Psychiatry Training in Competency-Based Medical Education: What to Teach? How to Teach?

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In 2019, competency-based medical education (CBME) was introduced in India by the National Medical Commission (NMC).[1] It is a landmark initiative, where faculty, undergraduate and postgraduate medical students have to join hands towards exploring new methods in medical education.

Psychiatry CBME at the undergraduate level has been a boon in the Indian context because of the enhancement of teaching hours: theory from 20 hours previously to 45 hours currently and clinical exposure from 2 weeks earlier to 6 weeks in the latest notification. India has a huge gap in mental health treatment, and timely emphasis of psychiatry education was indeed needed in training of all the upcoming doctors. Unfortunately, even in the new CBME curriculum, none of the psychiatry competencies are mandatory for licensing, and an undergraduate in India can still become a doctor without any competencies for providing mental health services in the community; psychiatry is not among the mandatory subjects in any phase of MBBS practical examination.[2] It is at this juncture that the responsibility of all psychiatry teachers in more than 700 institutions across India becomes critical in engaging more than 100,000 medical students annually for optimal training that ensures upcoming doctors provide better psychiatry services across the nation.[3]

Medical students and psychiatry teachers should join hands to make the best of CBME. Defining a specific learning objective (SLO) for every session is important as it gives immense clarity to optimise CBME. The affective (communication skill/professional skill) and psychomotor (physical skill) domains of CBME must be given precedence in the active teaching-learning sessions. For example, in a teaching-learning session on depression, the focus can be on how to develop a rapport with patients and how to elicit mood. This is predominantly an affective domain, where psychiatry teachers and students should play an active role. For the cognitive (knowledge) domain, information is available in the standard book. Here, teachers can guide and students can learn by themselves. For example, what are the diagnostic criteria for depression? This is predominantly a cognitive domain. When the psychomotor domain is taken up, the teacher has to demonstrate. For example, in alcohol dependence syndrome, students are expected to learn the demonstration of alcohol withdrawal tremors, which is an important skill. Clarity of domains helps acquisition of competencies in the available time, and more time can be spent on enhancing the curiosity of medical students towards self-directed learning. Empathetic listening, keen observation and the Socratic method of interview can be emphasised at every step.

Psychiatry teachers can also take up the task of imparting simple skills in psychotherapy such as the 'BATHE' model[4] or involve students to learn the benefits of disability certification for the mentally ill in India; these are not explicitly mentioned in the CBME curriculum, but a teacher can always use their wisdom to choose the topics and engage undergraduate students.

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Postgraduate psychiatry training in CBME is all about instilling 'critical thinking' ability that stands on a strong foundation of patient-centred learning opportunities. The basic principles of imparting training in CBME are the same as mentioned in the undergraduate section with more focus on defining SLOs all the time with clarity in domains. The crucial part in training is about postgraduate ability to examine the socio-cultural background of the patient and the context of psychopathology captured through the narratives, and the psychiatry teacher has to ensure that this is considered in SLO. Unlike the undergraduate programme, in the postgraduate programme, the resident has to move up in the Miller's pyramid of learning, from knows to knows how, from shows to shows how, and ultimately performs under supervision or independently. The learning is organised around work situations rather than subject matter units. Assessment is crucial in CBME,[5] and psychiatry teachers have to play a very important role in assessment and feedback. The NMC has given psychiatry postgraduate guidelines on assessment; it is indeed simple and useful in most scenarios. However, more emphasis on 'reflection' can be embedded in postgraduates, from the very first year of training. It should be clear to the psychiatry teacher and postgraduate resident that the documentation of progress in learning through an electronic logbook helps in objective evaluation in the training period. CBME also places a lot of emphasis on building teaching skills, skills in research and leadership skills. These have to be an integral part of psychiatry training.

To further guide psychiatry teachers, it is interesting to note that in the past few months, there have been many initiatives such as consensus on the Mental Status Examination (MSE)[6] and *CBME Undergraduate Manual*.[7] Upgradation of teaching skills among all faculty is imperative for the successful implementation of CBME; innovative methods are needed.[8] The NMC, Indian Psychiatric Society, Indian Teachers of Psychiatry Forum,[9] universities and institutions should consider constant training opportunities for psychiatry teachers. When psychiatry faculty and students join hands, CBME training can be meaningful and useful in providing the best training, which should translate into providing optimal psychiatry services by graduating doctors and specialists.

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