

GUIDELINES

FOR

**POST GRADUATE
PSYCHIATRY TRAINING
IN INDIA**



INDIAN PSYCHIATRIC SOCIETY

'Rajasthan House'

Plot 43, Sector 55, Gurgaon, NCT Delhi

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Guidelines for Post Graduate Psychiatry Training in India 2013

Indian Psychiatric Society

TASK FORCE

Chairman:

Dr Mohan K Isaac

Professor of Psychiatry (Population Mental Health)
School of Psychiatry and Clinical Neurosciences
The University of Western Australia, Perth

Convenor:

Dr Pratima Murthy

Professor of Psychiatry
Center for Addiction Medicine
Department of Psychiatry NIMHANS

Ex-officio Members

Dr Roy Abraham Kallivayalil

President, Indian Psychiatric Society
Professor of Psychiatry, Pushpagiri Institute of
Medical Sciences
Tiruvalla, Kerala

Dr Asim K Mallick

General Secretary, Indian Psychiatric Society
Professor of Psychiatry, Institute of Psychiatry
Kolkata

Members:

Dr PSVN Sharma

Professor and Head,
Department of Psychiatry,
Kastuba Medical College, Manipal

Dr Malay Ghosal

Professor
Dept of Psychiatry,
Medical College and Hospital, Kolkata

Dr Ajeet Sidana

Assistant Professor
Department of Psychiatry
GMCH, Chandigarh

Dr Rishikesh Behere

Assistant Professor
Department of Psychiatry,
Kastuba Medical College, Manipal

Dr Subodh BN

Assistant Professor
Department of Psychiatry
PGIMER, Chandigarh

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Message from the President, Indian Psychiatric Society

Dear Colleagues

The publication of this document, “Guidelines for Post- Graduate Psychiatry Training in India is a landmark event. The most widely referenced document so far, was the previous one published 11 years back in 2002. This was prepared by a task force headed by Mohan Isaac and Pratima Murthy and was made available in printed format as a book and was extensively circulated. Another document “Recommendations for Minimum Standards of Competency Based Training in Psychiatry” was prepared by Prof RC Jiloha and Prof Shugangi Parker for the IPS Psychiatric Education Committee in 2010, although this was not published in book format.

We could see, there was exponential growth in the number of PG Centres and PG seats in Psychiatry in India during the last 2-3 years. Besides, the views expressed in the two documents of IPS needed to be streamlined and updated. Hence the IPS Executive Council decided to appoint a task force and entrust this job to them. It may be important to mention that the first M.D. Psychiatry course in India was started by Medical College, Patna in 1941 and the first M.D. Candidate was late Prof. L.P. Verma, a Past President of I.P.S. and Past Editor of Indian Journal of Psychiatry and Neurology (Sharma et al 2010)

We are grateful to the task force headed by Prof Mohan Isaac and Prof Pratima Murthy for having taken up this arduous task. They have completed the assignment within the time of six months allotted to them. They have sent questionnaires to all PG Centres and got their feedback. This is a most comprehensive work done on PG Training in India. We are sure, this will be a valuable document, which will considerably enhance the standards of training and teaching in the country. Let me offer our heartiest congratulations to all the members of the task force.

Yours in IPS,

Prof Roy Abraham Kallivayalil

President, Indian Psychiatric Society

Vice- Principal, Professor & Head, Dept of Psychiatry,

Pushpagiri Institute of Medical Sciences, Tiruvalla, Kerala- 689 101, India

E mail id: roykalli@gmail.com

Letter of IPS President to all Fellows & Members dated July 20, 2013

From : Roy Kallivayalil <roykalli@gmail.com>
Date : Fri, Jul 20, 2012 at 12:39 AM
Subject : IPS Task force “Guidelines for PG Training in Psychiatry- 2012” :
Suggestions Invited
To : Abhay Matkar <drabhaymatkar@hotmail.com>, Ajit Avasthi &
Others

Dear Fellows and members,

We are appointing a Task force “Guidelines for PG Training in Psychiatry-2012” to update the 2002 guidelines published by IPS. As you know, the 2002 task force had Mohan Isaac as Chairman and Pratima Murthy as Convenor. In the last one decade, PG training in Psychiatry has spread far and wide, the PG seats have more than doubled and the number of PG training centres have multiplied more than three times.

Our Guidelines need revision, taking into consideration the vast changes which have occurred in the field of mental health. Hence, as IPS President, on the advice of the Executive Council, I have appointed a task force on “Guidelines for PG Training in Psychiatry- 2012” of Indian Psychiatric Society with the following members:

Chairman Prof Mohan Isaac mohan.isaac@uwa.edu.au

Convenor Prof Pratima Murthy (Nimhans, Bangalore) pratimamurthy@gmail.com

Members Prof Malay Ghosal (Kolkata)

Prof PSVN Sharma (KMC, Manipal)

Dr Ajeet Sidana (Chandigarh)

Ex-officio IPS President and Gen Secretary

This appointment is in acknowledgement of their expertise in this area as well as the significant contributions they have made to IPS. We are confident, the task-force will make a remarkable contribution to PG medical teaching in India.

We request you to send your suggestions and views to this task force at the earliest, latest by August 31, 2012. The task force has been asked to submit the draft Guidelines by **December 31, 2012** for consideration by our Executive Council. Once approved by EC, it will be published as the IPS official document.

Yours in IPS,

Prof Roy Abraham Kallivayalil

President, Indian Psychiatric Society

Background

1

Formal post graduate Diploma training in Psychiatry started at the All India Institute of Mental Health in 1955 and at the Central Institute of Psychiatry in Ranchi in 1962. Until 1967, there were only 6 institutes in the country offering post graduate psychiatry training.¹ During the last 4 decades, there has been a significant increase in post graduate training throughout the country.

The Medical Council of India (MCI), established in 1933, has a permanent committee on post graduate medical education since 1956. The MCI is the central body that formulates and implements post-graduate training in the country. In its objectives on post graduate education², the MCI clearly enunciates the need for competency based training in post graduate programs. Objectives of post graduate training as per the MCI include needing to equip the trainee with:

- Basic skills in psychiatry and scientific foundations in behavioral sciences.
- The competencies pertaining to psychiatry that are required to be practiced in the community and at all levels of health care system;
- Awareness of the contemporary advances and developments in medical
- Sciences as related to mental health;
- An orientation to principles of research methodology; and
- Acquisition of skills in educating medical and paramedical professionals.

1 Sharma S. Postgraduate training in psychiatry in India. Indian J Psychiatry 2010; 52:89-94.

2 MEDICAL COUNCIL OF INDIA POSTGRADUATE MEDICAL EDUCATION REGULATIONS, 2000, amended upto February 2012. <http://www.mciindia.org/rules-and-regulation/Postgraduate-Medical-Education-Regulations-2000.pdf>. (accessed 29/12/2012)

The Indian Psychiatric Association (IPS), in its first year of inception in 1947, set up a committee on post-graduate education. Since then, it has regularly had a sub-committee on post-graduate education. The Society has periodically deliberated on the objectives and nature of post-graduate training and held a workshop on post graduate training in 1979. In 2002, the IPS formulated a set of guidelines for PG training.³

The 2002 IPS Guidelines recognised that there were many small departments of psychiatry that had just begun post-graduate training programs and thus set out to establish basic requirements and training programs as a minimum guideline upon which institutions could build to improve training. It was suggested that constraints in meeting these minimum guidelines could be overcome through posting trainees to larger centers for training, having guest faculty to conduct workshops and expose the students to the CME programs of the Indian Psychiatric Society. A specific suggestion at the Workshop on Post Graduate Education at the ANCIPS 2001 was the preparation of a common set of training and resource materials for use at different centres.

In 2010, there were 112 Medical Colleges and Postgraduate Institutes which admitted 266 M.D. degree students in Psychiatry each year and 55 medical colleges with training facilities for 124 D.P.M. students. In addition 50 to 60 Postgraduates appeared for D.N.B. of the National Board of Examination. Presently, as per the official website, there are 141 MD psychiatry centers with 358 seats 37 DNB centres with 60 seats.^{4,5}

In September 2012, a task force was established to modify these guidelines in the light of radical changes in post graduate psychiatry training all over the world, as well as the fact that there has been a significant increase in post graduate training centres in India.

The Task Force had invaluable inputs and recommendations from academicians and luminaries from all over the world. We gratefully thank the following persons for their ideas and suggestions which have all helped in modifying the 2002 guidelines.

3 Indian Psychiatric Society. Guidelines: for post graduate training in psychiatry, 2002

4 <http://www.mciindia.org/InformationDesk/CollegesCoursesSearch.aspx?N=47> (accessed 29/12/12)

5 www.natboard.nic.in (accessed 29/12/12)

Drs Alok Sarin, Anand Pandurangi, Anil Shah, Arabinda Chowdhury, D Basu, SK Chaturvedi, Dilip Patel, DS Goel, Henal Shah, Himanshu Gupta, Kaustav Chakraborty, Mathew Yaltho, Nalini Juthani, D Natarajan, Nirmala Srinivasan, Ponnudurai, Prabha Chandra, Prabhakar Korada, KS Shaji, Smitha Ramadas, R Sreenivasa Murthy, JK Trivedi, Vikram Patel.

The Task Force specifically acknowledges the following Heads of Departments of Psychiatry/Training co-ordinators who responded to the questionnaire sent, some of whom also provided specific suggestions for revision of the post graduate training guidelines:

Drs Abhay Matkar, Amar Bavle, Anil Prabhakaran, Anurag Srivastava, Aparajeet Baruah, Asim Kumar Mallick, PS Bhat, BS Chavan, Christina George, PK Dalal, Daniel Saldanha, Deepa Ramaswamy, Deepak Kumar, Dilip Kumar Mondal, HA Gandhi, PD Garg, Gunugurti Prasad Rao, Harihar Chilikuri, Harish Arora, Hemangi S Dhavale, John P Mathai, GD Koolwal, SM Manohari, DG Mukherjee, Murali Thyloth, Mushtaq A Margoob, Nilesh Shah, Om Prakash Singh, NM Patil, Pradeep Sharma, Praveen Khairkar, G Raghunathan, R Raguram, Rajat Ray, Rajiv Gupta, MSVK Raju, TSS Rao, Ravi Philip Rajkumar, Ravindra Kamath, Roy Abraham Kallivayalil, Sandip Shah, Sanjeev Jain, Satheesh Rao, V Satheesh, Savita Malhotra, KS Shaji, DK Sharma, PSVN Sharma, Shivananda Kattimani, Shubangi R Parkar BS Sidhu, Smita N Deshpande, Sudhir Kumar, Sunita Simon, Sushil Kerada, Thirunavukarasu M, Varghese Punnose, Vijaya Mahadevan, Vishal Indla, Yousuf Matcheswala.

While regulatory bodies like the MCI set uniform standards for training and monitoring, it should be the responsibility of professional bodies in different specializations like the IPS to evolve guidelines for training. The professional body can play an important role in assisting post-graduate centers set up training facilities that meet the essential requirements for training. They can assist the regulatory bodies in monitoring adherence to standards, be closely involved in evaluation of trainees' fulfillment of training requirements and participate in evaluation of the trainee's competence to fulfill his/her obligations as a specialist in the area.

The Task Force on Guidelines for Post-Graduate Training in Psychiatry has attempted to fulfill its mandate with the hope that the 2013 guidelines will be widely disseminated to all post graduate centers, will be adopted by the MCI and will serve as the blueprint for psychiatry training all over the country.

Between September and December 2012, the IPS constituted a Task Force to revise the 2002 guidelines as relevant to the present times.

In order to fulfill its obligations, the Task Force carried out the following:

1. Carried out an international review of post graduate training, with a focus on countries which presently have a well designed program in psychiatric training.
2. Carried out a selective literature review of information relevant to post-graduate training in India, including published articles, earlier reports and monographs.
3. Formulated a list of addresses of all PG departments in the country and contact details. This was done from the MCI website as well as through personal contacts as some of the information available was not up to date.
4. Developed a questionnaire on post-graduate training that was circulated to all Heads of Department via email. At least three reminders were sent to non responders between September and November 2012. A further attempt was made to contact non responders through telephonic contact. This questionnaire contained details of the time since inception of the program, department structure, the type of post-graduate program (MD/ DPM/DNB), training content, modalities for selection to the PG course and assessment, compliance with MCI guidelines and IPS recommendations, suggestions for modification of the existing guidelines. Contact details of the heads of department were obtained from the IPS membership directory, and personal contacts.
5. Sent out a brief survey to senior academicians for their specific suggestions for modification of the existing IPS guidelines.
6. Sought specific suggestions from IPS for modification of the existing guidelines and new recommendations. An online request was sent by the President, IPS inviting these suggestions.
7. Incorporated the findings from the survey, review and suggestions received into the revision of post-graduate training in India 2013 task force guidelines.

International review of post graduate training

1

Training in psychiatry is evolving all over the world and is becoming more formal. In many developed countries with many years of such training, the program is much more evolved and structured. The following table compares training in the United States of America, the United Kingdom, Australia and New Zealand. The references for these are provided at the end of the accompanying table.

Highlights of Post Graduate Psychiatry Training Programs in Select Countries

	USA	UK	Canada	Europe	Australia
Regulatory Body	American Board of Psychiatry and Neurology (ABPN) and Accreditation Council for Graduate Medical Education (ACGME)	Postgraduate Medical Education and Training Board (PMETB) and Royal College of Psychiatrists (RCP)	Royal College of Physicians and Surgeons of Canada (RCPSC)	European Union of Medical Specialties (UEMS)	Royal Australian and New Zealand College of Psychiatrists (RANZCP)
Duration	4yrs	6 yrs	5 yrs	5 yrs	5 yrs
Postings	Adult Clinical postings, Sub-specialty training opportunities are available in the fields of addiction, child and adolescent psychiatry, forensic, and geriatric psychiatry, as well as psychosomatic medicine,	2-year Foundation program. Psychiatry training is divided into core training (3 years) and specialist training (3 years); Specialist training is available in general adult psychiatry	A basic clinical year, core training years, and a senior year; Subspecialty training is available in psychosomatic medicine and child, geriatric, and forensic psychiatry	Training in in-patient psychiatry (short, medium and long stay), outpatient psychiatry (community psychiatry, day-hospital), CL, emergency psychiatry and Psychotherapy training; Cover general adult psychiatry,	Training in Adult Psychiatry training (in acute setting), CL Psych, CAP, Addiction, old age, forensic, adult, indigenous, rural and any other as specified by the board; the duration is for 3 yrs. Specialist training is available in Addiction, CAP,

	clinical neurophysiology, pain medicine, sleep medicine, and hospice and palliative medicine.	(subspecialties include: liaison, substance misuse, and rehabilitation), learning disability, psychotherapy, CAP, forensic, and Geriatric psychiatry.		old age psychiatry, psychiatric aspects of substance misuse, developmental psychiatry (CAP, learning difficulties and mental handicap) and forensic psychiatry. The training program can include not more than 1 year of flexible training (e.g. research or other subjects to be approved by the head of training).	old age, forensic, Research/Academic, adult, CL, Psychotherapies - indigenous, rural and any other as specified by the board for 2 yrs
Training programs and infrastructure	Yes	Yes	Yes	Yes	Yes
Core competencies	Patient Care, Medical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication skills, Professionalism, and System Based Practice	Medical Expert, Communicator, Collaborator, Manager, Health Advocate, Scholar and Professional	Medical Expert, Communicator, Collaborator, Manager, Health Advocate, Scholar and Professional	Medical expert/clinical decision-maker, communicator, collaborator, manager, health advocate, scholar and professional	Medical expert, communicator, collaborator, manager, health advocate, scholar and professional
Psychotherapy	Competence required in supportive, cognitive, and psychodynamic, and some exposure to family, couples, and group therapies	Five basic requirements: development of interviewing skills, psychotherapeutic formulation, training required in minimum of 3 short cases and one long-term individual case, along with experience of group or family therapy	Mandatory training in cognitive, psychodynamic, group, and family therapies; Trainees have 4 months of skill-building sessions with psychiatrists and psychologists.	Training required in systematic, cognitive, and psychodynamic, and some exposure to family, couples, and group therapies	Psychotherapy practical experience, cases managed predominantly by psychological methods under supervision

Training curriculum and teaching methods	Yes	Yes	Yes	Yes	Yes
Curriculum and competency expectations	Train for a minimum of 4 months in primary care, 2 in neurology, 6 in adult inpatient psychiatry, 12 in continuous adult outpatient psychiatry, 2 in child and adolescent psychiatry, 2 in CL psychiatry, 1 in geriatric psychiatry, 1 in addiction psychiatry and electives during year 4	First 3 years of psychiatric training (CT 1-3) involve a minimum of 12 months' experience in general adult psychiatry and some experience in CAP, old-age psychiatry, and psychotherapy. Trainees must then choose their subspecialty (ST 4-6), in which they will eventually be awarded their certificate of completion of training	Year-1 includes rotations in inpatient psychiatry and primary care. Year-2 trainees rotate through inpatient and outpatient service. Year 3 and 4 include CAP, chronic care, CL, substance abuse, and geriatric rotations. In Year 5, residents choose elective rotations. During year 2 -5 (upto 1½ day/ week) may be spent on clinical or research electives		12 month FTE in Adult Psychiatry training (including 6 month in acute setting); 24 month proficient training of 6 month each in CL, CAP and elective 2 postings in any of the above Addiction, old age, forensic, adult, indigenous, rural and any other as specified by the board; 24 month of advanced in any one of the following areas like Addiction, CAP, old age, forensic, Research/Academic, adult, CL, Psychotherapies-indigenous, rural and any other as specified by the board
Research	Research and publication requirements by some programs; others require participation in a QA/QI project	Emphasis on clinical audits (like QA/QI); case reports or a small literature review in Core Psychiatry training	Expectation to complete a QA/QI or research project at least once during residency	Emphasis on planning research or audit projects	A quality assurance project or clinical audit; a systematic and critical literature review; original and empirical research (qualitative/quantitative); a case series.
Evaluation of the training	Evaluation after each rotation (usually 360-degree), patient logs, annual PRITE and CSV exams, Psychotherapy evaluation,	WPBA and ARCP, Weekly CBDG in first year; SAPE used for psychotherapy evaluation, Case report or small literature review in the Core Psychiatry training;	ITER (and FITER at the end of training), annual Oral examinations, including STACER in the final year, Psychotherapy evaluation,	Annual assessment of the trainee's progress (clinical, clinical), training log books, final evaluation in the form of a written report	Work place based assessments (WPBA); Entrustable Professional Activities (EPAs); Supervisor In-Training Assessment (ITA) forms and reports; Scholarly Project; Psychotherapy Long Case;

	ABPN certification examination	original research required in year 4-6, MRCPsych examinations	RCPSC certification examination		Theory examination; clinical examination by OCIP and OSCE
Certification	ABPN certification, Part I (written) and Part II (clinical)	MRCPsych examinations consisting of three written examination papers and CASC clinical examination	RCPSC exam, consisting of written and oral (OSCE) components	national requirements for psychiatry training should be compatible with the UEMS Board of Psychiatry	Fellowship certification by – Fellow of Royal Australian and New Zealand college of psychiatrists

QA/QI: Quality Assessment and Quality Improvement; CSVs: Clinical Skills Verification Exams; ITERs: In-Training Evaluation Reports; FITER: Final In-Training Evaluation Report; WPBA: Workplace-Based Assessments; ARCP: Annual Review of Competence Progression; MRCPsych: Membership of Royal College of Psychiatrists; OSCE: Objective Structured Clinical Examinations; CASC: Clinical Assessment of Skills and Competencies; FTE – Full Time Equivalent; OCIP - observed clinical interview and presentation; OSCE - observed structured clinical examination; CL Psych – Consultation Liaison Psychiatry; CAP – Child and Adolescent Psychiatry; CT – core training; ST- specialist training.^{6,7,8,9,10,11,12,13} (accessed 29/12/2012)

- 6 American Board of Psychiatry and Neurology, Inc: 2010 Information for Applicants-Initial Certification in Psychiatry; available at http://www.abpn.com/downloads/ifas/IFA_Cert_Psych_2010.pdf
- 7 European Union of Medical Specialties European Board of Psychiatry. European framework for competencies in psychiatry. October 2009. (www.uemspychiatry.org)
- 8 The Royal Australian and New Zealand College of Psychiatrists. Competency based Fellowship Program. The Royal Australian and New Zealand College of Psychiatrists, 2012. (<http://www.ranzcp.org/Pre-Fellowship/2012-Fellowship-Program/About-the-training-program.aspx>)
- 9 The Royal College of Physicians and Surgeons of Canada: Information by Specialty or Subspecialty. The Royal College of Physicians and Surgeons of Canada, 2012. (<http://rcpsc.medical.org/information/?specialty=165&submit=Select>)
- 10 A Competency Based Curriculum for Specialist Core Training in Psychiatry. Royal College of Psychiatrists, London, 2010. ([http://www.rcpsych.ac.uk/pdf/CORE%20CURRICULUM%20October%202010%20\(Mar%2012%20Update\).pdf](http://www.rcpsych.ac.uk/pdf/CORE%20CURRICULUM%20October%202010%20(Mar%2012%20Update).pdf))
- 11 Royal College of Psychiatrists. Revalidation guidance for psychiatrists. Royal College of Psychiatrists, London, 2012. (<http://www.rcpsych.ac.uk/files/pdfversion/CR172.pdf>)
- 12 American Board of Psychiatry and Neurology. Maintenance of Certification Program. ABPN, 2011(http://www.abpn.com/downloads/moc/moc_web_doc.pdf).
- 13 Royal College of Physicians and Surgeons of Canada. Maintenance of Certification Program (MOC). Royal College of Physicians and Surgeons of Canada, 2011 (<http://www.rcpsc.org>).

There are regulatory bodies in most countries which certify and regulate training. However, as evident in the accompanying table, the professional body plays a key role in many countries in developing and monitoring training, as well as in the certification. Sub-specialisation receives a greater focus in these countries, which already have much better psychiatrist to population ratios, better grounding in mental health care issues in medical school and a very close involvement of professional bodies in developing standards of care and monitoring training.

Highlights of training content and methodology in these settings include the following:

- Highly structured programs with the primary focus on developing competencies, problem based learning, learning based on critical thinking and scientific methods, developing skills of working in diverse clinical and career settings, employing comprehensive models for clinical work, learning collaborative work skills and learning flexible and adaptive approaches in applying different forms of therapy
- Individual supervision, mentoring and percepting of each resident through co-ordinators/supervisors at faculty and senior resident levels throughout the training with arrangements for academic mentoring as well as research mentoring
- Elective opportunities to develop skills in one or more areas of interest
- Opportunities to participate in regional, statewide and national meetings as well as institutional conferences, interdisciplinary meetings and workshops
- Programs to enrich and boost the trainee morale through informal interactions with faculty, social events and extra-curricular activities.

The techniques popularly used for training as summarised in the table include didactic teaching, problem based learning, diagnostic interviewing, on call supervision, supervision for psychotherapy, assignments, grand rounds, debriefing, periodic feedback and resident evaluation of faculty teaching. For each training program, the resident psychiatrist receives a formal orientation, instruction regarding responsibilities for patient care and record maintenance, details of teaching and reading references in the area.

In many centers, assessment includes regular evaluation of progress throughout

the training, monitoring of regular attendance at teaching programs, regular evaluation by education and training committees, evaluation of log-books maintained by residents. These have variously been referred to as formative assessments, summative assessments and 360 degree assessments. Satisfactory completion of the program is a pre-requisite for board eligibility or appearance for the qualifying examination.

The evaluation for the board certificate consists of two parts, one is the ongoing clinical work performance and another consists of the final evaluation. The final evaluation consists of the theory and practical examination. Depending on the board the number of theory papers varies. (E.g., Royal College of Psychiatrists consists of 3 papers). The practical examinations basically assess the core areas of clinical skills in a structured format as shown in the earlier table.

The maintenance of certificate (Revalidation in UK) exams should be taken at fixed interval with specified sets of areas as given by the board.

While psychiatric training has really evolved in the countries mentioned earlier, these form an exception. A collaborative survey on psychiatric training by the WHO and WPA in 143 national medical societies from 171 countries, revealed a general deficiency and a marked variability in training around the world. Many developing small- to medium-sized countries have either no training facilities or cater to a very small number of trainees, and the content and quality of training vary considerably¹⁴. Recently, the WPA has come up with guidelines for resident training which states that ‘in regions where very few psychiatrists exist, there must be broader resident training experiences in preparation for roles in developing, implementing and evaluating all aspects of mental health care and policy locally, regionally, and nationally.’¹⁵

14 WHO Atlas Psychiatric Education and Training across the World 2005, WHO Geneva 37, Switzerland, 2005.

15 Tasman A, Kay J, Udomratn P, Alarcon R, Jenkins R, Lindhardt A, Fahrner R, Gureje O, Hirayasu Y, Dusica Lecic Tosevski DL, Stein D. WPA template for undergraduate and graduate psychiatric education, 2011 (http://www.wpanet.org/uploads/Education/Template_for_Undergraduate_and_Graduate/WPA-Template-rev.pdf)

In-country review

The growth in centers offering post graduate training in India is obvious. Till 1967, only 6 institutes offered postgraduate psychiatric training. This has substantially increased in the last twenty years.¹⁶ A survey of postgraduate centers in India in 1985¹⁷ found a marked variability in the course duration, content of curriculum, clinical postings and research requirements. Since then, there have been several reviews of post graduate training.^{18,19} In 2010, the Indian Psychiatric Society made recommendations to the Government of India and Medical Council of India for Minimum Standards of Competency Based Training in Psychiatry.²⁰ A recent review of training and training centers in psychiatry in India²¹ provides an exhaustive review of both undergraduate and postgraduate training and related issues. What is clear is a wide variation in the syllabi and modes of training in postgraduate courses throughout the country. There are variations in the eligibility examinations, with separate central entrance examinations, state entrance examinations and separate examinations of central institutions. Very few centers offer specialised training in sub-specialties through post doctoral fellowships, DM in the subspecialty or PhD programs. Existing training methods consist predominantly of lectures and seminars. The need to focus on learner centered learning and evaluate programs

16 Sharma S, op cit.

17 Kulhara P. Postgraduate psychiatric teaching centers: Finding of a survey. *Indian J Psychiatry* 1985; 27:221-6.

18 Channabasavanna SM. Editorial, Psychiatric education. *Indian J Psychiatry* 1986; 28:261.

19 Agarwal AK, Katiyar M. Status of Psychiatric Education at Postgraduate Level. *Postgraduate Psychiatric Training in India-I*. In: Agarwal SP, editor. *Mental Health: An Indian Perspective 1946-2003*. New Delhi: Elsevier; 2005.p218-20.

20 Jiloha, Parker S. Recommendations of the Indian Psychiatric Society for minimum standards of competency based training in psychiatry, 2010.

21 Rao TSS (Ed). *Psychiatry in India: Training and Training Centers*. 2011.

from both trainee and trainer perspectives has been highlighted²² There have been positive experiences with techniques like OSCE²³ and the role of self-evaluation of trainees in seminars.²⁴

22 Murthy P, Chaturvedi SK, Rao S, Learner centered learning or teacher led teaching: a study at a psychiatric center. *Indian J Psychiatry* 1996;38,3:133-136.

23 Chandra PS, Chaturvedi SK, Desai G. Objective standardized clinical assessment with feedback: Adapting the objective structured clinical examination for postgraduate psychiatry training in India. *Indian J Med Sci.* 2009; 63:235-43.

24 Goswami K, Chandra P, Desai G, Thennarasu K, Chaturvedi SK. Do I Know What I Do Not Know? Self-Evaluation of Performance in Student-Run Seminars by Psychiatry Trainees in India.

Survey of post graduate training departments

4

As earlier mentioned, a survey questionnaire on current post graduate training was designed and sent by email to heads of post graduate training centers. Contact details were available for 87 centers, and the head of departments of these centers were sent out questionnaires by email and 60 responses were received, indicating a response rate of 69%. Three departments had not yet started a post-graduate program as they were still awaiting approvals, and filled questionnaires were received from 57 centers. Responses were obtained from 28 government centers and 29 private centers. Forty seven centers were psychiatry departments in general hospital settings and 10 were psychiatric hospitals. With respect to State/Union Territory, the responses received were as follows: Andhra Pradesh-4, Assam-1, Chandigarh-2, Delhi-3, Gujarat-2, Haryana-1, Jammu and Kashmir-1, Karnataka-10, Kerala-6, Maharashtra-8, Madhya Pradesh-1, Pondicherry-1, Punjab-3, Rajasthan-4, Tamil Nadu-4, Uttar Pradesh-2 and West Bengal-4.

Duration since initiation of PG course

Many centers have newly started post graduate courses. Eighteen (31.6%) centers have started the course in the last 5 years or less. Seventeen centers (29.8%) have been running the course for 20 years or more.

Staffing and bed strength

Centers had a median of 1 professor, 1 associate professor, 2 assistant professors, 2 Senior Residents, 1 faculty each in Clinical Psychology (CP) and Psychiatric Social Work (PSW). Only 2 centers (3.5%) did not have CP and 7 centers (12.3%) did not have any PSW.

The median number of beds was 40. A significant number (33 centers, 58.9%) had only 1 clinical unit and the median number of specialty clinics run was 4.

Services

39 (70%) centers offered specialty CGC and deaddiction services. Twenty two (38.6%) and 31 (54.4%) centers respectively did not offer any community psychiatry and rehabilitation services. All centers barring one practiced modified ECT. TMS services were available in 7 centers (12.3%) and 15 (26.3%) centers had telepsychiatry.

Regulations

35 (61%) centers reported following MCI guidelines²⁵, 9 (15.8%) centers followed both MCI and IPS guidelines, 4 (7%) centers followed DNB guidelines, 1 center (PGI) followed its own guideline. Only 1 center reported that it was not following any guideline.

36 (63.2%) centers selected postgraduate trainees through the All India Entrance examination, 31 (54.4%) centers through the State entrance examination and 10 (17.5%) centers through the university entrance examination. Some of the centers follow more than one pattern of intake of intake.

The MD intake ranges from 1 to 22 with a median intake of 2 post graduates annually.

Course Structure

There is a lot of variation in the post graduate course structure. The median number of postings during the course duration are 6 in MD, 4 in DPM and 5 in DNB. A majority (60-90%) of the centers have neurology or medicine as special postings. However, postings in psychiatric sub-specialty areas like Child Psychiatry, Addiction Psychiatry, Community Psychiatry and Psychology occurs in only 20-40% of centers. Ten centers (17.5%) report special postings to Radiology.

Psychotherapy supervision - All the centers considered skills in psychotherapy to be either very important or important, however only 32 (56.1%) centers had

25 Medical Council of India. Guidelines for competency based post graduate training programs for MD psychiatry, 2002.

a mandatory psychotherapy supervision program. Centers that reported a psychotherapy supervision program with a median of 60 hours of mandatory therapy during the course

There is a high reliance on external postings for training in specialities like neurology, radiodiagnosis and child psychiatry, with minimal input from the center itself. Very few centers offer specialised training in consultation and liaison psychiatry (CLP), and where it is recorded as provided (26% and 33% of centers respectively), it is acquired through 'on call duties'.

A high percentage of centers (30-52%) have reported that they do not provide any specific inputs to post graduates in many sub-specialties including medical law ethics (45%), CLP (38%), radio-diagnosis (52%) and neuropsychology (48%), addiction medicine (35%).

Training providers, content and modalities

The departments running PG course over 20 years have a greater student/teacher ratio of 2 as opposed to newer departments which have ratio of 1.2. However, while older departments have faculty strengths of 7-9, the newer ones have fewer faculty available (5) to teach the same course content to the PGs. Though the post graduates may be fewer, this increases the burden of teaching responsibilities requiring group supervision (such as chairing or moderating seminars or journal clubs, or more frequent teaching sessions, which can lead to overload and fatigue. On the other hand, faculty in larger departments have a greater load of teaching responsibilities requiring individual supervision (like dissertation, psychotherapy etc).

Senior Residents seem to have an important role to play in PG training as they probably get to spend maximum time in interaction with PG students (median interaction time of 26 hours per week, 4-6 hours more per week compared to consultants).

Over 90% centers agree that psychopathology, psychopharmacology and clinical interview skills are very important for postgraduates in the real world. Other areas considered as very important for training in order of prioritisation include somatic treatment (70%), medical law and ethics (67%), neurology (55%), psychotherapy (55%), psychodiagnostics (36%), radiodiagnosis (25%).

Traditional teaching methods such as lecture, seminars and student presentation still seem to be the most commonly existing and preferred teaching methods (in 40% and 70% of centers respectively), though many centers (40%) have expressed need for OSCE and OSPE based methods of assessment. Though 90% of the respondents agreed that imparting skills for clinical interview were very important, none of the centers reported use of teaching methods like video demonstrations or faculty demonstrations. Bedside clinical rounds remain the only source of learning these skills by passive observation. Only 55.6% and 45.8% centers reported that they were satisfied with the current teaching methods and assessment methods respectively.

Journals relevant to psychiatric training

Median number of journals (electronic and hard copy) available across centers is 5 each. 30% of center had access to less than 5 journals and 7 centers (12.3%) reported no access at all to journals.

Research requirements

Forty four centers (77.2%) reported that they had a mandatory research requirement – students were expected to present 1 paper, 1 poster and publish 1 paper as per MCI norms. Dissertation is currently mandated under MCI regulations.

Assessment methods

50% of centers did not have system of assessment during the course, for example, at end of posting or semester.

There was a great uniformity in the final assessment methods, with 95% of centers having 4 theory papers in the final year. The broad areas examined included basic sciences related to psychiatry, psychology and sociology, psychiatry, psychiatric specialties, neurology and medicine related to psychiatry and recent advances in psychiatry. One center each 3 papers and another had 5 papers as part of the final examination.

Practical/Viva

Two thirds of the centers (66%) report using multiple methods for end of course assessment including case discussion and viva. The commonest pattern for the

practical examination carried out in 37 centers (64%) is 1 long case and 1 short case in psychiatry, 1 case in neurology. A few centers (20, 36%) have 2 short cases in addition to the others. Almost all the centers have 2 internal and 2 external psychiatry examiners. Only one center has an external neurology examiner and another center has a psychology examiner.

Summary of the survey findings

Responses to the questionnaire survey on post-graduate training was received from 17 states/UTs throughout the country, from facilities in both the government and private sectors, primarily from general hospital settings and from old as well as new facilities. A limitation is that though the MCI lists the post-graduate centers offering training, lack of proper contact details prevented our being able to contact more centers. Nevertheless, the diverse nature of the responses received allows a reasonable understanding of the status of post-graduate training in the country. It is clear that many psychiatric training facilities have emerged in the private sector in general hospital settings, are relatively new, are limitedly focused on meeting MCI norms, do not provide training opportunities in psychiatric subspecialties, use primarily passive methods of training, and almost entirely rely on end of course assessments. Much of the training is carried out by younger staff (Senior residents and junior faculty) who have not received any formal training in teaching methods. Only a small percentage of centers are following the IPS 2002 guidelines, suggesting that the guidelines have not been widely disseminated.

5

Specific suggestions on modification of the 2002 guidelines

As earlier mentioned, the Task Force sought the suggestions of leading academics in the country and abroad to provide their suggestions on modifying the 2002 guidelines. Twenty –one specific responses were received from active post-graduate teachers from different parts of the country, senior academicians who had exposure to postgraduate programs in the country and abroad, psychiatrists of Indian origin who were senior administrators of teaching programs abroad and professionals who had worked in an advisory capacity on mental health. The younger task force members also sought informal responses from postgraduates in training. The suggestions received are summarised under the broad headings of program attributes, training content and delivery and assessments.

Program attributes

General suggestions regarding training programs included the following

- Need for post graduate programs in the country to be uniform
- The objective of training to be consonant with the mental health program of the country and train the professional in multiple skills
- Greater focus on socio-developmental dimensions rather than a purely bio-medical approach
- Introduction of guidelines as essential rather than minimum guidelines
- Need for accreditation and periodically evaluation of programs at each center
- Aptitude assessment as a part of selection

Areas of training

Suggestions for areas of training meriting special focus included:

- Formal training in addiction, child, community, consultation-liaison, emergency and forensic psychiatry
- Greater emphasis on training in neurosciences, neuropsychological evaluation, molecular genetics
- Focus on ethics of practice and research
- An exposure to different models of mental health service delivery
- Greater exposure to non-pharmacological interventions including psychotherapy
- Training in serious incident reporting

Training content and delivery

Most of the suggestions were specific to training content and modalities and include:

- A focus on knowledge application rather than knowledge acquisition
- Emphasis on problem-based learning, development of communication skills, interview skills, case-based discussion (CBD)
- Use of audio-visual aids and modern technology applications such as online training and virtual classrooms
- Formal training in newer areas like evaluation of research evidence
- Greater encouragement to postgraduates to attend conferences and workshops, present papers and posters
- Training in grant application, writing and publishing papers, carrying out systematic reviews, clinical audits. These could be considered as useful alternatives to dissertations as part-fulfillment of the postgraduate course

Assessments

A common suggestion was the need for periodic assessments throughout the course. Other suggestions included training log to monitor progress.

Other areas:

Suggestions included the need to train young faculty in training methods, a focus on continuing professional development and for postgraduate research outputs to feed into a central repository

For guidelines to be translated into practice, it is necessary that accrediting and professional bodies work closely together and for professional bodies to be closely involved with both postgraduate and undergraduate training.

The modified guidelines are intended to:

- Serve as a reference to all teaching departments in psychiatry in the country
- Be integrated into the MCI guidelines for psychiatry
- Aid in the advocacy and development of adequate faculty and facilities in all postgraduate centers/departments of psychiatry
- Increase linkages with other allied departments to foster an integrated, multidisciplinary approach
- Sensitise the teaching faculty to the need for updating their teaching skills, knowledge and expertise
- Broaden the role of the IPS in providing an advisory role to upcoming departments of psychiatry in different parts of the country, overseeing the CME programs held at the regional and national levels, and liaising with the MCI to maintain adequate standards in post graduate teaching in psychiatry.

IPS Guidelines on Postgraduate Psychiatry Training in India: 2013 revision

6

Introduction

Psychiatry has traditionally been a bridge between medicine and the humanities. A core skill of the psychiatrist continues to be his or her ability to synthesize information from various domains, including the biological, psychological, social and cultural, in order to make a diagnosis and formulate a plan of management tailored to the needs of the individual patient.²⁶ This involves a highly developed capacity for scientific thinking as well as considerable interpersonal skills. While the role of psychiatrists as consultants to other medical and allied health practitioners is likely to increase, a substantial component of direct clinical work is essential for the psychiatrist to maintain his or her clinical skills and credibility. In addition, the explosion in the understanding of human behavior and psychiatric disorders, emergence of newer treatments and the sea of information currently available, makes it necessary for the psychiatrist in training to keep abreast not only of traditional approaches, but also be aware of recent advances in the area of mental health.

Psychiatric training has undergone major development over the past decades and scientific developments in the field of molecular biology, neurobiology, genetics, cognitive neurosciences, neuroimaging, psycho-pharmacology, psychiatric epidemiology and many other related fields have contributed to the increasing growth of psychiatry as a medical discipline.²⁷ There are constant tensions

26 Adler R. Through the Glass Darkly: Toward Options for Training, Examination and Continuing Education. The Royal Australian and New Zealand College of Psychiatrists. College Statements. 2001

27 Rubin EH, Zorumski CF. Psychiatric education in an era of rapidly occurring scientific advances. Acad Med 2003;78(4):351-4.

between keeping abreast of the knowledge and its translation into more effective clinical care on the one hand, and ensuring the delivery of basic psychiatric care in the community on the other. This is particularly relevant in India where there is an acute shortage of trained psychiatrists and other mental health professionals.²⁸

Teaching methods in general have moved in the direction of interactive and active learning rather than passive modes of learning. While the shift in training towards a competency based, and learner led program is clear in spirit, and reflected in the MCI guidelines, translating this into action involves consistent and collaborative effort. While the MCI sets a broad mandate for all postgraduate programs, there is a need for training guidelines to be essential yet aspirational, pragmatic yet directed towards improvement, focused on present learning, yet moving the trainee in the direction of lifelong learning.

In India, the locus of training is shifting to post graduate departments in medical colleges, unlike in earlier times when the training was concentrated in specialised psychiatric institutions.

Leadership and administrative competencies, particularly to contribute to various components of the National Mental Health Program need to be developed during training. At the same time, post graduate training needs to be elevated to a standard that is comparable to training anywhere else in the world.

Post graduate training cannot occur in a vacuum. It can be effective only when placed in an appropriate training environment, which focuses on a strong undergraduate grounding in psychiatry and is complimented with opportunities in the form of specialised training through post doctoral programs and superspecialisation.

The guidelines for the 3 year training program have been modified keeping the overall objectives of training and competencies expected to have been achieved by the end of training. It is recommended that a single postgraduate course is conducted, rather than multiple courses, in order to maintain uniform standards in post graduate training.

An important aspect of effective training is an effective trainer. Young faculty and senior residents, who do a lot of the hands on training of post graduates need to

28 Thirunavukarasu M, Thirunavukarasu P. Training and National deficit of psychiatrists in India – A critical analysis. Indian J Psychiatry 2010; 52:S83-88.

be formally trained in teaching and mentoring, as well as in administrative skills. They should regularly participate in programs of continuing professional education and workshop on teaching and evaluation.

Post Graduate Psychiatry Training

1. Eligibility :

1. Successful completion of the final MBBS course after study in a medical college recognized by the Medical Council of India.
2. Completion of one year compulsory rotating internship in a teaching institution or other institution recognized by the MCI.
3. Permanent registration with the respective State Medical Council.

Centers participating in post graduate training should have a process of course accreditation and monitoring to ensure that they meet the essential requirements for a post graduate training program. The Indian Psychiatric Society can play an important role in such an accreditation process.

2. Selection Procedure

In the earlier guideline, the existing practice of multiple mechanisms of selection, i.e. national entrance, state entrance and institution-specific examinations was listed. This was in keeping with the existing regulations.

It is now recommended to have a common national entrance examination for selection to the post graduate course. This may be followed by counseling for selection of post graduate center.

3. Objectives of the Course

The overall objective of post graduate training in psychiatry is aimed to create a professional with competencies ranging from the clinical management of complex mental disorders to managing a population based integrated mental health care plan.

At the end of the course, the candidate should be able to:

1. Have a firm grounding in the understanding and application of a biopsychosocial model in understanding and dealing with mental disorders
2. Have working knowledge in a variety of disciplines related to mental health and disorder
3. Develop the clinical skills required to manage a range of psychiatric disorders in the areas of assessment, diagnosis, medical and psychosocial management
4. Develop humanistic attributes to patient care including care and concern, genuineness, empathy and understanding
5. Practice an ethical approach to psychiatric service and research
6. Deal with the medico legal aspects of psychiatric illness
7. Acquire basic skills on planning, implementing, carrying out and reporting research
8. Develop the qualities to be an effective leader of a multidisciplinary mental health team and an effective teacher
9. Develop skills required to function as a mental health consultant to physicians in primary care and physicians in other specialties
10. Develop the administrative and leadership abilities to contribute to various components of the national mental health program

The program needs to be structured, focused on problem-based learning, safe and scientific clinical practice, focused on development of skills in diverse clinic, community and career settings.

4. Competencies to be acquired during the course

The candidate, at the end of the post graduate training course is expected to have competencies in the following areas:

4.1. Clinical competence

1. Assess and diagnose psychiatric disorders (history taking, mental state examination, physical examination, formulating a diagnosis, differential diagnosis, assessment of medical co-morbidity, investigations as appropriate)

2. Formulate of a comprehensive treatment plan that includes pharmacological and psychosocial management, rehabilitation, aftercare and engagement of care givers
3. Be able to manage psychiatric emergencies
4. Communicate effectively with patients and care givers
5. Learn the use of Evidence-Based Medicine (EBM) which refers to the process of making medical decisions that are consistent with evidence from relevant research and envisages a therapeutic alliance between research-evidence, clinicians and patients.

4.2. Practice Competence

1. An understanding of the general and ethical considerations as pertaining to medical and psychiatric practice, including issues of confidentiality, patient autonomy, preventing boundary violations, respecting and ensuring human rights of patients
2. Knowledge of medico-legal issues relating to admission, discharge, record maintenance, standards of care
3. Proper documentation in patient records
4. Arranging care for patients, collaborating with mental health professionals and other health professionals
5. Knowledge and practical experience of using community networks for the improving awareness of mental disorders, support networks like self help groups, government assistance programs etc.
6. Mental health care planning through participation in public mental health care initiatives including primary care, district mental health program, school mental health programs etc
7. An understanding of administrative and programmatic aspects of service delivery in clinic as well as community based settings

4.3. Research and Training Competence

1. Basic knowledge of research methods
2. The ability to think critically and evaluate evidence, the ability to separate 'fact' from 'factoids'. The trainee must develop the ability to discern

whether the evidence from research can be trusted²⁹.

3. Ability to develop research ideas, carry out a review, plan a protocol, carry out a research study or clinical audit, carry out statistical analysis, write a report, present and publish original work or reviews
4. Exposure and opportunities to train in areas of recent advances such as neuroimaging, molecular genetics, neuropsychological assessments, newer psychotherapeutic interventions and other specialised areas
5. Acquisition of teaching experience through involvement in postgraduate and undergraduate teaching as well as teaching of mental health and health personnel

Training faculty to be effective and objective examiners, *Faculty need to be provided training and specific guidelines on how to carry out the examination, how to select cases, how to mark the candidate, and how to retain objectivity.*

5. Scope of the PG course

While the trainee needs to develop an understanding of all aspects of psychiatry, and allied mental health and neurobehavioral aspects, the focus of training should shift from being:

- Reductionistic to holistic.
 - Discipline oriented to problem oriented.
 - Disease oriented to patient oriented.
 - Theory oriented to skill acquisition oriented.
 - Teacher taught to student led learning.
- The course should inculcate in the trainee a spirit of learning and enquiry which the trainee retains as a quest for lifetime learning.
 - The subjects should be addressed in an integrated manner in the 3 year course with the trainee being able to solidify his / her identity as a psychiatrist in their third year as well as anticipate their future role in a career and practice.

29 Tharyan P. Evidence-based Medicine. Can the evidence be trusted? Indian J Medical Ethics (editorial) 2011, 7, 4: 201-207

- The training will occur through the three years of the MD course. The MCI guidelines suggest a semester system of six months duration each. Thus each year will comprise of two semesters. Each center may organize the teaching suggested during the year within two semesters, based on its resources.

6. I year (I and II semester)

6.1. Objectives of the I year course:

To:

- Acquaint students with the history of psychiatry
- Instruct them in clinical skills in their daily work with patients through small group teaching Provide introductory courses in investigations, treatment and research methodology in psychiatry
- Encourage students to critically review a topic of interest, to find a research supervisor and by the end of the first year, to produce an outline proposal for research
- Orient the trainee in making a presentation, appropriate use of audiovisual aids, performing a net search.

6.2. Postings

- Clinical Postings in General Adult Psychiatry
- Out-patient and Emergency Postings

During each posting, the trainee must be provided with a formal orientation, a set of instructions regarding responsibilities for patient care, record maintenance, details of teaching and reading references in the area. End of posting evaluation must be structured.

6.3. Clinical Skills

- Comprehensive history taking and physical examination
- Working knowledge of major psychiatric diagnoses as per the ICD and the ability to present a reasoned differential diagnosis
- Psychiatric formulation
- Ability to develop a comprehensive treatment plan

- Knowledge of psychopharmacological agents, including indications and significant and adverse effects
- Administration of treatments like ECT, TMS etc
- Understanding of and basic competence in identifying psychiatric emergencies and their management
- In particular, the assessment and management of suicidal risk
- Ability to write clear and thorough histories, consultation notes and follow-up notes
- Demonstrate appropriate professional demeanour and ethics including respect for patient's confidentiality.

6.4. Learning Modules

6.4.1. Organisation

The teaching can be organised either as a modular series, or broken into terms (2 terms per year), in addition to informal teaching that occurs throughout the training program. In centers which do not have facilities for basic sciences, or mental health allied sciences, various alternatives such as a guest lecture series, common program for trainees from different centers at a regional center could be considered. Centers with small faculty strengths can use modern technology facilities like e-classroom, tele-teaching.

6.4.2. Content:

- Communication skills, including the do's and don'ts of effective communication
- Mental State Examination
- Phenomenology
- History of psychiatry and evolution of concepts
- Ethics
- Legal issues in admission / discharge
- Common psychiatric disorders
- Acute care / Inpatient and Outpatient care, handling psychiatric emergencies
- Diagnostic skills

- Use of investigations in psychiatry
- Management planning-biological, psychological, social
- Psychopharmacology
- ECT administration
- Appropriate referral
- Gender issues with regard to epidemiology, presentation, assessment and management
- Introduction to psychotherapy including communication skills and counselling skills
- Making a presentation
- Team skills and leadership

Technique of Training

Clinical teaching Interactive Sessions Case based discussion

Problem based learning

Role Play

Audio-Video demonstrations

Use of case vignettes Assignments

Seminars

Web-based training

Common Psychiatric Disorders

Organic disorders

Schizophrenia and related disorders

Mood disorders Anxiety disorders

Personality disorders

Other behavioural disorders

Substance use disorders

Stress related disorders

An effort must be made to create an optimum hybrid of “face-to-face” methods of training with web based learning.

6.5. Sciences basic to psychiatry

- Brain sciences -neuroanatomy, neurophysiology and neurochemistry,
- Psychology
- Sociology
- Statistics and Epidemiology
- Molecular Biology and Genetics

Techniques

Didactic teaching with audio- visual aids Focus on applied aspects to psychiatry Short assignments Seminar topics

Broad content

The focus of teaching in basic sciences should be on applied aspects of the topics to psychiatry. While the broad content under the basic sciences are outlined for convenience, integrated teaching would be more useful: eg. Prefrontal cortex: anatomy, connections, neurochemistry and role in psychiatric disorders. Wherever feasible, it would be desirable to incorporate topics from allied disciplines such as neurophysics (e.g. Cybernetics, signal processing, computational brain models)

6.5.1. Neuroanatomy

- Developmental and topographical neuroanatomy
- Brain cytoarchitecture
- Central, peripheral and autonomic nervous system and relevance in psychiatry
- Principles and techniques of brain imaging (CT, MRI, PET, etc) and application of imaging studies in psychiatry
- Applied neuroanatomy in psychiatric disorders

Modular Teaching

An effective and integrated approach combining basic sciences and clinical aspects of common psychiatric disorders can be planned. For e.g. A module on mood disorders can focus on:

- Historical aspects
- Diagnostic approaches
- Neurotransmitter changes
- Neurophysiological correlates
- Genetics
- Imaging
- Rating scales
- Life events research
- Pharmacological management including Prophylaxis
- Psychotherapy Research issues
- Course and Outcome

6.5.2. Neurochemistry

- Basic understanding of neurotransmission, including receptor structure and function
- Neurotransmitter pathways
- Role of neurotransmitters in human emotion, motivation, thought, memory and behaviour
- Neurotransmitters in psychiatric disorders (eg. Dopamine and psychiatric disorders, neuro-chemical basis of addictive disorders)

6.5.3. Neurophysiology

- Basic cell structure and physiology
- Physiology of thought, cognition, mood and motor functions
- Neural connectivity, networks and circuitries
- Synaptic-level and subcellular phenomena involved in learning and memory
- Physiology of appetitive behaviours (e.g. hunger, sex)
- Normal sleep and disorders of sleep
- Methods of physiological investigations in psychiatric disorders (e.g. EEG, Evoked Potentials, NMS etc)

6.5.4. Psychology

- Background to psychology including relevance to psychiatric practice
- Normative development, including cognitive, language and emotional development
- Personality theories and application in practice
- Explanatory paradigms of psychopathology in common mental disorders
- Psychological testing dimensions, rationale, conduct and interpretation
- Stress – concepts, management and prevention
- Positive mental health
- Indian perspectives in understanding psychology

6.5.5. Sociology

- Relevance of sociodemography in psychiatric disorders and health care delivery
- Social role of doctors
- Family in relation to psychiatric disorders
- Social factors and specific mental health issues
- Changing societal dynamics
- Methodology in social sciences including surveys, social, anthropological and ethnological approaches
- Social anthropology
- An understanding of user and carer groups, self help groups

6.5.6. Statistics and Epidemiology

- Psychiatric epidemiology
- Descriptive Statistics
- Analytical Statistics
- Qualitative Research methodology
- Research Design
- Critical review of statistical procedures

- Meta-analysis and systematic reviews
- Evidence Based Research
- Commonly used statistical packages
- How to read / write a research paper

6.5.7. Genetics

- Basic principles of genetics
- Patterns of inheritance
- Introduction to molecular genetics
- Genetic epidemiology
- Genetic studies in psychiatric disorders
- Endophenotypes in psychiatry
- Understanding of population genetics
- GWAS

7. II year (III and IV Semester)

7.1. Objectives of the Second Year Training

- To encourage students to actively participate in advanced teaching courses in speciality and subspeciality subjects
- To carry out data collection for the dissertation/to carry out clinical audits/ other types of research
- Refinement of clinical skills in patient management
- Sharpening of psychotherapeutic skills

7.2. Clinical Postings

Postings to specialities:

- Child Psychiatry
- Medicine / liaison psychiatry
- Neurology

- Addiction Psychiatry
- Geriatric psychiatry
- Family Psychiatry
- Rehabilitation
- Forensic Psychiatry
- Community Psychiatry
- Psychology
- Psychiatric hospital*

The minimum duration of specialised postings are indicated in the accompanying figure. These are guidelines. It is desirable to have postings in specialised areas, but there may be constraints in terms of lack of specialised facilities and lack of competent trainers. Individual centers may plan postings based on local and regional resources, but must take steps to provide trainees with some exposure to the various specialities.

As this is also the year of data collection and analysis for the dissertation, it is desirable that the trainee have an optional posting to a clinical unit, community, or if the trainee is undertaking biological work, for a posting to the laboratory.

** for trainees in general hospital*

7.3. Broad areas to be covered (Theory and skill based learning):

7.3.1. Child Psychiatry

- Normative child development
- Interviewing in children
- Classification, epidemiology, etiology and presentation of child and adolescent psychiatric disorders
- Conduct, emotional and behavioural problems in children
- Mental retardation etiology, manifestation, assessment, management and prevention
- Specific learning disabilities

- Psychopharmacology in children
- Adult outcome of child psychiatric disorders
- Liaison with teachers, schools, child care institutions

7.3.2. General Medicine with relevance to psychiatric disorders/ Liaison Psychiatry

- Assessment including history taking, examination and investigations
- Knowledge of common medical disorders with psychiatric manifestations
- Knowledge of common psychiatric disorders with physical manifestations
- Recognition and management of physical complications in psychiatric disorders
- Recognition and management of psychiatric problems in the medically ill
- Holistic care of chronic and terminal illness
- Care of HIV / persons living with AIDS

7.3.3. Neurology

- Clinical history taking, neurological examination, diagnosis, localisation
- Common neurological disorders encountered in general practice
- Neurobehavioural disorders
- Special methods of investigation in neurology (including reporting and interpreting)
- EEGs, reading CT scans / MRI, PET, fMRI
- Treatment approaches including recent advances

7.3.4. Substance Use Disorders

- Basic pharmacology and epidemiology of drugs of abuse
- Neurobiological substrates of addiction
- Substance use and public health impact
- Etiology and progression of substance use and addiction
- Behavioural addiction

- Assessment and biopsychosocial management of addiction
- Specific focus on motivational interviewing and relapse prevention
- Self help groups
- Comorbidity
- Prevention strategies
- Legal issues relating to substance use

7.3.5. Geriatric psychiatry

- Psychiatric evaluation of the elderly with specific emphasis on history taking related to disability, activities of daily living and care giver issues
- Use of specific instruments to evaluate cognitive functions and psychopathology in the elderly
- Comprehensive biopsychosocial management of the patient and specific emphasis on care giver interventions

7.3.6. Forensic Psychiatry

- Admission / Discharge procedures
- Psychiatric testimony (fitness to stand trial, assessment of psychiatric state)
- Insanity Plea, Criminal issues (Relevant IPC / CRPC sections)
- Civil – Marriage and divorce, testamentary capacity, child custody, property issues
- ACTS – Mental Health Act, NDPS Act, PDA, CPA – Antecedents, critique, application
- Other developments – Initiatives – public initiatives, judicial initiatives, NHRC initiatives, etc
- Psychological sequelae of victimisation
- Psychiatric ethics – Basic human rights, Ethical principles in care, confidentiality, research, informed consent for treatment, preventing boundary violations
- Training for the psychiatrist in court

- Liaison with legal services authority, handling mental health and substance use in prison and other correctional settings.

7.3.7. Family Psychiatry

- Knowledge and skills to interview, assess and intervene in families with a mentally ill person or families with significant interpersonal problems
- Marital therapy

7.3.8. Rehabilitation

- Knowledge of deficits and disabilities associated with chronic mental illness
- Familiarity with tools to assess disabilities, including rating scales
- Strategies of tertiary care and disability limitation
- Long term community care of the chronically mentally ill including day care, residential care, networking with community agencies
- Rights based approaches

7.0.9. Psychology

- Practical exposure to psychological assessments including assessment of
- intelligence, thought deviance, and personality
- Training in neuropsychological testing
- Application of behaviour therapy and cognitive therapies

7.3.10. Psychotherapy

- Historical development of approaches in psychotherapy
- Formulation of cases and planning different stages in therapy
- A working knowledge of dynamic, cognitive behavioural, humanistic models of therapy
- A knowledge of non specific factors in psychotherapy
- Techniques of Supportive psychotherapy

- A working knowledge of group therapy and specific therapies in different disorders
- Supervised psychotherapy employing one or more models of psychotherapy

8. III Year (V and VI Semester)

8.1. Objectives of the Third Year

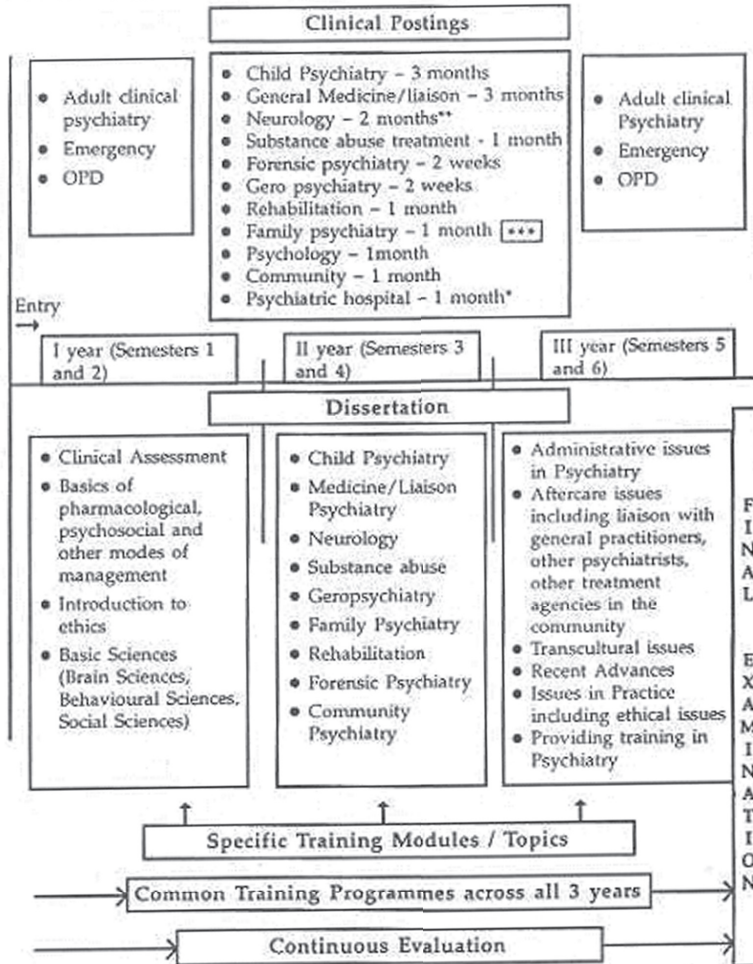
To:

- Consolidate the knowledge gained in the first two years
- Consolidate skills of assessment and management
- Formal evaluation of training in evaluation of research evidence
- Successfully complete data collection, analysis and writing up and submission of dissertation/submission of an audit/submission of a paper for publication
- Provide training and range of clinical experience which will prepare students for the qualifying examination
- Stimulate students to take up training / research / service / administrative activities following completion of the course
- Encourage trainees to participate in training of junior post graduates and other mental health trainees. Focus attention on cross-cultural issues, with special emphasis on issues influencing psychiatric illnesses and practice of psychiatry in India.

8.2. Clinical Postings

- Rotation in specialty postings
- Return to adult psychiatry postings at least for six month prior to course completion

9. Summary of Postings and Training



Note *** The duration of specialty postings and type of posting keep in mind local constraints and are advisable guidelines. Mandatory postings are in adult psychiatry, neurology, and child psychiatry. In centers with specialized clinical facilities / training resources, such training may be advanced into the first 3 months of Year III or begin in the last 3 months of Year I. In all centers, however, it must be ensured that some form of training is provided in all the specialties.

* - for trainees working in general hospital departments

** - where feasible, training in neurology may include one month in clinical neurology, and 15 days each for orientation to neuroradiology and other investigations in neurology including EEG.

10. Common Training Program during the 3 year training

10.1. Objectives:

The purpose of the common training program will be to:

- Sharpen the knowledge and skills acquired by the trainee during formalised teaching and clinical teaching.
- Bring together trainees from different stages of training and encourage peer learning
- Stimulate the trainee to pursue subject related reading, broaden their reading on mental health and behaviour, and strengthen their abilities of critical thinking. Trainees must develop the ability to discern and deconstruct all sorts of information/propaganda (“information overload”)
- Expose the trainees to the real world of patients and families through interactions and seminars involving users and carers
- Expose the trainees to issues outside of core psychiatry

10.2. Modalities

Standard modalities for common departmental level activities are suggested below. These serve as guidelines and may be adapted according to local facilities and resources. Three to four hours per week is an optimal time allocated to common teaching programs, apart from the formalised teaching mentioned in the respective years. Trainees may begin to make departmental presentations preferably after the first year training is complete.

- Faculty facilitators should be actively involved to assist in orientation, provision of knowledge and practical experience and facilitate discussion.
- Each teaching program should be co-ordinated by a faculty member, preferably with inputs and assistance from one or two senior residents.
- Faculty co-ordinators should foster among trainees a spirit of enquiry, critical thinking, objective evaluation of evidence, learning techniques of clinical decision making

- It must be emphasized that small group activities which are learner led are very effective ways of learning. Larger programs, while necessary, may therefore be kept at the minimum.

10.2.1. Making a Presentation

Common skills of making a good presentation should be discussed. These would include:

- Guidance on the sources for literature review
- The process of literature review
- Ways of accessing information including the internet
- Planning the presentation
- Effective use of audio-visual aids, including how to make a power-point presentation, or video-recording for case conferences.
- Emphasis should be placed on preparation of handouts to be circulated for a common teaching program including standard referencing styles.
- Formal training is also useful for making conference presentations, preparing and presenting posters at conferences, delivering public lectures in mental health and professional lectures.

10.2.2. Seminars

Topics to be chosen for seminars should be those that supplement the formal teaching program, provide an opportunity for critical review, or cover recent advances in a particular area. A seminar list should be prepared in advance at the beginning of each semester, with details of the topic and the identified presenter. One faculty should be identified to assist the presenter and moderate the seminar discussion.

10.2.3. Case Conferences

A trainee by rotation, in consultation with a consultant, identifies a case for presentation. At the beginning of the academic year, it is recommended that more prototypic cases are presented, so that these aid the entrants in becoming familiar with psychiatric syndromes / presentations. The subsequent focus may be on diagnostic problems, atypical presentations, or management problems.

10.2.4. Journal Review

This exposes trainees to critically evaluate a research paper or book review. Senior trainees may conduct journal club reviews. The presenter in consultation with the chairing consultant may either identify the paper in advance, or a list of papers may be put up by the co-ordinator of each program.

This forum can also be used to review work carried out by the center.

10.2.5. Joint Conferences

During each semester, at least one joint conference involving allied disciplines, either the brain science disciplines, medical disciplines or the social science disciplines would be useful in enlarging the scope and purview of the topic. For eg. Inviting a urologist for a discussion on managing a case of sexual dysfunction, inviting a neurologist for a case of movement disorder, involving the psychiatric social worker for a discussion on social case work in a homeless mentally ill person.

In addition to the psychiatric trainee, trainees in allied disciplines of mental health may also participate in such conferences

10.2.6. Research Forum

The faculty and senior residents can present the research work done at the center on a once a month basis. Clinical audits should also be periodically presented. This would help the trainees become familiar with the work being done at the center and learn some of the practical aspects of planning and conducting research. It would also stimulate entrants into the post graduate course to think about potential areas for their own dissertation.

10.2.7. Psychotherapy tutorials

This could occur in two ways. In large departments, trainees may be allotted in small groups to psychotherapy supervisors, with whom they would discuss psychotherapy cases on a weekly basis throughout the training period. In smaller departments with fewer faculty, trainees in turn could present a psychotherapy case for discussion by rotation, as in a case conference. Each student must undertake a minimum of 50 hours of supervised psychotherapy. He / she should

submit one case seen in therapy for evaluation as part of the internal assessment in the final year.

10.2.8. Extra-Mural activities

- Trainees should be encouraged to participate in academic activities in allied areas-brain sciences, behavioural and social sciences. In addition, they must be facilitated to attend workshops and conferences.
- Each trainee should have attended at least two such events during the course of training.
- Opportunities to enrich the trainee morale through informal interactions with faculty, social events and extra-curricular activities should be encouraged. Trainees should acquire the ability to benefit from “professional social networking”

11. Dissertation/Thesis/Research obligations

Under the MCI regulations, the dissertation is mandated as a part fulfillment of the MD course, under the guidance of a recognised post graduate teacher.

The dissertation is to be periodically supervised by the guide and co-guide, at the stages of formulation of the protocol, finalisation of the protocol, including instruments to be used, ensuring that the post-graduate is well versed with administration of the instrument, supervise quality of data collection, help overcome problems in methodology, including practical problems, supervise analysis and writing-up. Disseminating the work done as part of the dissertation, either in the form of paper presentation or publication must be encouraged by the guide, in keeping with the university regulations.

Although the dissertation is mandated by the MCI, a lot of variability in the quality of dissertation has been noticed and in many cases, this exercise is carried out as a coercive exercise rather than stimulating the student’s interest in research. The Task Force thus recommends serious rethinking about the usefulness of the dissertation and considering other alternatives like carrying out systematic reviews, audits, qualitative studies, formulating a proposal, and other such tasks suitable for publication and dissemination as alternatives.

12. Continuing Evaluation and Feedback

Objectives:

- To assess the trainees' performance during the course
- To provide regular feedback to the trainee and encourage insightful learning
- Evaluate the training content and procedure periodically

Modalities

These include monitoring of regularity in teaching programs, regular evaluation by education and training committees and evaluation of log books.

12.1. Evaluation of clinical work

The trainee should be periodically assessed on the quality and consistency of clinical work including regularity, punctuality and sincerity. Feedback should be provided on communication skills, diagnostic and management abilities. It is important to provide regular feedback to the trainee and provide an opportunity for insightful learning.

12.2. Evaluation of knowledge and critical thinking

This should be regularly assessed by the supervising senior resident or consultant during supervised rounds / presentation / discussion. The supervisor should give periodic assignments to the trainee and provide assistance to source information.

12.3. Log Book / Work Diary

The trainee should maintain a work diary and record his / her participation in training programs conducted by the department. The log book should be provided by the department. In addition to performance in adult psychiatry posting, performance and attendance to the specialty postings, teaching modules and departmental programs must be assessed. The assessment must be made by the concerned supervisor, desirably in discussion with the trainee, thus providing a feedback of trainee's strengths and weaknesses, and suggestions for improvement.

The log book should be reviewed by the Head of the Department / his or her designee at the end of each semester. The evaluation may be made out of 50 marks at the end of each semester based on the aggregate of assignments carried out. The total out of 300 marks may be reduced to a total out of 50 and this score be provided during the examination.

The log book should be made available to the University or MCI.

12.4. Periodic Assignments

Giving and evaluating periodic assignments either topic oriented or speciality oriented may be an effective way in encouraging self study, in addition to the vicarious learning that occurs through departmental programs.

12.5. Program Evaluation

Regular feedback must be obtained from the trainees regarding adequacy, format, and content of training. This must include clinical teaching, modular programs or specialised topics, as well as departmental programs. Suitable modifications may be undertaken in consultation with a larger body.

It would be desirable to have a supervisor evaluation by the trainee, which would encourage supervisors' active participation and self monitoring.

12.6. Academic Co-ordinator

A senior faculty member must be appointed as academic co-ordinator to oversee the smooth conduct of training and academic activities. He / she may recruit faculty and senior residents for specific activities but will take complete responsibility for the program. The co-ordinator should also handle grievances from trainees with regard to various aspects of the academic program.

Trainee related issues

Trainees can be under significant stress during their course, both from the professional demands of work and training, and personal stress, as well as inadequate support. It is important to provide guidance and easily accessible professional support.

A system of trainee mentoring must be in place. Each trainee must be assigned to a faculty co-ordinator/senior resident for individual supervision and precepting throughout the course.

Trainee misconduct must be viewed seriously and each center must have guidelines for reporting trainee misconduct.

12.7. Mock Examination

It would be desirable to conduct a mock examination to prepare the trainee for the final examination. Senior faculty can act as mock examiners.

13. Qualifying Examination

13.1. Objective:

- To assess the theoretical and applied knowledge gained by the trainee in the 3 year course
- To assess the ability of the trainee to function as a competent psychiatrist in the areas of identification, evaluation and management of psychiatric disorders

13.2. Format of Examinations

Eligibility to take up Examination

- The eligibility will be decided by the department, based on satisfactory attendance and participation in the training activities as reflected in the log book
- Approval of dissertation by the examiner
- Having appeared in the theory papers of the examination

13.3. Theory

The theory examination presently comprises:

Four written papers of three hours each as follows:

Paper I	Basic Sciences as related to Psychiatry*	100 marks
Paper II	Clinical Psychiatry	100 marks
Paper III	Psychiatric specialties, Applied psychiatry in special situations	100 marks
Paper IV	Neuropsychiatry and behavioural neurology	100 marks

The traditional approach has been to have two long essay questions and six short notes. It would be desirable to change the format to only short notes to enable a greater coverage of topics and minimise examiner bias in topic selection. There should be a focus on recent advances in each of the papers.

(* - should have sections on both brain sciences and behavioural sciences)

The exams should be distributed across the years of training.

13.4. Clinical Examination

Although marks are not commonly awarded in the examinations, a making pattern is suggested below to provide some uniformity in assessment. These are guidelines for concurrence. These may be communicated as per university regulations as pass / withheld or in terms of grades.

OSPE/OSCE pattern of evaluation is recommended for clinical evaluation. Examiner rounds of selected cases, problem based assessment and fewer candidates per day to avoid examiner fatigue are useful approaches to make the clinical examination more effective.

i. Long Case Presentation (in adult psychiatry):

Case selection and allotment:

A list of potential cases must be prepared by the examination center. Case allotment must be done in the presence and with the approval of the external examiners to allow neutrality. Given the plurality of languages and language competencies of the trainees and patients, this aspect must be given due consideration in case allotment.

Time for history taking

The trainee may be given 45 minutes for evaluation, including history taking, mental state examination and relevant physical examination.

An additional 15 minutes may be given for the trainee to organise the presentation.

The examiners may interview the patient in this time, or ask the trainee to elicit specific phenomena / clarify specific aspects during the viva.

Viva examination of Long case:

Duration: 30 - 40 minutes

Presentation by trainee: 8 - 10 minutes Clarifications with patient: 10 minutes

Discussion with examiners: 15 - 20 minutes

Marking for Long case should consider

Adequacy of history taking: 20 marks

Mental state Examination: 20 marks

Diagnosis: 10 marks

Management: 20 marks

Discussion: 20 marks

Style of Presentation (organisation, interview with patient, ability to synthesise information): 10 marks

Total: 100 marks

ii. Neurology Case

Case selection:

The neurology case for the examination should be a neurobehavioural disorder, a neurological condition commonly associated with co-morbid psychiatric symptoms, or movement disorder. There should be demonstrable signs that the trainee can elicit.

The trainee may be given 45 minutes for history taking and clinical examination and an additional

15 minutes for preparing the presentation.

Viva for Neurology Case

History: 10 marks

Clinical examination: 15 marks

Diagnosis: 10 marks

Management: 10 marks

Discussion: 15 marks

Total: 50 marks

Duration of neurology discussion: 30 minutes (10 minutes for presentation and 20 minutes for discussion)

iii. Short Case

Two formats may be followed for short case presentations:

- a) 3 short cases focusing on mental state examination, spotters, or case of a subspeciality
- b) 3 cases worked up by the trainee during the course – these may be used to examine record keeping, actual practice methods, comprehensive care.

Final exams could have OSCE stations which can help assess adult psychiatry, neuropsychiatry, CLP, addiction, child, therapy skills, interview skills, forensics, ethics, rehabilitation, etc.

The modality of short case examination must be decided and conveyed to the trainees in the initial phase of the training.

Duration: 15 – 20 minutes each

Marks: 60 (20 for each case)

iv. Final Viva

Objective: to test the trainee's ability to interpret findings, analytical ability and formulating ability. It is desirable that a uniform pattern is followed. It could include.

- Case vignettes
- CT/MRI films for interpretation
- EEG for interpretation
- Videos to demonstrate phenomena/clinical conditions can also be used
- Questions on commonly used instruments in psychiatry
- Practice based questions in psychiatric subspecialities
- Recent advances

Duration of Viva: 30 minutes

Marks: 40

Marks: Theory papers (100x4) 400 marks

Psychiatry long case 100 marks

Neurology case 50 marks

Short case 60 marks

Viva 40 marks

Internal Assessment 50 marks

Clinical examination + internal assessment 300 marks

14. Eligibility for Award of Final Degree:

- Pass in theory
- Acceptance of dissertation/research assignment
- Pass in clinical examination

