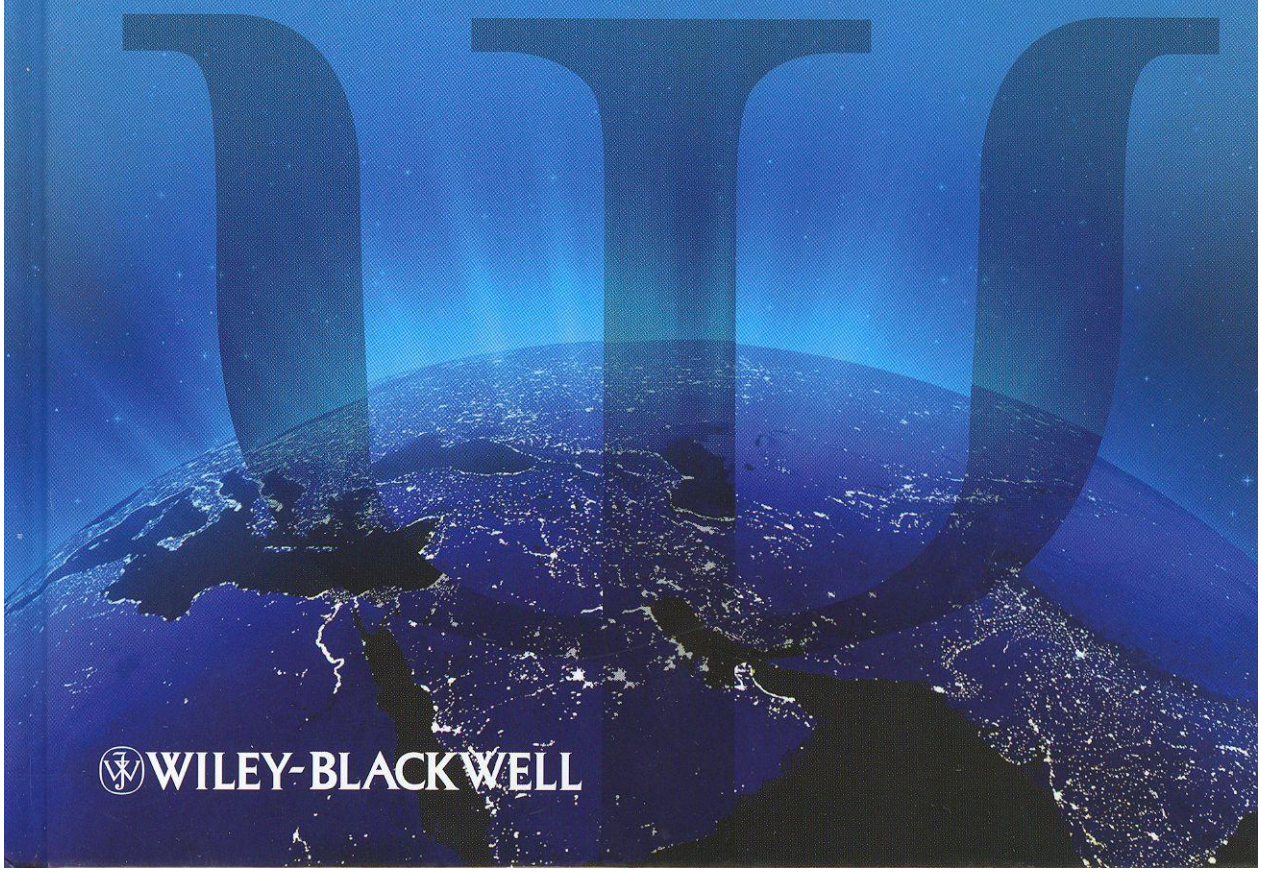
Teaching Psychiatry

Putting theory into practice

Edited by
Linda Gask, Bulent Coskun
and David Baron



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Developing a Medical Student Curriculum in Psychiatry

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4.1 Introduction

The aim of this chapter is to highlight necessary changes in medical curricula to reflect the needs and challenges of contemporary psychiatry. Psychiatry as a medical discipline on one hand shares the fate of other medical disciplines, on the other hand as a profession dealing also with *mental health* it overlaps with non-medical domains, such as social care, well-being, consumers' protection, human rights, gender issues, ethics and so on. Psychiatry as a medical discipline investigates the brain and its relationship to human experience and behaviour. On the other hand, *social* psychiatry is concerned with social influences on human mental health. It can provide partial social explanations for psychiatric phenomena. Students need to be aware of both these aspects. Psychiatry also faces challenges in the guise of the anti-psychiatry movements.

In Europe, and to some extent worldwide, psychiatry made its contributions in eighteenth and nineteenth century medicine, mainly in Germany (e.g. W. Griessinger, E. Kraepelin, E. Bleuler), France (J.-É. Esquirol, J.-P. Falret, Ph. Pinel, B. Morel) and the United Kingdom (W. Tuke). Since the twentieth century psychiatry has developed on a more global level, and more increasingly under the influence of North American research progress in the neurosciences and related disciplines. These common denominators, as well as common challenges of a globalized world, justify to some extent our contemporary attempts to find a common way forward.

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Quite recently, reflecting increasing emphasis on human rights, ethics and public health, attention has been increasingly paid not only to illness as such but also to mental health, and, therefore, to quality of life and well-being. This development raises new needs and challenges for the discipline. We need to ensure it remains within medicine and this may need re-conceptualization of psychiatry and re-definition of its position amongst other medical disciplines. On one hand, psychiatry is fighting stigma, on the other hand it needs to find a new place in taking care of human beings in their complexity. The medical curriculum is a good place to begin [1].

Last, but not least, we see a declining interest of medical students in choosing psychiatry as a specialization. Besides the low rate of recruitment into psychiatry, a shortage of psychiatrists may be also due to a high rate of failure to complete training, failure to practise after completion of training and poor retention of psychiatrists. There is a danger that much needed reform in mental health care will be seriously hampered if recruitment problems persist (see Chapter 2 for more discussion of recruitment). Again, the undergraduate medical curriculum is the appropriate place to start in order to attempt to increase students' motivation and interest in psychiatry.

4.1.1 Defining a Curriculum

For the purpose of this chapter, a *curriculum* is the set of courses, and their content, offered at a school or university. A *core curriculum* is a curriculum, or course of study, which is deemed central and usually made mandatory for all students of a school. Historically, curriculum (from the Latin word for race-course) was understood as an idea, the course of deeds and experiences through which children become the adults they should be (John Franklin Bobbitt in 'The Curriculum', the first textbook published on the subject in 1918 [2]).

Curriculum usually has two meanings [3]. Firstly, the range of courses from which students choose what subject matters to study and, secondly, a specific learning programme. In the latter case, the curriculum describes the teaching, learning and assessment materials needed and/or available for a given course of study. So the curriculum is a superior set to syllabuses or modules.

In this chapter, while talking about curriculum, we have in mind first of all a core curriculum at a medical school. If we refer to *education,* we usually talk about a broader system of gaining knowledge, skills and attitudes. It may include also residency programmes, postgraduate education, continuing medical education and public education in large.

4.1.2 Devising and Implementing a Curriculum

There is a big difference between devising a curriculum and implementing it. For example, most accreditation bodies require a certain minimum amount of hours of teaching to recognize a university grade in medicine. A school outlines the proportion of different subjects and forms (lectures, practices, workshops etc.). This structure can be quite uniform across a region or country but still lead to huge differences in the content, in the practice, in the student experience, outcomes and the overall atmosphere and culture of a school.

4.1.3 Historical Background of Development of a Core Curriculum in Psychiatry for Undergraduates

It has been known for decades that the majority of mental patients are first seen by general practitioners (GPs) and that 30–40% of the patients seen by GPs suffer from mental disorders, mostly depression and anxiety disorders [4]. On the other hand, it is well documented that the presence of mental disorders is associated with significant worsening in health-related quality of life, and that impairment associated with mental disorders is greater than that associated with physical illness in patients seen by GPs [5]. It was therefore felt in the early 1990s by the World Psychiatric Association (WPA) that it was necessary to address the quality of undergraduate teaching in psychiatry and to sensitize future GPs and non-psychiatric specialists to psychiatry and mental health. Additionally, it is arguable that there is a need for **all** doctors to have a working understanding of mental health issues, as patients with mental health disorders and problems may present to any health care professional. Being able to undertake a mental state examination should be part of every doctor's basic skill set. This is supported by the fact that patients with mental health problems may receive care for their physical health problems that is not as good because doctors may not address their biases or fail to involve the patients in decisions about their care (on false assumptions of what decisions the patient may or may not be able to make).

In 1994, The WPA (president: F. Lieh Mak) decided with the World Federation of Medical Education (WFME) (president: H. Walton) to devise a core curriculum for undergraduates in psychiatry [6]. It was the second time after neurology, all medical specialities included, that such collaboration between the WFME and a major medical speciality took place. The WPA Section on Education in Psychiatry undertook this task.

The project was designed by one of the authors (Moussaoui) and A. Freedman within a committee chaired by M. Gelder. The first step was to conduct a survey in medical schools about the existing curricula for undergraduates in psychiatry. Out of a list of 1305 medical schools provided by the WFME, the questionnaire was sent to 500 faculties of medicine. Responses came from 124 departments of psychiatry belonging to 40 different countries; only 113 responses were usable. Seventy seven departments were from high income countries and 44 from low to middle income countries.

Almost half (47.8%) of these departments had a national curriculum for undergraduates in psychiatry, and more than half (53%) were dissatisfied with their teaching. There was no relationship between the availability of a national core curriculum and satisfaction with the teaching of psychiatry to undergraduates. The most frequently taught topics were: mental state assessment, psychopathology, personality disorders, affective disorders, schizophrenic disorders, alcoholism and drug dependence, psychosexual disorders, organic psychosis, psychiatric aspects of medical disorders and psychosomatic medicine, mental handicap and treatment in psychiatry.

The mean duration of theoretical teaching of psychiatry was 46.4 ± 24 hours. Most of it was lectures (34.9%) or lectures and discussions (24.8%). Rotations or practical training varied from 1 to 32 weeks (mean: 6.2 ± 4 weeks). The teaching was done through clinical cases (70%), presentation of patients (79%), writing case reports by medical students (56.9%). Only 46.9% of the responders mentioned that undergraduates were involved in emergency rooms by being on duty. Another interesting finding was that only 10% of all departments used audiovisual means to teach psychiatry to undergraduates in 1994.

The learning was assessed through the following means: written examination (68.8%), student participation (62.3%), checklist (20.2%), oral examination (20.2%), multiple choice questions (0.9%) and evaluation by objectives (0.9%).

The suggested topics for inclusion in the core curriculum were psychiatric disorders (63.5%), especially depression (25.4%), substance abuse (22.2%), anxiety disorders (22.2%) and organic mental syndrome (19%), as well as psychopharmacology (39.7%), psychotherapy (28.6%), interviewing skills (28.6%) and patient–doctor relationship (17.5%). There was no expectation that curricula would be different between high and low to middle income countries.

The main outcomes were that there was a need to sensitize other specialities to the importance of psychiatric teaching, to stress the importance of mental health in the community, to improve teaching of behavioural sciences and psychotherapy, and to emphasize the importance of an internationally coordinated education for undergraduates in psychiatry.

The majority of departments of psychiatry (86.7%) were also in charge of the teaching behavioural sciences to undergraduates (Chapter 5).

This kind of survey concerning curricula for undergraduates in psychiatry, to our knowledge, has not been replicated. It is unclear whether the results of a similar survey would be fundamentally different today, 16 years after the first one. A survey of teaching undergraduate psychiatry in United Kingdom and Irish medical schools in 2005 found that the content of programmes remain highly variable with a range of teaching and assessment methods applied [7]; this is discussed further below in the example described. The variation of time allocated for the clinical discipline also varied between two and twelve weeks, which is perhaps somewhat surprising given that all UK schools are expected to deliver the curriculum as outlined by the General Medical Council (GMC) in *Tomorrow's Doctors* [8].

The use of the Internet as a major source of medical information and teaching has certainly led to changes in teaching methods (Chapter 16). Audiovisual teaching is also probably more used than before. There has also been a greater emphasis on teaching those who teach medical students how to teach more effectively. It is also likely that GPs more frequently diagnosis and treat depression [9]. However, the main concerns of the profession are probably still the same today.

4.2 The Evidence and Context

When devising a curriculum, the responsible authorities should first of all respect general rules regarding the educational system in a country (e.g. presence of colleges) and the accreditation criteria (total amount of teaching hours – usually not less than 5000 per the whole study, and the proportion of different teaching settings). In this respect it is important to ask whether the retention of knowledge is proportional to the amount of a teaching burden [10]. It seems that the relationship between self-education and the amount of teaching activities in the curriculum is bell shaped (Figure 4.1).

Several studies have shown that problem-based learners retain knowledge much better than students receiving conventional teaching [11]. Problem-based learning (PBL) (Chapter 6) leads to better recall of information for three reasons: (i) mobilization of previous knowledge stimulates learners to constructs explanatory models, and this facilitates the processing and comprehension of new information; (ii) new information is better understood if learners are

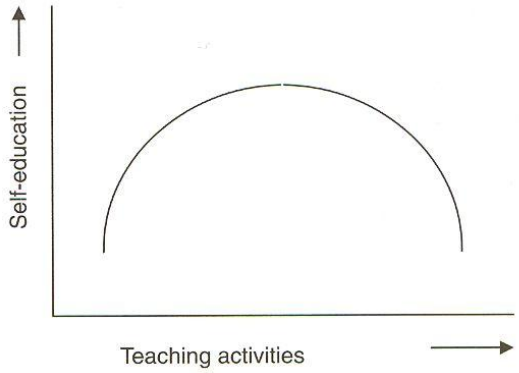

Figure 4.1 Correlation between self-education and the amount of teaching activities in the curriculum.

stimulated to elaborate on it (elaboration in PBL can take several forms, such as discussion); and (iii) learning in context makes information more accessible for later use [12].

There are basically two models of learning: one based on active problem solving and the second based on learning in terms of conditioning (Table 4.1). The latter corresponds with traditional European curricula while the former represents problem-based learning. However, problem-based learning is highly dependent on student motivation and the skills of their facilitators. There is some evidence that when the psychosocial sciences are not highlighted, students using problem-based learning may pay minimal attention to these components [13].

4.2.1 Socio-Political Considerations

Medical curricula in Europe, particularly in traditional countries and in Central and Eastern Europe (CEE), share the tradition and transformation of the university training under the strong German influence, modified in CEE by decades of the communist educational system. This tradition is characterized mainly by the classical educational formats (plenary lectures and practices), by the split of a discipline into 'general' (psychopathology) and

Table 4.1 A comparison of models of learning.

Learning		
Model:	Constructivist	Behaviouristic
Principle:	Active formation	Stimulus → Reaction
Theoretical background:	Piaget and others	Skinner, Pavlov and so on.
Learned behaviour:	Problem solving	Avoidance behaviour
Condition:	Previous experience	Inherited patterns
External influence:	Support and 'scaffolding'	Reward and punishment
Environment:	Democratic	Restrictive

'special' (diseases) parts, and by a predominant medical approach based on the Kraepelinian nosological system. In recent decades, however, a more problem orientated, integrated and interactive style of medical training has also penetrated into this part of Europe. It was reflected by the introduction of new medical curricula with diversified teaching, meaning that psychiatry could be taught in many different modules, such as applied neuroscience, medical ethics, patient orientated approach and modern educational formats including electives in psychotherapy, biological psychiatry, psychopathology, assessment techniques and methodology. Psychiatry would also be a relevant component of modules on specific presentations such as pain, dyspnoea, basic medical problems and the broader medical context. Neurobehavioural sciences are now more integrated and clinical rotation is more practically orientated (that is problem orientated). Examples of such curricula can be found at the University of Dundee in the United Kingdom (the so called *Dundee model*, based on outcome – Figure 4.2) [14].

The Maastricht, Limburg (the so called *Limburg model*) is characterized by the training in communication skills and a significant proportion of self-study assignments with emphasis on review sessions (see also Chapter 6). The Linköping curriculum (characterized by the so called *Srimman*, that is the *common thread*) has at its core contact with patients; from the

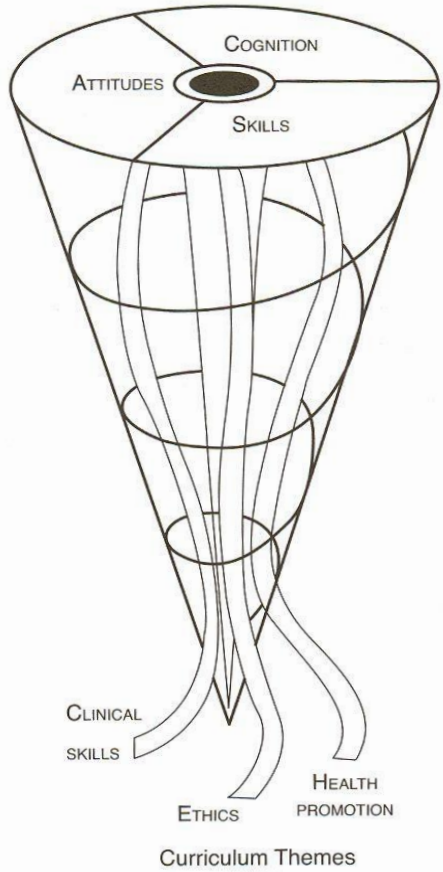

Figure 4.2 The Dundee curriculum.

time they begin training medical students are exposed to patient contact and this remains constant throughout their undergraduate experience. This is also the case for CEE at the Third Faculty of Medicine of Charles University in Prague [15, 16] and some other schools. The key does appear for psychiatrists to remain integral to the teaching programme wherever it appears in the curriculum. There is evidence that medical students value teaching that is taught by clinicians and relates their learning to practice [17].

4.3 Developing the Curriculum

4.3.1 The Process of Devising a Curriculum

To paraphrase Citrad John, a Czech immunologist:

> Students are mainly interested in theoretical aspects of their learning for its application to their future roles as clinical doctors.

Although medicine had significantly changed during twentieth century, undergraduate medical curricula in many European countries had not reflected this. In particular, the medical curricula had not been responsive to the clinical (practical) needs of the undergraduate student. Moreover, the traditional curricula did not motivate students to learn the theory, as the theory and practice are often artificially separated and there might be few links made to highlight the relevance of the theory to practice. Plenary lectures used to prevail as a form of education, although this has changed and continues to do so, but are dependent on appropriate resources. Lectures remain an important part of delivery but perhaps now are more thoughtfully used.

In some countries, the medical curriculum became a matter of bitter criticism from students. Therefore, attempts to launch new curricula occurred in different parts of Europe (see above). Their main objectives usually were:

1. To adjust the medical curricula to the 'state of art' of contemporary medicine.
2. To support more individual contact of students with both teachers and patients.
3. To increase the motivation of students to study the theory by demonstrating its relevance to practice, and also to encourage students to conduct research.
4. To support active training forms and the acquisition of skills.
5. To gain the skills in data processing and its interpretation.
6. To support critical thinking and the ability to discuss.
7. To evaluate long-term feedback from students and incorporate their perspectives into curriculum development.

Any change of a system of education, including the introduction of a new curriculum, is a social and political process dependent on the strength of authority, charismatic leadership and external circumstances [18]. In the worst case, leadership may be delegated to someone else and diluted in different committees and thereby provides little direction. On the other hand, it may have its source in an authority of a strong personality. A successful leader supports leadership, hires managers and leaders who induce reliability, understands obstacles, plans how to tackle them and strategically avoids islands of resistance. Effective communication means problem anticipation, recognition and description, necessity of change, and buy-in of the new vision. The goal is that others will identify themselves with the new curriculum (or with the change) and take full responsibility for it because they have a vested interest to do so. It inevitably needs constant communication and interaction face-to-face (not just written circulars or e-mail messages). To a leader some of this may feel redundant but even those committed to change can be dissuaded if the direction becomes altered or lacks focus. The centralization of a system is the basic condition of its function. It enables both its quality control and the balance between orders, recommendations and instructions. In addition, curricular problems are much easier solved from the top. Centralized leadership also enables the participation of different stakeholders and their burden to be balanced better. Appropriation of a central fund for a new curriculum is absolutely essential. Without that it is not possible to administer a new curriculum. A central budget enables power to be removed from individual departments, which is essential when introducing teaching activities that cut across the old institutional structure. Central budgeting also emphasizes institutional responsibility for a curriculum. A system of incentives, rewards, prizes and recognition must be introduced to support the implementation of a new curriculum.

A major problem is the image projected by psychiatry in the general population, and particularly amongst the medical students. This may be due to the complexity of the bio-psycho-social model in psychiatry, which makes it both fascinating as a concept to medical students but means that it also perceived as too difficult a speciality to be implemented. This is why it is essential to develop sophisticated educational mechanisms for the best possible teaching of psychiatry to undergraduates, if we do not want to see psychiatry and psychiatrists to become an 'endangered species' [19].

4.4 Developing a Core Curriculum: Example from the UK

A survey of UK medical schools regarding their teaching of undergraduate psychiatry, [7] found that some aspects of the curriculum were consistent across the medical schools while other areas showing great variability. The course content was broadly similar but the assessment, length of experience and course structure differed. The authors concluded that there are significant differences in how psychiatry is taught to undergraduate students in the United Kingdom and Ireland, and it is unclear if this variation has any effect on the levels of competency achieved. A qualitative study of key personnel involved in the education of psychiatry at undergraduate level found that educators identified several problems and potential solutions. The fact that teaching was not valued much either by universities or the National Health Service was seen as a significant issue. The research was reviewed in the context of the evidence that psychiatric departments that have high recruitment rates

prioritize and resource medical education sufficiently for quality teaching to be delivered [20]. This built on work by Langsley *et al.* [21] who concluded that high quality programmes for teaching medical students psychiatry are characterized by a well rounded faculty, a psychodynamic orientation, a greater commitment to medical student education than to resident training, varied teaching methods, enthusiastic student response and systematic evaluation that produces change in subsequent years.

The above research played a part in the Royal College of Psychiatrists establishment of a scoping group to review undergraduate psychiatry education as a means of trying to address some of the issues raised; one of which was the benefits or otherwise of having a core curriculum and how this might help improve the quality of teaching [22].

Until recently the *ad hoc* nature of medical curricula has resulted in curricula of which the objectives bear little relationship to what is actually delivered to students, how students learn and how students are assessed, and this is probably true for other countries as well as the United Kingdom. The intervention of medical educationalists has perhaps enabled the relationship between these four components to become more coherent. In the United Kingdom, since 1993 the GMC has produced *Tomorrow's Doctors* (now on version three) [23]. By publishing *Tomorrow's Doctors,* the GMC set the framework within which it expected medical education in the United Kingdom to develop. Although the GMC and the Quality Assurance Agency (QAA) regularly visit medical schools to monitor standards of medical education, medical schools remain free to develop curricula as they see fit. The criteria used by the QAA are similar to those used for other university courses and cover six aspects: (1) curriculum design, content and organization; (2) teaching, learning and assessment; (3) student progression and achievement; (4) student support and guidance; (5) learning resources; and (6) quality management and enhancement [24]. The GMC choses not to develop a national curriculum, as diversity within medical education was, and is, considered important for innovation [25].

Medical schools in the United Kingdom have had to review what is most important for students to know and how might they best learn it rather than subjects being taught because they have always been taught. The newer medical schools curricula (for example the Peninsula Medical School and the University of East Anglia Medical School) have been in a position to develop courses with less historical baggage than perhaps the more traditional schools. They have also been in a position to engage with educationalists from the outset. The drive behind *Tomorrow's Doctors* was a desire to overhaul medical school curricula. There was a great emphasis on a shift from a heavily content-laden taught curriculum to teaching students key facts and other skills, which are transferable, for example attitudes towards life-long learning. There was also an emphasis on moving away from formal didactic teaching and working towards self-directed student learning. This was, in part, an acknowledgement of the growing evidence that curricula could not continue to expand at the same rate as medical knowledge [26–28].

4.4.1 Development of the College Core Curriculum

The development of this Core Curriculum was carried out by a subgroup within the Royal College of Psychiatrists' Scoping Group on Undergraduate Education in Psychiatry [22]. The subgroup met over a year and produced a draft core curriculum, which was then reviewed

by members of the wider Scoping Group. It was modified and then sent for consultation, specifically to the educational leads for psychiatry in each medical school, to key academic General Practitioners with expertise in teaching on mental health issues and to key members of the Royal College of Psychiatrists. In addition, members of the College were invited to comment via the College e-bulletin. The Core Curriculum subgroup then integrated many of the comments received into the final version, which went before the Education Training Committee of the Royal College of Psychiatrists as part of the final project report. The final version is reproduced below. Medical students were consulted through their membership of the Scoping Group and also through discussion with students undertaking their clinical placements with those working on the document. Unfortunately, funding was not available to allow any detailed consultation with users or carers or medical students. However, use was made of some research which had been undertaken with service users on their views of the contents of an undergraduate programme [29]. It may be helpful to be aware that most of the comments received related to specialist interest but the document on the whole was well received. Three United Kingdom medical schools are using the document in its entirety as they review their undergraduate programmes.

In formulating this 'Core Curriculum', those involved recognized that there are variations between medical schools in the amount of time allocated to, and integration between, 'core' theoretical and clinical teaching within psychiatry (usually in the third or fourth year of the undergraduate programme) and what is taught on related topics, often in other years in the 'preclinical components' of the course, such as psychology, sociology, psychopharmacology and communication skills. There was also an acknowledgement that the document could not be too lengthy to be unusable. The variation in curricula was also relevant to consider, as some schools have considerable 'vertical integration' of aspects of psychiatry throughout the curriculum. In other schools psychiatry may be less well integrated across the curriculum and appear mainly in one clinical block. The purpose of the core curriculum proposed is to outline the 'core' aspects of knowledge, skills and attitudes related specifically to psychiatry that medical students require for basic competence and to meet the standards of '*Tomorrow's Doctors*'. That is, these learning outcomes should be the minimum requirement of UK medical schools. There was a recognition that being prescriptive was unlikely to be useful. This learning then becomes the scaffolding for further learning. The philosophy of the Scoping Group was that all doctors need to be able to safely and comprehensively undertake a full assessment of patients' health. Students must be able to assess mental health as well as physical health and be aware of the importance of social circumstances [22].

The core curriculum presented here is relevant for all doctors and can easily be supplemented by other components, such as student selected components or elective to meet the needs of those with a greater interest in psychiatry. Those devising the core curriculum accepted that the areas of knowledge, skills and attitudes are linked and that there may be overlap. However, in developing curricula it is helpful to think about the three domains to ensure comprehensive cover.

The learning outcomes are described in the following section; the eight appendices that formed the document are also included. Six appendices give greater detail regarding what might reasonably be included within the knowledge, skills and attitudes required. The final two appendices provide brief statements regarding delivery and assessment of the curriculum, again suggesting what may be an ideal approach.

4.4.2 The Royal College of Psychiatrists Core Curriculum (UK)

Specific to teaching in clinical psychiatry, the principal **aims** of the undergraduate medical course should be:

- To provide students with knowledge of the main psychiatric disorders, the principles underlying modern psychiatric theory, commonly used treatments and a basis on which to continue to develop this knowledge.
- To assist students to develop the necessary skills to apply this knowledge in clinical situations.
- To encourage students to develop the appropriate attitudes necessary to respond empathically to psychological distress in all medical settings.

The **Learning Outcomes** are:

4.4.2.1 Knowledge

On completion of undergraduate training the successful student will be able to:

1. Describe the prevalence and clinical presentation of common psychiatric conditions and how these may differ according to age and developmental stage.
2. Summarize the major categories of psychiatric disorders, for example using ICD-10 (International Classification of Diseases, version 10).
3. Explain the biological, psychological and socio-cultural factors which may predispose to, precipitate or maintain psychiatric illness and describe multifactorial aetiology.
4. Describe the current, common psychological and physical treatments for psychiatric conditions, including the indications for their use, their method of action and any unwanted effects.
5. State the doctor's duties and the patient's rights under the appropriate mental health legislation and mental capacity legislation.
6. Describe what may constitute risk to self (suicide, self harm and/or neglect, engaging in high risk behaviour) and risk to and from others (including knowledge of child, adults with learning disabilities and elder protection requirements).
7. Describe how to assess and manage psychiatric emergencies, which may occur in psychiatric, general medical or other settings. In particular, be able to describe the elements of a risk assessment and the management of behavioural disturbance.

8. Describe the basic range of services and professionals involved in the care of people with mental illness and the role of self help, service user and carer groups in providing support to them. As part of this students should be able to describe when psychiatrists should intervene and when other clinicians should retain responsibility.

4.4.2.2 Skills

On completion of the course the successful student will be able to:

1. Take a full psychiatric history, assess the mental state (including a cognitive assessment) and write up a case. This includes being able to describe symptoms and mental state features, aetiological factors, differential diagnoses, a plan of management and assessment of prognosis.

2. Screen empathically for common mental health problems in non-psychiatric settings and recognize where medically unexplained physical symptoms may have psychological origins.

3. Evaluate and describe patients presenting with abnormal fears/anxieties, pathological mood states and problematic, challenging or unusual behaviours.

4. Summarize and present a psychiatric case in an organized and coherent way to another professional and be able to discuss management with doctors or other staff involved in a patient's care.

5. Recognize the differences between mental health problems and the range of normal responses to stress and life events.

6. Evaluate information about family relationships and their impact on an individual patient, which may involve gaining information from other sources.

7. Assess a patient's potential risk to themselves and others, at any stage of their illness and, in particular, be able to assess a patient following an episode of deliberate self harm.

8. Evaluate the impact of psychiatric illness on the individual and their family and those around them.

9. Find, appraise and apply information and evidence gained from in depth reading relating to a specific clinical case.

10. Discuss with patients and relatives the nature of their illness, management options and prognosis.

4.4.2.3 Attitudes

On completion of the course the successful student will be able to:

1. Use an empathic interviewing style, which is suitable for eliciting information from disturbed and distressed patients.

2. Recognize the importance of the development of a therapeutic relationship with patients, including the need for their active involvement in decisions about their care.

3. Demonstrate sensitivity to the concerns of patients and their families about the stigmatization of psychiatric illness.

4. Recognize the importance of multidisciplinary teamwork in the field of mental illness in psychiatric, community and general medical settings, primary care settings and some non-medical settings.

5. Demonstrate awareness of capacity, consent and confidentiality issues as they apply in psychiatry.

6. Reflect on their own attitudes to patients with mental health problems and how these might influence their approach to such patients.

7. Reflect on how working in mental health settings may impact upon their own health and that of colleagues.

Further information to clarify these learning outcomes is provided in the form of appendices and these are included at the end of the chapter.

4.5 Implementing the Curriculum

We should keep in mind that a new curriculum is a continuing dynamic process which inevitably needs to take into account the development plan of a school; many other factors will also need to be considered. Any problem has to be solved at various levels and diverse approaches may be needed. The main goal of the process would be an institutionalization of a school development. Such a process includes redefinition of roles, establishment of task forces to tackle specific challenges, definition of responsibility of individual members of academic community and, therefore, foundation of principles of a new culture. Hand in hand with the implementation of a new curriculum it is necessary to make a plan of outcome evaluation. A good change of curriculum has a chance to succeed if it minimizes the number of people losing a job, a position or a power and maximizes the number of those who keep the position or profit. A new curriculum is also likely to be more successfully implemented if staff are invested in the changes and have been involved in the development

through meaningful consultation. This needs a directed and clear leadership which is able to make decisions when needed.

A new curriculum is likely to fail because of the following factors:

1. Ineffective leadership, which may result for several reasons and includes: an autocratic curriculum leader, a leader who is inefficient in coping with problems, unable to delegate and create several other leaders, has no charisma, cannot articulate his/her positions and visions, and is insufficient in motivation of others. It may also happen that newly appointed staff do not support changes and undermine the implementation of a new curriculum.

2. Ineffective communication. Some institutions are rather hierarchically structured, some are based rather on representation; some are rather formal in communication, and some are less formal. Bad communicators do not pay enough attention to faculty opposition and to concerns.

3. Insufficient centralization, which may be accompanied by the lack of support from individual departments and laboratories for interdisciplinary conception of teaching programmes. If a curriculum does not have support from different parts of a school or have central support and also lacks a clear infrastructure, then the curriculum may be unmanaged. This means that there is no central overview and individual departments end up doing what suits them as opposed to what might be required.

4. Lack of resources.

5. Resistance to change and an opposition based on different philosophy. Increasing demands on publications and research ('publish or perish') can further jeopardise the capacity for teaching, which is usually underestimated at evaluation processes. Faculty loses the motivation for a new curriculum because of a lack of sufficient reward. All of this can lead back to regression to the mean and to a failure of the whole plan.

4.6 Summary

As we have shown in this chapter, curriculum development is a complex area that is probably more influenced by socio-cultural and political aspects than by educational needs. Developing a coherent curriculum is only part of the challenge, as it is meaningless unless it is successfully implemented. We have suggested how curriculum planners may want to develop curricula in psychiatry and given an example of one such curriculum that could be modified for local use. We have also highlighted the potential pitfalls that may arise and need to be overcome if a curriculum is to be a dynamic entity that is responsive to changing needs. Keeping those who ultimately deliver the education involved in the development of curricula may be an important component, as it is at the point of delivery that success can be judged. Whilst the process is no doubt complex, it can be managed if the approach to it is systematic and focused.

Appendices for the Core Curriculum in the UK

These outline in more detail specific aspects of the knowledge and skills that are referred to above and also to wider areas of knowledge and skills that should ideally be taught across the curriculum.

Appendix 4.A – Brain function

This will include aspects of neuroanatomy, physiology and psychology:

- Physiology of neuronal function.
- Mechanisms underlying attention, perception, executive function, memory and learning.
- Mechanisms relevant to the experience of emotion.
- Mechanisms related to psychological function.
- Human development and life cycle.

Appendix 4.B – Sociological Issues

- The meaning of 'illness' to individuals and society.
- Awareness that different models of illness (and the competing claims made for each of the models promoted by various groups) are important to the understanding of psychiatric illness, its symptoms and associated behaviours. The following models should be considered: biopsychosocial, multi-axial, medical, developmental and attributional as they relate to mental health problems.
- Ethics and the values that underpin core ethical principles.
- The law and mental health and issues relating to 'capacity'.
- Relevance of family, culture and society and the individual's relationship with these.
- Importance of life events.
- Stigma.
- Understanding of the public health importance of mental health nationally and internationally in terms of personal economic and social functioning, including a knowledge of prevalence, disability, chronicity, carer burden, cultural attitudes and differences, suicide and service provision.

Appendix 4.C – Psychiatric Disorders and Related Topics

Knowledge of the following is a minimum:

- Simple classification of psychiatric disorders.
- Anxiety disorders.
- Mood disorders.
- Psychosis and specifically schizophrenia.
- Substance misuse, especially alcohol and cannabis (acute and chronic effects).
- Delirium.
- Dementia.
- Somatoform disorders.
- Acute reactions to stress and PTSD.
- Eating disorders.
- Disorders of personality.
- Effects of organic brain disease.
- Patients who self harm.
- Major disorders in childhood and differences in assessment.
- Differences in presentation in older people.
- Problems of those with learning disability.
- Comorbidity.

The degree to which a student may have clinical exposure to individual disorders will depend on the time allocated within the curriculum and the nature of the clinical experience available. It will not always be the case that exposure takes place in the setting of the psychiatric clinical attachment.

Appendix 4.D – Psychopharmacology

- Function of the main neurotransmitter systems in the CNS.

- Basic neurochemical theories of depression, schizophrenia and dementia.
- Mechanism of action and clinical pharmacology of commonly used psychotropic drugs:

  Anxiolytics

  Antidepressants

  Antipsychotics

  Mood stabilizers

  Drugs for dementia.

Mechanism of action of common psychoactive drugs used recreationally such as:

Alcohol

Cannabis

Stimulants.

Appendix 4.E – Psychological Treatments

In understanding psychological treatments, students should have an understanding of the principles of psychological management of common psychiatric disorders, especially those that are likely to be seen in primary care such as depression and anxiety.

Approaches to common conditions include cognitive behavioural therapy, counselling and motivational interviewing.

Recognition of the importance of lifestyle on mental health and its impact on treatments, including: sleep hygiene, nutrition, social interaction, physical activity, education, occupation and family and community involvement.

Appendix 4.F – Communication Skills

The following aspects of interview skills are important but often difficult for undergraduate students to fully attain. Observation and feedback on assessments is recommended:

- Active listening.
- Empathic communication and building rapport.
- Understanding non-verbal communication.
- Skills in opening, containing and closing an interview.

Appendix 4.G – Delivery of the Curriculum

Delivery of the curriculum will depend on local resources, support and history and should involve a variety of different teaching methods. During the clinical attachment it is important to ensure that contact time with consultants is effectively used, as sometimes there may be very little of this. It is also important that consultant psychiatrists are a visible component of the student experience. Students need any teaching to be made relevant to practice [16] and there are benefits from seeing senior clinicians interested in their educational experience (especially for recruitment to psychiatry). Attention needs to be paid to consideration of which learning outcomes are expected to be achieved in different parts of the attachment. It is also important to ensure that where observation is used as a learning experience it is of little value without any adequate follow up. A ward round or clinic in which observation alone is used is unlikely to successfully help in meeting the learning outcomes outlined. Teaching should, where possible and appropriate, be delivered in the clinical settings where patients are present and include professionals involved in their care.

Appendix 4.H – Assessment

'Assessment drives learning' is a frequently quoted aphorism. It should also be recognized that assessment confers value to a course. For psychiatry to receive recognition as a valuable element of undergraduate medicine, assessment has to be robust and included in the terminal assessment of the whole undergraduate medical course.

Two elements are key to assessment of undergraduate students in psychiatry. These are formative and summative assessment:

- Formative assessment provides information for students about where they are in their learning process and what they need to do to reach their learning objectives. Ideally students should be directly observed interviewing patients and feedback should be given on their clinical skills. Additionally, through case presentations, students' progress in attaining required knowledge outcomes can be assessed. Further, by employing a continuing process of assessment, attitudes can be assessed and, if required, challenged.

- Summative assessment needs to be related directly to the specified learning outcomes for each medical school's course. It should be at the end-point of a student's learning in psychiatry. Each assessment should include components that address knowledge, skills and attitudes. For each of these areas differing assessment methods are indicated and assessors need to be clear about what objectives they are assessing in each component.

Clinical skills may be assessed using real patients or role players in a variety of objectively driven examination formats. It is important that the complexity of the cases is appropriate for the students' level of experience. Direct observation of students is the best means to assess clinical skills. The use of clinical cases for students at the end of their courses should allow them to demonstrate higher level skills, such as synthesis of multiple sources and types of information and clinical application of knowledge.

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