WPA template for undergraduate and graduate psychiatric education

V. Graduate education: a competency based approach

All the competencies elucidated for medical students are relevant to training and educating the psychiatry specialist. As is true in all of medicine, the depth and breadth of the postgraduate experience is greater and additional skills and knowledge are required in both clinical and administrative domains. Specialist training in psychiatry, for example, should also include, but is not limited to, sufficient didactic and clinical experiences to develop competency in:

1. The major types of psychotherapy
2. Somatic therapies (electroconvulsive therapy, biofeedback, phototherapy)
3. Understand the principles of, and conduct clinical practice in an ethical manner respective of human rights
4. Psychiatric administration (leadership of interdisciplinary teams, quality assurance and performance improvement)
5. Providing psychiatric care to patients who are receiving treatment from non psychiatric physicians and nonmedical therapists and coordinating such treatment
6. Teaching psychiatry to medical students, residents, and others in health professions

7. Training in neurology to develop expertise in the diagnosis of those neurological disorders and conditions often encountered in psychiatric practice that must be considered in the differential diagnosis of psychiatric disorders.
8. Understanding the designing and interpretation of psychiatric research studies
9. Developing expertise in the critical assessment of new therapies and scientific theories
10. Participating in national professional and scientific societies especially through presentations at regional and national scientific meetings.

To demonstrate specific aspects of the competency based approach, we selected three among many models that designate resident competencies. These include the UEMS , an American and an international public health approach. Educators and administrators are urged to select topics, ideas, and approaches that are compatible with and practical for their own programs, countries and regions.

A. European Union of Medical Societies (UEMS) approach

The UEMS (1) has proposed a general competency model wherein the psychiatric specialist must perform within seven diverse overarching competencies, adjusted to, but also independent of, working environment, including sociopolitical and cultural context.

The role of the psychiatrist includes caring for individual patients and their families, and from a public mental health perspective, for the society at large. In such context, the competencies of a fully trained resident can be described as follows.

1. **As a *clinical* expert, a psychiatry resident should be able to:**
    a. elicit a comprehensive psychiatric, sociocultural and medical history;
    b. conduct a psychopathological investigation;
    c. establish a diagnosis;
    d. document properly the clinical findings and actions taken;
    e. formulate and implement a treatment plan in collaboration with the patient, his/her family and other health professionals;
    f. utilize the appropriate therapeutic skills;
    g. apply relevant medical technologies.
2. **As a *health advocate,* he/she should be able to:**
    a. appreciate the determinants of mental health in a given society;
    b. promote mental health and prevent mental disorders in individual patients and society.
3. **As an *academician,* he/she should be able to:**
    a. formulate a self-addressed life long program of continuing medical education;

b. read scientific literature and interpret new findings;

c. investigate the determinants of mental health and disorders;

d. integrate and apply new knowledge and technologies in his/her daily work;

e. conduct research;

f. perform quality assurance and contribute to quality development;

g. document epidemiological changes in psychopathology.

4. As a *professional collaborator,* he/she should be able to:

a. establish treatment plans through working with patients and caretakers;

b. work effectively with other healthcare professionals including those in primary care.

5. As an *administrator/leader,* he/she should be able to:

a. develop cost effective treatment plans and mental health services;

b. utilize resources effectively.

6. As a *communicator,* he/she should be able to:

a. establish a therapeutic alliance with patients and relatives;

b. educate the patient, families and other health and social services professionals;

c. educate the public about mental health to combat stigma.

7. **As a *professional,* he/she should be able to:**
    a. abide by ethical principles of the profession;
    b. respect patient rights and broader human rights;
    c. support patient autonomy and dignity;
    d. respect the patient's culture, beliefs and values.

Psychiatrists must identify and deal with the prevention, diagnosis and management of urgent psychiatric conditions. Residents must develop skills in triage, often within multidisciplinary settings. Common conditions seen in emergency psychiatry include, but are not limited to, severe agitation and panic, some conversion reactions, acute psychotic episodes, poisoning and substance related intoxication or withdrawal, depression with severe suicidal ideation/suicide attempt, homocidality, some eating disorders, rape and other types of assault, child maltreatment, and disaster management.

Based on a well-formulated treatment plan, psychiatry residents must be able to provide the least restrictive environment for intermediate care. Effective treatment, no matter the length, often requires sophisticated collaboration with primary care clinicians and social services/staff with clear goals of recovery and rehabilitation while being mindful of resources.

B. The United States Accreditation Council for Graduate Medical Education approach

The Accrediting Council for Graduate Medical Education (ACGME) in the US has established for all medical specialties six general competencies expected of a new practitioner. Psychiatry programs must define the specific knowledge, skills, behaviors, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate the following competencies (2):

1. *Patient care* that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Each resident must receive supervised experiences in the evaluation of treatment of patients of all ages and gender from across the life cycle and from a variety of ethnic, racial, sociocultural, and economic backgrounds. These experiences must occur in hospital and outpatient rotations and include, in addition to general adult psychiatry, assignments in child and adolescent, geriatric, addiction, consultation/liaison, forensic, emergency, and community psychiatry.
2. *Medical knowledge* about established and evolving biomedical, clinical, and cognate sciences, as well as their application of this knowledge to patient care. The didactic curriculum, for example, must include, but is not limited, to the following components: a) the major theoretical approach to understanding the doctor-patient relationship; b) the fundamental principles of epidemiology, etiologies, diagnoses, treatment, and prevention of all major mental

disorders, including the factors that affect the prevention, incidence, prevalence and long-term course and treatment; c) comprehensive discussions of the diagnosis and treatment of neurologic disorders commonly encountered in psychiatric practice, such as dementia, neoplasms, headaches, traumatic brain injury, infectious diseases, movement disorders, multiple sclerosis, seizure disorders, stroke, and intractable pain; d) instruction in research methods in the clinical, biological, and behavioral sciences, including techniques to appraise the scientific and professional literature and to apply evidence based findings to patient care as well as opportunities to participate in research.

3. *Practice-based learning and improvement* that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care. This competency focuses on life long learning to improve knowledge, skills, and practice performance.
4. *Interpersonal and communication skills* that result in the effective exchange of information and collaboration with patients, their families, and other health professionals.
5. *Professionalism,* as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds.
6. *Systems-based practice,* as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Specific knowledge, skills, and attitudes should include but are not limited to: a) practicing cost

effective health care and resource allocation that does not compromise quality of care; b) advocating for quality patient care and assisting patients in dealing with system complexities, including disparity in mental health care; c) knowing how to advocate for the promotion of mental health and the prevention of disease; d) acknowledging the importance of medical errors and examining systems to prevent them.

Table 1 provides an example of the skills component of competency requirements, including the number of patient experiences to establish these skills, based on the US residency of 48 months. Because the ACGME requirements are too extensive to present here, the reader is referred to the ACGME website, www.acgme.org, to review all the requirements for graduate medical education in psychiatry.

Table 1 An illustration of competency requirement skills for psychiatry residents (numbers represent minimal number of cases to be managed) (modified from the US ACGME requirements, ref. 2)

Domain	Year 1	Year 2	Year 3	Year 4
Assessment and presentation	Perform clinically appropriate H&P ≥10			
	Perform basic MSE ≥10	Perform cognitive examination ≥10		
	Perform basic psychiatric case presentation ≥10	Present biopsychosocial case formulation ≥10		
	Assess safety and make appropriate disposition: harm to self ≥6	Determine competency to consent or refuse treatment ≥8	Present psychodynamic case formulation ≥10	

	harm to others ≥5			
	Diagnose: Major depression ≥5 Bipolar disorder ≥4 Schizophrenia ≥4 Substance abuse ≥8 Substance dependence ≥6	Diagnose: Schizoaffective disorder ≥4 Anxiety disorders ≥5 Dysthymic disorder ≥4 Somatoform, malingering and/or factitious disorders ≥3 Psychiatric disorders due to general medical condition ≥4 Substance-induced psychiatric disorders ≥4 Mental retardation ≥3		
	Recognize presence of personality disorder ≥3	Diagnose dementia ≥4 Diagnose delirium ≥4 Diagnose common personality disorders ≥4	Developmental disability ≥3	
			Diagnose disorders of childhood: ADHD ≥5 Depression ≥4 PDD, separation anxiety disorder, psychosis ≥2	
Somatic treatment – Demonstrate safe and effective use of:	SSRIs ≥5 Antipsychotics ≥5 Mood stabilizers ≥5 Sedative hypnotics ≥5	Typical and atypical antipsychotics ≥4 of each Anticonvulsants ≥5 Antianxiety agents ≥5	Tricyclic antidepressants ≥3 Lithium ≥5 Augmentation for treatment refractory depression ≥5 Augmentation for treatment refractory psychosis ≥5 Augmentation for treatment refractory bipolar disorder ≥5	Stimulants ≤3 Long-acting antipsychotics ≤3 Observe ECT ≥3
Side effect management		EPS ≥5	Sexual dysfunction due to antipsychotics or antidepressants ≥5	Tardive dyskinesia ≥2
Detoxification	Alcohol ≥5		Benzodiazepines ≥3	
Provide consultation to medical and/or surgical		Delirium ≥6 Dementia ≥4		

services		Psychological response to illness, injury or treatment ≥5		
Psychotherapy		Supportive psychotherapy: Inpatient ≥10 Consultation ≥5 Partial hospitalization ≥5	Crisis intervention ≥5 Outpatient supportive psychotherapy ≥10	Psychodynamic Psychotherapy at 40 sessions ≥4 Marital and/or family therapy ≥2 Brief dynamic therapy ≥2 CBT ≥2 At least one of: Outpatient group psychotherapy ≥1 Interpersonal therapy ≥1 Behavior therapy ≥1
			Provide psychotherapy for: Major depression ≥6 Dysthymic disorder ≥6 Personality disorders ≥5	Provide psychotherapy for anxiety and/or somatoform disorder ≥8
			Demonstrate effective recognition and management of transference and contertransference (documented by supervisor)	

H&P – History and physical examination; MSE – Mental Status Examination; ADHD – attention deficit hyperactivity disorder; PDD – pervasive developmental disorder; SSRI – selective serotonin reuptake inhibitors; EPS – extrapyramidal side effects; ECT – electroconvulsive therapy; CBT – cognitive behavioural therapy

C. An international public health approach

This model assumes that, in regions where very few psychiatrists exist, there must be broader resident training experiences in preparation for roles in developing, implementing and evaluating all aspects of mental health care and policy locally, regionally, and nationally. This model, therefore, also addresses training about the impact of civil and political unrest and natural disasters, to name but two areas not included specifically in the earlier approaches. Further, this model emphasizes that mental disorders are no less prevalent in low-income countries, as well as the increasing importance of mental health problems as epidemiological transitions from communicable to non-communicable diseases take place. There is greater emphasis also on the link between mental health and personal and national poverty as reflected in educational, social welfare, and criminal justice issues. There is clear acknowledgment of the salience of mental health to the achievement of the majority of the objectives of the United Nations Millennium Development Goals by 2015, that include: a) eradicate extreme poverty and hunger; b) achieve universal primary education; c) promote gender equality and empower women; d) reduce child mortality; e) improve maternal health; f) combat HIV/AIDS, malaria, and other diseases; g) ensure environmental sustainability; h) develop a global partnership for development

Competencies in this model require that residents:

1. have a clear conceptual understanding of the epidemiological information on prevalence, risk factors and consequences of mental illness;
2. understand the contribution of mental disorders to global burden of disease;

3. understand the public health framework of mental health promotion, prevention, treatment, rehabilitation, and prevention of mortality;
4. appreciate the various components of social policy, health policy, mental health policy, and mental health service delivery, including the role of primary care;
5. appreciate human rights issues;
6. can diagnose and manage the common psychiatric disorders;
7. understand the principles of suicide prevention;
8. understand the definition and impact of disasters and their management;
9. comprehend the importance of lifelong learning through familiarity with the characteristics of evidence based psychiatry.

References

1. Adopted from *European Curriculum for Emergency Medicine*. (2008). A document of the EuSEM Task Force on Curriculum. Approved by the Council of the European Society for Emergency Medicine and by the UEMS Multidisciplinary Joint Committee on Emergency Medicine, May 2008.
2. Accreditation Council for Graduate Medical Education. (2007). ACGME program requirements for graduate medical education in psychiatry, 1 July 2007. Retrieved from www.acgme.org