The cornucopia of articles in this issue of *Academic Psychiatry* illustrates the richness and creativity of medical student education in psychiatry. This collection, which arose through spontaneous submissions to our journal from dedicated teachers and scholars throughout the world, also demonstrates that educational innovation in psychiatry is flourishing in several countries. Because psychiatric disorders have been identified as a critical cause of premature death and disability in every country, and the psychiatric workforce globally is tragically small, these exceptional efforts in medical schools to advance the field of psychiatry are vital, perhaps essential, to the future.

Different venues for clinical experience and learning in psychiatry, students’ satisfaction with these venues, and their possible effect on recruitment to psychiatry are themes explored in several articles. Students clearly liked spending part of their medical school clerkship on an inpatient psychosomatic medicine service (1). Bourgeois et al. felt that this clerkship possibly contributed to the high rates of students matching into psychiatry at their institution, which, over a 5-year period, was a truly remarkable 12%. According to the authors, the comments from students and residents also suggested a uniquely useful role for psychosomatic medicine in countering the notion that students will be “giving up medicine” when choosing psychiatry. This rotation may also address the need to give all medical students a “dose” of psychiatry that will be applicable to their specialty choice outside of psychiatry. Interestingly, child and adolescent psychiatry was highly regarded as a career choice at several German medical schools. In the study by Lempp et al. (2), 25% of medical student respondents considered seriously the choice of child and adolescent psychiatry as a possible career choice. It should be noted that almost no U.S. medical school offers core child psychiatry experience during medical school and that U.S. students have to take child and adolescent psychiatry as an elective to appreciate this field. Perhaps this report should alert us to the importance of including child and adolescent psychiatry within a core psychiatric clerkship experience. In contrast, a single home-visit to a home-bound senior citizen (3) did not change students’ attitudes about geriatric patients in a small study also reported in this issue, although students still found the experience to be useful. We suggest that changing attitudes with one visit was probably too high or unrealistic a goal for an educational intervention. Given psychiatric educators’ enthusiasm for studying different ways of enriching medical students’ experience within our field, with the hopes of increasing recruitment to it, it would be interesting to see whether other specialties with equally low matching rates develop similar strategies and whether they are more or less successful.

Two studies examined the effect of a student-run clinic on student attitudes (4, 5). Almost all students who answered a questionnaire after participating in one small study of a large, urban-area clinic felt that their experience at the clinic was a valuable supplement to their psychiatric education (4). Most of them agreed that their work at the clinic taught them a skill or attitude that their formal curriculum could not provide. It is interesting that, frequently, medical students need to make their career choices on the basis of in-hospital training, with about 85% high acuity and lack of

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continuity of care, when most practicing psychiatrists (and primary-care physicians) experience 10%-15% high acuity in practice and extensive continuity of care. This may herald a real problem in the traditional medical student experience of many specialties, including psychiatry, and perhaps some exposure to the real world of ambulatory care may prove valuable in better exposure to real-world practice and helpful in career choice. Many students complain about the limited time to talk with patients and the lack of continuity. The student-run clinic provides an alternative to the current model. Similarly, a student-run clinic designed to increase training experience and address the unmet needs of homeless patients at an Omaha homeless shelter provided an overwhelmingly positive experience and contributed to an enhanced sense of compassion for homeless persons and a positive view of psychiatry (5). Schweitzer and Rice point out the following:

In student-run clinics, participants have substantially more patient-care responsibility than in the standard teaching hospital, where tiers of attending physicians, fellows, and resident physicians often separate students from clinical decision-making. The organization of student-run clinics also requires a high level of teamwork, which may be disrupted by an academic model in which students compete for grades. Finally, the voluntary nature of student-run clinics may foster genuine public service (4, p. 235).

As teachers know, many students complain about their relative lack of autonomy under supervision. Also, it appears that many students currently have a strong sense of social and community consciousness and wish to contribute, but lack opportunities to do so. Service learning programs throughout the United States are increasingly popular. Clinics such as those described in this issue, which are highly relevant to psychiatric practice, may be another means of providing students with a bit more autonomous clinical training and exposure to the field that we wish them to pursue in the future.

How students respond to and deal with emotionally demanding issues such as homelessness and the stigma of mental illness was the focus of five other reports (6–10). In a study in the United Kingdom (6) comparing attitudes of medical students toward several clinical conditions (pneumonia, depression, psychosis, intravenous drug abuse, and long-standing unexplained abdominal symptoms), attitudes of senior students toward patients with mental illness were not more positive than those expressed by junior students. On the basis of their data, the authors suggested that the students’ background and culture must be taken into account in addressing negative attitudes. In another study (7), few medical students’ attitudes about homelessness changed during psychiatry and emergency-medicine rotations, although psychiatry clerks showed at least some changes in their beliefs about homeless patients. Medical educators in psychiatry should strongly consider how to combat the stigma of mental illness that is so rampant, both in the United States and internationally. It is our professional role and the professional role of physicians of all medical specialties to find innovative ways of diminishing the stigma of mental illness, such as that also described by Cutler et al (8), in which students had a field experience among mentally ill individuals at an art studio.

An inspiring report described the active role a medical student took toward the issue of homelessness and mental illness (9). The student devised a computerized mental health screening tool to screen for the presence of mental illness among residents at a homeless shelter. The authors felt that “medical student-initiated psychiatric outreach programs to the homeless community have the potential to reduce mental health disparities by both increasing access to mental health services and by providing education.” It is possible that the more positive results of the reports by Morrison et al. (7) and Owusu et al. (9) reflect a proactive public health service role adopted by the medical students in these situations.

Another interesting study demonstrated that discussion about death and dying between students and family members of recently-deceased hospice patients improved comfort levels with, and knowledge of, end-of-life issues among medical students (10). This study demonstrated how psychiatry and palliative medicine could successfully collaborate in medical education.

Two articles address general emotional issues related to the experience of being both a medical student and, more specifically, a psychiatry clerk (11, 12). The study by Chang et al. (11) reports quite high rates of burnout (55%) and depression (60%) in a sample of 1st-through-3rd-year medical students at a large medical center. Although these results are from only one medical school, and thus should be interpreted with caution, the rates reported are higher than in previously reported studies, and, as a consequence, medical schools ought to evaluate the level of burnout and emotional well-being of their own students. Devlin and colleagues (12) focused on dealing with stressful issues. They described an approach to helping students understand and manage feelings related to role-expectations in the therapeutic relationship and to exploring role-expectations in emotionally stressful clinical situations. We clearly need to continue monitoring students’ emotional experiences during medical school and the effect of these experiences on students’ well-being. Psychiatric educators should be active in implementing courses and workshops for medical students to help with monitoring and modulating their stress and to decrease burnout. This could