with interdisciplinary professionals in psychiatry clerkship teaching is a new approach that will hopefully continue to grow as further evidence-based teaching practice is developed.

- (6) The use of both SPs and simulation-based teaching is becoming more mainstream in clerkship teaching. With this in mind, development of faculty training for the use of SPs and simulation is essential, with avenues for collaboration and knowledge translation across the country, especially as a significant financial and resource burden is tied to these endeavours.
- (7) Psychiatry clerkship teaching in Canada has a very limited evidence base. It is recommended that further Canadian-based research be conducted to better support practices in clerkship education to allow for a more robust discussion of methods and outcomes for students.

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