POSTGRADUATE TRAINING IN PSYCHIATRY IN INDIA

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Modern Medical Education

Modern medical education in India began in 1822 in a medical school at Calcutta, but postgraduate medical education started much later. It was restricted to two or three medical colleges at the beginning of this century and was confined to a few specialties such as medicine, surgery and midwifery. Where such qualifications existed, very few students enrolled. Today more than 80 out of a total of 107 medical colleges have facilities for postgraduate training in sixteen broad specialties and over a dozen sub-specialties such as cardiology, nephrology and aviation medicine.

The Indian Psychiatric Society was founded in 1947, and in the same year the Society appointed a committee on Postgraduate Psychiatric Education which paved the way for the establishment of the All-India Institute of Mental Health at Bangalore in 1954. Today there are over two dozen medical institutions providing postgraduate training in psychiatry and producing 80 to 100 psychiatrists each year. This is a remarkable achievement when compared with the past. From 1947 to 1967 there were only four institutes in India offering postgraduates degrees (M.D.), and from these centres about 14 doctors qualified as psychiatrists. During the same period, 450 to 500 qualified with a two years diploma (DPM) training. However, there are no reliable data available on the number of doctors from India trained in the UK and USA, though figures from the Institute of Psychiatry, London, do give an indication of their number. From India alone 101 received training in psychiatry between 1949 and 1966; they formed about 10 per cent of the total number of trainees during those years.

This trend is gradually changing, and during the last decade dramatic developments have taken place. Today it is obvious that like most other specialties, psychiatry is becoming increasingly specialized and fragmented. The postgraduate level of education in India, in general, is based on Western methods, particularly those of Britain. Because of this historical factor the development of psychiatry as an independent discipline was delayed in India, as the internists continued to maintain their grip on psychiatry. For the same reason most of the present day teachers of psychiatry in India have received their training in the West in a Western model and in a foreign tongue.

Standard of Psychiatric Education

The development of psychiatric education, including its objectives and standards is guided by the Medical Council of India, a statutory body established in 1933. Since 1952 it has had a permanent Committee on Postgraduate Medical Education whose function is to formulate rules and curricula of studies and to specify the minimum requirements for teaching centres. It also maintains the quality of teachers and examinations conducted by the universities so as to bring about uniformity of standards.

In many ways the recommendations of the Council are mandatory and should be fulfilled before an institute is recognized as a postgraduate department, and the following areas should be covered:

1 (a) The teaching staff is adequate and qualified.
  (b) The student to teacher ratio is satisfactory, normally one postgraduate student (M.D.) per teacher per year.
  (c) The ratio of student to number of patients he handles is satisfactory.
  (d) Each postgraduate teacher has at least thirty in-patients, with out-patient, follow-up and adequate laboratory facilities for research in the unit.

2 The selection is strictly on merit, and in some institutions credit is given to performance at interview.

3 The duration of a postgraduate degree course is a minimum of three years and for the diplomas two years, after one year of compulsory rotating internship in a recognized medical institution. This period of three years training has to be full-time, and every postgraduate student is either a resident or a full-time scholar.

4 As regards the contents and method of training, the main purpose is to expose the student by graded residency posts to a wide variety of clinical psychiatry, and also internal medicine, including neurology. The student participates in the care and management of patients, and is given increasing responsibility as his experience develops. By the time he is in his last year of training he is able to diagnose and initiate treatment independently. He also becomes conversant with allied subjects such as neurobiochemistry, neurophysiology including electroencephalography, electromyography, neuroradiology and psychometrics during his training.

5 Organization of the teaching programme is a complex task for anyone given this kind of responsibility. It is easy to preach ideals but

https://doi.org/10.1192/S0140078900005137 Published online by Cambridge University Press

difficult to practise, and at present our leaders face two formidable tasks: first, to train and provide for over 600,000,000 people of India a sufficient number of medical personnel, including psychiatrists; second, to maintain high standards in the scientific field in order to ensure a high quality of teaching and research activity.

The central problem is how to distribute our limited teaching and training resources in the specialty, in order to provide postgraduate education in the most efficient way possible, and there have been numerous debates on the issues of priorities, and demands and needs (Sharma, 76). There is a general consensus that the basic knowledge needed should include:

(a) fundamental neuroanatomy, neurophysiology, neurobiochemistry, neuropathology and genetics
(b) basic principles of biophysics, with special attention to the recording and amplifying electrical circuits and EEG
(c) fundamentals of psychopharmacology and its application to psychiatry
(d) principles of behavioural sciences, including psychology, sociology and basic cultural anthropology and Indian philosophy
(e) operation of the mind
(f) knowledge and skill in the fields of statistics, epidemiology and demography
(g) knowledge of child, adult, geriatric, subnormality and forensic psychiatry
(h) the acquisition of psychotherapeutic skills and
(i) the stimulation of interest in research and community service.

To equip students satisfactorily in basic knowledge and essential skills, the training must be well structured and organized. A student is exposed to didactic lectures, seminars, journal reviews, ward rounds and clinical pathology conferences. There is also increasing responsibility in the care of the patients.

Evaluation

After completing the three years of the training programme, each student is evaluated by his university. There are two internal and two external examiners and, if successful, he is awarded the appropriate degree or diploma in the specialty. The final examination usually consists of:

1 Thesis or Dissertation: this is necessary for adequate training and to assess the candidate's abilities. The writing of a thesis helps the candidate to critically evaluate the literature.
2 Theory papers: most of the universities have four theory papers, of three hour duration; one on internal medicine including neurology; two devoted to applied sciences and clinical psychiatry, including child, adult, forensic and community psychiatry; and the fourth normally devoted to an essay on a particular subject.
3 Clinical examinations include assessment of skills in the diagnosis and management of cases.
4 Oral, to evaluate general knowledge including that relating to recent advances in the field of psychiatry.

The examinations are usually of a high standard and the percentage of successful candidates varies from 25 to 75 per cent. But the standards of M.D. vary a good deal from one university to another, in spite of a supervision by the Medical Council of India. Because the teaching, hospital and laboratory facilities vary, the standard of examination cannot be uniform. To overcome this the Government of India in 1976 established the National Board of Examinations and entrusted to the National Academy of Medical Sciences, which was established in December 1961, the responsibility of conducting a postgraduate examination of high standard on an All-India basis in the various disciplines of medicines, including psychiatry. The aim was to ensure a uniform standard of postgraduate qualification throughout the country, and this examination is termed the MAMS (Member of the National Academy of Medical Sciences).

In the next few years the National Board will aim to maintain a high standard of examination and ensure that candidates who pass have received adequate and appropriate training in theoretical and practical fields. At present such examinations are held at medical colleges in thirteen states of the Union and in London. It is hoped that all medical colleges in India will adopt this system. Naturally, this has given rise to some confusion and contradiction between the functions and role of the Medical Council of India and the National Board of Examinations, but efforts are being made to bring about uniformity. Both these bodies agree on the need for urgent modification in the existing training and evaluation system.

Comments

Objectives of any training must be relevant to what is to be practised and must be practical in terms of the time and resources available. Such objectives should be influenced by local needs and community demands. It is preferable to train the psychiatrist in his own culture. Beside the problem of the 'brain drain', the psychiatrists trained abroad are not only reluctant to return to their home country but may find themselves misfits on their return.

https://doi.org/10.1192/S0140078900005137 Published online by Cambridge University Press

Psychiatry is the only field in medicine which is founded on both biological and behavioural sciences. It requires understanding of the biological basis of human behaviour, a grasp of new behavioural mechanisms and an understanding of psychopharmacology. A background of behavioural sciences is needed in order to understand the essentially human aspects of human adaptation and maladaptation and to comprehend psychodynamic theory.

Lack of clear boundaries of the scope of psychiatry in a developing country like India is not a serious drawback. As rightly pointed out by one of the former Presidents of the Indian Psychiatric Society, Dr Ajita Chakraborty, (1974), 'Developing countries are underdeveloped in relation to developed countries in matters of technology and its implementation, the Western expertise and know-how are being accepted with open arms by these countries. But the idea of underdevelopment should not be carried too far, especially in the social sciences. Medicine is perhaps a part of technology, but psychiatry is surely part of both technology and the social sciences. What panacea has been achieved in psychiatry in the West that needs to be imported? Take the two well developed facets: (a) Physical methods and drug treatment—these are being widely used all over the world without any difficulty, the techniques of application are not too complex; (b) Psychotherapy with all its ramifications—an immensely controversial area, the usefulness and universal applicability of which are doubted. The inherent limitations of time, expense and number of patients who can be treated make the usual methods of psychotherapy of restricted value. Above all, indigenous practices often serve the same purpose. The fact that these are not recognized as psychotherapy nor codified as such, does not make a great deal of difference.'

Today, India is in a better position in the field of medical technology and has the added advantage of its cultural heritage and social system, so necessary and valuable in the field of psychiatry. Recent trends in postgraduate education seem both healthy and hopeful.

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CORRESPONDENCE

CRITERIA FOR SENIOR REGISTRAR APPOINTMENTS

DEAR SIR,

In their statement in the June 1979 issue of the *Bulletin*, Professor Pond and Professor Rawnsley gave the criteria for a Senior Registrar's appointment in Psychiatry.

Although slightly belated, this directive would be helpful to both the candidate, who will know that there is no point in applying until he obtains the MRCPsych, and to the Appointment Committee as well as the Regional Health Authorities, who should mention clearly this minimum educational qualification when inviting applications. The statement recommends 'that the entry point for this grade should normally be the possession of the MRCPsych or an equivalent higher degree (this does not include the DPM)'.

I assume that this guideline will be applicable to all sub-specialties of psychiatry, to which the College has a duty to maintain the standard, and therefore this is equally applicable to the sub-specialty of mental handicap. Unfortunately, this sub-specialty still remains the Cinderella of the Health Service. Periodical scandalous outbursts occur, followed by Inquiries: some scapegoat is promptly found and then everything is forgotten for a time—where radical surgery is needed, only superficial cosmetic application is done. As a result, young psychiatrists generally become very unenthusiastic about entering the field of mental handicap, especially in view of the lack of scope for study, research and general financial gains.

Owing to the above, quite a large number of mental handicap hospitals are functioning with a third or half the number of Consultants they should have, which

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