



A Core Curriculum for Psychology in UK Undergraduate Medical Education

SECOND EDITION • 2026

**Behavioural & Social Sciences Teaching in Medicine (BeSST) Psychology
Subcommittee**

A Core Curriculum for Psychology in UK Undergraduate Medical Education

Produced by the Behavioural & Social Sciences Teaching in Medicine (BeSST)
Psychology Subcommittee

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Executive summary

We have designed this second edition of the Psychology Core Curriculum to meet the needs of contemporary medical education and increasing student numbers; reflecting the realities of a post-pandemic world and the evolving challenges of modern society including widening health inequities, rapid social change, climate change and digital communication. Shaping how future doctors understand and apply psychological principles in practice is paramount. Thus, this document embraces modern reality and sets a clear intention: psychology teaching is not abstract or siloed; it is applied, evidence-based, person-centred and embedded in real clinical contexts.

In revising the Psychology Core Curriculum (Bundy et al., 2010) and processes (Cordingly et al., 2013), we have mapped suggested psychology learning outcomes to the General Medical Council's (GMC; 2018) Outcomes for Graduates which sets expectations for future doctors to develop essential professional capabilities. These outcomes include:

- Upholding professional values and behaviours (including ethical responsibilities)
- Demonstrating professional skills (e.g., the ability to manage complexity and uncertainty, demonstrate effective and compassionate communication with patients and colleagues)
- Updating professional knowledge such as applying psychological principles.

All of these must be grounded in a strong understanding of behavioural, social and cultural contexts of healthcare. This foundation enables graduates to prevent and manage illness effectively, safeguard vulnerable populations and apply research methods with confidence.

Our updated curriculum was developed through a rigorous, inclusive and collaborative process. Psychology educators from UK medical schools worked alongside a broad range of stakeholders, including patient and public representatives, clinicians, students and medical educationalists to review content and reach consensus on topics for inclusion. This consultation was complemented by a national survey (Lavallée et al., *under peer review*) and a scoping review (Jones et al., *in draft*) to explore the teaching and assessment of psychology in UK undergraduate medical education.

The psychology core curriculum is a comprehensive guide comprising seven topics (Table 1), which are underpinned by the Biopsychosocial Model (Engel, 1977). This overarching framework has enabled us to outline key psychological theory influencing health and illness in the context of the interaction of biological, psychological and social factors. We have included core learning outcomes, indicative content and behavioural outcomes for each topic.

Table 1. The Psychology Core Curriculum for UK Medical Education (2026)

The Biopsychosocial perspective	
Topic 1 covered via Topics 2–7	
Topic 2	Psychological factors in health and illness
Topic 3	Cognitive functioning in health and illness
Topic 4	Psychological aspects of mental health and mental ill health
Topic 5	Psychological responses to illness
Topic 6	Psychology across the lifespan
Topic 7	Psychology in team-based healthcare

We have enjoyed collaborating with all our stakeholders throughout this process and hope you find the BeSST Psychology Core Curriculum a helpful tool to support your curriculum development.

BeSST Psychology subcommittee, 2026

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Foreword

We are delighted to welcome this revised and updated Psychology Core Curriculum. The new edition heralds an important phase in the advance of medical education, which has seen a growing recognition and implementation of behavioural and social sciences, and specifically psychology, within how generations of doctors are now trained and practice medicine. Psychological literacy of the health workforce is a crucial, implicit part of many of our current health system challenges and plans.

We were both part of the first Psychology Core Curriculum. This came at a fertile time, when the idea of embedding psychology and behavioural sciences within medical education was novel. It required us, with our colleagues Chris Bundy, Lis Cordingly, Judy Rock and Laura Hodges, to convince the medical education establishment of our vision that the science of psychology was central to relatively new ideas emerging within medicine such as patient-centred care and evidence-based practice. We argued that psychology needed to be learnt by tomorrow's doctors alongside other key disciplines such as pharmacology, anatomy, biochemistry and ethics. We also understood that to be feasible the 'how' was just as important as the 'what'. Fundamental to this was the creation of the Behaviour in Social Science Teachers (BeSST) in medical education organisation, which enabled individual behavioural scientists who were often isolated in medical schools, to form a community of practice. Consequently, psychologists and behavioural scientists became a must-have within medical school faculty, and learning about psychological frameworks and ideas moved from 'nice to know' to 'need to know'. Moreover, this helped build a workforce of medical educators who have the knowledge and skills to ensure these ideas permeate across all facets of medical training.

As health psychologists, many of our esteemed colleagues have had roles in medical and other health professional schools, shaping medical education. This has helped us to see the importance and opportunities of working with health professionals and has undoubtedly enhanced robust research, practice change and education.

This latest edition of the Psychology Core Curriculum succinctly reflects considerable systematic and thoughtful activity. The authors have used rigorous methods and inclusive consultation with relevant stakeholders, including patients, carers, students, clinicians and medical educationalists. We commend the team on their commitment to producing this, and for the BeSST organisation more generally in providing the supportive environment to enable the work to be achieved. This updated core curriculum will be of enormous help in our changing medical education landscape. We can see how the team have ensured that this work makes excellent use of the most contemporary theories and frameworks. Integration is a key facet of medical education internationally, and the revision is aligned with and contains helpful links to important related curricula guidance such as public health, sociology and communication, and is mapped directly to GMC Outcomes for Graduates.

One of the concerns about core curricula for all the 'ologies' is that if we incorporated the full breadth of each discipline, the medical education programme would be many many years long. The framing and specificity of this core curriculum gives a great basis for translation into integrated programmes. The broad and inclusive consensus methods used mean that the guidance will be useful to specialist behavioural scientists who are so vital to translate the science into concrete teaching, learning and assessment, but also their multi-disciplinary medical educators. A key

development is that there is consideration of teaching and learning approaches including links to assessment (and the new UK MLA) and explicit behavioural outcomes, making the resource both informative and practical.

We are excited to see how this curriculum is successfully operationalised to achieve and enhance our outcomes for medical graduates, and create a psychologically literate workforce.

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1. Introduction

This Psychology Core Curriculum has been developed by members of the Psychology Subcommittee in collaboration with a broad network of educators and practitioners within BeSST. It provides a practical, flexible framework for delivering an intellectually robust and engaging psychology curriculum in undergraduate medical education. This document is designed to support colleagues who teach psychology, as well as those responsible for managing and shaping medical curricula.

To ensure integrated and connected learning across subjects within medicine, we recommend that educators and learners refer to relevant core documents and guidelines in related disciplines such as the [Sociology Core Curriculum](#) (BeSST, 2025), [Public Health](#) (Public Health Educators in Medical Schools, 2019), [Clinical Communication](#) (Noble et al., 2018) and [Medical Ethics and Law](#) (Institute of Medical Ethics, 2019). The Psychology Core Curriculum helps educators identify areas where content overlaps with other disciplines and where it complements them. It also clarifies the unique contributions psychology brings to medical education, ensuring its integration across the curriculum.

This document:

- Describes what psychology is and its relevance to undergraduate medical education.
- Explains the rationale for revising the Psychology Core Curriculum and the inclusive processes used.
- Provides a practical guide to support medical schools in achieving the learning outcomes set out by the GMC in *Outcomes for Graduates* (2018).
- Maps psychology learning outcomes directly to the GMC's (2018) Outcomes for Graduates framework and The Quality Assurance Agency for Higher Education Subject Benchmark Statement for Psychology (2023) to ensure alignment and integration.



2. Psychology in medical education

What is psychology?

Psychology is the scientific study of the mind, brain, experience, behaviour and sociocultural contexts of humans, as well as non-human animals. Psychology explores how we think, feel and behave, and investigates the underlying cognitive, emotional and behavioural processes in individuals and groups. Psychologists and psychology researchers employ robust scientific methodology to understand why people act as they do and to address real-world issues.

How does psychology apply to medicine?

In recent decades there have been significant advances in our understanding of the leading causes of illness and death, how patients respond psychologically to health and illness, and the behavioural and social factors central to prevention and treatment of illness. Around half of preventable deaths are linked to behaviours such as smoking, alcohol use, physical inactivity and inadequate health practices (Office for National Statistics, 2025). Psychological and social influences across the lifespan also shape health outcomes and the risk of developing long-term conditions through beliefs, expectations and emotional responses. Global health challenges in recent years, such as the COVID-19 pandemic, underscored the profound impact of behaviour, mental health and social determinants on health outcomes, while accelerating changes in education, healthcare delivery, technology use and patient expectations.

Psychology is fundamental to providing a scientific framework by which medicine can extend beyond biological pathology and begin to understand the individual's actual experience of illness, as well as changing psychological needs and functions. Through providing mechanistic frameworks to understand symptom perception, pain modulation and treatment concordance, clinical care can help to integrate biomedical interventions with those that address the behavioural drivers of health and illness. Psychological principles are also central to the practice of safe, effective, patient-centred care in medicine and within the National Health Service (NHS); supporting the application of models of human cognition to optimise diagnostic reasoning and mitigate error in high-pressure clinical environments. Knowledge of psychological processes helps clinicians to understand and navigate complexity, build empathy to understand the patient's perspective, take care of their own wellbeing and work skilfully in teams.

Psychology and medical education

The adoption of the biopsychosocial model in medical education challenges the reductionist view of patients as identical biological systems. Psychological knowledge is fundamental to understanding how individual differences in coping, personality and cognitive variation can explain why similar pathology might manifest differently in people. By understanding how these specific psychological factors interact with biology to influence disease onset, symptom progression and treatment outcomes, clinicians can adapt their treatment to the person rather than just the condition.

Integrating psychological theory and knowledge into medical training equips graduates to manage modern health challenges where the disease burden has shifted from acute infection to complex,

chronic and behaviour-related conditions. As the prevalence of functional disorders and multimorbidity rises, the biomedical model is increasingly insufficient, and physicians must now have a sophisticated understanding of the way in which biopsychosocial factors interact to shape a person's perception of symptoms and their ability to self-manage their care. Indeed, in an era defined by information overload and high-stakes decision-making, this psychological understanding is critical for patient safety, equipping doctors with the metacognitive tools to recognise their own heuristic biases, manage cognitive load and mitigate the human factors that can lead to diagnostic error and burnout.

The current iteration of Outcomes for Graduates (GMC, 2018) includes a section on 'Applying Psychological Principles'. Crucially, this edition mentions the importance of psychological principles across all three overarching outcomes, namely professional values and skills, professional behaviour and professional knowledge. Newly qualified doctors are expected to consider the impact of psychology in their consultations, diagnosis, management and treatment of health conditions. Graduates are also expected to apply these principles to their own behaviour and those of their colleagues. The appearance of psychological principles throughout the guidance, rather than as a standalone section, is testimony to the significant value of psychology within medical education. This is also reflected by patients' desires for more holistic care beyond a purely biomedical model (Adams, Harrison, & Wolf, 2024).



3. Teaching and assessing psychology in UK undergraduate medical education



Where is psychology taught in the medical curriculum?

From our research, we know Psychology theory and knowledge informs broad topics fundamental to medical practice and education. However, psychology can sometimes be ‘hidden’ within curricula under other guises; making it difficult to de-couple from other core topics such as professionalism teaching (Jones et al., *in-draft*). For example, psychological theory related to teamwork, leadership and power dynamics may inform teaching about working in a multidisciplinary team. Medical students may also be taught psychological interventions under another aspect of the curriculum, for example students might learn Motivational Interviewing (Miller & Rollnick, 2013) as a tool to support patient behaviour change within a Clinical Communication Skills curriculum. Currently, psychology is mainly taught within the early years of the undergraduate medical degree (Lavallée et al., *under review*) and it is important to scaffold student learning using a spiral and vertical curriculum, alongside the layering of teaching knowledge and skills within the later years of the programme.

Who teaches psychology?

Psychology is broad and far reaching as a field. Delivering the Psychology Core Curriculum in undergraduate medical education will need to be a collaborative effort across each medical school. Psychologists working within medical schools provide essential expertise in key topic areas and work with clinical colleagues and across other

areas of specialism (e.g., clinical communication, ethics and law, public health, professionalism). Patients and caregivers are often invited to medical schools to share their lived experiences of daily life managing symptoms, accessing and navigating healthcare services, managing treatment and communication with healthcare professionals. Teaching by patients and caregivers can take many forms (e.g., as guest speakers in a teaching session or on placement, delivery of a lecture, assessment of skills) and may not necessarily sit within the ‘Psychology’ curriculum. However, we must not underestimate the value of this type of learning in terms of meeting a variety of Psychology learning outcomes included in this Core Curriculum.

Psychology in curriculum design and pedagogy

Psychology's contribution to the educational process has long been recognised. The acquisition and maintenance of new knowledge and skills is an integral aspect of medical practice. The recognition that medicine requires self-directed learning skills and the ability to assess current knowledge levels is incorporated into undergraduate medical curricula. In undergraduate medical education, psychology underpins many of the pedagogies used every day to build safe, capable clinicians. Moreover, students can apply their psychology learning (e.g., memory, attention) to their own methods for learning and wellbeing approaches.

Curriculum design in medical education requires a strategic and collaborative approach. There can be challenges to introducing new topics and ideas, into a well-engrained programme that has been delivered for many years. However, medical curricula need to adapt to changing healthcare systems and modern practice to meet the needs of patients today. Opportunities to review existing psychology curricula may present themselves during a typical 'curriculum review', or with the appointment of staff dedicated to psychology with time protected for curricula design. A good place to start might be to map existing curricula to our updated Core Curriculum, to identify any key topics, teaching methods or assessment currently omitted. Local patients and caregivers should be involved in curriculum co-design, reflecting a higher level of involvement (Level 6 on the taxonomy of patient involvement in clinical education; Towle et al., 2010) and meeting GMC requirements for patient involvement in teaching (GMC, 2011).

By inviting patient representatives to School committees, or by arranging specific co-design workshops with key stakeholders, medical schools can design curricula directly informed by local patient needs and priorities. Of course this process should be well managed and appropriately rewarded (e.g., covering costs of involvement work to patients and caregivers) and we would recommend using GMC or National Institute for Health and Care Research (NIHR) public and patient involvement guidance for specific considerations. Patients and caregivers can bring new perspectives and creative ways of approaching topics.

What learning and teaching approaches are used?

Psychology teaching in medical education has evolved over recent decades, embracing a rich mix of methods that support deep learning and clinical transfer. Alongside large group formats (e.g., lectures), programmes now routinely use small group seminars and tutorials; as well as active learning models such as problem-, case- and team-based learning, with flipped classrooms and blended approaches helping students connect theory to practice. Increasingly, medical schools are incorporating authentic, experiential pedagogies such as patient simulations, interprofessional education, narrative medicine and patient as educator initiatives to bring psychological concepts to life in realistic contexts. Co-teaching is particularly valuable whereby psychologists work alongside clinical colleagues and people with lived experience to integrate scientific understanding with practice; for example, joint sessions with psychologists, neurologists, GPs and expert patients to explore pain or stroke and role-model multidisciplinary working. Structured feedback and guided reflection are treated as essential components of the learning cycle, reinforcing key psychological principles and supporting the development of safe, person-centred doctors.

How is psychology assessed in medical education?

Assessment forms an important part of medical learning and psychology topics feature in the GMC Medical Licensing Assessment (MLA). Notably, psychological principles are interwoven throughout the MLA content map in the following ways:

- (i) Explicitly featuring under 'areas of professional knowledge'
- (ii) Clinical and professional capabilities may include several underlying psychological skills and treatments (e.g., 'deals effectively with complexity and uncertainty including managing multimorbidity...', 'manages pain')
- (iii) There is strong evidence for prevention and/or management of many of the clinical presentations listed using a behavioural or biopsychosocial approach (e.g., addiction, anxiety, depression, obesity, vaccination). Therefore, it is crucial that behavioural and psychological science principles are included in any traditional medical exams, including Applied Knowledge Tests (AKT) and Clinical and Professional Skills Assessments (CPSAs). The inclusion of psychological principles in assessment also emphasises to medical students how crucial this learning is to their clinical practice.

Producing assessments, for example subject-specific questions, may require assessment teams to work collaboratively to refine questions and clinical scenarios to ensure they are tailored to the appropriate learning stage. Involving stakeholders such as patients, clinicians and psychologists in practice, can be helpful to support the development of questions assessing relevant and up to date person-centred clinical practice. Indeed, there is growing evidence for pursuing a more inclusive approach to designing skills in medical education (e.g., Moulton, McKinley & Yeates, 2021). The learning objectives outlined in this curriculum can be used to create a variety of exam questions, reflective essays, presentations and other methods to assess students' knowledge, skills and behaviours.

The curriculum in practice

This Core Curriculum has been designed using collaborative and scientific approaches, mirroring the delivery of medical education. Teaching psychology to medical students offers an exciting opportunity for further collaboration and role-modelling of multidisciplinary working. As mentioned, this Core Curriculum has been designed to be used in conjunction with other core curricula to support the overall development of the medical workforce.

4. Developing the core curriculum: 2024–2026

We have taken a collaborative and inclusive approach when revising this Core Curriculum, ensuring individuals responsible for teaching psychology in UK medical schools and representatives from regulating bodies have had the opportunity to contribute. In addition, we have sought feedback from a wide range of stakeholders including patient and public representatives, students, clinicians and expert academics. We have outlined the stages involved in revising this Core Curriculum below.

Stage 1: Survey and scoping review

We undertook two concurrent research projects, including a survey and scoping review, to gain an understanding of how psychology is taught and assessed in UK undergraduate medical education (Figure 1). For further information on the methods and findings of both the survey and scoping review, please see Lavallée et al. (*under peer review*) and Jones et al. (*in draft*).

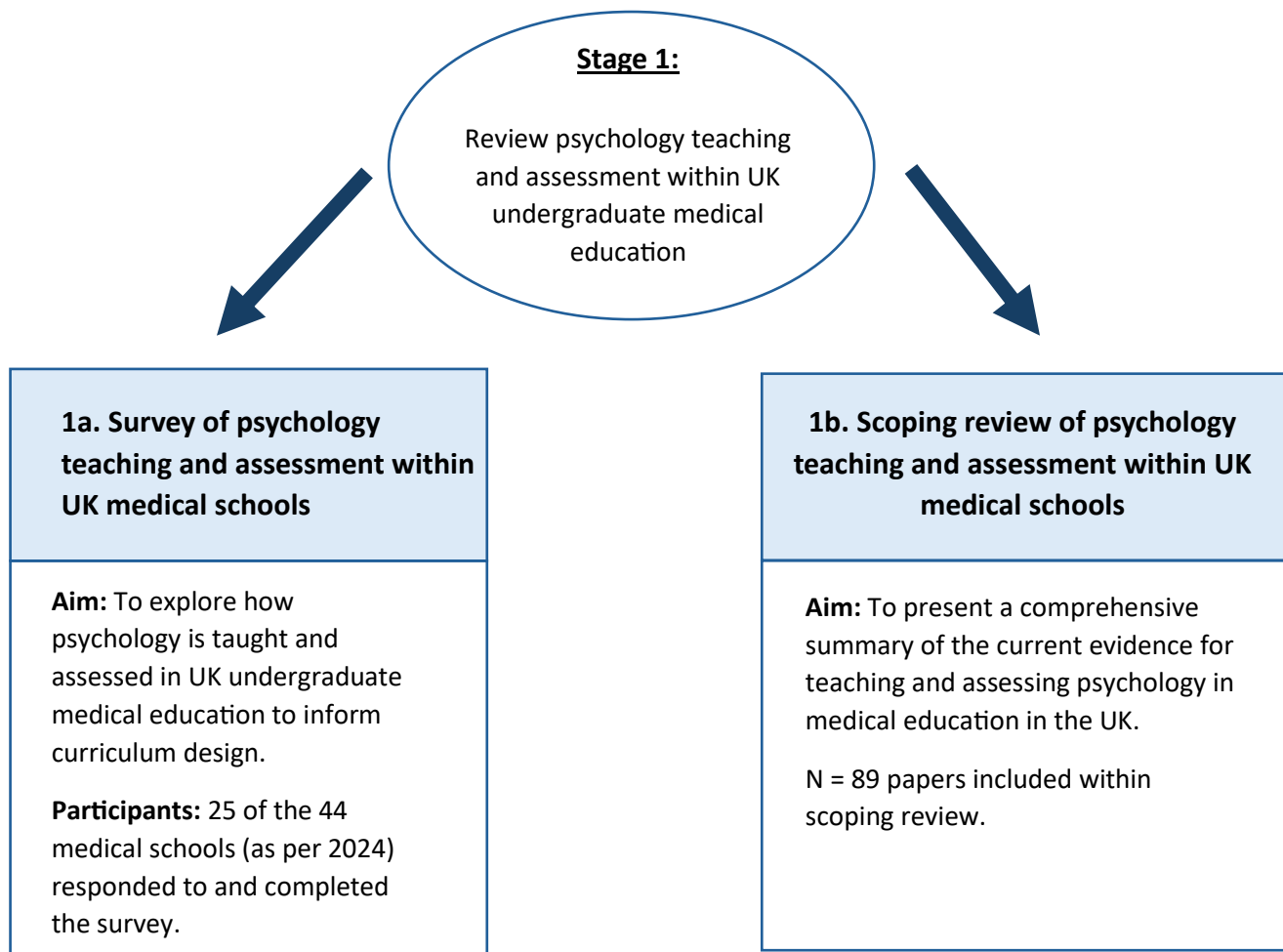


Figure 1. Stage 1 of psychology core curriculum revision

Stage 2: Consultation to evaluate the original Psychology Core Curriculum

We consulted with 27 individuals from 12 UK Institutions, including medical students ($n=7$) and expert academics ($n=13$), as well as clinicians ($n=5$) and patient and public involvement and engagement partners ($n=2$). We asked this steering group to review the original Psychology Core Curriculum and consider and comment on:

- Which content needed updating or removing
- Any additional content that should be included
- Which topics are essential within medical education
- Which topics are beneficial but not essential within medical education
- The most effective methods for teaching and learning psychology content within medical education
- The most appropriate methods for assessing psychology within medical education
- Any additional feedback and comments

We collected this information via email and held an online meeting with the steering group to discuss their comments.

Stage 3: Revising the core curriculum

The survey, scoping review and consultation resulted in the production of an initial list of 33 'core' topics and 15 topics considered 'additional extras' (e.g., learning to learn). We held a 2-day in-person workshop for our psychology subcommittee enabling us to group the content into smaller, more specific topics and refine the draft Core Curriculum. To avoid repetition, we signposted to relevant core curricula that are already available and cover specific topics that cross over with psychology (e.g., prejudice, discrimination, health inequalities, the doctor-patient relationship, person-centered consultation).

Stage 4: Consultation of the draft Core Curriculum

We sent the updated draft to the steering group to gather their views on the content, readability and usability of the document. Sixteen stakeholders, including expert academics ($n=8$), clinicians ($n=2$), medical students ($n=4$) and clinical academics ($n=2$) provided feedback on the revised draft, commenting on:

- **Strategic fit and purpose** including the purpose and scope of the document, the knowledge, skills and attitudes covered by the curriculum and mapping to GMC's Outcomes for Graduates (2018).
- **Learning outcomes** paying particular attention to clarity, pitch and measurement, essential versus beneficial nature of the learning and behavioural outcomes, whether any content was missing from the document.
- **Document quality and usability** including the structure of the document, language used within it and intention to use the document in future.

We incorporated feedback within the Core Curriculum presented here.

5. Core curriculum for psychology in UK undergraduate medical education

We have developed this Core Curriculum as a guide to support educators to deliver psychology within medical education. Please implement the content to suit your institutional context and practices.

The Psychology Core Curriculum is divided into seven topics. Topic 1 is overarching because the biopsychosocial perspective underpins all psychology learning in medical education.

Topic 1	The biopsychosocial perspective
Topic 2	Psychological factors in health and illness
Topic 3	Cognitive functioning in health and illness
Topic 4	Psychological aspects of mental health and mental ill health
Topic 5	Psychological responses to illness
Topic 6	Psychology across the lifespan
Topic 7	Psychology in team-based healthcare

For each topic we have provided the following to support educators in developing their psychology teaching:

- **Core learning outcome:** the principal learning outcome for each topic.
- **Key learning outcomes:** more detailed learning outcomes linked to the core learning outcome.
- **Indicative content:** suggested content linked to each key learning outcome. Indicative content is intended to be suggestive rather than prescriptive and can be adapted by educators to suit local contexts.
- **Behavioural outcomes:** describe what learners should be able to do following teaching and training, and are designed to support constructive alignment between curriculum content, learning activities and assessment. Useful behavioural outcomes specify who needs to do what, how, with whom, and when or where this should occur (Hart et al., 2023). The examples provided in each topic are intended to be adapted to local contexts, including clinical placements, simulation, case-based teaching, reflective assignments and assessment. They are not intended as an exhaustive checklist.

Using the topic guides: begin with the core learning outcome, select key outcomes, adapt indicative content to local context, then translate learning into observable behavioural outcomes (examples have been provided).

Topic 1: A Biopsychosocial Perspective

Core learning outcome

Describe and apply the principles of the biopsychosocial perspective to health, illness and medical practice

Key learning outcome*	Indicative content
Define and apply knowledge of the biopsychosocial perspective	• The biological, psychological and social factors influencing health outcomes (e.g., obesity)

*The learning outcome within this topic can be addressed through topics 2-7

Behavioural outcomes

- When speaking with patients on placement, a medical student will gather information about a patient's economic and social situation (e.g., housing, income/ poverty, employment, social networks).
- When speaking with patients about weight management, a medical student will identify biological factors (e.g., medication-induced weight gain) and explore psychological and social factors (e.g., low motivation linked to depression, limited time for physical activity due to shift work).

Topic 2: Psychological factors in health and illness

Core learning outcome

Describe how psychological, biological, social and environmental factors interact to influence health and illness, and apply this knowledge to patient care

Key learning outcomes	Indicative content
Describe behavioural factors in health improvement	• The role of health-protective behaviours (e.g., physical activity, taking medication) • Knowledge of modifiable and non-modifiable risk factors • Theories and models of behaviour (e.g., COM-B, Health Belief Model) to support understanding of why individuals and groups engage in different health behaviours • The role of habit in behaviour formation and maintenance • Behaviours affecting climate change and health outcomes, as well as the risk of climate change on health behaviours and outcomes
Describe psychological factors in health improvement	• Self-efficacy, self-esteem, motivation • The Big Five personality traits, impulsivity and alexithymia
Apply psychological knowledge and skills of behaviour change to improve health outcomes	• Psychological interventions to support behaviour change, acknowledging the role of emotions, cognition and behaviour • Motivational interviewing • Behaviour change techniques and their use in healthcare (e.g., goal setting and action planning)
Describe how the mind, body and environment interact	• Psychobiological features of stress and coping • Interaction between psychological processes, the nervous system and immune function; • Individual differences in responses to health and illness (e.g., attention, mood, perception, catastrophising) • The role of environment and genetic factors in health outcomes • The role of weight stigma, including definition, origins and the psychological and health impact • How physical symptoms, psychological wellbeing, social functioning and environmental factors influence perceived quality of life and health related quality of life and ability to engage in activities (e.g., activities of daily living, work, social interactions)
Define the impact of social support (including structural and functional) and loneliness on health outcomes	• Direct and indirect effects of perceived availability of social support, including social isolation • Cultural influences on social support, including the role of formal and informal carers • The physical and psychological consequences of loneliness • Interventions that can build community and increase social connectedness (e.g., social prescribing)

Behavioural outcomes

- On placement or during simulation, a medical student will support a patient to identify a specific health-related behaviour for change by using a behaviour change model or framework (e.g., COM-B, Health Belief Model) and exploring the components.
- During clinical debrief, a medical student will explain how psychological, biological, social and environmental factors influence health, illness and quality of life by linking symptoms, stress, coping, social support, loneliness, stigma and environmental triggers with the patient's presentation and discuss with peers and supervising clinicians.

Topic 3: Cognitive functioning in health and illness

Core learning outcome

Apply key areas of cognitive theory to health and illness including language, perception, memory, attention, executive function, and behavioural and learning theory.

Key learning outcomes	Indicative content
Describe the neural basis of language and normal language development	• Key structures of the brain involved in language (e.g., Broca's, Wernicke's, angular gyrus), and how damage in these areas is implicated in neurological illness/injury (e.g., stroke, dementia, acquired brain injury) • Stages of language acquisition in early childhood (e.g. Chomsky, Bruner) and associated developmental impairment (e.g., neurodevelopmental disorders) • Factors influencing language development (biological, social, cognitive)
Outline models of memory and apply to clinical communication, patient care and management of cognitive challenges	• Models of memory (e.g., working memory, primacy & recency effect) and how they can be used to improve information retention of the clinical consultation • Types of long-term memory and how they can affect personal experiences, motor skills and ability to recall facts and knowledge • Psychological impact of memory loss
Define top-down and bottom-up processes of perception and sensation, and how these impact symptom presentation and patient experience	• Cognitive and emotional modulation of pain signals, including cognitive biases • Biopsychosocial approach to pain • Influences on interpretation of physical symptoms, including prior expectations • Consciousness • Visual and auditory perception • Pain management and phantom limb pain • Medically unexplained symptoms
Describe how attentional processes and poor sleep can impact cognition	• Developmental process of attention and the associated impact on information provision • Degenerative process of attention in the context of aging and dementia and implications for clinical care • Impact of circadian rhythms and sleep cycles on cognitive performance • Attentional capacity limits of the brain and the impacts of selective and divided attention (e.g., Kahneman's capacity model of attention) • The impact of stress and anxiety on attentional processes

Describe executive function and relevance to the development of cognitive biases, risk factors in mental health, perception of stress and emotion regulation	• Core executive functions: response inhibition, working memory, and cognitive flexibility (e.g., Miyake and Friedman model) • Developmental trajectory of executive function and impact on mental health vulnerability and emotion regulation capacity • The role of executive function in our ability to cope with adversity and challenge • Impact of cognitive heuristics on decision making and medical error
Apply behavioural principles and learning theories to patient behaviour	• Classical conditioning and associative learning • Operant conditioning (positive and negative reinforcement, positive and negative punishment), function and impact on behaviour • Social Learning Theory • Knowledge of skill acquisition

Behavioural outcomes

- When speaking with patients (e.g., during their paediatric placement), a medical student will adapt their level of language complexity based on age and/or language ability of patient.
- A medical student will write a reflection for their portfolio discussing the structure of the clinical environment and how it can they can adapt it to support patients with poor response inhibition (e.g., removing distractions, setting clear, short-term goals).

Topic 4: Psychological aspects of mental health and mental illness

Core learning outcome

Apply psychological principles to promote wellbeing and physical health, understand mental health and illness, and demonstrate sensitivity and professionalism in patient care and self-care

Key learning outcomes	Indicative content
Explain the basic principles of wellbeing	• Basic principles of wellbeing maintenance, including health behaviours (e.g., sleep, eating behaviours, stress management, physical activity, coping strategies) • The interconnectedness between physical and psychological health
Describe common mental health conditions and psychological therapies, applying the biopsychosocial model to support patient care	• Common mental ill health experiences including symptoms and impact on patients, through the lens of the biopsychosocial model • Psychological therapies for mental ill health (e.g., second and third wave therapies)
Identify different types of trauma and their impact on physical and mental health across the lifespan	• Signs of emotional/psychological distress in self and others • Different types of trauma (e.g., public health emergencies, natural disasters, Intensive Care Unit admission, moral injury, adverse childhood experiences)
Use appropriate terminology to describe mental ill health and psychological approaches to treatment and recovery	• Sensitive and stigma-aware information about self-harm, suicide, substance misuse, addiction, addictive behaviours and risk/protective factors • Approaches to the treatment of addiction and the promotion of recovery (e.g., talking therapies, group support). • Psychological evidence and interventions for substance misuse, behavioural addiction, self-harm and suicide

Behavioural outcomes

- Medical students will write a comprehensive management plan integrating physical, psychological and social factors, including mental health needs, health behaviours and appropriate psychological and/or pharmacological interventions, with patients and the multidisciplinary team, during supervised clinical encounters and case discussions.
- Using appropriate, sensitive and non-stigmatising language, medical students will explore a patient's psychological state, social context, risk and protective factors during supervised clinical encounters and case discussions.

Topic 5: Psychological responses to illness

Core learning outcome

Identify and apply psychological principles to support responses to illness and support individuals with managing illness

Key learning outcomes	Indicative content
Identify patient responses and adjustment to illness using the biopsychosocial perspective	• Factors influencing individual patient responses to illness and disease (e.g., symptoms, diagnosis, health anxiety, hypervigilance, illness cognitions, attribution theories, self-esteem) • Differences in how individuals behave, think or feel in response to new symptoms and/or diagnosis (e.g., help seeking theories) • Different coping strategies (e.g., problem-focused vs. emotion-focused coping) and their direct and indirect effects on health • Individual differences between patients in how much information they want about a condition (e.g., information seekers vs avoiders) and how much they understand (e.g., health literacy)
Outline psychological models and theories (including cognitive, social, developmental and stress models) to explain variation in patient responses	• Cognitive, social and developmental theories and models (e.g., self-regulation model) • Theories of stress (e.g., Transactional Model of Stress, Seligman's model of stress, learned helplessness) • Function of health threatening behaviours in response to stress • Impact of cognitive dissonance on health outcomes • Social influences on health, social support networks and cultural beliefs
Critically evaluate and use evidence-based approaches to improve quality of life, address patient responses that are associated with harm and support patients with possible multimorbidity	• Psychological interventions designed to: - Address responses to illness and disease (e.g., cognitive behaviour therapy, acceptance and commitment therapy), and how to refer patients to local psychological services (e.g. NHS Talking Therapies) for further support - Improve quality of life, including understanding the interaction between psychological process, clinical symptoms and physical health
Explain the roles of the multidisciplinary team and caregivers in supporting self-management of long-term conditions	• The role of the multidisciplinary team, including clinical and allied health professions • The variety of roles a caregiver has in supporting individuals to manage physical and/or mental health conditions and multimorbidity

Behavioural outcomes

- Medical students will critically evaluate and adapt patient information to meet health literacy needs by analysing a patient information leaflet for clarity, accessibility and appropriateness. During case-based discussions, medical students should propose modifications to align with an individual patient's health literacy level, preferences and information needs.

- Medical students will recognise patients who may benefit from psychological support and appropriately escalate care by identifying clinical, behavioural, and psychosocial indicators and clearly communicating these to a supervisor, including suggesting appropriate referral pathways.

Topic 6: Psychology across the lifespan

Core learning outcome

Identify psychological principles across the lifespan, including development, trauma, diversity, neurodivergence and end-of-life care, and apply these principles to deliver inclusive, compassionate and evidence-based healthcare

Key learning outcomes	Indicative content
Identify psychological development and adjustment across the lifespan	• Epigenetics and prenatal development: how environmental factors influence gene expression and foetal development • Psychological milestones in infancy and early childhood (e.g., Theory of Mind, attachment styles) • Identity formation, risk perception and social relationships in adolescence • Psychological aspects of parenthood, caregiving, menopause, retirement and adjustment in later life, including individual differences and the interplay of biological, social and psychological factors
Describe the impact of adverse childhood experiences (ACEs) and trauma on health across the lifespan	• Implications of adverse childhood experiences (ACEs), trauma and protective factors on mental and physical health • Trauma-informed care in clinical practice*
Provide respectful, equitable and inclusive care by understanding gender identity and sexual orientation	• Definitions and distinctions: gender identity, gender expression, biological sex and sexual orientation. • Implications of gender identity and sexual orientation for healthcare needs across the lifespan. • Principles of inclusive clinical practice, including social determinants of health inequalities
Describe neurodivergent conditions and disability across the lifespan	• Characteristics of neurodivergent conditions (e.g., autism, ADHD, dyslexia) • Experiences of neurodivergence across the lifespan • Evidence-based, person-centred approaches to support neurodivergent individuals • Barriers to care and strategies for inclusion • Intersection of neurodivergence with gender, ethnicity and social context

Identify psychological aspects of death, dying, and bereavement	• Psychological aspects of death, dying and bereavement, including miscarriage, stillbirth and suicide • Key theoretical frameworks (e.g., dual process model) • Implications of bereavement and moral distress on personal wellbeing and coping strategies (e.g., reflection, debriefing, seeking support, self-care) • Cultural implications and sensitivity
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**Specific types of trauma (e.g., ACEs, public health emergencies, moral injury) and psychological therapies for trauma are covered in Topic 4; this KLO focuses on the lifespan trajectory of adversity and resilience*

Behavioural outcomes

- Medical students will explore relevant developmental stage, trauma history, identity, neurodivergence and psychosocial context during clinical encounters with patients and carers, and use this information to guide clinical reasoning.
- During simulated and clinical practice, medical students will adapt their communication and care to deliver inclusive, trauma-informed and compassionate practice by adjusting language, approach and management to reflect developmental stage, cultural identity, neurodivergence and experiences of trauma.

Topic 7: Psychology in team-based healthcare

Core learning outcome

Apply social and organisational psychology principles to work effectively in teams, understand group dynamics, communicate collaboratively and contribute to safe, coordinated and patient-centred clinical practice.

Key learning outcomes	Indicative content
Explain how groups and teams function in healthcare	• Groups vs teams in clinical environments • Group dynamics and intergroup processes • Leadership roles in clinical teams • Shared mental models in multidisciplinary team working • Human factors: cognitive biases, systems thinking, error
Identify social influences on behaviour within clinical teams	• Social cognition, attribution and attitudes • Stereotyping, stigma and team behaviour • Intergroup relations across disciplines • Bystander effect in clinical and educational settings • Influence of group norms on decision-making
Demonstrate effective interprofessional and multidisciplinary collaboration (e.g., psychologists, clinicians, public health educators)	• Roles of different health and allied professions and effective teamwork • Interdisciplinary teaching models • Working with different professional cultures
Apply aspects of organisational psychology to learning, communication and team performance	• Leadership models in healthcare • Team-based learning and group assessments • Human error from systems perspective • Cognitive biases in clinical reasoning • Organisational influences on communication • Reflective practice within teams
Recognise and respond to moral distress and moral injury	• Moral distress vs injury • Ethical dilemmas • Impact on wellbeing • Support strategies

Behavioural outcomes

- During multidisciplinary team-based teaching or clinical placement, a medical student will contribute to safe, patient-centred team working by clarifying team members' roles, checking shared understanding of the patient's needs, and communicating relevant information respectfully with peers, supervising clinicians and other healthcare professionals.
- During case discussions, simulation or clinical debriefs, a medical student will identify social and organisational influences on team decision-making, including group norms, hierarchy, cognitive bias and bystander effects, by using structured reflection and speaking up appropriately with peers and supervising clinicians in the medical school or clinical placement setting.

Conclusion

This Psychology Core Curriculum brings together robust evidence with the expertise and experience of a diverse group committed to ensuring psychology remains integral to medical education. By highlighting psychology's unique contribution (i.e., understanding behaviour, cognition, emotion and social context), we aim to enhance medical students' learning and support their own wellbeing; and ultimately improve patient care and health outcomes.

Psychology offers powerful insights into behaviour, cognition, emotion and social context, and equips medical students with the competencies for patient-centred care across the lifespan, shared decision-making and managing complexity in today's healthcare systems and beyond. We are committed to supporting the implementation and ongoing development of this Psychology Core Curriculum as it becomes fully embedded within medical education and supports students prepare for the realities of modern healthcare.



Abbreviations

AKT	Applied Knowledge Tests
BeSST	Behavioural and Social Sciences Teaching in medical education
CPSA	Clinical and Professional Skills Assessment
GMC	General Medical Council
MCQ	Multiple Choice Question
MLA	Medical Licensing Assessment (often called UK MLA)
NHS	National Health Service
NIHR	National Institute for Health and Care Research
SBA	Single Best Answer
QAA	Quality Assurance Agency

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Appendix 1

Mapping of the Psychology Core Curriculum to GMC Outcomes for Graduates (2018) and Quality Assurance Agency Subject Benchmark for Psychology (2023)

We mapped the Psychology Core Curriculum to the GMC's *Outcomes for Graduates* (2018) and the Quality Assurance Agency (QAA) Subject Benchmark Statement for Psychology (2023) to demonstrate both its relevance to medical education and its grounding in recognised disciplinary standards. The GMC mapping shows how psychology contributes directly to the capabilities expected of newly qualified doctors, including clinical reasoning, communication, patient-centred care, health improvement, teamwork and professional knowledge. The QAA mapping reflects the breadth and integrity of psychology as an academic discipline, including biological, cognitive, developmental, social and individual differences. Although health psychology is not identified as a core area within the QAA statement, our work demonstrates its central importance within undergraduate medical education. Together, these mappings strengthen the curriculum's transparency, credibility and utility for educators embedding psychology within medical programmes.

Topic 1: Biopsychosocial perspective

GMC Outcomes for Graduates: 6a, 14, 14a; 23, 23a, 23b, 23c, 23d, 23e, 23f, 23g; 24a, 25, 25d, 25j

QAA subject benchmark: Biological psychology; Social psychology; Individual differences

Topic 2: Psychological factors in health and illness

GMC Outcomes for Graduates: 6a, 6c, 6d; 15; 23, 23a, 23b, 23c, 23d, 23e; 24, 24a, 24b, 24c, 24d, 24e; 25a, 25c, 25d

QAA subject benchmark: Health psychology; Social psychology; Individual differences; Biological psychology

Topic 3: Cognitive functioning in health and illness

GMC Outcomes for Graduates: 10a; 14a, 14b; 23, 23a, 23b, 23c, 23d

QAA subject benchmark: Cognitive psychology; Developmental psychology; Health psychology; Biological psychology; Individual differences

Topic 4: Psychological aspects of mental health and mental ill health

GMC Outcomes for Graduates: 2j; 6, 6a, 6b, 6c, 6d, 6e; 14a, 14m; 23, 23a, 23b, 23c, 23d, 23e, 23f; 25a, 25d; 26, 26b, 26e

QAA subject benchmark: Health psychology; Individual differences; Biological psychology

Topic 5: Psychological responses to illness

GMC Outcomes for Graduates: 3, 3a, 3b; 8; 10, 10a; 23, 23a, 23c, 23f; 24, 24e; 25, 25a

QAA subject benchmark: Individual differences; Health psychology; Social psychology; Cognitive psychology

Topic 6: Psychology across the lifespan

GMC Outcomes for Graduates: 6, 6a, 6b, 6c, 6e, 6g; 7, 7b, 7c, 7d, 7e, 7h, 7i; 10a, 10b; 11d; 14, 14a, 14j, 15; 22, 22a; 23, 23a, 23b, 23c, 23d, 23e, 23f, 23g; 24, 24a; 25, 25c, 25d, 25h

QAA subject benchmark: Developmental psychology; Individual differences; Social psychology; Biological psychology

Topic 7: Psychology in team-based healthcare

GMC Outcomes for Graduates: 5, 5c; 6, 6d; 8a, 8b, 8c, 8d; 9, 9a, 9b; 10, 10a; 23, 23g; 24, 24a

QAA subject benchmark: Social psychology