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A comparative analysis of psychiatry curriculum at undergraduate level of Bangladesh, India, Nepal, and Sri Lanka

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INTRODUCTION

The concern for mental health is not being adequately addressed, resulting in a daunting treatment gap of 90% in many parts of the world, especially lower- and middle-income countries (LMICs).[1-3] Human and nonhuman resources available for mental health services in the South Asian countries are dismayingly inadequate in comparison with the developed world. Within-region differences also exist; the number of psychiatrists per 100,000 population in Bangladesh, India, Nepal, and Sri Lanka is 0.1, 0.3, 0.4, and 0.5, respectively.[4] The evidence suggests that one of the important strategies to reduce this gap in low-resource settings is involving the nonspecialist health worker in the treatment.[5] In the South Asian region, the majority of patients with mental health issues contact the physician or primary healthcare services first. Unfortunately, the evidence suggests that the training of psychiatry is inadequate at the undergraduate level, which leads to difficulty in recognizing and treating psychiatric disorders.[6] These countries are similar in terms of sociocultural contexts, social requirements, the priorities needed in terms of mental health services, financial limitations, and government priorities.[7]

A curriculum is a basic structure of any degree, and the quality of its implementation brings the output.[8] Hence, there is a need for a comparable and compatible curriculum in medical education among these countries. While the curricula in the region should address the specific educational issues arising from the shared sociocultural factors, in the setting of globalization, it is important that these curricula attempt to meet the international standards of medical education as well.[9] Poor training in psychiatry during undergraduate teaching influences the attitude of medical graduates toward the subject. At the same time, poor awareness of psychiatric disorders results in inappropriate management of these conditions in primary healthcare settings. A considerable number of patients with psychiatric disorders visit the medical settings for their treatment from primary care to tertiary care level, but unfortunately, these patients were often poorly managed due to inadequate training or exposure of the general physicians in psychiatry during the undergraduate period.[10] Strengthening undergraduate psychiatric education can be a possible solution for the identification and management of common mental health ailments at primary care settings.[6] Adequate psychiatric training during medical undergraduate training not only increases the clinical competency to diagnose and manage patients with psychiatric illnesses; but it also helps in the development of core clinical skills such as listening skills, empathizing ability, effective communication, and humanitarian values.[11] These skills are required for dealing with patients irrespective of discipline they belong to. Psychiatric training gives a lot of emphases on these skills. As patients with psychiatric disorder are more stigmatized than any other medical disorders, these skills become paramount importance in psychiatric teaching and training. Therefore, we aimed to review and compare the undergraduate psychiatry curricula among four South Asian countries (Bangladesh, India, Nepal, and Sri Lanka) considering the mental–health gap among the countries. This will not only help us to assess our current status but also form the basis to advocate for updating the curricula proportionate to the disease burden and inclusion of psychiatric services in primary care in all the counties.

METHODS

A working team was formed with faculties from each of the countries (Bangladesh, India, Nepal, and Sri Lanka). An assessment template for the existing curriculum was developed by the team. The template broadly focused on the total time spent on mental health, the teaching–learning methods used, the content coverage, assessment modality, and weightage on mental health, and the requirements of respective medical councils. A narrative review was conducted on the existing undergraduate psychiatry curriculum of the four selected South Asian countries (Bangladesh, India, Nepal, and Sri Lanka).

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RESULTS

Bangladesh

The undergraduate course is called the Bachelor of Medicine, Bachelor of Surgery (MBBS), which is a 6-year duration degree consisting of 5 academic years and 1 year of internship. The 5 academic years includes four stages, i.e., Phase 1 (1.5 years) for anatomy, physiology, and biochemistry; Phase 2 (1 year) forensic medicine and community medicine; Phase 3 (1 year) for pathology, microbiology, and pharmacology; and Phase 4 (1.5 years) for pharmacology, surgery, and gynecology. In 2012, Bangladesh Medical and Dental Council revised its existing curriculum.[12] This program provided a 3-week ward placement in the third phase for clinical classes in psychiatry. In addition, in the last phase, 20 h was allocated for 20 didactic lectures. During the block posting, an extra employment was distributed for 3 days (preparatory time for the final step examination).[12] There is no mandatory placement in psychiatry during the internship preparation of the last 1 year. It was given a period of 5 days as a possibility to engage. Several medical students have also finished their clinical placement with no interaction with mentally disordered patients.[13]

India

Many medical teaching institutes introduce psychiatry during the initial year of medical graduates in the form of behavioral science lectures. Till 2011, psychiatry is taught to the undergraduates through 2 weeks of bedside clinical teaching (to make them familiar with the clinical presentation of various psychiatric illnesses and history-taking skills). Further, 20 lectures are taught to medical graduates on various common mental health issues. As a part of the assessment of psychiatry, the students are expected to face short notes on psychiatric disorders as a part of the general medicine theory examination.[14] The teaching methods are also designed in a manner that the components of classroom teaching should cover 80% of must-know things and 20% of desire-to-know things.[14]

After 2011, the psychiatric training of the undergraduate students was intensified by the Medical Council of India (MCI) by increasing the hours of teaching from 20 to 40 h and increasing the clinical posting from 2 to 4 weeks.[15] Internship posting in psychiatry is also made compulsory as a part of posting in internal medicine. Recently, the All India Institute of Medical Sciences (AIIMS), Rishikesh, has made psychiatry as a compulsory subject during the undergraduate training. It is to be noted that in India, there are nine AIIMS and two Jawaharlal Institute of Postgraduate Medical Education and Research, which are out of the purview of MCI; hence, there can start a new course or curriculum without the permission of MCI. The Indian Psychiatric Society is paying a lot of emphases to make psychiatry as an independent subject in the undergraduate medical training. A recently held meeting of experts of the Indian Psychiatric Society emphasized the importance of competence-based training in psychiatry for the undergraduate students.[16]

To homogenize the medical curriculum for undergraduates across India, the MCI has developed a set of core competencies for the Indian medical graduates. The number and the content of core competencies have been decided by taking the opinion of medical teaching experts.[17] This revision facilitates increased exposure to psychiatry during medical graduation in India; however, none of the core skills in the psychiatry is made compulsory to complete the medical graduation.[16] The new MBBS curriculum included components of attitude, ethics, and communication to the foundation courses.[16]

The competency-based training helps in the collection and analysis of data related to the competency of the medical graduate, with respect to the year of medical graduation. Two types of assessments have been recommended in the competency-based training. Two types of assessment (ongoing assessment and summative assessment) have been performed.[18]

In the undergraduate competency-based curriculum, 19 topics and 117 outcomes have been identified. The topics are on the core and important mental health issues and the outcome measures focus on judging the clinical competency.[18] The outcomes are measured in terms of knowledge, skill, attitude, and communication [Figure 1]. The students were expected to attend the lectures, seminars, and bedside teachings for learning these skills. Basics of behavioral science are taught during the 1st year of medical graduation. Clinical postings are scheduled in

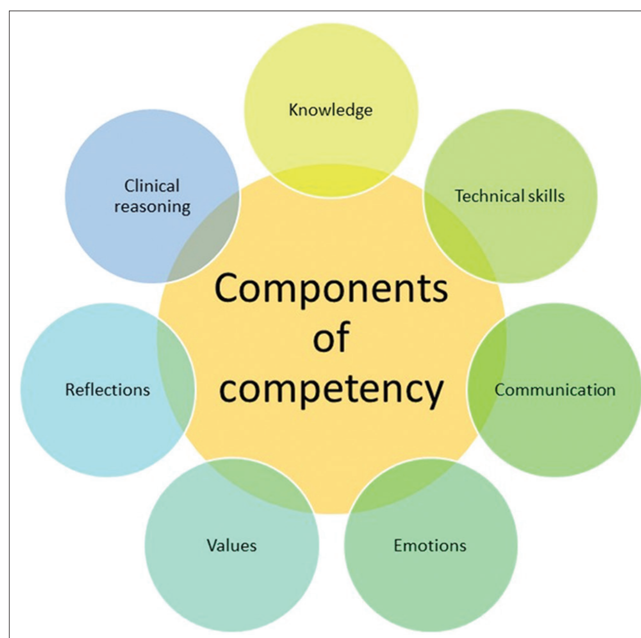

Figure 1: The competency-based assessment designed by the Medical Council of India[18]

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the 2nd year of medical graduations. Systematic lectures on various mental health issues are expected during the 3rd and 4th years.

Nepal

The undergraduate education of medicine in Nepal was started in 1978 in the Institute of Medicine under Tribhuvan University (TU).[19] Currently, there are 20 medical schools offering MBBS under four universities and academies; Kathmandu University (KU),[20] TU,[21] B.P. Koirala Institute of Health Sciences (BPKIHS),[22] and Patan Academy of Health Sciences (PAHS).[23] The duration of this course ranges from 5½ to 6 years depending on the university and academy. The internship rotation is of 1 year and is present in all schools. The governing body of medical education in Nepal, the Nepal Medical Council (NMC)[24] requires medical schools to have a separate psychiatry department with daily outpatient and inpatient service. There is no clear requirement for the content to be covered, duration of theoretical teaching, clinical rotation, assessment modality, or the internship requirements. Around 1.1% of the total assessment marks in the NMC Licensing Examination are allocated to mental health.

The duration of psychiatry teaching ranges from the lowest 25 h at KU to the highest 92 h at PAHS. The clinical rotation is mostly 2 weeks in all the medical schools. The weightage of summative assessment ranges from the lowest 0.21% of the total curriculum at KU to the highest 2.5% of the total curriculum at PAHS. All the schools have mandatory 2-week internship, except the KU Medical School under KU which has a 1-week internship. BPKIHS has an elective internship rotation, but all other schools have a compulsory rotation. Most of the curricula teach psychiatry predominantly through the didactic lectures, except for the PAHS, where the curriculum is based on problem-based learning. Notably, the lectures of BPKIHS are called structured interactive sessions in an attempt to engage the students in the lessons. There is heterogeneity among the medical schools regarding the curriculum of psychiatry; hence, we emphasize competency-based homogenous curriculum all over the nation.

Sri Lanka

All the medical schools in Sri Lanka offer psychiatry as one of the five major components in the final examination, on par with medicine, surgery, pediatrics, and gynecology/obstetrics.[25] Minor differences are seen in the duration and layout of the psychiatry teaching program in different medical faculties. In general, the teaching program involves a total of 8–12 weeks of clinical training and 40–75 h of lectures, along with subsidiary teaching methods, such as tutorials and seminars.[26-28] The clinical component includes two separate clerkships placed in the 4th and 5th years; for instance, at the University of Kelaniya, this involves 2 weeks in the 4th year and 8 weeks in the final year. The effectiveness of the newly introduced final-year attachment in changing the students' attitudes toward psychiatry was affirmed in a study conducted in 2012.[29] The final qualifying examination in psychiatry, which is given almost equal weightage as the other components, includes a clinical case viva, essay and multiple-choice question papers, and objective structured clinical examinations.

Students who pass the final examination will undergo 1 year of training as an intern medical officer, in two 6-month rotations, before receiving full registration in the Sri Lanka Medical Council. At the moment, psychiatry is not included as a component in the internship for medical graduates in Sri Lanka.

DISCUSSION

Regular assessment, feedback, and monitoring of the undergraduate curriculum of psychiatry are the fundamental work for the development of psychiatry in a country.[8] This review was aimed to assess the undergraduate psychiatry curriculum of four LMICs of South-East Asia (Bangladesh, India, Nepal, and Sri Lanka) [Table 1]. The study revealed wide variations in allocation of time and place in psychiatry at the undergraduate level among the four countries. Sri Lankan medical schools offer a longer duration of psychiatric training at the undergraduate level, with considerable homogeneity, compared to the other countries. Nepal showed heterogeneity within the country among the different universities and schools. India has started the competency-based curriculum, while Bangladesh has the minimum attention for psychiatry at the undergraduate level among the four countries. Previous studies revealed that there are inadequate human resources in the mental health sector across the Asian region, creating the paradox that there is the least resource where the need is highest.[6] Similarly, it seems that inadequate attention

Table 1: Undergraduate psychiatry curriculum in four countries of the South-East Asia

Variable	Bangladesh	India	Nepal	Sri Lanka
Duration of medical graduation	5 years	4 years 6 months (9 semesters)	5.5-6 years	5 years
Duration of internship	1 year	1 year	1 year	1 year
Hours of teaching	20 h	40 h	25-92 h	40-75 h
Duration of clinical posting	3 weeks+3 days	4 weeks	2 weeks	10 weeks
Psychiatric posting during internship	5 days Optional	2 weeks Compulsory	2 weeks/1 week Compulsory/optional	Not applicable
Psychiatry as an independent subject	No	No	No	Yes

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has been paid to the importance of undergraduate training in psychiatry, in this part of the world. In the majority of these countries, psychiatry has been taught merely as a branch of medicine, which is clearly observed in the current study as well.[6] To improve the mental health services in the South Asian region so that the overwhelming burden of mental health issues can be catered to, it is crucial that psychiatry is given greater emphasis during the undergraduate training period.[11] Compared to the Western part of the world, psychiatry education in Asian countries has long been rife with deficiencies.[9] If the future doctors graduating from medical schools are not adequately exposed to the management of psychiatric patients, mental health problems of patients presenting to primary care physicians will go undetected and untreated, and this will further aggravate the mental health gap seen in the Asian region. Previous recommendations have been suggested, following a review of the situation in South Asian countries in 2007, to increase the duration of exposure to psychiatry in the undergraduate curriculum (minimum 1-month clinical posting) and to consider it as a mandatory subject within the undergraduate examinations.[6] Even though more than a decade has elapsed since these recommendations were made, most of the South Asian countries have failed to meet these requirements. The duration of clinical training in psychiatry in most medical schools in the region still falls short of 1 month. The target for a total of 60 lectures in psychiatry has also not been achieved by most faculties. With the exception of Sri Lanka, the weightage given for psychiatry in the undergraduate examinations of medical schools in this region seems gravely unsatisfactory. In Sri Lanka, to tackle the lack of recruitment and to combat the stigma of psychiatry, the Sri Lanka College of Psychiatrists has taken immense efforts over the past two decades, culminating in quantitative and qualitative improvements in the undergraduate training program. Several of the targets proposed by Trivedi and Dhyani[6] have been achieved by now. Possibly reflecting the impact of these curricular changes, in a recent island-wide survey of the attitudes of final-year medical students toward psychiatry in Sri Lanka,[25] a strikingly positive attitude was observed. Whether these positive observations will be reflected in the future recruitment of trainees into psychiatry needs to be explored. On the other hand, psychiatry still remains excluded from the internship for medical graduates in Sri Lanka.

Recommendations

We recommend that leadership should be taken by the authority such as SAARC or the WHO (SEAR) in making the curricula of all the South Asian nations homogenous. Although contextualization at respective nation can occur, the core competencies and framework should be similar. As India has taken up a competency-based approach in its undergraduate curriculum as a whole, other nation should follow the same footsteps in devising a similar curriculum. Another approach would be to set up a psychiatry curriculum task force and devise a major framework and define competency. Regarding the more depth analysis of the different aspects of curriculum, we can device a nominal or ordinal scale to rate the quality among the larger numbers of psychiatrists from each country. Furthermore, there is a need to compare the different aspects of the curriculum such as the topics covered, skills imparted, methods of teaching, must-know areas, and assessment methods in this region. Another important area to explore is the outcome of psychiatry training exposure in each country that will give us an in-depth idea.

CONCLUSION

There is a wide variation among the undergraduate curriculum of psychiatry of most medical schools in the four LMICs of South Asia (Bangladesh, India, Nepal, and Sri Lanka) along with under prioritization. Persistent and rational advocacy should be directed at relevant authorities in these countries to drastically improve the undergraduate psychiatry curriculum. Particularly, expanding the duration of clinical training and lecture hours, ensuring that a qualifying examination is held in psychiatry for all medical undergraduates, and incorporating a psychiatric attachment into the intern training period are the timely needs.

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Conflicts of interest

There are no conflicts of interest.

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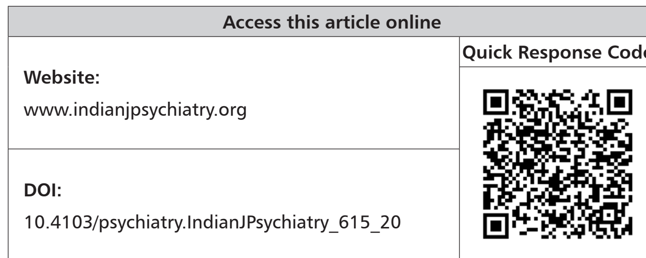

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