Editor’s Note: The following is a response to a review by Steven L. Dubovsky, M.D., of the American Society of Clinical Psychopharmacology Model Psychopharmacology Curriculum, which appeared in this journal in Winter 1999.

Response to Dubovsky’s Book Review

TO THE EDITOR: We have carefully considered Steve Dubovsky’s thoughtful review of our ASCP [American Society for Clinical Psychopharmacology] model psychopharmacology curriculum (1). We agree that the teaching of psychopharmacology is important, especially now. Dr. Dubovsky raises a number of knotty educational issues that deserve a dialogue we hope to begin below.

Our goal in developing this curriculum has been to make the teaching of psychopharmacology to psychiatry residents easier and more accessible, especially for the faculty of those residency programs where formal psychopharmacology teaching expertise is sparse. The Model Curriculum was designed as a framework on which programs could add. It was meant to provide a variety of suggestions, guidelines, and teaching aids from which faculty could choose. It was not designed to provide an encyclopedic exposition of the science of psychopharmacology, nor of its vast collection of references, texts, facts, or, for that matter, its future.

Dubovsky agrees that “it is important to be certain that psychiatric residents learn enough about basic principles and applications of psychopharmacology.” He notes that, although we advocate “integration” with the rest of the psychiatric curriculum, the model curriculum seems “disintegrative” to him. He lists three reasons why he thinks this. The first is that we don’t “reconcile the content and process” of the curriculum with Residency Review Committee requirements (we discuss the ACGME requirement on p 11) or with “other national standards” (we’re not clear what other standards he refers to) or with the “current state of most residency programs.” Our response is that we did include two professors, David Previn of Einstein [Albert Einstein College of Medicine] and Sid Zisook of UC San Diego on the committee. Both have been (or are) training directors who have worked closely with relevant AADPRTD committees. We are confident that the ASCP Curriculum provides at least as much relevant psychopharmacologic information as the vast majority of training programs currently impart. Similarly, the ACGME’s requirement for “adequate and systematic instruction in psychopharmacology” is more than satisfied by this curriculum.

The second reason he notes is that we advocate for a coordinator for psychopharmacology training to actively coordinate the program and a chief resident (or Fellow) in psychopharmacology to expedite carrying it out. We find it hard to understand how these two positions “split psychopharmacology from other routine aspects of psychiatric practice,” as Dr. Dubovsky states, any more than having a director of outpatient or consultation-liaison psychiatry causes such a split. Furthermore, we qualified this recommendation by saying that the curriculum coordinator should have a “broad orientation” and “should be an integral part of a given department’s residency education committee”—in order to “integrate,” and not “split.” We, ourselves, have not observed that “a chief resident in psychopharmacology may serve to further split psychopharmacology from other routine aspects of psychiatric practice,” and are mystified by Dr. Dubovsky’s judgment that “the inclusion of content on diagnosis and psychotherapy seems to imply that the expert psychopharmacologist knows more about these areas than other subspecialists.”

Dr. Dubovsky notes that most of the topics we include have “slides only” (vs. both lecture notes/outlines and hard-copy of slides). Our committee debated long and hard over this issue, concluding that most psychopharmacology lecturers assemble a “lecture” just this way—that is, assembling hard-copy of slides and lecturing from them. Although both formulas would be useful, must lecturers in psychopharmacology use only the hard-copy format. We explain this, and how to use the hard-copy we provide, on pp 119 and 120 of the Curriculum. We agree that it would be beneficial to include lecture notes, key references, and, perhaps, even a brief manuscript on each topic. Possibly, we will provide such materials in future editions. For now, however, we leave it to the users to supplement the slides with information obtained from the literature and from their own experience.
Dr. Dubovsky notes that most slides “use the same format, but many seem to come from other lectures that the authors have given.” We are unclear as to the implication of this comment, but note that the slides may, indeed, be an integration of several lectures, as provided by the authors of the slide sets. He also notes that the slide sets are not necessarily directed toward the specific type of courses suggested in the first part of the book. However, no samples of this discrepancy are given, and, in fact, we designed the lecture series/slide sets to match the courses mentioned on pp 14–17.

Dr. Dubovsky notes that the lecture on electroconvulsive therapy (ECT) is “excellent” but criticizes the omission of transcranial magnetic stimulation (TMS), artificial bright light, sleep deprivation, social-rhythms therapy, and other “biologically-oriented” topics. We agree in part, but note that our curriculum is focused principally on psychopharmacology, with ECT considered in part because of the intricacies of its use in patients receiving psychotropic drugs. The curriculum, and/or a course in psychopharmacology, cannot appropriately cover all effective or experimental treatments. Rather, we have hoped to cover what we considered essential for residency training in psychopharmacology.

Dr. Dubovsky points out that “the recommendation for a baseline EKG and EEG for children taking any medication seems whimsical, at best, as does the recommendation for monoamine oxidase inhibitors, but not venlafaxine or bupropion, in children.” In response, our child psychopharmacologists tell us that the judicious use of EKGs for specific agents, such as tricyclics, pemizide, thioridazine, and risperidone is well documented in the child population. We did, on p 70, mention MAOIs in drug interactions, but no specific recommendation was made for their use in treatment (although they are listed for discussion in the Depression section).

Dr. Dubovsky finds the discussion of atypical antipsychotics “excellent,” but notes that it lacks material on “ziprazidone and other new drugs” (which, by the way, are not marketed in the United States). He believes we have minimized the problem of “weight gain with olanzapine.” We disagree with this statement, given that we noted it on p 22 with an asterisk, saying, “the weight gain is ≥7% of body weight.”

Dr. Dubovsky finds that the “greatest weakness of the model curriculum is that it focuses almost exclusively on current information deemed important by the lecturer, and not at all on the weaknesses of today’s hypotheses or on the direction tomorrow’s hypotheses are likely to take. The resident is given a lot of information but is not taught how to think critically. The authors of the text emphasize the progressive nature of education in psychopharmacology, but the course work offered here does not progress.” We, in fact, discuss this issue in detail on pp 14–17 and pp 38–39. We can accept the comment that the curriculum “focuses on current information deemed important by the lecturer,” and we can see many shortcomings in the curriculum, but to blame us for not teaching residents how to think critically perhaps goes a bit too far.

We agree with Dr. Dubovsky’s suggestion to put the slides into PowerPoint (we have done just that for the approximately 2,000 slides in our second edition, now in preparation). In our next edition, we have included case vignettes tied to each lecture topic, and, if we can find support, we plan to put the curriculum on the Web.

We wish to emphasize a few final points:

Dr. Dubovsky notes our references to major texts, but omits the fact that we annotated the list. He makes a point of noting that one of them, the Don Klein et al. classic, is 20 years old; this inclusion, we explained in the annotation, is because it is a “review of data-based information on efficacy of drugs used clinically up to 1980 . . . [It] demonstrates critical thinking and evaluation of data bases (p 35).”

Dr. Dubovsky faults us for not helping educators find videotapes. We provided such a list (which includes his videotaped lecture) on p 701. More to the point, our surveys suggested that residents want “live” lecturers, not videos. We agree that finding a mechanism to regularly update key teaching material, such as videotapes, would enrich the program.

Finally, the curriculum was co-authored not just by “senior” members of the ASCP, as Dr. Dubovsky states, but also by one mid-level faculty member (Jessica Osterheld) and one recently graduated resident (Murali Durawaimy), as well as the executive director of the National Foundation for Depressive Illness, and the ASCP (Peter Ross).

In summary, the lectures and slide sets provided in the Model Curriculum came from the files of expert psychopharmacologists who teach psychopharmacology at their own institutions and nationally. These materials are obviously limited to what these experts consider to be important. They obviously can be modified by the addition of details by the faculty members who give a specific lecture. The Curriculum represents our own perspective on the teaching of psychopharmacology, and we have purposely not attempted to make it “politically correct” by integrating it with all the changing man-