



symptoms of psychoses over recent years requiring active treatment. Clozapine, which this patient is now receiving, has been shown to be of value after an episode of NMS (Weller & Kornhuber, 1992). However, atypical antipsychotics including clozapine, olanzapine and risperidone may also cause NMS and catatonia. Clozapine is not available on the Japanese market owing to reports of malignant hyperthermia.

Despite the decline in the prevalence of classical catatonia, we should remain alert to it, and to NMS. While remaining aware of the benefits that traditional neuroleptics have brought, and their continuing value as part of a package of treatment in the emergency situation, we must continue to use them with caution. When catatonia does occur, a prompt response and liaison between psychiatrists and physicians is essential.

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Psychiatric training in India

With the population of India recently increasing to over 1 billion, the need for personnel to cater to the health services is ever increasing. This article will touch upon various aspects of psychiatric training in India and briefly cover some aspects of psychiatric practice and services in the country.

Health care services and medical training

India comprises 28 states, with each state having its own health care delivery service. The central government's Ministry of Health and Family Welfare is responsible for policy development and there are a large number of centrally funded health care delivery institutions. India has a large government funded health care system, although standards of care and funding vary. The private sector has been increasing year by year and there are many independently practising general practitioners and specialists and a network of private hospitals. The government funded service functions on a three tier level, with primary health centres covering a defined area. The secondary level comprises various district hospitals. On the tertiary level are various medical colleges and centrally funded hospitals with subspecialties.

India has one of the largest number of doctors in training in the world, with 17 000 students entering

medical school every year. Medical graduates train in state or centrally funded medical colleges. There are about 162 medical colleges (Ministry of Health and Family Welfare website: <http://mohfw.nic.in>). Medical training in government funded colleges is relatively cheap. Competition to enter medical training is high, with a few hundred thousand students competing in a common entrance examination. Additionally, there are 49 private medical colleges and the number is increasing. These colleges have their own entrance system and fees can be high.

Training to be a psychiatrist

Doctors train for 4-and-a-half years, after which they do a year of internship (equivalent to house officer) and are ready for postgraduate training. Emphasis on training in psychiatry during undergraduate training is dismally low; the Medical Council of India guidelines show that students are required to participate only in a 2-week programme of clinical postings, excluding a number of theory lectures. Also, the staff teaching the undergraduates are relatively junior and not fully trained in teaching methodology, curriculum planning and use of teaching aids (Alexander & Kumaraswamy, 1995). Those interested in gaining experience can work as junior residents



(equivalent to senior house officer) in 6-month posts in various district hospitals and medical colleges. Postgraduate training in psychiatry, like most other specialities, is on a 3-year residency system with an exit exam leading to the degree of Doctor of Medicine (MD); 2-year diploma courses are run by a small number of institutions. Competition to undergo postgraduate training is intense, with limited training posts available. Currently, there are about 300 training places annually for psychiatry, low considering the demand for psychiatric care in such a large population. Entry to postgraduate training in all specialities is via entrance examinations conducted by each state and also by a countrywide common entrance examination. Some central institutions, highly regarded for their training, conduct their own entrance examinations.

Training posts are spread across various state medical colleges. However, there are a few central institutions that offer postgraduate training, namely: the National Institute of Mental Health and Neurosciences (NIMHANS) in Bangalore; Post Graduate Institute of Medical Education and Research (PGIMER) in Chandigarh; All India Institute of Medical Sciences in Delhi; and Central Institute of Psychiatry in Ranchi. Training in these institutions, including some centres in Mumbai and Chennai (formerly Madras), are highly sought after. Standards of training vary across institutions but training standards in some institutions are high. Trainees rotate through out-patient and in-patient and on-call placements. Training hours are not regulated as in the UK and can be lengthy and antisocial. In institutions like NIMHANS and PGIMER, doctors undertake a comprehensive training programme covering placement in out-patient and in-patient services, addiction, liaison psychiatry, psychotherapy, child psychiatry, forensic psychiatry, community psychiatry and neurology.

Generally speaking, during the training period, each resident (or postgraduate student) is expected to imbibe the essentials of history taking, mental status examination, arriving at a diagnosis, formulating and implementing treatment and follow-up for out-patients or in-patients. This is carried out under the direct supervision of consultants or senior residents (equivalent to specialist registrars). Apart from routine clinical care, residents are expected to handle psychiatric emergencies (in psychiatric and medical/surgical settings); usually under the indirect supervision of consultants. Training and expertise in non-pharmacological modes of therapy is, however, not provided in all training centres; the quality and intensity of such training varies across centres too. Trainees also attend theory lectures and make mandatory presentations in journal clubs, case conferences, research forums and inter-departmental meetings. Though not mandatory, they are also encouraged to indulge in research activity, attend conferences and make oral/poster presentations.

One of the unique aspects of postgraduate training in India is the MD thesis, which every trainee has to complete in order to achieve his or her degree. This involves a research project, which the trainee plans, executes and writes up under the guidance of a supervisor from within the same department. Unlike in the UK,

the exit exam for the degree of MD is not conducted by one central institution but is conducted by the trainees' local institution. The examiners consist of two faculty members from within the department and two external examiners from other academic departments of psychiatry within the country. The examination is generally similar across institutions. But, to illustrate, at PGIMER it is conducted over 6 days. Four essay papers (3 hours each) covering all aspects of psychiatry are held over 4 days; thereafter the clinical examinations are held over 2 days. This comprises an individual case presentation, a case management presentation of an in-patient that the trainee has managed in the weeks preceding the exams, a brief neurology case and viva voce examinations. The duration of the clinical examination is not as structured as in the UK, and the examination for the individual case presentation (in front of the examiners) has been known to last as long as 2 hours!

Further training after the MD degree as a senior registrar for a period of 3 years leads to eligibility for consultancy. Many doctors do not opt for senior registrar training, but go into private practice or work as a psychiatrist in a district hospital. In some hospitals it is not deemed necessary to complete senior registrar training to become a consultant. However, senior registrar training is essential if the trainee plans a career in academia or plans to join a teaching institution. A significant number of trainees go abroad to the UK or USA for further training and experience. Sub-specialities in psychiatry are not yet developed (except at some central institutions where posts are available for addiction services) and hence nearly all senior registrar posts are currently in general psychiatry. However, many psychiatrists develop their own areas of special interest during training. One of the reasons for lack of sub-specialities in psychiatry is probably the low priority placed on psychiatry compared to other specialities and other pressing issues in the health care system of a developing country.

There are positive aspects of the training scheme in that it is structured with a clear time frame of 3 years, with emphasis on compulsory research in the form of a MD thesis. However, one of the glaring deficits is the lack of uniformity in the training offered by various institutions, with training in some institutions comparable to the best in the world and training in others being poor (Kuruville, 1996). Also, there is a paucity of supervisors/consultants with formal training and expertise in various forms of psychotherapy (Sharan, 2000) and few centres provide sub-speciality services for training. There is need to evolve a consistent national programme of training. The main organisation of Indian psychiatrists – The Indian Psychiatric Society – needs to be more involved in the process of training and services planning.

Practice of psychiatry in India – some issues and differences

Psychiatry is an evolving speciality in India (Trivedi, 1998). The bulk of current training is in general psychiatry and



liaison psychiatry. It is expected that training programmes in areas like child psychiatry and substance misuse disorders will evolve in the near future.

There are currently approximately 3000 psychiatrists in India. A significant number are in private practice. There is still a considerable number of so called 'asylum era' mental hospitals that house patients with chronic mental illness. Community psychiatry is not yet developed, although pilot schemes like the Raipur Rani project in Punjab (Wig et al, 1981) have shown its feasibility. At the moment community psychiatry services are functioning in Karnataka under the aegis of NIMHANS, Bangalore (Srinivasamurthy & Burns, 1992). This could serve as a model for further development of community services across the country. However, this appears to be low on the priority list of the government and funding is a major issue.

Although there is a Mental Health Act, use of mental health legislation is virtually non-existent, with most trainees having only read about it. The probable reasons for less reliance on the mental health law are cultural; family members often persuade patients to seek treatment and the advice of the doctor is often seen as binding. Similarly, the strength of social networks and involvement of the family in the management of the patient probably makes up, to some extent, for the lack of community care. Effective management of patients can be compromised because primary care is not well developed and lines of communication between the private and government psychiatrists are poor.

There are important differences with respect to developed countries in the epidemiology, manifestations and outcome of mental illness, which influence the practice of psychiatry in India (Varma & Das, 1995). Also, traditional medicine and religious beliefs play a large part in the treatment seeking patterns of patients. Large numbers of patients from rural areas are initially seen by religious healers (Kapur, 1975) and only ever get to see a psychiatrist (who are almost always urban-based) if the problems do not resolve. Many patients also seek treatment from alternative systems of medicine like Ayurveda and homeopathy. Stigma about mental illness is significant and symptoms of mental illness are often interpreted along religious lines. It has also been suggested that the

practice of psychotherapy, as in the Western world, has to be adapted to Indian cultural beliefs (Neki, 1977).

Comment

Psychiatry is still an evolving speciality in India. There is an organised and well-proven postgraduate training programme; however, the number of training places and psychiatrists is low. Training in sub-specialities of psychiatry is in its infancy. The practice of psychiatry is affected by cultural factors, with many patients seeking treatment from magico-religious healers. Services are both hospital and private sector based. In terms of providing psychiatric care, there is a need for a more coherent and involved policy from the government and national bodies (i.e. The Indian Psychiatric Society) alike.

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