WPA template for undergraduate and graduate psychiatric education

I. Introduction and Description of the Approach in this Document

In the years just before and after the turn of the 21st century, the WPA produced its first set of curriculum recommendations for both undergraduate (medical student) and graduate (residency) psychiatric education. The goal was to improve the quality of education and, consequently, the quality of care for patients with mental disorders.

The decade since the publication of these recommendations has been marked by a significant growth in the field of psychiatry. Advances in all aspects of the field, ranging from basic understanding of the function of the brain, to diagnosis, treatment, and development of systems of psychiatric care, have stimulated an evolution in our profession and the care we deliver. In addition, remarkable advances occurred in medical and psychiatric education, in response to the progress in our knowledge of illness and the development of new treatments and systems of care. The need for a new WPA core curriculum project for undergraduate and graduate psychiatric education was therefore identified.

A task force appointed by Prof. Allan Tasman, WPA Secretary for Education, carried out the development of this project. The task force included individuals with significant experience in educational leadership, representing all parts of the world and a cross section of developed and developing countries. Prof. Jerald Kay of the United States chaired the task force. The co-chair was Prof. Pichet Udomratn of Thailand. Drafts of the material were presented in the form of symposia at several WPA international and regional congresses, in order to obtain a broad spectrum of reactions and recommendations about the content.

The project was developed with the task force's appreciation of the tremendous diversity in psychiatric education across the globe. In the field of medical student education, we are aware of the broad range of expectations across continents and countries, ranging from formal continent wide requirements for medical student education in psychiatry to countries in which there are no requirements that psychiatric education be included in the medical student curriculum. A parallel situation exists for residency education in psychiatry. Further, the great diversity of educational resources was an ongoing focus as the task force developed the recommendations. Moreover, in order to be useful throughout the world, recommendations needed to be constructed in such a way that local or national educational leaders could modify them based on their own requirements and resources, while considering the role that culture plays in both psychiatric diagnosis and treatment and in medical and psychiatric education. In addition, there are significant influences on program structure, content, and design related to the size of the program and the institutional resources available. Thus, specific teaching content and methods must be compatible with all of these factors.

Recommendations regarding content, design, structure, methods, and evaluation tools were based on the most recent advances in psychiatric education. The medical student and resident psychiatric education sections in this document include what can be considered optimal standard descriptions of content and implementation. Although the educational and clinical competencies discussed in this document are common to all regions of the world, modifications will be needed based on local realities. These include, but are not limited to, the availability of resources such as teachers, patient populations in various teaching settings, patient demographics, facilities, educational equipment and materials, technological support, financial support, and the designated time available to complete the prescribed course of education and training. Whether

programs are offered in public, private, community based, religious, or other types of sponsoring institutions will also dictate modifications. Political and legal regulations and standards are also likely to be influential in the curriculum decisions made at the local and national level.

Some content recommendations in this document will have differential importance from country to country. For example, certain areas of the world are geographically and geologically prone to natural disasters. In these areas, an emphasis on mental health consequences of disasters would be more important than in other regions. As well, topics such as ethnopsychopharmacology, family related issues, culture bound syndromes, and dealing with the impact of violence are undoubtedly influenced by the country of implementation and therefore may be modified in a wide variety of ways.

Rather than prescribing a specific model for use in locations with a wide range of expectations and resources, this document was produced with the appreciation that, even in areas with few resources, there are differing points of view regarding content and structure of education. Some believe that, where desirable resources are few, psychiatrists must be trained more extensively than is generally considered optimal, as these few professionals may play a greater role in developing national policies or advocating within governmental agencies for psychiatric education and services. A role in the development of public health policies and programs is a specific example, requiring additional education for the health professional. A second approach favors reliance on existing state of art educational guidelines from other regions to implement even in low resource areas. A third perspective suggests that the optimal approach to both medical student and residency education, where resources are limited, is to focus on a select set of “must know” skills and knowledge. Circumscribing education to the diagnosis and treatment of common disorders exclusively is an example of this last approach. Rather than

prescribing these or other approaches, such as taking state of art guidelines and modifying them based on specific national requirements, the task force advocates these decisions are best made at the national and local level. Last, this document can become a vital resource in lobbying governments and institutions to improve educational programs and ultimately health care.

Following this introduction, the first section of this document describes general aspects of developing, implementing and evaluating curricula at the medical student and resident levels. The following two sections focus on specific recommendations and teaching approaches for medical students. The fourth section outlines expected competencies for residents and reviews three different models in use today. The fifth section highlights the importance of cultural competence at both the student and resident levels. The following two sections outline a competency-based approach to evaluating medical students and residents. In the last section, recommendations are presented for improving the education of teachers and supervisors of both students and residents.

We believe the material in this report will serve as a practical template for developing or revising educational programs in psychiatry, which can be modified in a wide variety of ways to fit local needs. We hope educators will find that time spent reviewing these pages will be as gratifying as the task force members experienced in the preparation of this work.

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