Guest Editorial

Medical Council of India's New Competency-Based Curriculum for Medical Graduates: A Critical Appraisal

The Medical Council of India (MCI)'s new competency-based curriculum for medical graduates is a major landmark for medical education in India;[1] it represents a paradigm shift. The Council's attempt to modernize medical education is laudable and in keeping with recent global trends.[2-4] This editorial attempts to highlight the new curriculum, foregrounds the problems related to the mental health service delivery in the country, critically examines the new curriculum and its application to the Indian context, discusses its advantages and limitations, and suggests future directions.

COMPETENCY-BASED EDUCATION

Unlike the old curriculum which focused on knowledge, was organized on systems and disciplines, was time-based, and had a summative evaluation, competency-based learning emphasizes the skills required for good medical practice. It focuses on learning the critical competencies needed for success in clinical practice and provides standards and framework for measuring performance. The basic feature of any competency-based training is that it measures learning that occurs in a training program, rather than time. It allows for self, objective, and multisource assessments. The approach has been used for training in diverse medical specialties.[5,6]

GOALS OF THE NEW CURRICULUM

The thrust of the new curriculum attempts to make medical education in India more learner- and patient-centric, gender-sensitive, and outcome- and context-oriented.[1] It underscores the need for integration of disciplines both horizontally and vertically, while respecting the strengths and necessity of subject-based instruction and assessment. While the new curriculum emphasizes competencies, it continues to focus on traditional medical disciplines and on time rather than on mastery of a specific set of skills, making it different from ideal competency-based models.

The new curriculum identifies essential skills, describes methods and contexts of teaching, and recognizes standardized measurement of competencies.[1] It aims to produce "Indian Medical Graduates" with requisite knowledge, skills, attitudes, values, and responsiveness, so that they may function appropriately and effectively as physicians of first contact in the community.

The new curriculum co-opts national goals of "health for all," of providing holistic care, of developing a scientific temper, and of producing ethical medical practitioners.[1] It aims to focus on common medical conditions and provision of comprehensive care, emphasizes bio-psycho-socio-economic dimensions of health and illness, and aligns with national health priorities. It aspires to produce medical graduates who are competent clinicians, who develop patterns of lifelong learning to keep up with advances in science, who become excellent in communication and bedside manners, and who will lead multidisciplinary healthcare teams and provide leadership for the many national public health programs. Its intention is to produce clinicians who understand and provide preventive, promotive, curative, palliative, and holistic care with compassion.

It lists 412 topics for learning and 2,949 outcomes to be mastered.[1] It argues that broad competencies can be achieved in a phased manner, while retaining the subject-wise character of the current organization of

specialties and integrating teaching and learning across disciplines during the undergraduate course.

CHANGES TO THE CURRICULUM

The changes to the curriculum, proposed by the MCI, are welcome as they are aimed at empowering physicians. The shift in focus from knowledge to the acquisition of skill will result in confidence to manage problems in medical practice. The identification of the skills required for a successful practice, being based on common conditions seen in primary and secondary care, will necessarily improve medical education. The older curriculum, which focused on traditional teaching (e.g., lectures, which transmit information) and assessment methodology (written and oral examinations, which examine knowledge imbibed), should now be replaced by an emphasis on skills to be acquired. The formative assessments planned should augment summative assessments.

The Clinical Implementation Support Programme, being planned for medical faculty, will train teachers in competency-based education; its aims, principles, and scope; competencies to be mastered; methods of teaching and learning; and types of assessments and evaluations. The new curriculum aims to deemphasize the compartmentalizations of the traditional medical disciplines through horizontal and vertical integration of teaching–learning methods which focus on outcome competencies to be mastered.

The new curriculum also encourages the use of skill laboratories. It requires simulated and guided environments to demonstrate how skills are acquired and also mandates the performance and certification of some skills during the course, prior to clinical internship. It streamlines formative and internal assessments to achieve the objectives of the curriculum. It attempts to support and strengthen curricular governance by increasing the involvement of the Curriculum Committee and Medical Education Departments/Units.

The document provides subject-wise outcomes, so-called "sub-competencies" that must be achieved at the end of instruction in that subject. It includes the core subject outcomes and outcomes/competencies in other subjects which need to be integrated. Learning domains (Knowledge, Skill, Attitude, Communication) and the expected level of achievement in that subject (Knows, Knows How, Shows How, Performs) are also identified. The suggested learning methods include lectures, bedside clinics, small group discussion, and demonstration-observe-assist-perform sessions. The suggested assessment methods include written examination, viva voce, and skill assessment – clinical, skill laboratory, and practical. However, independent performance without supervision is required rarely in the preinternship period.

COMPETENCIES RELATED TO MENTAL HEALTH AND ILLNESS

Competencies related to mental health and illness are divided into 19 topics and 117 outcomes.[1] The 19 topics include (i) doctor–patient relationship, (ii) mental health, (iii) introduction to psychiatry, (iv) alcohol and substance use, (v) psychotic disorders, (vi) depression, (vii) bipolar disorders, (viii) anxiety, (ix) stress-related disorders, (x) somatoform disorders, (xi) personality disorders, (xii) psychosomatic disorders, (xiii) psychosexual and gender identity disorders, (xiv) psychiatric disorders in childhood and adolescence, (xv) mental retardation, (xvi) psychiatric disorders in the elderly, (xvii) psychiatric emergencies, (xviii) therapeutics, and (xix) miscellaneous. These topics are broad and cover all disorders currently being taught in Psychiatry to medical students.

Each topic has specific competencies to be learned, resulting in 117 outcomes.

Table 1 shows the specific outcomes for mental health and psychosis. These competencies focus on a basic understanding of psychiatric disorders and their treatment. In addition, there are 45 competencies across nine subjects where Psychiatry is either vertically or horizontally integrated, specifically with General Medicine, Geriatrics, Paediatrics, and Community Health.

The main advantage of the new curriculum is the highlighting and a new focus on the basic competencies required of a medical graduate. The fact that Psychiatry features as a subject in the new curriculum suggests that the discipline is being considered a core subject and that many competencies related to Psychiatry are mandatory for future Indian doctors.

COMMENTARY

The new curriculum and its relevance, usefulness, feasibility, impact, advantages, and disadvantages are discussed under the following heads: (i) mental healthcare delivery, (ii) primary and secondary healthcare, (iii) impact of settings, (iv) examination systems, (v) new curriculum in perspective, and (vi) future direction.

Mental healthcare: Aspiration and reality

India, a signatory to many international agreements (Alma Ata Declaration,[7] 65th World Health Assembly

Table 1: Examples of topics, competencies, domains, levels, teaching-learning methods, assessment, and integration

No.	Competency The student should be able to	Domain K/S/ A/C	Level K/KH/ SH/P	Core (Y/N)	Suggested teaching- learning method	Suggested assessment method	Competencies to certify	Vertical integration	Horizontal integration
Topic: Mental health No. of competencies: (5) No. of procedures that require certification: (NIL)									
PS2.1	Define stress and describe its components and causes	K	K	Y	Lecture, SGD	Written/ viva voce	Nil		
PS2.2	Describe the role of time management, study skills, balanced diet, and sleep-wake habits in stress avoidance	K	KH	Y	Lecture, SGD	Viva voce	Nil		
PS2.3	Define and describe the principles and components of learning memory and emotions	K	K	Y	Lecture, SGD	Written/ viva voce	Nil		
PS2.4	Describe the principles of personality development and motivation	K	K	Y	Lecture, SGD	Written/ viva voce	Nil		
PS2.5	Define and distinguish normality and abnormality	K	K	Y	Lecture, SGD	Viva voce	Nil		
Topic: Psychotic disorders No. of competencies: (6) No. of procedures that require certification: (NIL)									
PS5.1	Classify and describe the magnitude and etiology of schizophrenia and other psychotic disorders	K	KH	Y	Lecture, SGD	Written/ viva voce	Nil		
PS5.2	Enumerate, elicit, describe, and document clinical features, positive symptoms	S	SH	Y	Bedside clinic, DOAP session	Skill assessment	Nil		
PS5.3	Describe the treatment of schizophrenia including behavioral and pharmacologic therapy	K	KH	Y	Lecture, SGD	Written/ viva voce	Nil	Pharmacology	
PS5.4	Demonstrate family education in a patient with schizophrenia in a simulated environment	K/S/ A/C	SH	Y	Bedside clinic, DOAP session	Skill assessment	Nil		
PS5.5	Enumerate and describe the pharmacologic basis and side effects of drugs used in schizophrenia	K	KH	Y	Lecture, SGD	Written/ viva voce	Nil	Pharmacology	
PS5.6	Enumerate the appropriate conditions for specialist referral in patients with psychotic disorders	K	K	Y	Lecture, SGD	Written/ viva voce	Nil		

Domain: K: Knowledge, S: Skill, A: Attitude, C: Communication. Level: K: Knows, KH: Knows How, S: Skill, SH: Show How, P: Perform independently. Teaching: SGD: Small Group Discussion, DOAP Session: Demonstrate (by Student) Observe, Assist Perform. Skill assessment: Clinics, Skills laboratory, Practical, etc.

Resolution on Mental Health,[8,9] the Mental Health Gap Action Programme,[10] and Comprehensive Mental Health Action Plan 2013–2020),[11] has developed many national mental health plans, policies, and programs (National Mental Health Plan –1982,[12] the Revitalised National and District Mental Health Programs,[13] and the Mental Health Policy – 2014).[14] These efforts recognize the significant burden of mental illness and the large treatment gap in mental healthcare delivery.

These plans, policies, and programs also acknowledge the lack of the required number of specialist mental health professionals (psychiatrists, psychologists, psychiatric nurses, social workers, etc.). They argue for training and empowering primary and secondary healthcare professionals for mental healthcare delivery. Care in the community for people with mental distress, illness, or disease through the integration of mental healthcare delivery in primary care through the National Health Missions has also been suggested. Despite these much-hyped efforts, the reality on the ground for people with mental illness has hardly changed across the country.[15-17]

Primary and secondary healthcare: The complex reality

The vision of the many national and international plans and programs has not been translated into reality in the Indian context. The problems related to health services in India are multifaceted and include poor infrastructure, overburdened primary care systems, inappropriate training for health professionals, professional apathy, limited finances, impoverished environments, and low morale of primary healthcare staff.[16] The lofty aims of the Indian plans and policies remain on paper because of the complex reality of healthcare delivery in India.[15-17] Mental healthcare delivery through primary healthcare requires robust systems mandating significant strengthening of existing facilities, organization, and procedures.

Settings and their impact on presentations and perspectives

The problems related to poor primary healthcare systems in the country are also compounded by significant differences in primary and tertiary care approaches to mental health and illness.[18] Differences in settings, patient profiles, and physician perspectives result in the lack of enthusiasm for tertiary care psychiatric concepts,

classification, diagnosis, and management strategies among primary and secondary care physicians. The fact that most patients report nonspecific symptoms and milder, mixed, and subsyndromal presentations associated with psychosocial stress and physical adversity makes the use of classical tertiary care concepts and categories (e.g., major depression) difficult to use in primary care. Yet, common clinical presentations seen in primary care (e.g., mixed anxiety depression) are not recognized as a psychiatric diagnoses even in psychiatric classifications for use in primary care.[18-20]

Family physicians argue that the use of symptom counts to diagnose mental disorders, without consideration of psychosocial context, particularly psychosocial hardship, identifies nonclinically significant distress, especially at lower degrees of severity.[18-20] They consider such efforts a medicalization of distress. On the other hand, general practitioners recognize the importance of psychosocial support, realize that spontaneous remission and placebo responses are common, and understand the limitations of using antidepressants for less than severe depression.[21,22] They readily acknowledge the importance of social determinants of mental health.

Population differences between settings, with lower prevalence of classic psychiatric presentations (e.g., generalized anxiety and major depression) in primary care, often result in high false-positive rates when such labels are used in general medical settings.[18-20] Primary care physicians argue that patients seek medical help when they are disturbed or distressed, when they are in pain, or when they are worried about the implication of their symptoms. Many such forms of distress are normal reactions to adversity and mainly require psychological and social support. Consequently, family and primary care physicians use the International Classification of Primary Care-2 (ICPC-2),[23] which focuses on reasons for clinical encounters, patient data, and clinical activity rather than psychiatric labels. They also prefer general guidelines for management to detailed, separate, and specific protocols.[18-20]

Similarly, categories like acute and chronic psychosis, easily identified and managed in primary care, are trumped by the specialist conceptualization of schizophrenia and bipolar disorders more commonly encountered and recognized in specialist practice but difficult to identify in general medical settings. Categories useful in primary care seem to be unacceptable to specialists and unsuitable in their settings and vice versa.[18-20]

Primary healthcare professionals demand caution in translating specialist concepts and classifications for use in primary care, and yet, their perspectives are marginalized in official classifications, management guidelines, and in curricula for training basic physicians. The many differences in patient populations and perspectives suggest a "category fallacy" (i.e., the unwarranted assumption that psychiatric categories and diagnoses have the same meaning when carried over to a new cultural context/clinical setting with its alternative frames or systems of meaning) when specialist cultures are imposed on primary care.[19]

The culture of Psychiatry in primary care borrows heavily from specialist approaches and attempts to adapt it to the reality of primary care. The low rates of recognition and treatment of mental illness in primary care across countries, despite education and retraining programs for general practitioners, suggest the failure of tertiary care approaches in primary care. The fact that such psychiatric approaches to classification for primary care (e.g., International Classification of Diseases 10 Primary Health Care[24] and Diagnostic and Statistical Manual IV Primary Care[25]) were unheard of and unused in general and family practice speaks of their mismatch to the primary care context.[18-20]

Despite major differences in settings, populations, and perspectives, psychiatric training continues to be provided in psychiatric facilities and in tertiary care settings. Consequently, the failure of physicians to recognize and diagnose classical psychiatric presentations, uncommon in primary care practice, results in their inability to manage patients with mental distress and illness. Psychiatric training often deskills and disempowers even the most diligent of students; physicians would rather refer their patients than manage common mental distress and illnesses. Clinical practitioners, while being unable to challenge the international psychiatric concepts and classifications for use in primary care, do not actually use them in their practice, undermining such schemes.[19-20]

Nevertheless, psychiatrists, trained in tertiary care and familiar and confident in specialist approaches, assume that patients presenting to primary care will have similar presentations and will benefit from specialist perspectives. Consequently, specialists devise curricula and training programs wholly inappropriate for use in primary care, thus, perpetuating inadequacy and lack of confidence among basic physicians to manage psychiatric presentations in primary care.[26-28] However, countries with strong traditions in general and family practice recognize these difficulties and pay lip service to the official and specialist classification, methods, and treatment protocols and train physicians in primary care using general practice and family physician perspectives, principles, and approaches.[3,4]

Examination systems

It is widely recognized that student learning is driven by assessments and examination systems. To change the curriculum while continuing with the present examination system which focuses on recall of knowledge predicts failure to achieve the goals of the new curriculum. Assessment in Psychiatry, currently done by single theory question in the final examination, will not inspire significant student enthusiasm for learning the subject. Psychiatry, currently assessed within general/internal medicine, cannot compete with current medical teaching which emphasizes physical diseases with a focus on rare conditions (e.g., mitral stenosis and regurgitation of rheumatic etiology) and an absence of emphasis on common clinical presentations (e.g., patients with medically unexplained symptoms). Summative assessment with a single theory question, often more than a year after the Psychiatry posting, does not communicate the importance of mental health and illness in routine medical practice and will not motivate students to engage with the subject. While the new curriculum does not specify the duration and distribution of postings in Psychiatry, it is still possible to have such exposure during the final year.

The new curriculum in perspective

While the focus on competencies is a major shift in emphasis, the new curriculum essentially maps the old psychiatric syllabus in bite-sized capsules. It basically takes tertiary care psychiatric concept and perspectives (e.g., separate diagnostic and management status of anxiety, depression, somatoform, stress-related, psychosomatic, and personality disorders) and transfers them as the competencies required for medical graduates, when most clinical psychiatric presentations in general medical settings are mixed, mild, subsyndromal, and associated with psychosocial adversity.[24-26]

Detailed examinations of the new curriculum related to mental health, distress, illness, and disease suggest that traditional psychiatric topics have been rewritten as competencies, with the majority of them focusing on the transmission of knowledge, taught in tertiary care settings, and assessed using traditional written and viva voce examination.

While the overall curriculum argues for formative evaluations during the clinical postings in psychiatric facilities, the majority of psychiatric competencies continue to focus on the transmission and recall of knowledge rather than the evaluation of skills required to recognize and manage such problems in busy general medical settings.

The new curriculum does not require a single mandatory competency related to Psychiatry during the course; the curriculum argues that these will be achieved during the internship, essentially suggesting old wine in a new bottle. It does not acknowledge the difference between specialist psychiatric and general medical settings, nor does it take into account the significant disparities between psychiatric and physician perspectives. The new curriculum essentially imposes tertiary care standards and specialist perspectives for Indian medical graduates who are to work in primary care and secondary care facilities in the country.

The new curriculum, while arguing for vertical and horizontal integrations, does not suggest any need to collaborate with departments of general and family medicine or community health where medical graduates will work after the internship.

The new curriculum, while arguing for formative assessments during the Psychiatry posting, does not suggest any contribution to the overall assessment (i.e., addition to summative assessments).

Future directions

Recent attempts at developing psychiatric curricula for training physicians for general medical settings take a radically different approach.[3,4,20,26-30] The following form the core components of these programs:

(i) They acknowledge the significant differences in settings, perspectives, and presentations in primary and secondary care. They are set in primary and secondary care settings and demonstrate clinical identification and management using patients attending such facilities for training medical students about mental distress and illness
(ii) Consequently, they collaborate and integrate teaching–learning with departments of General and Family Medicine and Community Health. While collaboration with the Department of Family Medicine is ideal and should be recommended, their absence in most medical colleges poses a major challenge
(iii) They use general and family physician concepts and perspectives for use in busy general hospital settings, for clinical exposure
(iv) They recognize that psychiatric diagnosis is essentially syndromic and management, symptomatic
(v) They identify broad clinical presentations commonly seen in primary and secondary care. Delirium, dementia, substance use, psychosis, physical symptoms, health anxiety, and suicide attempts seen in medical settings are used to teach about problems in adults. Intellectual and learning disability, attention deficit, nocturnal enuresis, and temper tantrums are the focus in children

(vi) They use simple, general, and common management guidelines for ease of mastery by physicians. These include recognition of the clinical presentation, ruling out underlying medical disease, eliciting and managing patient and family perspectives related to illness and educating them, discussing stress and context, prescribing appropriate medication, negotiating a plan of action, and considering situations for specialist referral

(vii) They also discuss and demonstrate the management of patients who attempt suicide; those with suicide risk; those who are angry, tearful or agitated; and those who present with grief and bereavement, as these presentations are common in medical settings and managing them requires competence

(viii) They attempt to emphasize "primary medical care" for common psychiatric presentations in general practice. They emphasize a holistic approach to care, which requires the use of psychotropic medications and simple psychological interventions which can easily be implemented in busy clinical practice

(ix) Assessment systems attempting to evaluate skills and competencies acquired during training need a change to Objective Structured Clinical Examinations. Emphasis should be on practical strategies to recognize and manage common conditions which present to general medical settings. Such evaluations should also be part of General Medicine and Community Health university examinations, as Psychiatry does not have university-level assessments

(x) Recognizing and managing common clinical presentations in primary care and general medical settings (e.g., unexplained medical symptoms, substance dependence and withdrawal, acute and chronic psychosis, delirium, suicide attempt, nocturnal enuresis, temper tantrums) should be mandatory competencies to be mastered during the medical course

(xi) A substantial proportion of the summative assessment for Psychiatry should be an internal assessment for competencies mastered. In addition, mental health and illness should also be evaluated as part of summative assessments in General Medicine, Community Health, Pediatrics, and Forensic Medicine

(xii) The new curriculum demands collaboration between departments, the curriculum committee of the medical college to develop specific learning objectives, and the integration and coordination between medical disciplines throughout the course. Specific learning objectives related to depression, anxiety, somatic presentations, and stress-related presentations in general medical practice require a coordinated approach to teaching. The ICD-10 for Primary Health Care[24] and the ICPC-2[23] can form the basis for such integration

(xiii) The Curriculum Committee of the Indian Psychiatric Society can take the lead in designing and implementing specific learning objectives in general medical settings. The time frame for implementation of the new curriculum allows time till May 2020 to develop a detailed competency-based curriculum for mental health and illness.

Mastery in recognizing and managing psychiatric presentations seen in general medical practice demands that training is necessarily situated in such facilities. Moving psychiatric training out of specialist settings and resituating it within primary and secondary care settings will allow for the recognition of common presentations and appreciation of local reality, encourage holistic management, and improve understanding of general practice and Family Medicine perspectives.[24-26] Encouraging psychiatrists to work in primary and secondary care and general medical settings will also allow for a liaison approach which understands local contexts and appropriate management strategies. Regular interaction between specialists and general physicians will result in fertilization of perspectives and practice relevant to primary medical care. It will provide confidence and professional satisfaction, which will result in a sense of ownership.[24-26]

There is a need to create transformative educational initiatives which provide key stakeholders the opportunity to collaborate, understand, invest, and develop the care of mental distress, illness, and disease in primary care. Reimagining psychiatric education for primary and secondary care practice demands the understanding of local reality, which should not only transform psychiatric practice but also influence psychiatric theory.

CONCLUSION

The new MCI curriculum which shifts the focus from knowledge to competencies is a major advance. However, the continued use of specialist concepts, perspectives, diagnoses, and management approaches set in tertiary care facilities means that the opportunity to train basic medical doctors in recognition and management of clinical presentations commonly seen in primary and secondary care has been lost. The discipline in India needs to collaborate and liaise with teachers in General and Family Medicine and Community Health, who run primary and secondary medical facilities, to develop a curriculum appropriate to the needs of the country.

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Access this article online	
Website: www.ijpm.info	Quick Response Code
DOI: 10.4103/IJPSYM.IJPSYM_166_19	

How to cite this article: Jacob KS. Medical Council of India's New competency-based curriculum for medical graduates: A critical appraisal. Indian J Psychol Med 2019;41:203-9.