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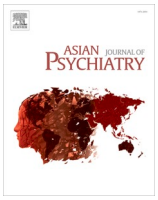

World Psychiatric Association-Asian Journal of Psychiatry Commission on Psychiatric Education in the 21st century

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ABSTRACT

Psychiatric practice faces many challenges in the first quarter of 21st century. Society has transformed, as have training requirements and patient expectations, underlining an urgent need to look at educational programmes. Meanwhile, awareness has grown around psychiatric disorders and there are evolving workforce trends, with more women going to medical school and specialising in psychiatry. Trainee psychiatrists carry different expectations for work-life balance and are increasingly becoming conscious of their own mental health. A tendency to see health as a commodity and the litigious nature of society has elicited additional pressures for healthcare professionals. Cartesian mind-body dualism has created further complexity and this can often be frustrating for patients and care-partners alike. In many cultures across Asia and beyond, patients can present with physical symptoms to express underlying psychological distress with increasing physical investigations. Simultaneously, in various countries, a shift from asylums to community-based interventions and then home treatments have changed psychiatric care in remarkable ways. These changes have added to pressures faced by mental healthcare professionals. However, trainees and other mental healthcare professionals continue to receive similar training as they did a generation ago. The tensions and differences in ideology/orientation between different branches of psychiatry have made responses to patient needs challenging. Recognising that it is difficult to predict the future, this World Psychiatric Association-Asian Journal of Psychiatry Commission makes recommendations that could

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help institutions and individuals enhance psychiatric education. This Commission draws from existing resources and recent developments to propose a training framework for future psychiatrists.

Executive summary

Background

1. Cartesian mind-body dualism has led to a theoretical separation between physical and mental health, which is reflected in education as well as clinical practice.
2. Internationally, the quality and content of psychiatric training varies substantially, both at undergraduate and postgraduate levels.
3. In many countries in Asia, the teaching period of psychiatry at undergraduate level is around two weeks in year four of medical school study. This is clearly inadequate.
4. During this time, students may be posted to psychiatric institutions, with a predominant focus on severe mental illness only. This adds to stigma and is likely to put many students off psychiatry.
5. Final undergraduate examinations often have no practical assessments and theory examinations may contain a limited number of questions or short notes.
6. In most countries, in line with rest of the medical education, at both undergraduate and postgraduate levels, psychiatric education is still delivered in a similar way as was the case decades ago.
7. Postgraduate education differs in content and assessment across countries. In many countries, local universities are responsible for standards and delivery of the curriculum, which can vary across settings. In other areas, national bodies are responsible for establishing the curriculum, assessments, and standards, and yet delivery can still be inconsistent.

Challenges

1. There are numerous challenges related to patient expectations, social and cultural transformations, and therapeutic developments.
2. Internationally, patient, care-partner, and family expectations have evolved and people often tend to seek equal relationships in psychiatric services, rather than a paternalistic approach.
3. In many countries, litigatory threats have increased, particularly in relation to treatments without consent and compulsory detention.
4. Social changes and cultures in transition have started to affect explanatory models for patients, their families, and care-partners, meaning that psychiatry's social contract is evolving. Services and training must change too.
5. Artificial intelligence and tele-and e-mental health approaches elicit specific challenges due to variability in accessibility and privacy and confidentiality issues. Hence training must evolve accordingly to meet population needs.
6. Attitudes to work-life balance are very different in younger age groups, which must be considered in educational contexts.
7. In a large number of countries, a majority of medical students and residents are women, who may have other obligations and thus wish to train part-time. Delivery of education must be shaped accordingly.

Solutions

1. International organisations such as the World Psychiatric Association need to take the lead in getting national societies to agree to a common curriculum.
2. Undergraduate teaching should include newer methods of learning through tele-health and, with careful consideration, simulation.
3. Clinical placements at undergraduate levels should be a minimum of two months spread through the clinical years.
4. Clinical placements at undergraduate level should include a range of common mental disorders, psychiatric disorders in primary care, and serious mental illnesses.
5. At postgraduate level, sub-speciality training must be offered, even if it is a couple of months duration. It should be possible to achieve this with the use of e-health and tele-health if specialists are not available locally.
6. At both undergraduate and postgraduate levels, flexible part-time training and learning should be the norm rather than the exception.
7. Recruitment and support of underprivileged communities must be promoted and encouraged.
8. Population-level and public mental health should form part of training and help shape policies at local, regional, national, and international levels.

1. Introduction

In most parts of the world, psychiatric education appears to be lagging behind evolving population and societal needs, demographic changes, and societal and patient expectations. Amidst rapid technological developments and structural changes to healthcare delivery, alongside increasing societal awareness towards mental health in the context of limited resources and inadequate funding, substantial gaps remain between needed and actual psychiatric services. This is further accentuated by continued stigma around mental illness in a large number of countries and the associated consequences. In almost all countries, there is a clear separation between physical and mental health; based on Cartesian dualism, the two subjects are taught in different settings and practised in different institutions with limited integrated training opportunities or service delivery.

Against this background, psychiatric training at both the undergraduate and postgraduate levels has essentially remained unchanged, despite prior initiatives to adapt or upgrade these programmes ((e.g., (West, 1973; Verduin et al., 2013)). Thus, the World Psychiatric Association jointly with the Asian Journal of Psychiatry established a Commission in October 2022. The Commission's objective was to examine psychiatric education in the context of today's environment, needs, and opportunities, and develop a blueprint for undergraduate and postgraduate training in psychiatry for the 21st century. The formal report is presented hereafter.

1.1. Background and overview

Psychiatry as a term emerged only in the 19th century. Until then, psychiatric patients were known as "aliens" and psychiatrists were called "alienists". Considered a branch of medicine, psychiatry has reflected the impact of Cartesian mind-body dualism (Ventriglio and Bhugra, 2015) and consequently, in many countries, asylums offering treatment to psychiatric patients were established in isolated settings, away from towns and cities. This served to reinforce the outsider status of patients, specialists, and the specialty. However, as part of new developments, in many high-income countries the delivery of psychiatric services has moved from inpatient treatments to community mental health centres and thereafter home treatment. Consequently the numbers of psychiatric beds have dramatically reduced. This has entailed additional pressures, which is further exacerbated in many countries in Asia, where limited resources, mental health stigma, and local factors have invoked distinct challenges. Furthermore, this shift in services has changed societal expectations in return and therefore the roles of psychiatrists too.

Accordingly, this raises several pertinent questions for the speciality

of psychiatry. What does the psychiatrist of the 21st century do that others cannot? How do we train psychiatrists to meet evolving societal and patient needs, now and in the immediate future? What is the added value that only a psychiatrist can offer in managing mental illnesses with interventions that others mental health professionals (psychologists, social workers, pharmacists, psychiatric nurses, occupational therapists, etc.) are not able to?

2. Changes and challenges

In the last few decades, medicine has changed dramatically and, as medicine faces fresh challenges, demands and pressures, so too does psychiatry. Hoffenberg (1991) noted that societal changes, public expectations of both doctors and the healthcare system, and increased litigation risks have led to the commercialisation of medicine, which has altered the status of physicians. Although Hoffenberg was referring to care in the United States, these paradigms are equally applicable to a large number of other countries around the globe, depending upon the healthcare system (i.e., whether it is private, public, or a mixture of the two). The commercialisation of medicine and healthcare delivery inevitably has had a major impact on individuals utilising those services, as well as those delivering care. For instance, in India, doctors fall under a consumer care act (e.g., (Bhattacharya, 2021)), affecting role expectations and the prestige of physicians as professionals.

Recent advances in medical investigations and interventions have certainly been advantageous to patients and populations. This has resulted in changing healthcare needs, with longer lifespans and an increased emphasis on managing chronic diseases and multiple complex conditions. Simultaneously, this has exacerbated the burden of care and already-limited resources, which may already be extremely stretched in many countries throughout Asia. In largely private healthcare systems, doctors are often suspected to have financial motivations; again, in certain societal contexts in Asia, physicians may receive referral fees thereby increasing patient doubts about unnecessary investigations. Furthermore, in a litigious world, doctors may be inclined to protect themselves by asking for more investigations, resulting in a vicious circle detrimental to the patient (O'Dowd, 2015).

These challenges to psychiatry and psychiatrists are not dissimilar to that of other medical disciplines, but with added complexities. Faced with stigma and discrimination, there has been a clear lack of equity in research funding and service development (Patel, 2021). Consequently, psychiatrists have been dragged into a *cul-de-sac* where people experience mental ill-health and mental illnesses. On the one hand, this has encouraged people to talk about mental health and has improved sensitivity, but on the other such open discourse has led to an increased demand on services, along with potentially pathologising normal human emotions (Foulkes and Andrews, 2023), thereby further contributing to stigma.

As another contemporary development, the advent of Large Language Models (LLM) and the acceleration of Artificial Intelligence (AI) are eliciting debates around animation, sentience, and emotion (e.g., Tiku, 2022) as well as their potential impact on individual functioning. These could also impinge upon concepts in mental health, like mind-body dualism and the biopsychosocial model. Equally, a rise in disinformation accelerated by social media and "fake news" can blur the boundaries between objective and subjective experiences (Xu et al., 2023), which could lead to an increasing individualisation of reality. Furthermore, using online tools for self-diagnosis evokes major ethical challenges. Psychiatrists have generally been good at understanding what patients tell us and what they are withholding, but with AI these assessments may become more difficult and could have nosological, aetiological, and therapeutic implications. In sum, these technological advancements will likely have a significant impact on various aspects of clinical practice as we move forward.

Of course, aetiology and diagnosis are valuable, but very often patients do not fit into uniform and clear diagnostic categories and we as professionals must acknowledge both the values and challenges as well as the possible implications of diagnoses. This is especially relevant in countries in Asia, where explanatory models are strongly influenced by cultures and can be important for help-seeking, therapeutic engagement, (e.g., (Della et al., 2021)) and pathways into care. Idioms of distress can shape care pathways, but, again, these do not always align neatly with established diagnostic categories.

Another factor in managing patients in modern services is the differentiation between disease and illness. Eisenberg (1977) noted that disease is *dis*-ease and focuses on pathology, which is what clinicians are trained to do. Disease encompasses social consequences, such as work and relationship outcomes; as conditions develop, disease becomes an illness. Importantly, patients tend to be interested in their illness, whereas physicians tend to be interested in diseases. Disease can condition financial circumstances, creating further problems for patients, especially in countries with private healthcare provisions. Distinctions between disease and illness are particularly pronounced within cultural frameworks. With a clinical focus on symptom reduction, clinicians may not always ask the patient about their priorities. Anecdotally, it is apparent that patients can often live with their symptoms as long as they have sufficient employment, socioeconomic security, and stable living conditions and relationships. As such, all clinicians, especially psychiatrists, have to manage their own attitudes and their patients' anxieties. Recognising and dealing with ambiguities is a key clinical skill of psychiatrists (The Royal College of Physicians and Surgeons of Canada, 2020a), as is controlling and manging anxieties of the patients, their families, and the clinical team.

Recent advances have illustrated connections between social and biological factors in psychiatry. Alongside various attachment patterns, adverse childhood experiences can influence brain development, affecting structures and functioning (Herzog and Schmahl, 2018). Newer medications and therapies (e.g., transcranial magnetic stimulation, psychedelic treatments) have helped move clinical psychiatric practice forward. Crucially, these advances must be reflected in educational structures and delivery. Cawley (1990) outlined various essential themes for delivering psychiatric education, highlighting how any developments should be seen within a multidisciplinary context whenever possible. Therefore, psychiatrists may need to assume leadership roles and collaborate not only with their immediate team members but also with epidemiologists, public health researchers, physicians in other specialities, policymakers, patients, and care-partners. These interconnections and interactions should be emphasised in training, as they serve to make the psychiatric discipline stronger.

Education must focus on teamwork and team building. Psychiatrists thus need to learn to train, mentor, and supervise other professionals. Pandemics like COVID-19 have also added further complications to existing training. Post-pandemic teamworking at a distance may require the acquisition of further online diagnostic and management skills rather through face-to-face interactions (Orsolini et al., 2021). Concomitantly, this raises challenges regarding ethics, confidentiality, and privacy. Each member of the team has a unique and a general role in investigating the patient, collating information, and offering suitable interventions. There will indeed be cross-disciplinary and interdisciplinary overlap, which will necessitate that psychiatrists respect individual views and expertise, even if there is some disagreement. The increased specialisation in medicine, particularly in psychiatry, can conceivably create elements of tribalism and competition. There certainly is a need for specialisation but this can also lead to care fragmentation. Hence, challenges can arise in matters of team responsibility and accountability, but Cawley (1990) argues that these can be resolved if its members are aware of a collective purpose which is good patient care. Educators must recognise that common training about team members roles and mutual respect can help support effective care delivery.

In contemporary psychiatry, there is a strong likelihood of patients with mental illnesses to be initially seen in primary care across the globe.

Goldberg and Huxley (1992) proposed a model where the majority of psychiatric disorders presented to general practitioners and are treated in these settings. Furthermore, in countries in Asia, there can be an acute shortage of mental health care staff and the burden of care often falls on primary care physicians, health visitors, and community visitors (e.g., (Maramis et al., 2011; Aliev et al., 2021)). This has clear implications for undergraduate education in medicine. As Cawley (1990) affirms, psychiatry is more than science alone. He emphasises that clinical practice has to focus on emotions and behaviours, which are strongly influenced by cultures. Accordingly, clinicians must learn to consider these variations. These aspects lie at the core of making psychiatry nomothetic (i.e., the recognition of and respect of patient individuality) but also universal through scientific observations. Clinical methods in psychiatry, again according to Cawley (1993), include a detailed and multifaceted history or biography, a rigorous examination of the patient's circumstances, behaviour, mental state, subjective experiences, and a physical examination and investigation. As part of this, psychiatrists must collate data and evidence from multiple resources, synthesising this to formulate a balanced diagnosis and treatment plan.

With the advent of new talking therapies and changing attitudes towards psychoanalysis, educational models need to evolve. Psychotherapy training is not universally available but must be an aspiration so that clinicians are aware of the complexities of transference and countertransference and the importance of patient engagement. Training and supervision can be offered online which makes psychotherapy training a strong possibility in curriculum both at undergraduate and postgraduate levels.

There is no doubt that psychiatry is a constituent part of medicine, but as mentioned earlier, Cartesian mind-body dualism has created difficulties in this conceptualisation. One solution is for psychiatric training to start from day one of medical school. Analogously, all physicians must learn to communicate and listen to their patients. To that end, teaching communication skills needs to be incorporated early within undergraduate training. Moreover, learning about management and clinical audit and quality improvement (going beyond clinical management to encompass resource management) should be embedded as soon as possible. In countries in Asia, there is very little focus on these skills, but this must change to better prepare trainees for modern patient care.

Psychiatry is an applied science (Cawley, 1993) and its knowledge and practice are scientific. This happens to be contemporary orthodoxy in the West, which can be imposed on the rest of the world in the guise of global mental health (Whitley, 2015). The focus on the brain gives psychiatry a sense of scientific validity, whereas developing an understanding of the mind incorporates numerous other disciplines like philosophy, anthropology, and sociology, amongst others. Yet, clinical science is a rigorous science. As Lewis (1934) indicated, it entails identifying problems at the bedside and using observations on healthy, sick, and dead people, and experiments and analyses in the laboratory, to produce and test new hypotheses. Even today, these principles still ring true. Cawley (1993) warns that although everything of value in psychiatry may ultimately be reduced to neuroscience (including most of psychology), social sciences, and clinical sciences, there is yet quite some way to go in putting it all together. At the heart of the psychiatric interaction is exploring, understanding, and making sense of behaviours, thoughts, and emotions subjectively experienced and expressed by the patient, and objectively understood by those caring for the patient. There is no doubt that cultures determine when and how emotions are displayed and the individual significance of these in defining normality and abnormality. Though cultural competency training has evolved over the years, there is a lot more to learn and develop.

In modern psychiatry, clinical methods include thorough assessment and management. The former comprises of detailed history-taking, third-party information, and investigations around physical, psychological, and social aspects. Disorder management may consist of biological, psychological, and social interventions (or a combination thereof) and subsequent prognosis and outcome. Unquestionably, psychiatrists of the future no matter where they train or work will have to undertake these functions. Assessment not only depends upon the actual purpose – whether it is to deal with individual distress, assess for detention or compulsory treatment – but also on the setting where it takes place – be it at home, in the hospital, prison, courts, community, or elsewhere. Assessment is a detailed enquiry into symptoms, explanatory models, examination, and observation of behaviours, mental state, subjective experiences, and also physical state, which will help discount underlying somatic problems. Akin to assessment, disorder management needs to be multifaceted, identifying what outcomes patients and their care-partners wish for and how agreement can be reached. Sociocultural factors determine how therapeutic interventions are expected and accepted. At the core of the therapeutic intervention is the patient, but it is evident that in many countries families and communities play a major role.

Multidisciplinary team-based approaches are optimal but may not be possible in many regions for a number of reasons including lack of resources and training opportunities. Nonetheless, this must be aspired to in service design, development, and delivery. Concurrently, clinicians must be cognisant of a patient's personal being, activities, and persona, all of which will be culturally influenced. These interactions and subjective experiences are critical in making sense of individual distress, unlike completely dispassionate observations (which arguably miss the essence of things (Jaspers, 1963)). Both verbal and non-verbal communications are critical for therapeutic engagement. These are a key part of mental state assessment and yet are often overlooked but are eminently amenable to scientific study. Essential principles of patient interactions in psychiatry should emphasise the uniqueness of the individual, awareness of the self (also by the clinician), and inner feelings, empathy, and interactions and alliances with others (Cawley, 1993).

Taken together, psychiatry is both an art and a clinical science. Accordingly, learning the art and the basis of the clinical science should be at the heart of psychiatric education. Explicit recognition, study, and development of how psychiatry extends beyond scientific contexts is complementary to its integrated components. This will ensure the survival of the discipline as a discrete and crucial first-line entity in understanding and treating psychiatric disorders. Therefore, psychiatric curricula of the future must include these facets.

At an undergraduate level, teaching about psychiatry in medicine, alongside its relationship and compact (or covenant or contract-various terms) with society, is imperative. To provide an illustrative example: an orthopaedic surgeon who carries out hip replacements must be aware of the signs and symptoms of dementia in their older patients as surgical prognosis is likely to be affected by rehabilitation, which in turn will be influenced by a patient's mental health. Similarly, a physician treating an individual who smokes must be aware of smoking cessation programmes. In sum, the medical world is full of cross-disciplinary interactions but at its core lie empathy and communication skills; psychiatric education must adequately reflect this. Whether we call these doctor-patient relationships, whole person medicine, personalised medicine, interpersonal medicine or any other term, the patient must be at the centre of all clinical encounters. Understanding the uniqueness of the person in front of the clinician is a must.

In turn, a patient has certain expectations of the medical specialists they see. As mentioned earlier, care pathways are informed by explanatory models of patients as well as their care-partners and families. Psychiatrists may see causation as brain disease, disorders of brain function, brain chemistry, social determinants or psychological development, and plan interventions accordingly. Nevertheless, all of these factors have to be discussed, explored, and outlined to patients and their care-partners. Causative factors should be seen in cultural contexts. Diagnosis needs to be reliable and acceptable, comprehensive and precise, bearing in mind that sometimes patients do not fit into neat diagnostic categories. Again, this means that clinicians must be aware of and capable of managing ambiguity. A worthwhile diagnosis and

classification be it categorical or multi-axial must be based on close observation and third-party information, provided by families and care-partners. Diagnostic classification and criteria must be understood separately (Cawley, 1993). Thus, education should focus on clinical attributes and additional skills.

Guidelines published by the Royal College of Psychiatrists (RCPsych) (The Royal College of Psychiatrists., 2009; The Royal College of Psychiatrists, 2017) suggest that the key characteristics of a good psychiatrist include: excellent clinical care through knowledge; competencies in assessment and management; suitable interventions and seeking help if and when needed; high levels of record keeping; excellent communications; maintaining life-long learning; leading where necessary; teaching; training; supervising and mentoring; establishing and maintaining trust; working with ethics, consent, and confidentiality; working effectively with colleagues as a team member in a collaborative way; working with management; understanding the importance of research; and demonstrating probity. Such traits are all based on principles of Good Medical Practice produced by the General Medical Council of the UK (General Medical Council, 2019).

As underlined below, these are further refined in the Canadian Medical Education Directives for Specialists (CanMEDS), which we utilise as a basic model for structuring psychiatric competencies and undergraduate and postgraduate psychiatric education in the 21st century. Many organisations have produced competency frameworks and lists including the Royal Australian and New Zealand College of Psychiatrists (RANZCP) (The Royal Australian and New Zealand College of Psychiatrists, 2012) and the Union Européenne Des Médecins Spécialistes (UEMS) (Union Européenne Des Médecins Spécialistes, Section of Psychiatry, 2017; Union Européenne Des Médecins Spécialistes, Section of Psychiatry, 2022), but the CanMEDS model can be especially helpful, as outlined below.

3. The Canadian Medical Education Directives for Specialists (CanMEDS)

To support future advances in psychiatric education, the CanMEDS offers a coherent and ethically-grounded basis for informing relevant competencies. Developed by the Royal College of Physicians and Surgeons of Canada and endorsed by numerous associations, the CanMEDS have become "the most widely accepted and applied framework of physician competencies in the world" (The Royal College of Physicians and Surgeons of Canada, 2023a). Notably, the CanMEDS have been operationalised in healthcare accreditation, assessment, and examination procedures, with validated use cases (Kassam et al., 2016; Nation et al., 2011). The Royal College of Physicians and Surgeons of Canada has updated the CanMEDS through several iterations to reflect healthcare changes and evolving patient needs, most recently in 2015 with a 2025 revision scheduled (The Royal College of Physicians and Surgeons of Canada, 2023b; Thoma et al., 2023).

The CanMEDS provide a taxonomy for medical competence and healthcare improvement across clinical settings and beyond. The system consists of seven distinct competency domains (the CanMEDS roles) that include skills, responsibilities, and activities that physicians should display to support their patients. Namely, these are medical expert (the integrating role), communicator, collaborator, leader, health advocate, scholar, and professional (The Royal College of Physicians and Surgeons of Canada, 2023a) (Fig. 1). In their current form, the CanMEDS have prompted exchanges about additional inclusions or exclusions and how existing competencies might be better refined or developed (Osei-Tutu et al., 2022; Thoma et al., 2023). Nonetheless, research has demonstrated the cross-disciplinary relevance of the CanMEDS (Lee et al., 2022). For example, scholars have highlighted their valuable theoretical foundation for medical education in different disciplines (van der Lee et al., 2013), including psychiatric training (Tuhan, 2003).

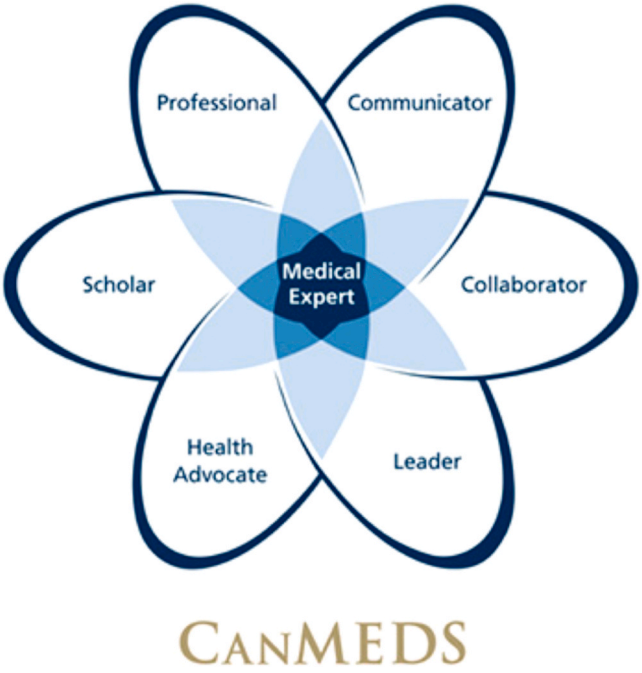

Fig. 1. CanMEDS Diagram. Each of the CanMEDS are summarised below using descriptions from the Royal College of Physicians and Surgeons of Canada (The Royal College of Physicians and Surgeons of Canada, 2023c).

3.1. Medical expert

The ability to share wisdom is central to a physician's function, as is gathering and interpreting information, making clinical decisions, and performing diagnostic and therapeutic procedures. The medical expert competencies are predicated on best practices and the latest evidence, accounting for patient needs and preferences. As the integrative CanMEDS role, a physician's ability to provide high quality care inevitably depends on their competence in other CanMEDS roles. These competencies support the medical expert domain, enabling doctors to communicate with their patients, collaborate with other healthcare professionals, and provide leadership and patient advocacy. Additionally, medical experts must demonstrate a commitment to lifelong learning and robust ethical and professional standards.

3.2. Communicator

The communicator role requires physicians to successfully connect with their patients. This includes eliciting individual perspectives, obtaining key medical information, and providing clear diagnostic and therapeutic explanations, including potential benefits and risks. Through shared decision-making, this role underlines the importance of trusting relationships, leading to greater patient engagement and satisfaction as well as positive health outcomes. Analogously, physicians must communicate effectively with other healthcare professionals to promote integrated care and improve service delivery. They also need to communicate with policymakers and other stakeholders as part of their role as advocates.

3.3. Collaborator

In this context, collaborator means team player. Characteristics of the collaborator role are centred around teamwork to achieve high quality patient care. This requires physicians to build relationships in a variety of settings, such as patients, care-partners and families, other healthcare providers, and community stakeholders. Accordingly, the collaborator competency extends beyond clinical environments,

supporting other CanMEDS such as communicator, advocate, leader, and scholar.

3.4. Leader

The leader according to CanMEDS necessitates participation in collaborative decision-making and requires physicians to take responsibility for patient care in clinical, scientific, administrative, or educational environments. Leaders must drive positive change and promote continuous quality improvement. Working with others, leaders must demonstrate interprofessional management skills to develop and deliver optimal services.

3.5. Health advocate

Per this role, a physician has responsibilities to proactively identify and address socioeconomic and environmental factors affecting health and wellbeing. As advocates, physicians must encourage policies that advance health equity at an individual and community level, which may involve prevention and promotion initiatives. This is particularly crucial in psychiatry in order to eliminate discrimination and stigma. Thus, physicians should develop clinical practice standards, often working together with different healthcare professionals, stakeholders, and communities. Physicians are well-placed to be advocates by dint of being clinicians as well as members of the society.

3.6. Scholar

Under this role, physicians must fulfil scholarly activities aimed at enhancing patient care and healthcare systems. This means that physicians should critically appraise and apply medical literature within clinical practice, engage in research, quality improvement, and teaching, and embrace lifelong learning principles and continuous professional development.

3.7. Professional

As professionals, physicians must recognise their ethical, moral, and legal obligations, including confidentiality and privacy especially now in the context of tele-health, practising with integrity and probity. Physicians must demonstrate compliance and accountability. Likewise, physicians should maintain their own wellbeing through self-care initiatives.

4. Competencies for modern psychiatry based on CanMEDS

The CanMEDs offer basic principles of best practice that can be adopted irrespective of the healthcare system and we are using this as a structuring framework for the activities, competencies, and responsibilities of psychiatrists and educational objectives in the 21st century (The Royal College of Physicians and Surgeons of Canada, 2020a; The Royal College of Physicians and Surgeons of Canada, 2020b). Specifically, this conceptualisation is tailored to and influenced by the COVID-19 pandemic, ongoing mental health policy discourse, evolving patient needs, and new technologies, amongst other continuing developments (Radfar et al., 2021; Tandon, 2023a).

4.1. Medical expert

To provide holistic treatment, psychiatrists, as physicians, must uphold core responsibilities of beneficence and nonmaleficence and their ability to recognise both mental and somatic conditions (Packer, 2013). Accordingly, per UEMS' materials (Union Européenne Des Médecins Spécialistes, Section of Psychiatry, 2017), psychiatric medical experts must possess "a defined body of medical and psychopathological knowledge and a defined set of procedural skills" to ensure "high-quality, safe and patient-centred care", but also comprehensive and compassionate care, incorporating features from each of the CanMEDS. This has to be the bedrock of education.

Firstly, as medical experts, psychiatrists must be able to carefully understand relevant diagnostic criteria, including around co-morbidities or complex conditions. However, in modern contexts, this can present inherent challenges, leading to inconsistent practices (Tandon, 2023b). Analogously, nosological uncertainty can arise around specific disorders, even when classified descriptions exist, such as for personality disorders in DSM-5 (Skodol, 2012) or drug-related problems in ICD-11 (Andrikyan et al., 2022). Therefore, dealing with clinical uncertainty has been highlighted as a key characteristic and psychiatrists should be equipped with skills to "recognise and respond to the complexity, uncertainty and ambiguity inherent in the practice of psychiatry" (The Royal College of Physicians and Surgeons of Canada, 2020a).

As mentioned above, distinctions between disease and illness are relevant in contemporary practice. In order to address this, psychiatrists should be able to demonstrate a comprehensive understanding of functional capacity and how diagnostic criteria can underpin additional assessments around symptom severity and primary role responsibilities (Zimmerman et al., 2018). This leads to more comprehensive care, ensuring that the patient's overall wellbeing and daily functioning are considered, thereby supporting the aims of personalised medicine, i.e., treating "the patient, not the disease" (Nasrallah, 2010).

Psychiatrists also need to be able to use standardised assessment tools, which are general or disorder-specific and are continually evolving (e.g. (Fried, 2017)). Difficulties can arise from their heterogeneous psychometric properties, leading to variations or even overlap between disorder-specific measures (Newson et al., 2020) especially when used across cultures without appropriate validation. Correspondingly, certain psychiatric instrumentation may neglect cultural nuances and disparities in symptomatology (e.g., in eating disorders ((Gallagher et al., 2021). An over-reliance on psychometric instruments can have adverse implications and psychiatrists need to be educated to understand how best to incorporate them into clinical practice as part of comprehensive patient assessment. This is pertinent since novel diagnostic procedures and decision-support systems may not have the same validity as conventional approaches (Bergman and Fors, 2008). In this regard, teaching and understanding of phenomenology, although overlooked in many settings, can be crucial.

The centrality of the therapeutic relationship must be emphasised. Within contemporary practice, diagnostic manuals and instrumentation are often just two parts of this process. Accordingly, per the biopsychosocial model, psychiatrists should be able to synthesise "all available information to accurately formulate and diagnose patient conditions" (The Royal Australian and New Zealand College of Psychiatrists, 2012). Similarly, UEMS' principles state that psychiatric medical experts should establish "a psychobiosocial formulation for patients with a mental health problem" (Union Européenne Des Médecins Spécialistes, Section of Psychiatry, 2017).

Hence, psychiatrists must be equipped with the skills to conduct a thorough patient assessment, accounting for varying factors in biological, social and psychological domains. This means that psychiatric education must incorporate a wide range of factors such as an understanding of genetic background and biomarkers, which should include neuropsychological diagnostic procedures ((e.g., neuroimaging) (García-Gutiérrez et al., 2020). Equally, examining an individual's history and psychosocial functioning can inform holistic care (Sarin, Jain and Murthy, 2018). Therefore, psychiatrists may need to collate collateral information, including healthcare and employment records or familial materials (Petrik et al., 2015). Gathering such documentation can raise ethical challenges (e.g., Varma et al. (2013)) which trainees must be equipped to navigate. For example, as an ongoing topic in modern contexts, the ethical probity of analysing a patient's social media or web presence continues to provoke debate (Dike et al., 2019), and this is likely to become more pertinent.

Psychiatrists must be able to assess a patient's social circumstances through familial relationships, socioeconomic aspects, social capital, and transcultural factors, which can affect psychopathology (Ventriglio et al., 2019). These can be identified within a structured or unstructured interview setting (Sarin et al., 2018), or through communication and collaboration with healthcare providers or care-partners. Moreover, psychiatrists must be adept at evaluating a patient's emotions and behaviours to gain an insight into life- course events and psychological functioning.

Alongside comprehensive assessments, psychiatrists must be able to provide effective therapeutic care and formulate appropriate interventions that are aligned with current evidence. Care that is patient-centred, accentuates personalised recovery goals, and applies global knowledge to local issues can facilitate this. Similarly, designing and communicating personalised, culturally sensitive-care programmes should be essential for modern services, incorporating individual preferences, circumstances, and determinants. These are especially important for at-risk populations who can experience distinctive psychopathological vulnerabilities (e.g., migrants (Union Européenne Des Médecins Spécialistes, Section of Psychiatry, 2016)). Correspondingly, psychiatrists must be able to explain the benefits and potential side effects of treatment to patients, families, and care-partners.

Depending on their jurisdiction, future psychiatrists will inevitably practice medicine within specific legal frameworks providing treatments in various settings (i.e., in inpatient facilities, outpatient care, or in the community), meaning any therapeutic plans need to be flexible. Contingent on the framework of care, various ethical problems can transpire, from informed consent to issues of court-mandated treatment (Neilson and Chaimowitz, 2015). Similarly, in some low- and middle-income regions, suicide remains criminalised both *de jure* and *de facto*. Therefore, to efficiently manage potential clinical dilemmas, psychiatrists must display characteristics from other competencies that support the medical expert role (e.g., communicator, leader, and professional). Further, they should be able to follow safety protocols and recognise immediate risks of harm, acting where appropriate. These can be conditioned by legal and societal structures. For example, the notion of dangerousness may be considered differently in one community to another (Large et al., 2008). Thus, psychiatric education must focus on these requirements so that practitioners can deliver the care their patients need.

For successful care models, psychiatrists should be well-versed in the latest treatment consensus, including pharmacological, neuropsychological, psychotherapeutic, or multimodal interventions. Psychiatric education in psychopharmacology and psychological interventions is relevant for keeping up-to-date and continuing medical education. As the Royal College of Physicians and Surgeons of Canada note, future psychiatrists must recognise "risks and benefits of complementary and alternative care modalities" (The Royal College of Physicians and Surgeons of Canada, 2020a). As a recent development since COVID-19, psychiatrists should be aware of the applications of electronic mental health programs, AI, and e-therapies (Ellis et al., 2021). Similarly, practical use-cases for blended therapy are expanding and should be harnessed in contemporary services (van Lotringen et al., 2023). Alongside the latest advances, future psychiatrists need to be provided with an understanding of the history of the discipline; this can help them appreciate past mistake and contextualise current debates (Moldawsky, 2020).

In conjunction with initial consultation, comprehensive assessment, and care programmes, psychiatrists should be able to systematically monitor their patients' progress and modify strategies and prognosis per clinical responses and patient feedback (Drukker et al., 2010). This is imperative to improve health outcomes and patient-centred treatment. Psychiatrists need to "prioritise professional duties in the face of multiple competing demands" (The Royal College of Physicians and Surgeons of Canada, 2020a). As care frameworks continue to develop, trainees may need to show competency beyond their area of speciality throughout their career, which can necessitate interprofessional interactions. This should include policy advice, medicolegal exchanges, or other duties as required, which can raise issues due to unspecialised knowledge.

4.2. Communicator

The ability to communicate with patients, their care-partners, and families on the one hand, and policymakers and populations on the other, is a key skill. Being a communicator does not come easy but can be learnt, and in many centres is a core part of undergraduate and post-graduate training. As psychiatric subspecialties have developed, regrettably this has had unintended consequences for care fragmentation (e.g., Kailasam et al. (2019)). In modern services, patients can experience disjointed care pathways, involving numerous mental health professionals, each addressing a distinct aspect of their condition, and as a potential result of this, underlying tribalism. Concerningly, this may create barriers, as different providers may not communicate efficiently (e.g. Chew-Graham et al. (2008)). Equally patients may not understand why they are being moved on to another expert, hence clear communication (both spoken and written) is crucial. Psychiatric education must therefore include awareness of roles of different team members and intra-team communication.

As has been highlighted, the core of mental health care is underpinned by a strong psychiatrist-patient relationship (Martin et al., 2000). To that end, interpersonal and relationship management skills, such as active listening and nonverbal communication, are key characteristics of modern mental health care. Alongside a safe physical setting, these can engender a supportive and trusting environment where patients feel comfortable disclosing phenomenological accounts of their symptomatology. Correspondingly, in these contexts, researchers have illustrated the value of empathetic engagement (e.g., (Ross and Watling, 2017)). Such proficiencies are particularly relevant during consultations with vulnerable age groups, like children, adolescents, or older adult patients. Within these demographic groups, flexible techniques tailored to the age of the patient and the context of care are important (Union Européenne des Médecins Spécialistes, Section of Child and Adolescent Psychiatry, 2021; Conn et al., 2017; Kelley et al., 2012).

Correspondingly, as technological developments are shaping communication methods, demonstrating and contributing to knowledge about these innovations and resources can help convey composite information in more accessible ways (Martin et al., 2020). In this regard, studies have explored how digital interventions can affect communication, which may become a common aspect of future treatment modalities (Wyler et al., 2021; van Lotringen et al., 2023). Issues related to ethics, privacy, and confidentiality are to be recognised under these circumstances and psychiatric education must take these into account.

Mental health care recurrently intersects with dynamics of race, ethnicity, culture, gender, sexual orientation, and religion, which can significantly influence a patient's beliefs, values, and coping strategies (Abernethy and Lancia, 1998). These cultural competencies can cultivate trust and rapport, rendering it easier for patients from diverse backgrounds to engage (Moreno and Chhatwal, 2020). Nonetheless, this can simultaneously create conceivable tensions, such as concerns about transference and countertransference (Abernethy and Lancia, 1998). Other challenges often materialise when patients do not speak the same language as their physician, who should be prepared to explore potential roles for cultural brokers (Moreno and Chhatwal, 2020) alongside tailored communication strategies (Aggarwal et al., 2016). Accordingly, per the RCPsych (The Royal College of Psychiatrists., 2009), modern practitioners must "into account whatever additional support may be required to meet any language or communication needs".

The role of the communicator encompasses shared decision-making, with a responsibility to provide patients with the information necessary to help them make decisions about their care, predicated on evidence-based guidelines (The Royal College of Physicians and Surgeons of

Canada, 2020a; Union Européenne Des Médecins Spécialistes, Section of Psychiatry, 2022). This can be a composite process, as patients may have difficulty coping with their symptoms or understanding therapeutic modalities. Notably, dilemmas can arise when the provision of psychiatric care is involuntary or court-mandated (Hachtel et al., 2019) and compulsory medication is needed. This will require psychiatrists to exhibit sensitivity and knowledge about de-escalation communication techniques (The Royal College of Physicians and Surgeons of Canada, 2020a). In order to achieve this active patient engagement and trust, whilst facilitating adherence and consent (Gilburt et al., 2008), clinicians need solid communication skills. For instance, open communication to support shared decision-making is essential in geriatric psychiatry, where prognostic uncertainty or cognitive decline can obfuscate care goals (Kelley et al., 2012).

Similarly, involving patients' relatives and care-partners in decision-making processes can cultivate detailed context and support bearing in mind issues related to privacy and confidentiality. Family-centred interactions and shared decision-making call for specific competencies, such as conflict resolution and the ability to provide comprehensive psychoeducation, which can be overlooked in psychiatric education (e.g., Motlova et al. (2017)). Closely aligned with the collaborator, leader, and professional competencies, interdisciplinary and interprofessional connections are vital to avoid adverse outcomes and gain a comprehensive understanding of patient needs. Constructive communication helps identify possible gaps in care, promoting timely interventions and mitigating possible inefficiencies or delays (Vermeir et al., 2015).

To achieve this, electronic health records and shared care plans can facilitate information sharing amongst team members. For the Royal College of Physicians and Surgeons of Canada (2020), documents must be maintained in an "accurate, complete, timely, and accessible manner, in compliance with regulatory and legal requirements" through "a written health record, electronic medical record, or other digital technology". In modern psychiatry, Chowdhury et al. (2021) have demonstrated how uses of machine learning and AI for electronic health records are expanding, which can concomitantly raise privacy and confidentiality issues that need to be considered across curricula and clinical practice.

It is incumbent on modern psychiatrists to promote the wellbeing of their patients in a range of situations, in line with the role of health advocate. For the RANZCP, this means that they should be able to "engage in dialogue about psychiatric issues with the wider community" (The Royal Australian and New Zealand College of Psychiatrists, 2012). Significantly, within mental health frameworks, this should include efforts to reduce stigmatising paradigms, which continue to negate help-seeking and service access (Kaur et al., 2021). Resultantly, psychiatrists must be able to engage in strategies to counter stigma and maintain a respectful discourse, as may be relevant during media appearances. Recently, however, there have been debates regarding commentary on the psychopathology of public figures (Smith et al., 2023). Thus, efforts should be made to ensure that contributions to public dialogues are ethically and scientifically grounded, drawing on other roles (e.g., health advocate, professional, and leader).

4.3. Collaborator

Modern psychiatric collaboration often involves working with diverse stakeholders across the care continuum. Liaison between professional silos can help modulate service fragmentation and ensure holistic treatment, thereby enhancing patient experiences and outcomes (Reinach Wolf, 2014). In demonstrating their abilities as collaborators, psychiatrists should be able to "engage in respectful shared decision-making processes with patients and health care professionals" (Union Européenne Des Médecins Spécialistes, Section of Psychiatry, 2017). The benefits of ethical and evidence-based models of shared decision-making have been previously outlined (Drake et al., 2009). Nevertheless, there are persistent technical and socio/ethnocultural obstacles to shared decision-making in clinical environments (Slade, 2017), especially for specific morbidities (e.g., Haugom et al. (2020)). Psychiatrists need to be aware of these potential issues, whilst still exhibiting a willingness to cooperate (Ahmed et al., 2021). This is applicable regardless of the care context, like within involuntary treatment programmes or detention settings; for RCPsych (The Royal College of Psychiatrists., 2009) psychiatrists must "involve detained patients in treatment decisions as much as possible, taking into account their mental health and the need to provide treatment in their best interests".

Alongside working with patients, collaboration involves the integration of community resources and support networks into therapeutic plans, where appropriate. In different contexts, mental health collaboration can extend beyond clinical scenarios, with organisations, groups, and relatives playing important roles in a patient's recovery (Waller et al., 2019; Castillo et al., 2018). These can be conditioned by local models and beliefs and involve additional stakeholders, like spiritual or community leaders (Stein et al., 2022). Likewise, it will be important for psychiatrists to recognise the value of different venues of care and social resources, like nursing homes, and complex care providers (The Royal College of Physicians and Surgeons of Canada, 2020a). Further, psychiatrists should be equipped with attributes to navigate interprofessional exchanges across different levels of treatment.

To reduce modern care fragmentation, future psychiatrists should be able to coordinate with relevant healthcare teams, as appropriate. This supplements skills from different CanMEDS, such as communicator, leader, and professional, amongst others (The Royal College of Physicians and Surgeons of Canada, 2020a). As a central facet of teamwork in psychiatry, The Royal College of Physicians and Surgeons of Canada (2020a) indicate that specialists must "deliver treatment in a shared care and/or collaborative care model with physicians providing primary care" and "apply an understanding of the roles and contributions of these physicians". Additionally, as the UEMS outline (2017), the "[c]ollaboration process requires understanding of the roles of others, pursuing common goals and outcomes, and managing differences" (Union Européenne Des Médecins Spécialistes, Section of Psychiatry, 2017).

Therefore, to fulfil these responsibilities, psychiatrists should be able to engage in interprofessional working, creating collegial environments that promote patient interests. As subspecialties continue to develop and may overlap, trainees will need to be adept at responding to conflicts (Sherry et al., 2016). Per the RCPsych, psychiatrists "recognise that although individual members of a team may have different roles, successful teams have shared goals" (The Royal College of Psychiatrists., 2009). In addition, to be team players, psychiatrists must possess detailed insights into the appropriate timing and support for transitions or handovers in patient care (Union Européenne Des Médecins Spécialistes, Section of Psychiatry, 2017). Nevertheless, touching upon competencies from the leader and professional roles, psychiatrists should be prepared for certain situations where knowledge sharing and collaboration might not be appropriate, especially for vulnerable patients. For instance, LGBTQ+ individuals may be reluctant to disclose mental health concerns due to stigmatising community backgrounds (Saenz, 2020).

4.4. Leader

Internationally, mental health remains an overlooked priority on political and governmental agendas, receiving insufficient attention and investment (Mahomed, 2020), and resource constraints and expertise shortages continue (Tandon, 2023b). The COVID-19 pandemic amplified these paradigms, stretching already under-resourced services (Zangani et al., 2022). Financial pressures on care delivery will likely increase over the coming years, especially during the ongoing "cost of living crisis" (Andersen and Reeves, 2022), which may widen health inequities.

Amidst these ongoing challenges, leadership competencies constitute a critical of a psychiatrist's professional work, irrespective of where they

practise. The medical leadership competency framework developed by the Academy of Medical Royal Colleges alongside the National Health Service Institute for Innovation and Improvement in the UK (National Health Service, 2009) contains five domains: demonstrating personal qualities, working with others, managing services, improving services, and setting direction. Yet, despite past initiatives in this area, prior research indicates that there has been a lack of practice-oriented detail around the CanMEDS leader domain in psychiatry (Thakur et al., 2020). Here, it should also be noted that management skills, include resource and people management (see Bhugra et al., 2013, 2016), and are different from leadership skills.

To demonstrate leadership, psychiatrists will need to actively engage with policymakers and advocate for the equitable allocation of resources, whilst raising awareness about mental health literacy (Kutcher et al., 2016). Consequently, leaders should draw on the competencies of health advocates, engaging in societal outreach and public education initiatives to moderate anachronistic and stigmatising views. Here, recent attention has been given to the positive effects of blogging and social media to promote discourse on current issues, when conducted appropriately and ethically (e.g. Peek et al. (2015)). As future psychiatric leaders, trainees should be aware of these trends and how best to integrate relevant multidisciplinary expertise into clinical teams.

In the modern context of care fragmentation, the leader role entails responsibility for "the operation and ongoing evolution of the health care system" (Union Européenne Des Médecins Spécialistes, Section of Psychiatry, 2022). This is an important ability which focuses on bringing different partners together to discuss their special skills and views and then cogently putting this all together to benefit patients. For The Royal College of Physicians and Surgeons of Canada (2020a), leaders in psychiatry must "engage with others to contribute to a vision of a high-quality health care systems and take responsibility for the delivery of excellent patient care". In many clinical settings, the doctor is *de facto* the team leader. A leader is someone who does the right thing, meaning making the correct evidence-based decisions and taking the team with them.

Psychiatrists should be equipped with attributes to pioneer the implementation of integrated care models that bridge the gap between primary care, mental health services, and community resources (The Royal College of Psychiatrists, 2019). For strong leadership, it is incumbent on them to facilitate communication, resolve conflict, and support the healthcare team (Union Européenne Des Médecins Spécialistes, Section of Psychiatry, 2017). Analogously, a "psychiatrist must acknowledge and work within the lines of accountability established in their own and partner organisations" (The Royal College of Psychiatrists., 2009). Optimising and safeguarding patient safety is another key responsibility. Svensson (2022) suggests that contemporary psychiatry may be lagging behind developments in safety science and needs to focus more on performance variability and risk. Considerations such as these will fall within the remit of trainees during their careers and should be emphasised in educational structures.

In addition, leaders should drive positive change within clinical governance structures. To that end, psychiatrists must identify gaps and inefficiencies and find solutions to enhance patient experiences and improve outcomes. A key characteristic of good leadership is namely the "ability to critically review and appraise different health systems and management structures" (The Royal Australian and New Zealand College of Psychiatrists, 2012). Notably, in modern frameworks, this includes a duty to challenge the status quo, exploring innovative methods to ensure that clinical settings reflect best-practices. For instance, studies have shown support for flattened hierarchies or collective leadership in healthcare settings (De Brún and McAuliffe, 2020) and additional transparency around recruitment and career advancement should be encouraged (Jureidini, 2012).

As technological advancements continue, this will inevitably mean that during their careers, trainees will need to make decisions about appropriate implementation. As discussed, recent digital developments have instigated shifts in clinical practice, offering clinical opportunities; e-mental health has shown great promise (Ellis et al., 2021), as have big data solutions (Ahmed et al., 2022). However, simultaneously, there are various implementation barriers that will to be considered now and in the decades ahead (e.g. (Tornero-Costa et al., 2023). Psychiatrists also need to be aware of contemporaneous geopolitical issues such as climate change affecting current and future practice, incorporating these into relevant governance considerations (The Royal Australian and New Zealand College of Psychiatrists, 2022).

Contemporary leadership approaches can be complemented by lean thinking and initiatives driven by data and metrics (Boland, 2020). To achieve quality improvements, the UEMS (Union Européenne Des Médecins Spécialistes, Section of Psychiatry, 2017) affirms that leaders should be comfortable with "submitting one's daily practice to peer review". Furthermore, psychiatrists often face ethical dilemmas, complicating principles of beneficence and nonmaleficence. Recurring scenarios may include balancing patient autonomy with the need for involuntary treatment, confidentiality, and interactions with legal structures (Okasha, 2000; Sidhu and Srinivasraghavan, 2016). Future psychiatrists will need to be able to approach these subjects with sensitivity and integrity, ensuring that any actions are guided by patient interests and underpinned by professional and ethical guidelines (Sidhu and Srinivasraghavan, 2016).

Expertise shortages and institutional pressures can make delivery of healthcare a complex challenge. Yanos and Ziedonis (2006) have illustrated how competing responsibilities elicit "interrole conflicts" in clinical practice. Therefore, psychiatrists should be able to recognise task prioritisation, delegate responsibilities, and streamline processes. Finally, embracing leadership in psychiatry entails lifelong learning and professional development (The Royal College of Physicians and Surgeons of Canada, 2020a; Union Européenne Des Médecins Spécialistes, Section of Psychiatry, 2017; Union Européenne Des Médecins Spécialistes, Section of Psychiatry, 2022), supported by additional competencies (e.g. Scholar), which educational structures should emphasise.

4.5. Health advocate

Being a successful health advocate requires efforts to actively improve the health and wellbeing of patients and the general populace, contributing to the development of equitable health systems (Union Européenne Des Médecins Spécialistes, Section of Psychiatry, 2022). The RANZCP's Fellowship Competencies underline how psychiatrists must "use their expertise and influence to advocate on behalf of individual patients, their families and caregivers, as well as more broadly, on an epidemiological level" (The Royal Australian and New Zealand College of Psychiatrists, 2012). Likewise, for the Royal College of Physicians and Surgeons of Canada, health advocates "contribute their expertise and influence as they work with communities or patient populations to improve health" (The Royal College of Physicians and Surgeons of Canada, 2020a). As substantial care disparities persist in the 2020 s, health advocacy activities are pertinent activities for modern psychiatrists (Kirmayer et al., 2018). Many people from diverse backgrounds, such as racial and ethnic minorities, LGBTQ+ groups, and disabled individuals, still experience stigma and discrimination (at both systemic and individual levels) (Ngui et al., 2010). This includes specific barriers to mental health care and higher risks of mental health disorders (Bhugra et al., 2023). For comparable reasons, Osei-Tutu and colleagues (Osei-Tutu et al., 2022) suggest anti-racism should be a core competency in the 21st century.

Against this background, psychiatrists must recognise and be able to promote mental health literacy. This could follow the four-tiers which include: 1) understanding how to attain and maintain positive mental health, 2) understanding disorders and therapies, 3) reducing stigma, and 4) enhancing help-seeking (Kutcher et al., 2016). For example, psychiatrists should be able to challenge misconceptions and reduce

stigma by educating patients, families, and society about mental health disorders and the importance of help-seeking (Saha, 2021). Initiatives like this may be embedded within public presentations, media interactions, and collaborations with organisations to create accessible and educational resources (Corrigan et al., 2012). For the latter, during their careers, trainees will inevitably need to work alongside community-based organisations, such as schools, workplaces, and social service agencies, to aid mental health promotion and prevention efforts (Pinfold et al., 2003).

Another area of focus for psychiatric health advocates centres around systemic barriers to care. Such issues may require future psychiatrists to participate in advocacy to ensure that mental health services are adequately funded and covered by insurance plans, thereby reducing financial burdens for patients and their families (Funk et al., 2006). For instance, psychiatrists in Switzerland engaged in advocacy efforts by disseminating articles on social security law, which ultimately led to legislative changes around addiction (Wyler et al., 2022). Psychiatrists now and in the future have a duty to support the expansion of the mental health workforce, including the development and recruitment of professionals, particularly in socioeconomically disadvantaged areas (Kim, American Academy of Child and Adolescent Psychiatry Task Force on Workforce Needs, 2003).

Finally, it is incumbent on psychiatrists to promote the integration of mental health care into broader public health and social policy initiatives (Bhugra et al., 2015). As geo-political and social determinants become increasingly recognised as causing mental distress and illnesses, psychiatrists may need to utilise their accumulated expertise to enrich policies and programmes that address the social determinants of mental health (e.g. poverty, housing, education). In this sense, comprehensive approaches to mental health promotion and prevention should be emphasised in education, with the aim of developing healthier and more resilient societies (Fusar-Poli et al., 2021).

4.6. Scholar

The role of the scholar underpins effective healthcare, ensuring specialists are equipped with the latest knowledge and tools to diagnose, treat, and manage disorders (The Royal College of Physicians and Surgeons of Canada, 2020a). The "active role of scholar ensures that a psychiatrist arrives at clinical decisions that are informed by evidence while taking patient values and preferences into account" (Union Européenne Des Médecins Spécialistes, Section of Psychiatry, 2022) and they must display "excellence in their professional work" (Union Européenne Des Médecins Spécialistes, Section of Psychiatry, 2017). The Royal College of Physicians and Surgeons of Canada has proposed similar classifications, in that psychiatrists should "demonstrate a lifelong commitment to excellence in practice through continuous learning, and by teaching others, evaluating evidence, and contributing to scholarship" (The Royal College of Physicians and Surgeons of Canada, 2020a).

Following postgraduate training, psychiatrists must have a deep understanding of the biological, psychological, and social aspects of mental health, but also be able to adapt and update their knowledge in line with new evidence. This means that they will have to be generators of new information throughout their careers, as well as well-informed consumers. This can be challenging given the increasing pace and volume of published research. In the pre-pandemic years between 2011 and 2015, Zhang et al. (2017) found that over eighty-four thousand psychiatric articles were published. The COVID-19 pandemic saw a prominent increase in scientific research activity. Notably, the Asian Journal of Psychiatry saw a four-fold increase to submissions between 2019 and 2020, publishing 227 articles on COVID-19 in 2020 alone (Tandon, 2021). Related to this, modern research assessment often reinforce "publish or perish" ideologies, prioritising the production of scientific evidence (Morgan, 2010). Furthermore, paywalls around academic research can hinder evidence-based principles, restricting access to scientific findings, particularly for those in the lower-income areas. Journals without open access options can exacerbate this issue, limiting the dissemination of knowledge across the psychiatric community .

Within this context, because of the substantial challenges to keep up-to-date, skills to distil the right information are crucial. Psychiatric education must include training on how to read, interpret and "critically appraise and apply psychiatric and other health information for the benefit of patients" (The Royal Australian and New Zealand College of Psychiatrists, 2012), identifying potential biases and limitations to the applicability of research in clinical contexts. This also necessitates lifelong learning, which could include a personal learning plan and attending conferences, workshops, and seminars, to keep informed about advances relevant for contemporary practice. Various methods to learn these skills are essential in education.

With new technologies and therapeutic processes evolving (Ellis et al., 2021), psychiatrists should stay at the forefront of developments in the field and be open to exploring potential new advances. This can better equip them to provide evidence-based care and advocate for mental health services and policies throughout their career (Wallace, 2011). For example, Hilty et al. (2018) have affirmed the importance of lifelong learning in the context of telemedicine and e-health. Other salient aspects of the role of the scholar in psychiatry centre around knowledge dissemination. Where possible, psychiatrists at all levels should be actively involved in the research cycle, demonstrating an understanding of ethics (Jain et al., 2017). Yet, there can be sizeable clinician-researcher gaps in modern practice, alongside translation and implementation gaps (Wallace, 2013). To address this, educational programmes should encourage trainees to participate in research, as we shall discuss.

In addition, during their careers, psychiatrists will often work as educators and teach team members, students, trainees and public about psychopathology, treatment programmes, and patient safety (The Royal College of Physicians and Surgeons of Canada, 2020a). Resultantly, in these scenarios, psychiatrists should share their own perspectives, successes, and failures to create a supportive environment that emphasises critical thinking (Bromley and Braslow, 2008). This can help ensure that the wider medical community is able to address the needs of people with mental illness and challenge established norms, thereby advancing the field of psychiatry and potentially leading to improvements in patient care.

4.7. Professional

The role of the professional encompasses the ethical, moral, and professional responsibilities during patient care. Psychiatrists are expected to keep learning and advancing knowledge along with increasing their expertise to benefit others, serving others' needs above their own and ensuring that their colleagues fulfil these responsibilities. The values of excellence, self- sacrifice and accountability are at the heart of every profession and underpin public trust in medicine (Roberts et al., 2004).

Ethical considerations and nonmaleficence in psychiatry can be complicated by the sensitive nature of mental health conditions and complex situations can frequently arise (Bipeta, 2019). Per UEMS documentation (Union Européenne Des Médecins Spécialistes, Section of Psychiatry, 2022), the responsibilities of the professional "incorporates contemporary society's expectations of physicians, which include clinical competence, a commitment to ongoing professional development, promotion of the public good, adherence to ethical standards and values". As professionals, psychiatrists must act with probity in clinical practice, ensuring "that their conduct at all times justifies their patients' trust in them and the public's trust in the profession" (The Royal College of Psychiatrists., 2009).

The professional domain in psychiatry involves adhering to ethical principles (Bhugra, 2009), complemented by other CanMEDS roles. In psychotherapeutic settings, this is paramount given the delicate nature of the therapeutic relationship, which can directly determine patient

outcomes (Gabbard, 1994). Sensitive information shared by patients during therapy sessions or psychiatric assessments must be handled with discretion and respect (Bhugra and Malik, 2010). Moreover, psychiatrists must be able to carefully understand the ethical considerations surrounding informed consent when prescribing medications or recommending treatment plans. RCPsych advise that "where the issues are complex, unclear or beyond their competence, a psychiatrist must seek legal advice and a second opinion" (The Royal College of Psychiatrists., 2009). Similarly, professionals should ensure that patients are provided with the necessary information before making decisions about their care (Del Piccolo and Goss, 2012).

Nevertheless, concerns about confidentiality, the duty to warn, and patient capacity can generate complex dilemmas. For instance, Hansson et al. (2022) underlined issues around patient autonomy and privacy in family participation for individuals with psychotic disorders. Psychiatrists will need be able to navigate these scenarios appropriately within modern services, balancing the best interests of the patient in accordance with legal and regulatory guidelines. However, if these are not informed by best-practice or current evidence, psychiatrists have a duty to try to influence the evolution of these frameworks. As a contemporary debate, it remains to be seen how legal and regulatory considerations will be shaped by therapeutic advances, like e-therapy (Stoll et al., 2020).

As in other CanMEDS (e.g., communicator and medical expert) cultural competence is a major feature of the professional domain (The Royal College of Physicians and Surgeons of Canada, 2020a), requiring psychiatrists to navigate the challenges and needs of diverse patient populations. Louie et al. (2006) remind us that emotional skills be considered as important as cognitive skills even though these are qualitatively dissimilar. Emotional intelligence is the ability to perceive and identify emotions, cognitively process emotions and use emotions to improve cognitive processes and manage one's and others' emotions (Mayer et al., 2000). Psychiatrists will deal with stressful emotional matters on a daily basis and must be aware of the importance and impact of emotional intelligence.

Since future psychiatrists will be regularly treating vulnerable individuals, it is critical for them to establish and maintain clear boundaries that protect both patient and healthcare professionals. RCPsych affirm that psychiatrists should recognise "the vulnerability of some patients and to the need to maintain clear boundaries in professional relationships with all patients" (The Royal College of Psychiatrists., 2009). Accordingly, this can involve situations where the therapeutic relationship may potentially be harmed (Friedman and Martinez, 2019), like instances of transference or countertransference. This could also include inappropriate relations or less obvious conflicts of interest, such as dual-role dilemmas (Robertson and Walter, 2008). Additionally, there has been extensive scholarly attention towards the personal biases of psychiatrists during patient interactions (e.g., Yager et al., 2021; Barnow et al., 2009), which can undermine patient-centred care and treatment outcomes. Psychiatrists will need to consider their own socio/-ethnocultural perspectives and be aware of how these could influence clinical exchanges. Consequently, self-awareness training and bias mitigation strategies have been underlined as a requisite part of the modern psychiatric profession, which should be developed in educational curricula (Moreno and Chhatwal, 2020).

Accountability is another essential characteristic, meaning that psychiatrists will need to take responsibility for their actions and decisions, addressing concerns or errors. When engaging in interprofessional teams, this "includes clarifying: lines of accountability for the care provided to individual patients" (The Royal College of Psychiatrists., 2009). According to the RANZCP competencies, psychiatrists must "actively engage in reflective practice, giving due consideration to feedback received from others" (The Royal Australian and New Zealand College of Psychiatrists, 2012). Significantly, professional oversight should extend to other colleagues and healthcare stakeholders, with a duty to report any observations of unethical conduct (Bhugra and Malik, 2010).

As professionals, altruism can be seen as a key responsibility, which brings about challenges in realm of private practice, as the primary responsibility of psychiatrists lies in non-maleficence and beneficence, promoting mental health, and supporting vulnerable individuals (Psychiatry, 2009). With the increasing commercialisation of medicine, future psychiatrists will need to be conscious of any potential conflicts of interest to maintain patient trust (Shimazawa and Ikeda, 2014). This needs further debate as part of psychiatry's social contract.

Furthermore, as providers of medical care, psychiatrists have a responsibility to uphold their own wellbeing. Posluns and Gall (2020) have shown how issues of burnout and stress can be major issues for mental health care practitioners. Alarming trends in suicidality and morbidities like substance use disorders also remain prevalent (e.g., (Wang, 2019; Yellowlees et al., 2014)). Future psychiatrists should thereby be encouraged to act as positive examples for health promotion and help-seeking through good self-care.

5. Supporting modern psychiatric education frameworks through CanMEDS -based domains

Worldwide, psychiatric training programmes at undergraduate and postgraduate level are heterogenous, encompassing diverse content and priorities dependent on the context of care (Ng et al., 2020). Against this background, the CanMEDS can offer an aspirational foundation for the development and application of educational strategies tailored to specific healthcare competencies. Consequently, this section discusses how the skills and activities included in the seven core roles we outlined can inform undergraduate and postgraduate psychiatry training, to prepare psychiatrists for the challenges and opportunities of future practice.

To support these extensive training goals, the duration of education, particularly at the postgraduate level, needs to be considered in-depth. At present, postgraduate training in psychiatry can range from 6 months to 7 years. As mentioned above, international discussions must take place to reach consensus on periods of learning and the time it takes to acquire basic skills. This will also depend upon available resources and teachers. In this regard, as mentioned earlier, modern technologies for online learning, assessment, and supervision should be encouraged.

5.1. *Medical expert*

5.1.1. *Undergraduate level*

Both undergraduate and postgraduate training programmes underpin medical expert competencies. For this domain, at undergraduate level, students should develop a strong foundation in medical knowledge and care principles. Specifically, in psychiatry, this should include a preliminary understanding of psychopathology, the clinical presentation of symptoms, and basic therapeutic options. Accordingly, any undergraduate curriculum related to psychiatry must include core information on subjects such as brain function, sociological issues, psychiatric disorders, psychological and pharmacological treatments, communication skills, and cultural values.

With the aim of supporting the biopsychosocial model and continuing the shift away from Cartesian ideologies (Ventriglio and Bhugra, 2015), psychiatric training should be well-integrated into undergraduate education for all medical students to develop holistic medical knowledge and potentially improve future interest in the field. However, mental health is currently not given sufficient prominence (Pinto da Costa et al., 2019) or time (Sampogna et al., 2022) in undergraduate programmes worldwide, which often hinders this. Concurrently, early-stage integration could help to assist future interactions between mental health and primary care providers. In addition, aetiological theories in general medical training should highlight intersections between somatic and psychiatric disorders, again with the aim of upholding the biopsychosocial model and promoting patient-centred and integrated care (Tayeb et al., 2022; Roy et al.,

2019). Finally, the inclusion of non-traditional teaching materials in undergraduate psychiatry courses, such as works from the medical humanities, could be adopted more holistically to enrich student engagement (Bhugra and Ventriglio, 2015).

Undergraduate medical curricula must take educational strategies into account. As Davis and Chandratilake (Davis and Chandratilake, 2011a) highlight, this needs to be student centred, problem-based and integrated. This can be facilitated by using a number of pedagogical approaches. Davis and Chandratilake (Davis and Chandratilake, 2011b) propose five potential aspects: early introduction of clinical practice, simulation, use of ambulatory care along with primary care, reflective practice, and multi-professional or interprofessional learning. Reflective practice is important to grow as an individual clinician, and there are benefits to reflection *in* practice and *on* practice. Logbooks, portfolios, discussion documents, and consultation videos can contribute to reflective practice. Elsewhere, Sandrone and colleagues (Sandrone et al., 2020) have explored the benefits of active learning in undergraduate psychiatry education, including recent advances in the flipped classroom concept. Similarly, clinical vignettes can introduce symptomatology and psychopathological theories. Using psychiatric case descriptions in the classroom, Simmons and Wilkinson (2012) observed that undergraduate students showed greater understanding of real-life patient problems. To facilitate case-based learning, researchers have demonstrated the promising functionality of AI technologies in the production of clinical vignettes (Smith et al., 2023).

5.1.2. Postgraduate level

To strengthen the role of the medical expert in postgraduate contexts, trainees should refine the clinical knowledge acquired at undergraduate level, which may include exposure to allied disciplines, like neurology, sociology, and anthropology. Whilst this should not be the primary purpose of postgraduate psychiatric education, it could enhance the ability of trainees to better understand phenological experiences and diagnose and manage symptoms. Furthermore, a focus on specialisation is important at postgraduate level (e.g. (The Royal Australian and New Zealand College of Psychiatrists, 2023)) and guidelines are available containing detailed recommendations of how this can be formulated. For example, a statement on geriatric psychiatric education in Europe outlines granular specifications (Union Européenne Des Médecins Spécialistes, Section for Psychiatry, 2013).

The debate about the respective roles of generalists versus specialists and training is important and decisions have to be made depending upon resources and local needs. It has been argued that subspecialty training does not always meet current needs, particularly given international expertise shortages (Balon, 2017). Accordingly, there have been calls for generalised models that equip trainees with diverse knowledge across various domains, alongside accreditation protocols that can be applied internationally, regardless of the country of training (Muijen, 2010). For example, Brenner (2022) has contended that substantial substance use disorder rates require all physicians to be able to accurately identify these conditions. The advantages and disadvantages of training programmes that emphasise transferrable expertise represents an evolving debate (Aggarwal et al., 2023), and it remains to be seen how these would affect patient care (and thus the importance of certain CanMEDS). Nevertheless, comparable discussions are taking place in parallel disciplines, like neurology, where some have argued for psychiatric training to become a minor specialty (Shalev and Jacoby, 2022).

Supporting characteristics from the medical expert role, psychiatric trainees should be proficient in the use of diagnostic standards from the ICD-11 (or DSM-5 where applicable), psychiatric instrumentation, and treatment courses. Observation of patients and detailed exploration of their history (including third-party information) and investigations leading to proper formulation must be at the core of future expertise. Gask (2011) suggests (role) modelling, role playing, group teaching with patients, and using videotapes as some pedagogical methods. Of particular importance are groups working together for which the teacher may need to set ground rules, providing an agenda, opportunities for rehearsal of new skills, constructive observation, and ensuring that the group does the work. Conclusions should be positive (Gask, 2011). Additionally, diagnoses can have a significant impact on a patient's life, yet, as we have highlighted modern psychiatrists often face diagnostic challenges. Therefore, trainee medical experts in psychiatry must be taught about dealing with ambiguities in empathetic ways. Here, teaching can be by example, through mentoring and apprenticeship.

Furthermore, trainees should be taught the fundamentals of psychopharmacology to ensure safe and effective patient-oriented care (The Royal College of Physicians and Surgeons of Canada, 2020b). For this purpose, diverse pedagogical approaches have been suggested, such as didactic courses, novel methods, and supervised practice (e.g., (Zisook et al., 2008; Shiroma et al., 2011). Psychiatric education in this context must include bedside teaching as well as research evaluation. Likewise, trainees should be educated about multimodal therapy and how treatment courses and resource availability can be contingent on the geographical setting. For example, depending on the region, this may involve learning about low-cost interventions in environments with resource limitations or further information about how to provide care in rural areas.

Postgraduates must be educated on psychotherapeutic care provisions, encompassing various evidence-based forms, theoretical frameworks, practical application, techniques, indications, contraindications, and tailoring interventions to patient needs (Union Européenne Des Médecins Spécialistes, Section for Psychiatry, 2019). Alongside this, teachers should be willing to explore recent technology-based advances in care delivery, like telepsychiatry, e-therapy, and blended therapy (Gratzer and Goldbloom, 2020; Kuhn and Hugo, 2017), to prepare trainees for the future demands of the profession. However, evidence suggests limited educational attention has been given to these areas (Orsolini, 2021). Together with these, to strengthen aspects of cultural competence, postgraduates need to be equipped with knowledge around complementary medicines (Bhugra et al., 2015).

Again, drawing from the medical expert domain, education on treatment pathways and diagnostic considerations must be informed by the biopsychosocial model, which should underpin education curricula within the wider social and cultural contexts. As we have noted, medicine (and psychiatry in particular) has intrinsic links to the societal framework within which a clinician learns and practices. Teaching the biopsychosocial model will allow postgraduates to gain an integrated perspective on mental health, including life course approaches. This is relevant as certain constituent aspects of the biopsychosocial model tend to be neglected, depending on individual programmes and perspectives (e.g., (Campbell and Rohrbaugh, 2006)). Further, the progenitor of this concept, George Engel, cited theoretical difficulties in its teaching (Engel, 1982), and studies suggest that trainees might find it challenging to practically implement (Khatri et al., 2020; Ross et al., 2016). Resultantly, proactive pedagogy and detailed learning objectives may be necessary to increase comprehension as has been beneficial elsewhere (Ross et al., 2016; McClain et al., 2004).

Incorporating cultural competency in education is a must for trainee medical experts in psychiatry. Every patient and their care-partners have distinctive cultural backgrounds, which, even if similar to that of the medical practitioner, may raise challenges in perception and therapeutic engagement. Americano and Bhugra (2008) describe how competence in diversity requires an awareness of different styles, values, beliefs and practices, which can be honed at postgraduate level. Americano and Bhugra (2008) go on to identify five essential elements of institutions focusing on organisational cultural competency that can help advance cultural competency pedagogy. These include valuing diversity, capacity for self-assessment, awareness of dynamics and interactions of cultures and diversity, knowledge about the groups they serve, and delivery adaptations to what is required and expected. Here, successful courses dedicated to gender and LGBTQ+ topics have been implemented, although wider adoption remains sparse (Spielvogel et al., 1995;

Hirschtritt et al., 2019). Furthermore, institutions should be encouraged to provide cultural adaptation courses to International Medical Graduates (IMGs) who have moved from different regions to pursue advanced studies. As Kirmayer et al. (2018) note, these individuals often make a significant contribution to the psychiatric workforce but can face acculturation stressors and other distinctive pressures.

Separately, trainees must be encouraged to engage in ongoing research and attend conferences, which can allow them to gain exposure to scientific developments outside of their immediate department and discipline (Harbishettar and Murthy, 2019). There should also be sufficient scope to engage with complex patient-centred materials and experiences, recognising that individual needs and clinical situations can vary. The latter must involve aspects of crisis management and risk mitigation, to support these competencies (The Royal College of Physicians and Surgeons of Canada, 2020a). For example, Salles et al. (2021) revealed promising findings from their blended learning program in emergency psychiatry. Similarly, Beach et al. have discussed the importance of education around other complex aspects of patient encounters, like simulation and deception, using didactic teaching, process rounds, and clinical experience (Beach et al., 2017). Furthermore, teaching trainees family engagement skills is vital for upholding holistic patient care (Tuhan, 2003) and is commonly embedded in residency programmes (Berman and Heru, 2005), but should be widely emphasised.

Alongside building their knowledge of the diagnosis and treatment of mental disorders and gaining clinical experience, prevention strategies must be integrated into future postgraduate psychiatric curricula. Prevention and promotion initiatives are becoming increasingly pertinent to mental health policy given the prevalence of psychiatric disorders and global expertise shortages. Accordingly, postgraduate training should encompass teaching on the social determinants of mental health, enabling future professionals to design effective interventions that address underlying issues in conjunction with relevant social institutions (Maryon-Davis, 2011).

Hansen et al. (2018) highlighted an innovative approach to teaching social determinants and institutional racism, centred around structural competency. Analogously, a survey conducted amongst n = 53 psychiatry fellowship directors revealed that 98% of them considered education on social determinants to be "essential" (Kronsberg et al., 2022). That said, these scholars noted how institutional and interprofessional cooperation is needed to improve learning content around social determinants (Kronsberg et al., 2022). Elsewhere, there have been proposals to teach postgraduates about other intersections between preventive psychiatry, epidemiology, and public health, like firearms and climate change (Aggarwal et al., 2023). Related to this, to prepare them for the demands of future practice, trainees should be educated about the potential impact of natural and human-made disasters, which are becoming increasingly pressing concerns in service delivery (Seritan et al., 2022).

5.2. Communicator

5.2.1. Undergraduate level

Undergraduates should start building strong interpersonal and active listening skills as early as possible. This can comprise of basic theories of empathetic dialogue and how to communicate sensitively with patients, especially when delivering difficult news. Nonetheless, this raises interesting questions as to whether empathetic communication can be taught. Here, specific interventions have been designed to improve students' ability to listen and communicate challenging aspects of care (e.g., (Nemec et al., 2017; de Moura Villela et al., 2020). Novais et al. (2022) reviewed prominent teaching methodologies for communication in psychiatric curricula. Students learn from observation and thus role models can be extremely helpful.

Moreover, evidence from other disciplines where compassion is a central foundation of care, such as emergency medicine, have indicated that evidence-based approaches may support teaching and learning (Riess, 2022). In their training recommendations for psychotherapy, UEMS (Union Européenne Des Médecins Spécialistes, Section for Psychiatry, 2019) affirm that theoretical teaching and video feedback "can improve measured levels of empathy". Comparably, in psychiatric contexts, Ngo et al. (2022) noted how singly didactic pedagogy, or those in combination with rehearsal and observational methodologies are effective techniques for this. Using digital mental health approaches, Louie et al. (2018) hypothesised about the benefits of virtual reality and avatars in teaching empathy. Equally, Perry et al. (2013) found that directly including service users in interpersonal training programmes can be educationally valuable for this purpose amongst mental health students.

5.2.2. Postgraduate level

Postgraduate training should build on foundational communication skills, accentuating the importance of the therapeutic relationship (The Royal College of Physicians and Surgeons of Canada, 2020b; Frank and Frank, 1993). To that end, different pedagogical methods have been suggested to enhance relevant attributes. For example, simulation techniques with actors could be adopted, although, anecdotally, some students and trainees may feel unable to generate empathy knowing that the person in front of them is only acting. AI also may be a useful mechanism for simulated dialogues. In the past, recordings of patient interviews have illustrated positive and negative ways of communicating through dedicated feedback at an individual or a group level, although these can be time-consuming. Other techniques, such as cinema or cultural productions, can engage students more effectively. Furthermore, training in how to present, how to teach, and how to communicate with the media can help enhance these skills.

In conjunction with this, residents should learn other aspects of patient-centred exchanges, including shared decision-making, communicating benefits and risks of treatment modalities, and best practices for obtaining informed consent (Anandaiah and Rock, 2019). As a resident discussing CanMEDS in psychiatric education, Tuhan (2003) underlined the benefits of interacting with patients' families at discharge meetings. Yet, the ability to provide psychoeducation for patients and their care-partners is often neglected in psychiatric curricula (Motlova et al., 2017) and warrants extensive focus. Moreover, in a qualitative study, Iezzoni et al. (2006) underlined major barriers to learning about communication with patients who have severe mental health conditions. Ultimately, more research is needed on the best approaches in this area to optimise patient care (Papageorgiou et al., 2017).

Separately, as highlighted by the characteristics within the medical expert role, cultural competency is a major component of modern psychiatric practice. By corollary, trainees should learn how to communicate appropriately, particularly when bridging linguistic, socio and ethnocultural, or intergenerational divides (Venkataramu et al., 2021; Bernstein and Bhugra, 2011). Others have indicated the importance of residents to learn how to communicate with religious or spiritual patients (Blass, 2007) or when there are gender-based differences (Davar, 2005). Relevant guidelines must inform training processes around cultural competency in communication. For example, work by Kirmayer and colleagues (Kirmayer et al., 2021) defines clear requirements for cultural competency training, which include interpersonal dynamics, techniques in cultural psychiatry, models of cross-cultural psychology, cultural brokers, cultural formulation tools, and interview techniques, amongst others.

Again, theoretical teaching can advance these objectives, as can simulated patient dialogues, mentorship, and supervised clinical exchanges (Kirmayer et al., 2021). Cultural competence should be taught and assessed regularly to ensure continuous improvement (Venkataramu et al., 2021). This can involve self-assessment by students, who should be encouraged to reflect on the values and beliefs that may affect open and constructive communication with their patients (Hagiwara et al., 2020). Similarly, educators may convey biases towards particular

demographics, as noted by Davar (2005) in the context of gender-based preconceptions, and efforts should be taken to mitigate against these.

In addition to these patient-centred competencies, postgraduate psychiatrists should be taught how to communicate with other healthcare professionals to minimise the adverse implications of care fragmentation (Hall and Weaver, 2001). This would give trainees an insight into the demands and realities of modern mental health care environments. Various teaching techniques have been found to be beneficial. For example, Reeves and Freeth (2006) used group-based discussion and shared reflection to promote this competency. Salberg et al. (2022) illustrated the potential of "round school" models, which can provide real-life experience of interdisciplinary communication in medical education.

5.3. Collaborator

5.3.1. Undergraduate level

As we have highlighted, interprofessional teamwork is an essential aspect of healthcare and academics have called for training to begin as early as possible at undergraduate level (van Gessel et al., 2018). Accordingly, undergraduate education should introduce students to the roles and responsibilities of allied professions, including psychologists, social workers, occupational therapists, and mental health nurses. This can reinforce knowledge around the multifaceted intersections within the biopsychosocial model and illustrate shared treatment models, thereby continuing the shift away from mind-body separations that have hindered psychiatric care (Ventriglio and Bhugra, 2015). In addition to group-based assessments, a hands-on interprofessional approach with patient involvement can allow students to navigate the intricacies of teamwork whilst providing in-depth insights into team-level dynamics (World Health Organization, 2010; Kinnair et al., 2014). Joint learning for short periods can help inculcate a feeling of professional awareness of what each discipline does.

5.3.2. Postgraduate level

At the postgraduate level, trainees should further develop their proficiencies in collaborative care and overcoming silo-based dilemmas (The Royal College of Physicians and Surgeons of Canada, 2020b). This should entail interdisciplinary meetings and comprehensive treatment plans under appropriate supervision, working with professionals from all backgrounds (Tuhan, 2003). As another valuable way of promoting interprofessional collaboration, this would enable students to gain a deeper understanding of the roles and expertise of different medical specialities involved in mental health care, such as neurologists and neuroradiologists. Kitts et al. (2011) provide a useful blueprint of how this can be practically implemented, with trainees creating a dedicated practice community. Balint groups and Schwatrz rounds can help gather peer support in a safe setting.

Moreover, in psychiatry, innovative schemes, like WhatsApp groups involving trainees, doctoral fellows, post-doctoral fellows, clinicians, and academics, have enriched collaborative peer-to-peer learning (Ransing et al., 2021). Educators should also instil knowledge on how to manage conflicts, delegate tasks appropriately, and provide feedback to improve team functioning. Nevertheless, whilst didactic, case-based, and clinical teaching studies have been conducted, evidence around pedagogical methods for integrated treatment in psychiatry remains inconsistent (Sunderji et al., 2018), although there have been some promising projects for multidisciplinary work (e.g., Sharma et al. (2015)).

Given contemporary paradigms in fragmented care in many countries and its possible detrimental impact on patient outcomes, detailed research is needed to examine this issue and ensure that students are able to gain appropriate knowledge of collaborative working through optimised pedagogy. Notably, enhanced communication skills can help interprofessional working. As the clinical lead, psychiatrists must be able to recognise expertise of different professions and acknowledge their experience and expertise so that team members can work in a complementary manner. Thus, a period of joint learning can help clinicians understand each other's roles and responsibilities, which educators can facilitate.

5.4. Leader

5.4.1. Undergraduate level

Modern training programmes should be designed to equip students and trainees for ongoing challenges affecting the psychiatric discipline (Martin et al., 2003). Consequently, undergraduate curricula in psychiatry should establish the importance of leadership qualities in health delivery contexts. This can be achieved through formal learning objectives structured around topics like organisational frameworks, resource allocation, and health policy. Educators should aim to engender conscientious leadership in their students, enhancing time management and organisation skills. Although, again, there is limited consensus on optimal methods, in general medical education programmes interventions geared towards the notion of leadership in undergraduates have utilised workshops, student organisations, and dedicated courses (James et al., 2021). Others have adopted cross-disciplinary approaches drawing on insights from business pedagogy (Cadieux et al., 2017). Modern psychiatric curricula should incorporate these learnings from different disciplines.

5.4.2. Postgraduate level

Teaching leadership skills is an important aspect of education and curriculum. Although there may be overlap, this diverges from management training. Furthermore, teaching leadership skills should start early and the curriculum must focus on various aspects of healthcare systems and speciality training. In promoting leadership competencies, postgraduate medical training must prepare students for more senior roles, dependent on their practice setting (Mokshagundam et al., 2019). This can involve developing relevant proficiencies and behaviours, like decision-making, flexibility, delegation, and interprofessional working (Brown and Brittlebank, 2013; Mokshagundam et al., 2019). As an example, Bell et al. (2010) have developed an outline for portable training in child and adolescent psychiatry, enabling trainees to explore issues like health care financing, academic medicine, administration and management. To reflect changes in clinical culture, it may become increasingly necessary to teach trainees about their personal leadership styles that are better aligned with contemporary demands, like flatter hierarchies. Whilst longitudinal studies may be needed to establish effective mechanisms for this (Brewer et al., 2016), learning about alternative management structures can allow future healthcare leaders to pioneer change.

Moreover, quality improvement initiatives should be embedded within relevant curricula, accentuating the centrality of patient needs. For instance, in a project aimed at psychiatric residents, Arbuckle et al. (2013) demonstrated how experience in group learning and didactic sessions can support learning. Similarly, researchers have underlined the efficacy of sessions for psychiatric trainees dedicated to gender dynamics, emphasising women in leadership positions, and conflict resolution and peer support in daily practice (Steiner et al., 2004). These should be extended to include other diversity and inclusion initiatives, mirroring ongoing developments in modern society. Analogously, targeted mentorship can be a valuable mechanism for cultivating the attributes of leadership, along with practical opportunities in clinical service management or research projects, which can help trainees gain a detailed understanding of the challenges of leading healthcare teams and overseeing patient care (Thakur et al., 2019).

In the context of leadership, Frenk and colleagues (Frenk et al., 2010) have called for more substantive changes to medical education curricula. These scholars underline the potential of transformative learning theories with the aim of creating "enlightened change" (Frenk et al., 2010). Transformative learning has been implemented in

psychiatric curricula with positive outcomes, notably in the context of patient advocacy. For example, a project on substance use disorders adopted transformative learning principles and innovative learning content, including person-centred workshops, interviewing, and an opioid overdose simulation (Muzyk et al., 2023). Subsequently, students outlined their personal reflections on substance use disorders; relevant themes emerged like racism, structural bias, sensitive language use, and social determinants of mental health (Muzyk et al., 2023). Consequently, transformative learning concepts may be beneficial for advancing psychiatric leadership in trainees by better attuning them to contemporary challenges that can affect patient care. However, prominent barriers, such as resistance to change, can affect transformative learning (Eschenbacher, 2020) and detailed work is necessary to encourage sufficient resource allocation for similar programmes in psychiatry.

5.5. Health advocate

5.5.1. Undergraduate level

Health advocacy should be integrated into undergraduate training, enabling students to understand and distinguish vulnerable populations, the geo-political and social determinants of health, and stigma, and to strengthen their attributes in multidisciplinary work. Stigma faced by psychiatric patients, but also by psychiatrists, can influence engagement by trainees so educators need to be aware of its implications. Formalised training has been suggested as a useful teaching mechanism for advocacy (Croft et al., 2012). Equally, educators have described how small-scale projects and manageable skill development can generate what they call “advocacy praxis”, amalgamating theory and first-hand experience (Premkumar et al., 2013). In addition, the advantages of cascading mentorship have been observed, offering students opportunities to understand social determinants and advocacy skills (Patel et al., 2021).

Again, students should be encouraged at an early stage to critically reflect on personal beliefs and biases, which can affect their ability to successfully advocate for improved patient care (Gonzalez et al., 2020). For this purpose, transformative learning techniques have proven useful, pairing students with vulnerable individuals to enable them to gain in-depth perspectives on patient experiences and understand their role as advocates of change (Hess et al., 2014).

5.5.2. Postgraduate level

Postgraduate psychiatric training should contextualise advocacy and social medicine in individual and systemic frameworks (The Royal College of Physicians and Surgeons of Canada, 2020b). Learning how to advocate using evidence can be helpful. Working with patient and family organisations can bring dividends in influencing policy. Wherever possible psychiatrists should be taught to work with community leaders and community organisations to create opportunities for change as co-partners. Approaching policymakers with patients can yield benefits and improve legislation and social equity, in turn advancing accessibility and appropriateness of services.

Notably, a follow-up study of paediatricians showed how specific training at residency level improved community involvement and advocacy in professional practice (Minkovitz et al., 2014). In psychiatry, an American Psychiatric Association (2018) report identified various programmes that used a mix of theoretical and experiential teaching. Relevant courses included lectures on social determinants and hands-on experiences, including advocacy days or opportunities to meet with legislators (American Psychiatric Association, 2018).

Other institutions have developed didactic curricula that highlight racial disparities in mental health, eliciting positive feedback (Medlock et al., 2017). Similar to at undergraduate level, mentorship is another beneficial component of postgraduate programmes to strengthen health advocacy. Pairing trainees with experienced clinicians who exemplify strong advocacy skills can confer benefits (American Psychiatric Association, 2018; Rafla-Yuan, 2022). Further, to reinforce teaching from the undergraduate level, educators should continue to encourage the importance of self-reflection and self-awareness, especially in relation to biases and beliefs. In this regard, ongoing self-assessment can help trainees become more effective and empathetic health advocates (Motzkus et al., 2019).

5.6. Scholar

5.6.1. Undergraduate level

Undergraduate training should accentuate the significance of evidence-based practice to support future psychiatric scholars. This can involve learning about analytical thinking skills, how to critically appraise medical literature, and how research findings can be embedded within clinical scenarios, with a specific focus on psychiatric contexts. Currently, promising results have been shared around team-based learning and group discussions involving medical students for critical appraisal teaching at this level (Daou et al., 2022). Likewise, bespoke evidence-based medicine courses have been implemented in different curricula (e.g. Al Shahrani, 2020), although follow-up studies are needed to assess their longitudinal efficacy.

Students should be introduced to foundational materials on research methodologies and ethical considerations (Peachey and Baller, 2015). Together with didactic and problem-based techniques, these can be enriched through non-traditional pedagogy. For instance, Ball and Pelco (2006) showed useful findings from a scheme that enabled psychology undergraduates to work together on student-led research projects.

5.6.2. Postgraduate level

It is important to recognise that not all clinicians will be researchers or even interested in carrying out research, but they must have the skills to interpret data and findings in research reports, which help them in clinical audits and quality improvement initiatives. Thus, psychiatric trainees should be encouraged to contribute to scholarly activities and learn more sophisticated research skills. To that end, there must be protected time for teaching and learning in clinical settings for trainees. In many places, one day a week is dedicated to teaching and an annual allocation of study leave is provided.

Hay et al. (2003) deemed practical research abilities to be a major attribute within postgraduate psychiatric education, expanding knowledge about evidence-based practice and preparing trainees for future scholarly engagement. This should entail cooperation on quality improvement and interprofessional and intergenerational collaboration on research studies. This is supported by a study from Koelkebeck et al. (2021), which showed that trainees consider these opportunities to be worthwhile. These authors identified prominent barriers such as lack of time and financial resources – sentiments that have been echoed by medical trainees elsewhere (e.g., Foley, 2015). Where appropriate, programme leaders must consider realistic goal setting for scholarly activities. Previously, there have also been calls for the alteration of accreditation requirements to offer more time for training on research literacy (Abrams et al., 2003).

Postgraduate students need to be encouraged to hone their skills in evidence-based practice, exploring epistemological interests and so-called “clinical curiosity” (Yager and Kay, 2020). As underlined by accounts from a psychiatric resident (Tuhan, 2003), journal clubs and grand rounds can be effective educational activities for supporting scholarly competencies in medical education, though these may not be universally adopted across all settings, which needs to change. Importantly, these interactions can allow trainees to stay abreast of the latest scientific advances and evidence-based principles, like risk of bias in a source or its methodological limitations (McGlacken-Byrne et al., 2020; The Royal College of Physicians and Surgeons of Canada, 2020b).

In modern contexts, research groups on WhatsApp have provided a useful platform for these exchanges, which, alongside peer-to-peer learning, can enhance scholarly activities (Ransing et al., 2021).

Furthermore, postgraduate curricula should incorporate opportunities for trainees to demonstrate communication skills. For this purpose, senior residents should be encouraged to participate in teaching, such as leading workshops, presenting posters at conferences, or mentoring junior colleagues. Again, time pressures can inhibit opportunities, but such experiences can allow advanced residents to learn how best to disseminate their knowledge and demonstrate ongoing learning (Hughes et al., 2022). More generally, psychiatric education is a lifelong pursuit and continuing medical education (called continuing professional development in some settings) must be encouraged. In many countries, regulators insist on keeping knowledge up-to-date and this is a mandatory part of revalidation for continuing registration as a doctor and specialist. Attending meetings, lectures, and personal study can help achieve this.

5.7. Professional

5.7.1. Undergraduate level

Undergraduate psychiatric training should provide a strong foundation in professional values. Again, this must be included as early as possible in psychiatric curricula (Bhugra, 2008). Therefore, students need to be taught about ethical principles that guide psychiatric practice (Scher and Kozlowska, 2020), including informed consent, confidentiality, patient autonomy, and boundary setting. Students should learn about basic legal and regulatory frameworks surrounding patient care and therapeutic practice. These can often be difficult to understand and innovative didactic pedagogies, again informed by the medical humanities, have been proposed (Smith, Dube and Liebrenz, 2022). Moreover, students should be introduced to the importance of self-care and careful, healthy habits to improve resilience and longevity in their medical careers. This could include resources and workshops on stress and burnout, given the high prevalence of these issues in medical undergraduate students (e.g. Nebhinani et al. (2021)).

5.7.2. Postgraduate level

During postgraduate programmes, psychiatric trainees should continue to expand professional attributes through ongoing reflection and self-awareness, similar to other competency domains. Being a professional is to understand and uphold ethical and moral aspects of psychiatry. This can be learnt by experience, apprenticeship and through mentoring. Teaching institutions have a duty to inculcate these values by using pedagogy with philosophical and sociological imperatives.

The teaching of emotional skills may require an environment that values and exemplifies these skills (Louie et al., 2006). Careful reflection around one's own emotional reactions and responses can be carried out through supervision, peer support groups or Balint groups (e.g., (McKensey and Sullivan, 2016)). Mentorship with clinicians can help students to learn from experience and navigate the complexities of clinical practice (e.g., (Cohen and Kassam, 2016)). Accordingly, postgraduate training must include experiential learning opportunities. Tuhan (2003) has highlighted the importance of these aspects in trainee schemes. However, Roberts (2009) notes that trainees wish for more training, support and education in professional and ethical values. Thus, psychiatric curricula should include developing first-hand knowledge of challenging ethical situations, such as legal matters (Morris, 2018) or involuntary treatment (Lewis, 2004). Similarly, Chandra and colleagues (Chandra et al., 2017) discussed a beneficial team-based roleplay project to teach postgraduates about professional dilemmas, such as confidentiality or gifts from patients.

Postgraduate programmes must emphasise professional identity and a renewed awareness around medicine's social contract. Additionally, educators should continue to highlight the importance of self-care, reinforcing learnings from undergraduate curricula. Notably, there can be tensions in maintaining a balance between being a professional and empathetic engagement, which may increase the likelihood of burnout. Trainees should be encouraged to request support when needed and engage in activities that promote wellbeing (Shapiro et al., 2007). This is essential for ensuring professionalism and optimal patient care, especially since modern psychiatrists can encounter difficulties maintaining a work-life balance and other health-related problems (Umene-Nakano et al., 2013). Concomitantly, residents with more experience and fully qualified psychiatrists have a duty of care to protect junior trainees and should proactively monitor their wellbeing through regular check-ins, providing support and advising them to seek help when necessary. Here, proactive interventions have had positive effects, with a postvention protocol helping residents who experienced patient suicide (Agrawal et al., 2021).

6. Assessments in modern psychiatric education

As we have discussed, psychiatric curricula as well as duration of training both at undergraduate and postgraduate levels and of clinical placements vary markedly internationally. This raises major concerns about the quality of education to support psychiatric competencies and the emphasis that is placed on mental health and wellbeing. Throughout the CanMEDs above, we have highlighted specific evidence-based needs and pedagogy for each domain, but more consideration of assessment methods is warranted to better meet modern patient needs. The key purpose of assessment should be about ascertaining the depth and nature of skills learnt, rather than focusing on examinations. This can be carried out in a number of ways and settings from short clinical assessments, workplace-based tasks, and long cases, in addition to theoretical tests.

Bloom (1956) noted that student learning can be grouped around three domains: cognitive (intellectual abilities and the learning of current knowledge); psychomotor (speed performance and precision of procedures and techniques) and the affective domains, which according to Gronlund (1976), include learning about attitudes, feelings, emotions, interest, and modes of adjustment. In psychiatric education, cognitive and affective elements may be likely to be more important. Six hierarchical levels have been introduced within the cognitive domain (Bloom, 1956), with key components including recall levels, comprehension, application, analysis, synthesis, and evaluation. Accordingly, the pedagogical emphasis on specific domains will inform the learning content. For example, if the teaching focuses on recall, students are more likely to learn by rote. Similarly, synthesis or application will use different cognitive methods. These are also likely to be influenced by the methods of assessment, i.e., learning facts and analysis will be useful in essay writing, whereas problem-based education will use different strategies. In reality, factual knowledge and practical skills must be integrated in a way that can enable students to analyse patient's needs and expectations within the therapeutic encounter. Students are said to use surface, deep, and strategic approaches for learning (Marton and Saljo, 1976), either individually or in combination according to various factors, in turn influencing assessment methods. A clear danger is that assessment will prioritise different aspects that are narrow, rather than broader knowledge and application.

At both undergraduate and postgraduate levels then, assessment methods can shape learning (Schuwirth and van der Vleuten, 2004). Yet, cross-culturally and internationally, education systems often prioritise qualifications and passing assessments, despite the fact that beyond postgraduate level, learning may form part of continuing professional development or continuing medical education. Moreover, in psychiatry, where clinical knowledge needs to be integrated with experience, feedback can assume multiple meanings – appraising clinical, practical, and theoretical knowledge – and hence may require multiple sources.

In many parts of the world, assessments are increasingly being conducted in workplace, which again has both disadvantages and advantages. The key advantage is that this allows proper contextual assessment, especially of clinical skills and collation of information, whereas examination settings outside clinical environments can be artificial and perhaps more stressful. Training may be delivered in

individual units or hospitals or other clinical settings in the community and the standards may be agreed and set centrally or by individual universities that are responsible for providing certificates of training. These have become of great importance as IMGs move around with or without postgraduate experiences and can shape their career prospects.

Whether they occur in workplace or in simulation centres, regular assessment and monitoring is critical. The clinical context of learning and practice matters. Knowledge and attributes are crucial to keep up with fresh developments along with maintaining basic clinical skills in history-taking, physical and mental state examinations, investigations, and relevant therapeutic interventions.

7. Recommendations

7.1. Institutional

Universities and medical schools need to review their curricula as a matter of urgency and introduce psychiatry at a very early stage of teaching at an undergraduate level.

They must also ensure that all subjects include the mental health implications of various illnesses and must consider how these are taught through effective pedagogy.

The curricula must focus on wider aetiological models such as the biopsychosocial model, emphasising explanatory models and differences between patient experiences and expectations and that of clinicians.

There must be appropriate teaching about investigations and interventions for co-morbid psychiatric and physical conditions.

Preventive and social medicine have a prominent place in Asia, so medical schools must focus on public mental health.

Apprenticeship and mentorship models need to be encouraged.

Assessment of communication skills and empathy are a must.

Medical students must be taught various components of leadership skills.

There must be regular assessments of practical skills related to mental illnesses and mental health implications of physical illnesses.

Every medical specialty or discipline must involve psychiatrists and other mental health professionals in teaching.

Cartesian mind-body dualism must be challenged.

Selection of students and trainees should be based on personal skills rather than simply on academic record.

7.2. Individual

Students and trainees must be encouraged to look after their own mental health and wellbeing.

Trainees must be taught communication skills and encouraged to practise and refine these. Video recordings and other methods can be used for this.

Trainees must be taught how to manage stigma and discrimination and focus on advocacy.

Trainees must be helped to develop emotional intelligence using a number of teaching methods and strategies.

Trainees must be exposed to philosophical, ethical, sociology and anthropological aspects of illnesses.

Trainees must be taught about emerging technologies and use of AI, e-mental health and tele-mental health.

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