Commentaries

Model Curricula

The Way We Teach, The Way We Learn

David A. Goldberg, M.D.

Psychiatric education is undergoing important changes. Traditional teaching strategies that use lectures, readings, and class discussion are now being augmented by student-based interactive learning experiences (e.g., problem-based learning and case-based teaching). With the rapid and in-depth information sources that are being developed through the Internet, there is increasing attention being paid to independent learning and Web-based discussion and teaching exercises, as well as collaborations among educators. A more varied and flexible attitude toward education is evolving with the appreciation that many of us teach and learn best in different ways. In the midst of these changes and new opportunities, we find ourselves at an excellent time to reconsider the place of model curricula within our medical student and graduate education programs.

Model curricula have had a checkered history in psychiatric education. The ideas behind them, however, are compelling and deserve continued attention. Psychiatric knowledge has been growing at a staggering rate, and educational resources within individual departments are increasingly limited. Hence, a curriculum, developed by experts, that can be used in multiple educational sites around the country (and even around the world) seems a natural evolution for our field. If a model curriculum could be successful, it would meet a variety of needs. Perhaps most importantly, it could provide educators at any given site a current, organized lecture or course in the widest possible range of subject areas in psychiatry. Medical student educators and residency training directors would be able to import teaching methods and course content developed by the best and the brightest in our field. Educators could use these training modules locally and adapt them in ways that could fit their personal style and experience. The scores of hours needed to develop a seminar of quality at each site could thereby be greatly diminished, and our educators could be utilized more efficiently and effectively. With shared experience, educators could collectively develop new teaching methods that utilize adult learning models and new advances in technology. A secondary advantage could be greater consistency and a shared knowledge base that could be widely disseminated.

Who could argue with the logic of this position? Unfortunately our experience to date has been less than satisfactory. In fact, there is no model curriculum that is being used extensively today. I will first outline the problems with the model curricula that have been available and then outline some of the aspects of model curricula that could enhance their usefulness and success.

Why have model curricula been so disappointing up until this time? First we must define what we mean by *model curricula*. At the simplest level, this is a single lecture or a series of lectures on a topic that is presented in outline form and often contains an annotated bibliography. Additions to this basic structure include slides and test questions. The other end of the spectrum is a model curriculum for a large body of knowledge, such as the one described by Glick and colleagues in this issue of the journal. This was a complex undertaking involving numerous authors, with lecture outlines, slides, bibliographies, various methods of presentation, and a variety of ideas about how to integrate the didactic material into a clinical-educational system including links to supervision and other available resources.

There has been no systematic study of the use of

Dr. Goldberg is at the California Pacific Medical Center, San Francisco, California. Address reprint requests to Dr. Goldberg, Dept. of Psychiatry, California Pacific Medical Center, 2340 Clay St., San Francisco, CA 94115.

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model curricula. There is considerable indirect evidence that these curricula have not been successfully embedded in our educational programs. This evidence comes from discussions among graduate and medical student directors, the absence of any single curriculum as a widely known successful example within the field, and numerous comments by senior educators who feel that model curricula have not been useful. There are a number of reasons for this. The first is that in spite of the possibility for constant updating of the content, model curricula have a static feel to them. Using them can make otherwise seasoned educators feel like substitute teachers. The sense of ownership is often lost. The idea that "the teacher is the curriculum" reflects this difficulty. Educators are left to their own idiosyncratic and intuitive skills in trying to teach someone else's material. Another difficulty has been the incomplete development of specific teaching and learning methods that can be utilized with aspects of the curriculum. Either it is left to the individual teacher to decide what to do or there is a lot of information that is intended to be delivered in a lecture format. The integration of active adult-learning models with model curricula has yet to be realized. Another important dimension that can cause difficulty is the fact that a teacher who is highly knowledgeable in a given field may take issue with the content and emphasis that has been presented in the model curriculum. It can take more time to edit the model curriculum than to prepare one's own. A teacher who knows little about the subject can feel insecure or even dishonest teaching a subject in which he or she has marginal competence. Teaching must be a dynamic, evolving, living experience if it is to be enjoyed by the teacher and be most effective for students. The challenge of adapting a fixed program in a dynamic way remains to be met.

The Psychopharmacology Curriculum developed by the American Society of Clinical Psychopharmacology (ASCP) has many of the components that should be included in a successful portable educational program. Dr. Glick and colleagues obtained input from the field, gathered a group of prominent educators and consultants, and developed a curriculum that is intended to span levels of training. They wisely included instructions on how teachers can use the lecture outlines along with slides, literature, and Web-based references. Perhaps most innovative, they present a sequence of courses through all years of training, a course on research methods, and ways the material can be learned in supervised formats, such as medication clinics, case-based discussions, and journal clubs. The focus is on how as well as what to teach. The curriculum also includes course evaluations and useful clinical rating scales.

This is a sophisticated, multimodal approach to curriculum development. Furthermore, the group has remained committed to improving their work by receiving feedback from people using it and making modifications. Because I have not used this curriculum to teach, I cannot specifically critique it. I will, however, list areas that need attention if this, or any, model curriculum is to have a good chance of ongoing success. The areas are 1) scope and content; 2) pedagogy; 3) ongoing updating, feedback and "collective authorship;" and 4) evaluation/assessment.

The scope of a model curriculum includes the subject matter, range and experience of the students, and the teachers. The larger the scope, the more there is a need for a "buy-in" from everyone involved. The stakes are much higher. Field-testing, development, justification (proof of effectiveness and validity), and active discussion/consultation are all essential, but are costly and time-consuming. There is great value in taking on a sequence of courses because there is an opportunity for thoughtful progression in learning (based on previous knowledge), the establishment of a comprehensive body of information that is a core for psychiatrists, and links with other education (supervision) in the program as well as with other sources (literature and the Internet).

Clinical education is best developed when conceptualized as sequential and linked to the rest of the program, and when it has a relevant, shared core knowledge base. Glick and colleagues attempted to actualize all of these areas. They considered the questions of what, how much, and depth of content. The more authors, however, the greater the chance for inconsistency, omissions, and unnecessary depth in obscure areas. Developing this or any curriculum by committee can be hazardous, since a "voice" and cohesion can be lost. Few people should construct the course, including scope of material, teaching and learning methods, structure and outline of content for each seminar, links to supervision, and ways to integrate it into the overall curriculum. Expert consultants can then be used to flesh out the content, provide updates, and suggest links to ongoing study.

Expert educators can develop assessment components and ways to research the outcomes of the use of the modules.

Teaching and learning methods have been undergoing exciting growth in recent years. The move to student as self-educator, active adult-learning models, creative use of technology, and case-based group learning are all enriching the field. The traditional lecture format is on the wane. A transitional phase has been the lecture with ongoing slides. Many of the portable curricula use this as the main teaching strategy, along with class discussion. Lectures are still necessary for large groups, but are limited in small-group teaching. Although we still want students to learn in groups with the inspiration, knowledge, and guidance of a skilled educator, the most interesting and effective ways need to go far beyond the lecture/slide format. In model curricula, the lecture notes and slides aren't created by the teacher—which leads to a potentially dead classroom ambience. Certainly, one way to correct for this is to have each teacher add his or her own slides and interactive exercises. However, when experienced and creative teachers abandon the prepared script and use only bits and pieces from the curriculum, the substantive value of the external course may be lost. Our current challenge is to construct a model curriculum with enough structure, content, and flexibility to be useful in an ongoing way, but also to enable individual teachers a range of creativity and individualization. A parallel here is for the model curriculum to enable students to learn on their own (and in peer groups), using cases, readings, CD-ROMs, and Web discussions, and to use the group (plus teacher) to expand on areas, stimulate further curiosity, and apply knowledge. This approach utilizes adult-learning methods. A model curriculum that is primarily a group of lectures with slides developed by numerous experts for each discrete area and put together by a "steering group" will likely not succeed.

Ongoing, collaborative development is another critical issue. Glick and colleagues have just finished another revision of their curriculum on the basis of suggestions from the field. Assuming the original course content and methodology are reasonably consistent and of high quality, this approach can be extremely useful. One helpful addition has been a more extensive presentation on how to use the curriculum and the availability for individual consultation. A more comprehensive approach to development and "collective ownership" is therefore possible. One way to achieve this is to construct the model curriculum to allow for maximum flexibility. Each seminar, module, and learning exercise should be able to be used by individual teachers in ways that are most consonant with their approach to presenting the material. Although this approach does not benefit from the efficiency and comprehensive impact of using the curriculum in its entirety, it opens up possibilities for broader acceptance and use. The evolution of the curriculum can then occur through the use of a website or listserve in which educators can present and discuss a wide range of uses and modifications of the original curriculum. The original authors can incorporate widely supported changes, additions, and creative uses in the ongoing new iterations of the curriculum. In fact, the curriculum could be Web-based and evolve steadily through interactive discussions and demonstrations of effectiveness.

The model curriculum *Learning Psychotherapy*, developed by Bernard Beitman, M.D. and Dongmei Yue (1), is an example of this kind of national collaboration in ongoing development. The authors have set up a listserve for teachers around the country to discuss ways in which they are using and modifying the curriculum according to their specific preferences. Although this "experiment" has just begun this year, it has already demonstrated the tremendous usefulness of having people using the same structured curriculum talk in some detail about specific teaching exercises and the ways in which individual modules within the overall course can be modified and taught in creative ways. Anyone involved with this project can then use these ideas in the ongoing teaching of the course at their site. We would hope that the modification that has found broader acceptance can then be incorporated into revisions of this model curriculum. Also, Dr. Beitman is planning annual meetings, which will primarily consist of collective discussion of the use of the model curriculum, with subsequent additions and changes. In this way, a curriculum that was essentially developed by two people can have a broader shared authorship and develop into a more useful and flexible teaching tool.

A model curriculum also offers us the potential to develop experience in the evaluation of the effectiveness of a teaching method, as well as assessments of specific competencies. When multiple training pro-

grams are using the same the curriculum, it is then possible to have a much wider basis for evaluating its effectiveness in a variety of ways. These include the evaluation of knowledge and clinical skills that are learned from the curriculum and comparing different teaching strategies using the same basic content.

The assessment of clinical skills is receiving tremendous attention now and will continue to do so into the future. The use of model curricula with ongoing discussion and experimentation across the country can be an extremely effective vehicle in which to spawn assessment methodologies. The Web and e-mail (listserves) now provide us with the mechanism through which to collaborate efficiently. National meetings can be another mechanism through which this development can be presented and discussed periodically. Another technological advance, CD-ROMs, also offers tremendous new creative opportunities for individual student learning as part of the model curriculum. They also can contain an assessment/feedback component. We will then be able to compare independent learning in this way with group learning around shared tests and determine what kinds of education might be best offered in different contexts.

A new era in psychiatric education is possible. Our students are increasingly utilizing adult-learning strategies to self-educate and are facile with computers and ongoing advances in technology. The more traditional model of independent reading and lectures with seminar-based discussion still has important uses in education but must now give way to more interactive, collaborative, and self-directed learning methods. Psychiatric educators are developing new teaching strategies with the use of active learning models and technology. The Internet has opened up the possibility for national and international collaboration among educators in the development and assessment of shared learning methods. There is a central place within this context for the blossoming of what has been called a model curriculum up until this time. The term *portable educational modules* is also coming into use. Success will depend on the ways in which we structure and develop portable curricula so that they can be used flexibly and further refined through the collaborative efforts of the multiple educators who are using them. The use of adult-learning models, integration with clinical supervision and case-based studies furthering pedagogy in the use of these models, and independent student learning through access to multiple information sources will be the bedrock on which these educational programs can prosper. If we, as educators, can find ways to collaborate meaningfully and find the financial resources to support development, we can begin a new era for education in psychiatry.

Reference

1. Beitman BD, Yue D: Learning Psychotherapy: A Time-Efficient, Research-Based, and Outcome-Measured Training Program. New York, WW Norton, 1999