REPORT OF THE WHO/WPA MEETING ON
PSYCHIATRIC EDUCATION
FOR THE 21ST CENTURY

Fukuoka, Japan
13 - 17 March 1989

Manila, Philippines
May 1989
REPORT

WHO/WPA JOINT MEETING ON PSYCHIATRIC EDUCATION FOR THE 21ST CENTURY

Convened by the

REGIONAL OFFICE FOR THE WESTERN PACIFIC OF THE

WORLD HEALTH ORGANIZATION

Fukuoka, Japan
13-17 March 1989

23 June 1989

Not for sale

Printed and distributed by the

Regional Office for the Western Pacific of the World Health Organization
Manila, Philippines
May 1989
NOTE

The views expressed in this report are those of the members of the WHO/WPA Joint Meeting on Psychiatric Education for the 21st Century and do not necessarily reflect the policies of the Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for the governments of Member States in the Region and for those who participated in the WHO/WPA Joint Meeting on Psychiatric Education for the 21st Century, held in Fukuoka, Japan from 13 to 17 March 1989.
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>2. TRENDS IN MEDICAL AND PSYCHIATRIC EDUCATION</td>
<td>1</td>
</tr>
<tr>
<td>3. WHO PROGRAMMES ON PSYCHIATRIC EDUCATION</td>
<td>3</td>
</tr>
<tr>
<td>4. SUMMARY OF COUNTRY REVIEW</td>
<td>4</td>
</tr>
<tr>
<td>4.1 Australia and New Zealand</td>
<td>4</td>
</tr>
<tr>
<td>4.2 Hong Kong</td>
<td>4</td>
</tr>
<tr>
<td>4.3 Japan</td>
<td>5</td>
</tr>
<tr>
<td>4.4 Malaysia</td>
<td>5</td>
</tr>
<tr>
<td>4.5 Philippines</td>
<td>6</td>
</tr>
<tr>
<td>4.6 People's Republic of China</td>
<td>6</td>
</tr>
<tr>
<td>4.7 Republic of Korea</td>
<td>6</td>
</tr>
<tr>
<td>4.8 Singapore</td>
<td>7</td>
</tr>
<tr>
<td>4.9 Viet Nam</td>
<td>7</td>
</tr>
<tr>
<td>5. SUMMARY OF DISCUSSIONS</td>
<td>8</td>
</tr>
<tr>
<td>5.1 Undergraduate education</td>
<td>8</td>
</tr>
<tr>
<td>5.2 Postgraduate education</td>
<td>9</td>
</tr>
<tr>
<td>5.3 Psychiatric education for medical practitioners</td>
<td>10</td>
</tr>
<tr>
<td>5.4 Humanization of medical education</td>
<td>11</td>
</tr>
<tr>
<td>6. CONCLUSIONS AND RECOMMENDATIONS</td>
<td>13</td>
</tr>
<tr>
<td>6.1 Conclusions</td>
<td>13</td>
</tr>
<tr>
<td>6.2 Recommendations</td>
<td>14</td>
</tr>
<tr>
<td>6.3 Recommendations to WHO</td>
<td>15</td>
</tr>
<tr>
<td>7. DECLARATION OF FUKUOKA</td>
<td>15</td>
</tr>
</tbody>
</table>

### ANNEXES:

<table>
<thead>
<tr>
<th>Annex</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>AGENDA</td>
<td>17</td>
</tr>
<tr>
<td>2</td>
<td>LIST OF MEMBERS, CONSULTANTS, REPRESENTATIVES, OBSERVERS AND SECRETARIAT</td>
<td>19</td>
</tr>
<tr>
<td>3</td>
<td>OPENING ADDRESS BY THE REGIONAL DIRECTOR, WHO REGIONAL OFFICE FOR THE WESTERN PACIFIC</td>
<td>25</td>
</tr>
<tr>
<td>4</td>
<td>KEYNOTE ADDRESS BY DR HIROSHI NAKAJIMA, DIRECTOR-GENERAL, WORLD HEALTH ORGANIZATION</td>
<td>27</td>
</tr>
</tbody>
</table>
1. INTRODUCTION

The WHO/WPA Joint Meeting on Psychiatric Education for the 21st Century was held in Fukuoka Garden Palace Hotel, Fukuoka, Japan, from 13 to 17 March 1989.

The objectives of the meeting were as follows:

1. to assess the changing mental health needs at present and in the future;
2. to review undergraduate and postgraduate psychiatric education in the Region;
3. to formulate recommendations on the content and processes of psychiatric education at undergraduate, postgraduate and continuing education levels to address broader mental health problems. The agenda of the meeting is attached as Annex 1.

Sixteen participants, three short-term consultants, 2 World Psychiatric Association representatives and 6 observers attended.

The list of participants is attached as Annex 2.

Dr S.T. Han, Regional Director, was unable to attend due to his previous commitments and Dr N. Shinfuku, Regional Adviser in Mental Health and Drug Dependence opened the meeting on behalf of the Regional Director. The Opening Speech of the Regional Director is attached as Annex 3.

Dr Hiroshi Nakajima, Director-General, attended at the opening and gave a keynote speech. His keynote speech is attached as Annex 4.

The following members were elected as officers of the meeting:

Chairman - Dr G. A. German, Australia
Vice-Chairman - Dr F. Lieh-Mak, Hong Kong
Rapporteurs - Dr E.S. Tan, Australia

The meeting was held in plenary sessions except on the 16th of March when small groups were formed.

The meeting was carried out in a very satisfactory manner. The local facilities were excellently arranged by the national organizing committee.

2. TRENDS IN MEDICAL AND PSYCHIATRIC EDUCATION

2.1 A survey of the historical, contemporary and future trends in medical and psychiatric education emphasized that education and training should be geared to the needs of the future. The issues of attitudes and
values in the training of professionals and the necessity of integrating these with the teaching of professional skills and scientific knowledge are of the greatest importance. The high incidence of mental illness in medical practice and the critical effect of behavioural change on the management of diseases in the future makes the expansion of training in these areas mandatory.

There is a great need to integrate the knowledge gained from the basic sciences with clinical psychiatry using the bio-psycho-social model. Both experience and biology contribute to mental illness. Treatment must combine both.

Several future trends were recognized which psychiatric practice and training will have to keep pace with. These include: psychiatric aspects of AIDS, the implication of new technology such as brain imaging, the psychosocial rehabilitation of psychiatric patients, the integration of psychotherapies and problems of alcoholism and substance abuse.

2.2 The limited resources available will have to be deployed wisely for the community to benefit from them. Psychiatric services will have to be provided on the basis of community needs. Psychiatric professionals will have to promote the humane approach to patient care.

2.3 The results of a questionnaire in regard to psychiatric education in countries of the Western Pacific Region reveal some interesting trends. The curriculum in most medical schools are divided into two or three phases: premedical, preclinical and clinical. The behavioural sciences are taught mostly in the preclinical phase. The duration of clerkship is variable. Different schools emphasize areas of psychiatry more than others. In some medical schools psychiatry is given a very low proportion of curriculum time.

2.4 It is proposed that the reform of the medical curriculum will have to be done on the basis of the bio-psycho-social model in the context of the various politico-economic-ecological situations. Reforms will have to bring qualitative as well as quantitative improvement. The old discipline-oriented curricula need to be replaced by ones which are oriented toward integration, problem-solving and community health needs.

This leads to the need for major reforms in the undergraduate and postgraduate curricula.

2.5 Some of the changes required in the undergraduate curricula are: the inclusion of the behavioural sciences and community mental health where this is lacking, the development of interviewing skills, an emphasis on the importance of clerkship and the introduction of a national examination and licensing.

2.6 Reform of postgraduate curricula should include a national system for postgraduate psychiatric training in which the curricula should be based on the bio-psycho-social model using a problem-solving approach. It should emphasize the psycho-social factors in mental health, child and adolescent psychiatry, psychogeriatrics, consultation-liaison psychiatry and alcoholism and drug abuse. It should include the prevention of mental disease and the rehabilitation of psychiatric patients. There should be an integration of the application of the scientific process with a humane
approach to the patient, and the promotion of clinical research. Training should be as much as possible in the community with supervision. There should be formal procedures of certification and re-certification.

3. WHO PROGRAMMES ON PSYCHIATRIC EDUCATION

Activities undertaken in the WHO interregional programme regarding psychiatric education are as follows:

3.1. Production of video teaching material in French and English on depression in general medical settings. These should not be used as they are outside the countries in which they have been produced, but suitably adapted and revised tapes could be produced in other cultures and countries, using the format and content of the existing tapes.

3.2. A meeting was held in 1986 on international collaboration in postgraduate psychiatric education, on the basis of which a WHO document produced, entitled Postgraduate training in psychiatry: options for international collaboration (WHO/MNH/MEP/88.7).

3.3. Modules for the teaching of psychiatry to undergraduates in general medical and primary health care settings are being prepared. These will include:

(a) Interview technique and doctor-patient communication skills, using video-feedback or getting students (in pairs) to rate each other's performance with patients using a checklist to observe desirable and undesirable aspects of the students' technique.

(b) Getting students to examine patients in general medical settings and then asking the students to:

(i) examine the patient's mental state;
(ii) take a social history;
(iii) see how the social history affects the mental state;
(iv) see how the mental state and social condition affect and are affected by the patient's physical illness or complaints.

3.4. WHO is preparing an annotated bibliography of journal articles and other written work on psychiatric education. It is also preparing information on a variety of teaching techniques and strategies, including problem-based learning, community-oriented learning, and the use of simulated patients.

3.5. WHO is currently preparing a document resulting from meetings on consumer involvement in mental health care. One recommendation resulting from this is that consumers - both patients and their families, should be
involved in the provision of education so that students can learn about the consumers' perspective of health care and develop a greater respect for consumer viewpoints.

4. SUMMARY OF COUNTRY REVIEW

4.1 Australia and New Zealand

4.1.1 The undergraduate curriculum in the ten medical schools in Australia and two in New Zealand is six years in duration, divided into a preclinical and a clinical phase. The curriculum structure varies from the traditional to the innovative.

4.1.2 In the last few decades there has been a significant increase in the time devoted to the teaching of behavioural sciences and psychiatry. The teaching tends to blur the distinction between the clinical and preclinical phases.

4.1.3 There is a move away from using didactic lectures to small group work and clinical teaching.

4.1.4 Postgraduate teaching is defined and controlled by the Royal Australian and New Zealand College of Psychiatrists (RANZCP). Certification is by examination leading to the election to the fellowship of the RANZCP. Re-certification is still an unsolved problem.

4.1.5 Psychiatrists are taking a bigger part in the provision of consultation services to various clinical facilities and in the training of other physicians, especially general practitioners, and of allied professionals.

4.2 Hong Kong

4.2.1 Undergraduate education consists of 2 years preclinical studies and 3 years of clinical studies. This is followed by a year of rotating internship approved by the 2 universities.

4.2.2. The Hong Kong University and the Chinese University of Hong Kong run a Behaviour Science Teaching programme in the first two years for a duration of 110 hours.

4.2.3 Psychiatry is taught in general hospital psychiatric units, outpatient mental hospitals and community facilities. The rotation is 10 weeks in duration. There is some integrated teaching with other departments.

4.2.4 Postgraduate training is a combined effort of the Government Mental Health Service with the universities. It is 5 years in duration. The trainee writes the certification examination of the Royal College of Psychiatrists of Britain or the Royal Australia and New Zealand College of Psychiatrists.
4.2.5 Continuing medical education is provided under the auspices of the Hong Kong Psychiatric Association.

4.2.6 Education of allied professionals in the mental health field is carried out by a variety of agencies and professionals such as the Hong Kong Polytechnic, universities, nursing schools, government departments and voluntary social welfare agencies and professional associations.

4.3 Japan

4.3.1 After 6 years of primary school and 3 years each of junior and senior high school, a student goes to six years of medical school, two years of premedical studies, two years of preclinical and two years of clinical studies.

4.3.2 There are 80 medical schools in Japan, many of which are private and nearly half of which have been set up in the last 20 years.

4.3.3 Although the first professor of psychiatry was appointed in 1986, there is no programme of postgraduate training in psychiatry which is accepted throughout the country. Each school has its own programme of graduate psychiatric training and education. There is no nationally accepted means of certification of completion of training in psychiatry up to now.

4.3.4 The training programmes in psychiatry in medical schools are usually three years in duration and have many areas in common. These include an initial introductory course, an orientation in the Department of Neuropsychiatry, ward and clinic work, EEG examination, neuropsychological testing, psychiatric interview, psychotherapy, clinical psychometrics, psychopharmacotherapy, mental health legislation, health insurance and social life therapy. These courses are aimed at teaching the candidate the skills of psychiatric diagnosis, investigation, treatment and research.

4.4 Malaysia

4.4.1 With the emphasis on primary health care, a curriculum of psychiatric training occurs in most institutions. It is usually integrated and implemented into the course where appropriate. Specific problems such as the importance of substance abuse are highlighted.

4.4.2 Postgraduate psychiatric training is four years in duration. The need for teachers to subspecialize and for the students to have critical reasoning taught is increasingly recognized.

4.4.3 With the integration of the teaching of clinical psychiatry and behavioural science in medical schools and the extension of postgraduate psychiatric training, the shortage of trained clinical teachers has become more apparent.

4.4.4 The mental health component in the curriculum of the training of allied professionals is also currently being reviewed.
4.4.5 There is a need to teach the behavioural sciences and the recognition of common psychiatric disorders to all medical practitioners.

4.5 Philippines

4.5.1 The Philippines consists of 7000 islands, it has a population of 58 million, and 26 medical schools, and is served by 7 mental hospitals with a bed capacity of 5000. Six medical centres offer residency training in psychiatry. There is both a shortage of manpower and maldistribution (150 psychiatrists mostly in the urban areas).

4.5.2 Psychiatry in most schools is done during the four medical years with an emphasis on psychosocial factors of illness, the doctor-patient relationship and the recognition of emotional disorders.

4.5.3 Residency training programmes range from 3 to 5 years and are eclectic in orientation. Emphasis is laid on consultation liaison, brief psychotherapy and psychopharmacology. Post-residency fellowships are available in child and social and community psychiatry.

4.6 People's Republic of China

4.6.1 Four mental health institutes have been set up in more than one hundred medical schools to train mental health workers. They are urgently needed to serve China with its population of one billion.

4.6.2 The training needs to be of at least 5 years' duration to meet the fundamental requirements of qualification.

4.6.3 There has been an increase in the hours devoted to behavioural sciences and psychiatry in all the medical schools. This reflects the shift from the pure biological to the biopsychosocial model of medical education.

4.6.4 Continuing education and the certification of psychiatrists are being considered.

4.7 Republic of Korea

4.7.1 In the Republic of Korea, the student enters medical school after six years of primary and three years each of junior and senior high school. An individual does two years of premedical studies and four years of medical school. Behavioural sciences are taught in the first year of medical school, psychiatry in the third year. Psychiatric teaching consists of both lectures and clerkship.

4.7.2 Specialist training in psychiatry starts after a year of internship and lasts for four years. Certification of professional competence is done by the Ministry of Health on the basis of written and oral examinations. The number of trainees in the country is controlled by the accreditation committee which has representatives from relevant organizations.

4.7.3 Every physician is required to have 15 credits of continuing education annually and there is a programme of community education on mental health matters.
4.7.4 Future activities in the field of psychiatric education include the consolidation of a core curriculum for psychiatric training, financial provisions for such training programmes, a review of the problem of using didactic instruction, the development of problem-solving educational programmes and the evaluation of students.

4.8 Singapore

4.8.1 Undergraduate psychiatric education is the responsibility of the Department of Psychological Medicine which was established in 1979 at the National University of Singapore.

4.8.2 Teaching of psychiatry is conducted from Year 2 to Year 5 of the 5-year medical course. The teaching consists of didactic lectures in behavioural sciences and psychiatry, interviewing techniques and 4 weeks rotation to psychiatric facilities, both hospital and community-based. An assessment is conducted at the end of the rotation.

4.8.3 Since 1982, the School of Postgraduate Medical Studies of the National University of Singapore has conducted a postgraduate course in psychiatry leading to the degree of Master of Medicine (Psychiatry), as an "entry" qualification.

4.8.4 Higher professional training in psychiatry is still to be formalized.

4.8.5 Continuing medical education is encouraged and stressed.

4.9 Viet Nam

4.9.1 In order to equip general practitioners for their key role in providing primary mental health care, there has been a reform of the education programme in psychiatry for undergraduates.

4.9.2 To emphasize the need for providing service to the community, lecturers and students spend a third of their practice time at dispensaries and in the community.

4.9.3 Postgraduate training in psychiatry is done in two stages. The training of Grade I psychiatrists takes two years full time or 3 to 4 years by self-study. These psychiatrists work essentially in the community. Grade II psychiatrists start their training after five years of work in the community and their training emphasizes advanced practice and this could occur at central or provincial locations.

4.9.4 There are also programmes for the psychiatric education of non-psychiatric doctors, allied professionals and the community.

5. SUMMARY OF DISCUSSIONS

5.1 Undergraduate Education

The conference accepted that a significant portion of the population
(estimated at 20%) suffered from mental health problems and psychiatric disorders. In addition various studies indicate that 30-40% of the patients seeking medical care have demonstrable psychiatric disorders. Doctors must be trained to recognize and manage this morbidity.

5.1.1 Objectives of education

It is essential that undergraduates should be equipped with well defined skills and knowledge, as well as an appropriate attitude, to deal with the mental health needs of individuals.

5.1.2 Content of education

Just as medical students are required to develop skills in medical history-taking and physical examination, it is equally important for them to learn psychiatric history-taking and mental status examination.

Basic psychiatric knowledge should include the following:

- principles of human growth and development, including communication style in different stages of life;
- the scientific basis of psychiatric practice;
- the common psychiatric disorders in the setting guidelines for future practice, their diagnosis, and the biopsychosocial aspects of management;
- legal aspects of psychiatry;
- ethical issues in psychiatry.

The conference affirmed that being psychologically minded and tolerating or accepting the whole spectrum of human behaviour were necessary attitudes which must be fostered and nurtured.

To achieve these objectives the conference recommended that 10% of the total medical curriculum time should be allocated to the teaching of psychiatry. Some of the teaching can be integrated and some done on-block.

5.1.2 Processes of education

The teaching should as much as possible be conducted in small groups. Individual and group supervision, self-directed learning and the use of audiovisual aids are also important. To ensure that students have a good grasp of a wide range of psychiatric disorders, it should be taught in both hospital and community settings. Some community input in these processes is also important in achieving the objectives of a community-oriented training.

5.1.4 Certification

Psychiatry must form a part of the professional examination either as a segment of a composite final examination or as a separate subject.
5.1.5 **Staff Support**

Since a good training programme can only be mounted with good staff, it is essential that their provision should take into account teaching, research, service and administrative requirements. There should also be a continuous staff development programme.

5.2 **Postgraduate education**

All countries have unique postgraduate training programmes of their own. The length of training is from 3 to 5 years. Most countries have an examination for the accreditation of professional postgraduate training. The areas of training vary according to countries, but share many common grounds except in the area of research training. Only two countries emphasize research as an important part of postgraduate training.

A few special features of postgraduate training were reported by some countries. There seem to be no accreditation examinations required in Japan and Hong Kong. Hong Kong and Malaysia seem to follow the British training system closely. Viet Nam has a multilevel professional training system in psychiatry. Some countries are suffering the effect or the after-effect of a "brain drain". The issue of re-certification and the acceptance of it by specialists is still controversial in some countries.

5.2.1 **Objectives of training**

An attempt should be made to forecast the future of psychiatry, and to form an idea of what medical and psychiatric practice are going to be like in the twenty-first century. What career patterns will be available? How can we prepare ourselves for the future?

5.2.1.1 In the future, there is likely to be an explosion of mental disorders; not only will the incidence of mental disorder increase but also the size of high-risk groups such as the elderly. There will be more stress-related problems due to rapid urbanization and industrialization. There will probably be more substance abuse.

5.2.1.2 Conventional biological medicine has not been able to handle these problems effectively, and postgraduate training in the past has been inadequate. In our postgraduate education, prevention has not been taught.

5.2.1.3 Psychiatrists can do a lot. Many problems in medical practice relate to exaggerated expectations from both patients and doctors for cures. Appropriate and effective care must be provided by psychiatrists which will demonstrate that even without a cure, such as in conditions like dementia, good care is still essential. The role of a psychiatrist particularly as a leader in this area should be emphasized.

5.2.2 **Content of training**

5.2.2.1 Rehabilitation psychiatry should be taught in postgraduate education. It should include the psychosocial rehabilitation of patients, sophisticated caring and effective handling of difficult problems and the maintenance of chronic patients.
5.2.2.2 All treatment modalities, psychological, biological and social therapies should be taught, although the content can meet particular needs in each country and each institution. Balanced treatment programmes that include all the treatment modalities are desirable.

5.2.2.3 Research training should be included as content in postgraduate training.

5.2.3 Selection of trainees

Many variables affect the process of selection. Who decides and how many trainees are to be selected should be determined by the needs. The problems of manpower differ according to countries, but an effort should be made to encourage medical students to enter psychiatry.

5.2.4 Certification and re-certification

The issues of certification and re-certification have been discussed. Since they are controversial subjects, special care should be taken when recommendations are made. Other pathways to re-certification, such as a continuation of the medical education system, should be explored. This issue of competence and standards should not be confused with unethical conduct by physicians. In general, every country should have a mechanism in place that ensures the control of continuous professional skills to protect the public.

5.3 Psychiatric education for medical practitioners

5.3.1 Psychosocial management

Many of the issues discussed in regard to psychiatric education of medical undergraduates are highly relevant to the postgraduate and continuing education of medical practitioners. Doctors, regardless of their speciality or area of practice, are required to deal with many patients who have psychiatric illness. Patients expect their practitioners to be sensitive in managing many common psychosocial problems. They are also often reluctant to seek referral to others. The growing specialization within medicine and within psychiatry itself does not decrease the need for medical practitioners to be adequately trained in these areas.

5.3.2 Continuing education and psychiatric training

Many doctors need both psychosocial and psychiatric continuing education. They must learn to deal with the effects of new management technologies, advances in the treatment of psychiatric disorders and changing community and consumer expectations and needs. Associations and colleges should be encouraged to allocate time in their training programmes to take account of the broad or speciality-specific psychosocial problems of practice. Failure to obtain such experiences and training should be considered as seriously as a deficit in another component of their training.
5.3.3 Processes

Many strategies are available for carrying out the objectives of continuing education. These range from peer review and innovative educational experiences to seminar programmes or credit systems.

5.3.4 Certification

Accreditation of specialists and doctors trained in other countries and medical schools should be based on psychosocial and psychiatric criteria as much as other clinical considerations.

5.4 Humanization of medical education

Quite apart from specific matters of psychiatric education, the meeting recognized the great importance of medical practitioners being more sensitive and responsive to human needs and human feelings.

5.4.1 Trends

It was accepted that current patterns of medical education have given rise to public and professional concern and disquiet for the following reasons:

5.4.1.1 The delivery of technologically sophisticated care is not matched by an equally sophisticated awareness of the emotional and psychosocial concerns of consumers and patients.

5.4.1.2 Increasing numbers of sick people seem to prefer the less technically competent (and sometimes dangerous) health care provided by alternative practitioners. These persons are seen to be more culturally and personally aware than doctors; more concerned to treat the whole person; and more in tune with contemporary fashions and superstitious, even when these are thought to be ignorant and irrelevant by the "scientifically"-oriented practitioner.

5.4.1.3 The dominating and all-pervasive emphasis in medical education is on facts; on technology; on Newtonian notions of cause and effect, which tend to exclude the more ambiguous realities of human existence; and on physical interventions alone being a sufficient approach to illness. This has resulted in the process of medical education becoming dehumanizing. In addition, modern medical education has not given sufficient attention to human behaviour, attitudes, aspirations and emotions.

5.4.2 Objectives

Aware of these trends and deploiring them, the conference asserted that the priority in medical education must be to shape the attitudes of medical students towards a sensitive and compassionate capacity to understand and accept the primacy of the inner world of perception, belief and feeling in shaping the health and health-related behaviour of people.
5.4.3 Content of education

To correct this situation the conference concluded that human emotional behaviour and human attitudes must be a major focus of all medical education so that all practitioners are aware of their importance in the processes whereby people

(i) acquire diseases,

(ii) feel ill, adopt (maintain) the role of a sick person,

(iii) seek help,

(iv) perceive professional help to be useful,

(v) use professional help effectively, as instructed,

(vi) perceive advice as relevant and therefore to be followed in prevention and health maintenance.

Through early and sustained experiential learning (e.g. by having to experience the patient role) the medical student must, first and foremost, and always, in any encounter with a patient, be aware that understanding of the patient's inner world-view and inner feelings, is the first step in health care delivery.

This understanding must take precedence over the details of history, physical examination or investigative testing.

The attitude must be instilled that technology is only a handmaiden of care and that caring is the first step in providing effective care, and is quite different from it.

5.4.4 Processes of education

Specifically the meeting believed that such attitudes could be promoted by a variety of approaches. These might include the following:

(a) Giving prominence and priority to certain qualities in student selection.

(b) Giving prominence and priority to similar human qualities in making faculty appointments, especially in appointments to leadership roles.

(c) Giving prominence and priority to similar qualities in the selection of associated clinical teachers.

(d) Providing experiential learning about human life, death, illness and health-seeking situations.

(e) Ensuring that psychiatrists and other experts who have specialized training, and who demonstrate concern for the human context, collaborate effectively with other specialists to catalyse a new ethic in medical education.
(f) Governments and government instruments, through such mechanisms as accreditation of medical schools and hospitals, should seek evidence of priority being given in teaching to these human issues. They should use effective methods of influence and pressure to ensure their establishment in medical schools where they are demonstrably lacking.

6. CONCLUSIONS AND RECOMMENDATIONS

The conference made conclusions and recommendations in the areas of

(1) humanization of medical education,
(2) psychiatric education for the medical practitioners,
(3) undergraduate education,
(4) postgraduate education.

6.1 Conclusions

6.1.1 Every possible means should be used to reorient medical education through a radical review of its priorities and methods to humanize every aspect of the delivery of medical care.

6.1.2 By reason of the breadth of their specialized professional training, psychiatrists should play a central role in collaborating with all other clinical and pro-clinical medical specialists to deliver a medical education which gives major emphasis to the fundamental importance of doctors being always aware of the human context and human sensitivity of every aspect of their work.

6.1.3 Education in relation to human issues and the human context be delivered, whenever possible, by medical qualified personnel whose teaching, is more likely to be considered relevant by medical students.

6.1.4 The community-oriented approach is to be preferred in teaching. This should include community participation as well as teaching in community setting.

6.1.5 All specialist medical colleges and associations and training institutions promote education in the psychological-medical training programmes relevant to their speciality or field.

6.1.6 The training of psychiatrists should include a wide experience in the community in addition to hospital-based education.

6.1.7 Postgraduate education should include training in research methodology and the evaluation of research. Where feasible, the conduct of research projects should be incorporated in the programme.
6.1.8 These training programmes should be orientated not only to the training of the psychiatrist in clinical competence, but also in areas such as the prevention of mental disorders including psycho-social rehabilitation. Attention must be paid to high-risk populations such as children, adolescents, the elderly, alcoholics and drug abusers.

6.2 Recommendations

Recommendations in the four areas are directed to organizations responsible for medical education at all levels.

6.2.1 Teaching institutions

6.2.1.1 The curriculum should include the knowledge, skills, and attitudes necessary for the biopsychosocial approach in the understanding, diagnosis and management of psychiatric disorders and should recommend that in undergraduate education teaching of psychiatry should be allocated 10% of the total curriculum time.

6.2.1.2 Senior management in medical schools, particularly in areas that determine curriculum, should include doctors with experience and knowledge of the psychosocial, community and behavioural aspects of health care as well as biological and hospital-based care.

6.2.2 Governments

6.2.2.1 In postgraduate education, accredited postgraduate psychiatric training programmes should be established in each Member State with specifically defined criteria of assessment, and with special regard to the relevance to the needs of each country.

6.2.2.2 In all health manpower development programmes more attention should be paid to the psychosocial and behavioural realities of people and communities, and their disease profiles. This requires that much more resources should be diverted to providing adequate numbers of health professionals with knowledge and skills in the behavioural and psychosocial aspects of health.

6.2.3 Professional organizations

6.2.3.1 International agencies such as WPA, WFME and WFMH, concerned with medical education and health service delivery, should be urged to take a higher profile position on the need to emphasize attention to the human factors in medical education. They should do this by holding regional seminars on this issue; by seeking the support and involvement of consumer groups where appropriate; by actively drawing the attention of governments, universities, medical schools and associations to the importance of these issues.

6.2.3.2 A mechanism should be devised for continuing education with a system of continuing competency development. Each country should also devise a mechanism for the re-certification of professional skills at defined intervals.
6.3 Recommendations to WHO

6.3.1 These matters should be given high priority by WHO in its development of policies and programmes at country, regional and at a global level.

6.3.2 Dissemination of the Declaration of Fukuoka.

7. DECLARATION OF FUKUOKA

Preamble

(1) Health is a state of physical, mental and social well-being, so that as much attention should be given within health care to promoting mental and social well-being as is given to promoting physical well-being.

(2) The public health importance of diseases related to life-style, habits and behaviour has been increasing dramatically. However, sufficient attention has not been paid to this in medical education.

(3) All Member States of WHO have accepted that primary health care should be the means by which health for all will be implemented. An important feature of primary health care is that people themselves should be mobilized to improve their own health. Such mobilization can only be achieved by giving attention to human emotion, motivation and behaviour.

(4) A very large amount of emotional disturbance, mental distress and psychiatric morbidity is found in patients being cared for in all branches of medicine. These conditions are currently not being taken care of because of the stigma associated with them.

(5) As the practice of medicine properly becomes increasingly reliant on technology and scientific treatment, the human element within medical practice is being compromised.

This meeting declares:

(1) That all physicians must learn communication and interpersonal skills. A lack of empathy should be regarded as being just as indicative of incompetence as technical inadequacy. Doctors must understand what it is like to be a patient. They must give due regard to the feelings of patients in their practice. Learning about this must continue throughout training, and beyond.

2. Physicians must learn to recognize the emotional disturbance and distress that can accompany any disease or disability and learn how to include the management of this in their practice. This applies with equal force to most common illnesses as well as the more obvious situations such as terminal illness.
3. Physicians must learn to recognize the common psychiatric disorders that are known to occur in a significant proportion of all patients, understand how physical and mental disorders affect each other, and become competent in managing such disorders as far as possible in their own practice.

4. Physicians must include prevention, care and rehabilitation in their practice, particularly for those for whom no cure is available.

5. Physicians must recognize the importance of peoples' own behaviour and perceptions in affecting their health and diseases, and must promote healthier patterns of living.

6. The training of physicians must take place in a setting as near as possible to those situations in which there is need for them to practise in the future.

7. These issues should be the responsibility of all physicians. Psychiatrists, however, as physicians particularly trained in the skills and knowledge which contribute to meeting needs for improved human and psychosocial well-being, should be encouraged to carry their knowledge and skills into the practice of all medicine and not to restrict it to just the limited area of specialist practice.
AGENDA

1. Opening ceremony
2. Keynote speech
3. Introductions and election of officers
4. Adoption of the agenda
5. New trends in medical and psychiatric education
6. Role of international professional organizations on psychiatric education
7. Reports from Member States in the Western Pacific Region
8. Field visit
9. Discussions on future actions
10. Specific subjects on psychiatric education
11. Formulation of the Declaration on Psychiatric Education for the 21st Century
12. Review of the draft declaration
13. Review and adoption of the report, including the declaration
14. Closing ceremony
LIST OF MEMBERS, CONSULTANTS, REPRESENTATIVES
OBSERVERS AND SECRETARIAT

1. MEMBERS

Dr Desen Yang
Professor of Psychiatry
Hunan Medical University
22, Beizhan Road
Changsha, Hunan
People's Republic of China

Dr Gordon Allen German
Professor of Psychiatry
and Dean of Medicine
Department of Psychiatry
Behavioural Science
The University of Western Australia
Nedlands, Western Australia, 6009

Dr K. Kiikuni
Professor of Medical Sociology
The University of Tsukuba
School of Medicine
Tennodai 1-1-1
Shinya-gun, Sakura-mura
Ibaragi-ken
Japan 305

Dr Chung-Kyoon Lee
Professor and Chairman
Department of Neuropsychiatry
College of Medicine
Seoul National University
Seoul
Republic of Korea

Dr Ho Young Lee
Professor and Chairman
Department of Psychiatry
Yonsei University
College of Medicine
C.P.O. Box 8044
Seoul
Republic of Korea
Dr Felice Lieh-Mak  
Professor and Head  
Department of Psychiatry  
University of Hong Kong  
Pokfulam Road  
Hong Kong

Dr Graham Mellsop  
Professor of Psychological Medicine  
Wellington School of Medicine  
P.O. Box 7343  
Wellington South  
New Zealand

Dr C. Ogura  
Chairman and Professor  
Department of Psychiatry  
School of Medicine  
University of Ryukyu  
Uehara 207, Nishihara-machi  
Nakato-gun, Okinawa-ken  
Japan 903-01

Dr Hyung-Jong Park  
Dean and Professor  
Graduate School of Public Health  
Inje University  
#633-165 Kekum-Dong  
Pusanjin-ku  
Pusan  
Republic of Korea

Dr Baltazar Reyes  
Chairman  
Department of Psychiatry  
University of the Philippines  
Philippine General Hospital  
Taft Avenue, Manila  
Philippines

Professor Shen Yucun  
Director  
Institute of Mental Health  
Beijing Medical University  
Huayuanbei Lu  
Beijing 100083  
People's Republic of China
Annex 2

Dr Eng-Seong Tan  
Professorial Associate  
Department of Psychiatry  
The University of Melbourne  
St Vincent's Hospital  
Fitzroy, Victoria 3065  
Australia

Dr Teo Seng Hock  
Medical Director  
Woodbridge Hospital  
Jalan Woodbridge  
Singapore 1954  
Republic of Singapore

Professor Nguyen Viet  
Head  
Department of Psychiatry  
Hanoi Medical College  
Hanoi  
Socialist Republic of Viet Nam

Professor T.H. Woon  
Head  
Department of Psychological Medicine  
Faculty of Medicine  
University of Malaya  
Kuala Lumpur, 22-11  
Malaysia

Dr Nariyoshi Yamaguchi  
Professor and Chairman  
Department of Psychiatry  
School of Medicine  
Kanazawa University  
Takara-machi, 13-1  
Kanazawa City  
Japan

2. CONSULTANTS

Dr J.C. Cubis  
Senior Lecturer in Psychiatry  
The University of Newcastle  
New South Wales 2308  
Australia
Annex 2

Dr Alfred Freedman  
Professor and Chairman  
Department of Psychiatry and  
Behavioural Sciences  
New York Medical College  
Valhalla, New York 10595  
U.S.A.

Dr Masahisa Nishizono  
Professor and Chairman  
Department of Psychiatry  
Fukuoka University  
School of Medicine  
7-45-1 Nanakuma, Jonan-ku  
Fukuoka 814-01  
Japan

3. WORLD PSYCHIATRIC ASSOCIATION

Dr Y. Nakane  
Chairman and Professor  
Department of Psychiatry  
Nagasaki University  
School of Medicine  
Sakamoto-machi, 12-4  
Nagasaki City  
Japan 852

Dr Sijds J. Nijdam  
Em. Professor of Psychiatry  
University of Nijmegen  
Langstraat 80  
6596 BS Milsbeek (L)  
The Netherlands

4. OBSERVERS

Dr Kazuhiko Abe  
Department of Psychiatry  
University of Occupational and  
Environmental Health  
Iseigaoka 1-1 Yahataku  
Nishi-ku, Kitakyushu-shi  
Japan 807
Dr Junichi Imatou  
Vice-President  
Japan Mental Health Association  
Wakahisa Hospital  
Minami-ku, Wakahisa  
5-3-1 Fukuoka-shi  
Japan

Dr Chuzo Michishita  
Director  
Takamatsu Hospital  
Kahoku-gun, Takamatsu-machi  
Aza-Uchitakamatsu Ya-36  
929-12, Japan

Dr Nobui Tashiro  
Professor of Psychiatry  
Faculty of Medicine  
Kyushu University  
Higashi-ku, Maidashi 3-1-1  
Fukuoka-shi, Japan

Dr Michio Tomii  
Director  
Okayama Municipal Hospital  
Shikada-Honmachi  
3-16 Okayama-shi  
Japan

Dr Sadanobu Ushijima  
Department of Psychiatry  
School of Medicine  
Fukuoka University  
Jonan-ku, Nanakuma  
7-45-1 Fukuoka-shi  
Japan 814-01

5. SECRETARIAT

Dr John Orley  
Senior Medical Officer  
Division of Mental Health  
World Health Organization  
Geneva  
Switzerland
Annex 2

Dr N. Shinfuku (Operational Officer)
Regional Adviser in Mental Health and Drug Dependence
WHO Regional Office for the Western Pacific
Manila
Philippines
OPENING ADDRESS BY THE REGIONAL DIRECTOR
WHO REGIONAL OFFICE FOR THE WESTERN PACIFIC

Mayor of Fukuoka City, Distinguished Guests, Participants, Ladies and Gentlemen:

It is a great pleasure and honour to be here with you and to deliver the opening address on behalf of Dr S.T. Han, the Regional Director of WHO for the Western Pacific. He asked me to convey his regret at being unable to attend the meeting owing to his previous commitments, and at the same time to express his best wishes for the success of the meeting.

However, to my great pleasure, our Director-General, Dr Hiroshi Nakajima is with us for the opening and will deliver the keynote speech. As he is going to speak, I will be very brief.

First I would like to express my sincere thanks to the Japanese Government for agreeing to convene this meeting in Japan. In particular, I am grateful to the Ministry of Health and Welfare, Ministry of Education and Fukuoka City for their official support of this meeting.

I would also like to express my appreciation to the World Psychiatric Association for organizing this event with us. I consider the link between WHO and WPA the most effective way to achieve our common objective of reorienting the content of psychiatric education.

The objectives of the meeting are threefold. First, to assess the changing mental health needs of the present and the future. Second, to review undergraduate and post graduate psychiatric education in the Region. Third and most importantly, to formulate recommendations on the content and processes of psychiatric education in relation to broader mental health problems.

I find these three objectives very challenging. Psychiatric education should contribute more actively to the understanding and prevention of diseases related to lifestyle, habits, stress and behaviour. These diseases have become major health problems both in developed and in developing countries of the Western Pacific Region. Therefore I shall be keen to see the report of your deliveries and your recommendations. I am convinced that your recommendations will be the essential tools for us to develop effective strategies for the prevention and control of diseases related to human behaviour.
To conclude, let me express my sincere thanks to Dr Masahisa Nishizono, the national coordinator for his invaluable work in preparing the meeting.

Also, I would like to extend my warm welcome to our distinguished colleagues who are participating in this meeting as consultants, temporary advisers and observers.

I wish you all enjoyable stay in this lovely city of Fukuoka.
KEYNOTE ADDRESS BY
DR HIROSHI NAKAJIMA
DIRECTOR-GENERAL
WORLD HEALTH ORGANIZATION

Dr N. Shinozaki, Director of Mental Health, Ministry of Health
and Welfare, Government of Japan, Honourable Mayor of Fukuoka City,
Professor M. Nishizono, Chairman of the National Organizing Committee,
Distinguished Guests, Dear Colleagues, Friends,
Ladies and Gentlemen:

It is a great honour and pleasure for me to be here today and to
wish this meeting every success. I am very pleased to see many
familiar faces, and to visit Fukuoka City once again.

I accepted your invitation to the opening of this meeting, and to
deliver a keynote address, because your subject is of tremendous
importance, and has direct implications for WHO's current all-out
efforts to attain health for all by the year 2000.

It is particularly gratifying that this meeting has been jointly
organized by WHO and the World Psychiatric Association. With 61 000
members in 70 countries, the Association is the largest international
nongovernmental organization in the field of psychiatry. Its
contributions to WHO's activities in the field of mental health have
been significant. More particularly, it has been very active in
upgrading psychiatric education.

From our Organization's point of view, cooperation with the World
Psychiatric Association will be highly desirable in implementing the
recommendations of this meeting, since it is the most influential
professional body in the reorientation and restructuring of both
undergraduate and postgraduate psychiatric education. I note with
satisfaction that your recommendations will be submitted to both WHO
and the Association for their consideration and action. This meeting
is of a regional nature, and it is an excellent example of cooperative
activities between WHO and a nongovernmental organization, which I
trust will be taken up in other region.

While I was serving as WHO's Regional Director for the Western
Pacific, we held a meeting in Tokyo in 1985 to discuss the future of
health and medical manpower, and to develop new education strategies
for the twenty-first century. The now-famous "Declaration of Tokyo"
emerged from that meeting. The Declaration stressed the importance of
reorienting medical education to meet the ever-changing requirements
of health. It also pointed out that human needs should be the centrepiece of medical education. Naturally, psychiatry should play a key role in this reorientation and humanization of medical education, to convert the currently predominantly medical model to what I would described as a medico-psycho-social model.

WHO's Constitution defines health as a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity. However, modern technology in medicine has focused largely on the diagnosis and treatment of physical disease, and it often happens that health professionals fail to pay due attention to the mental and social wellbeing of their patients. The emphasis on technology has thus sometimes resulted in insufficient attention being given to the human aspects of care. Furthermore, rapid technological developments have misled some health professionals and administrators into forgetting the fundamental medical realities. It is a fact that many of the world's major health problems could be prevented by changes in human behavior and these changes can usually be achieved at low cost.

Mental health professionals all over the world therefore are in a strong position to promote the humanization of medical care.

One of the important tasks of this meeting is to review current and foreseeable mental health needs in a time of change, and to reorient psychiatric education towards a broader approach to mental health problems. Your conclusions will, I am sure, have an important impact on international and national policies for medical and psychiatric education.

I should like to reiterate some of WHO's reasons for attaching so much importance to mental health in its broadest terms.

Firstly, diseases related to lifestyle and behavior have become a major problem in both developed and developing countries. Cancers, heart diseases, overnutrition, and diabetes mellitus are the main causes of ill health even in many developing areas of the world. The prevention of these diseases will thus be one of the most important health challenges in the coming years. However, it is a fact that medical schools today do not place sufficient stress on the skills and knowledge needed to encourage and maintain behavioural changes, and fail to emphasize disease prevention and health promotion. Psychiatric education can surely play an important role in the development of the necessary reorientation.

Secondly, according to studies carried out by WHO, 15% to 20% of the patients treated by general practitioners suffer primarily from psychological and family problems directly related to stress. These challenges may be even higher in the more affluent societies.
However, very few opportunities exist for most of these patients to receive appropriate psychological care. A high proportion may receive some medication as a token of medical attention, but will eventually become chronic complainers, who needlessly consume scarce health resources. It is therefore important that all physicians should have the knowledge and skills to deal with stress and stress-related diseases.

Thirdly, a growing number of health problems are associated with old age, as a result of the increasing relative size of the elderly population. More and more health resources are being devoted to the health problems of the elderly, in both developed and developing countries. As all of you know very well, many of the health problems of the elderly require that physical care and psychosocial support should be administered. More specifically, the elderly often suffer from a sense of isolation from which they need relief. Lack of psychosocial stimulation may well accelerate their physical decline. In many parts of the world, suicide rate among the elderly is going up. Senile dementia also needs special attention. Medical education should not overlook the need for adequate undergraduate and postgraduate education on the holistic approach to dealing with these patients and their families. This condition is perhaps one of the toughest challenges facing the medical and related social sciences in the coming century.

Among adolescents and young persons also, suicides are a leading cause of death, as are accidents associated with risk-taking behavior. Alcohol and drug abuse have become major public health and social issues in many countries. Medical education must address these problems, and provide students with the necessary guidance for prevention of high-risk behavior.

It is unfortunate that there are several factors that militate against the desired reorientation and broadening of psychiatric education, even in the highly developed countries. For example, in many countries, psychiatry is placed very low on the list of priorities in the undergraduate medical curriculum, and the time and resources allocated to psychiatric education are very limited. Even where such education is provided, it tends to be limited to such subjects as schizophrenia and depression.

I should like to remind you that, in 1986, WHO convened an interregional meeting to examine future orientations in postgraduate psychiatric education, with particular emphasis on how the situation worldwide could be improved by international collaboration. Among its recommendations was that greater attention needs to be paid to the ultimate functions of the trained psychiatrist in his or her own country. In many developed, and in some developing countries, the main work of the psychiatrist is to see patients on an individual basis. In many developing countries, however, psychiatrists have many
administrative functions, and are also responsible for the training and supervision of non-psychiatrist and non-physician health workers. The training of psychiatrists to work in such situations must therefore prepare them for these kinds of function.

For undergraduates too, there is a need to look carefully at the kind of psychiatric work that most of them will be called upon to undertake in the future. After all, many will work in general medicine, and the vast majority will certainly not work in the field of psychiatry. What is important, therefore, is that they learn how to recognize psychiatric morbidity amongst patients presenting in general and non-psychiatric clinics, and how to manage these problems in such settings. It is certain that psychiatric morbidity in most of these settings is very prevalent, and may affect other pathological symptoms. WHO's mental health programme is currently preparing a set of learning modules on this topic, for adaptation for use in undergraduate medical schools throughout the world.

There is also a lack of undergraduate and postgraduate training in the psychosocial aspects of health and communication skills. In most medical schools, training places great emphasis on the acquisition of knowledge about diseases and the technology available for their diagnosis and treatment. It has failed to give the same weight to training in humanistic approaches, such as advocacy and counselling techniques, and psychotherapy.

Especially in developing countries, the health care delivery system, confronted by more urgent and visible problems of infectious diseases, gives low financial priority to mental health. Problems related to emotion and behavior are common to rich and poor countries alike. Only their manifestations may differ from country to country, and from culture to culture. Although the transfer of technology and knowledge from privileged to less privileged countries must continue, the receiving countries must modify it, so that it becomes acceptable to the local conditions. In the case of mental health, this becomes more important because of the intimate link between behavior and culture.

WHO's activities relating to the reorientation of psychiatric education are still in the early stages, but this does not detract from their importance. As in our reorientation of medical education, the basic concern is the human being and his needs. I am gratified that this meeting has brought together some of the most influential experts in medical and psychiatric education, both in the Western Pacific Region and in the world. Your gathering is thus a vital forum for the exchange of views and for the formulation of constructive suggestions on this most challenging topic. I wish you every success and I await the results with the keenest interest.