Contents

1. Introduction:

Medical education is a continuum from Undergraduate through internship to Postgraduate Medical Training, which is further divided into two stages: basic and higher professional training. Universally postgraduate medical training is competency-based and structured. In fact, self-learning aided by Continued Medical Education (CME) programmes, should continue throughout the career of a medical practitioner and re-training is desirable whether re-certification is mandatory or not. This should not be construed to mean that doctors are not adequately trained for their job at graduation or on exit from higher professional training, but that Medicine is complex and evolving; therefore, continued update, review and re-education are mandatory in the Medical Profession.

Recently BSMMU has introduced its competency-based Residency Programme. Phase-A training of the programme which lasts for two years, aims at a broad-based training in general internal medicine and basic understanding in psychiatry.

Psychiatry as a specialty deals with mentally disordered patients. It deals with the assessment, diagnosis and management of psychiatric disorders. The patients are treated on the basis of bio-psycho-social model. The psychiatrist, in accordance with his medical professional responsibilities, occupies a central position in a multidisciplinary team whose members contribute their special competences to the common goal.

By the end of the eighteenth century it was recognized that the study of mental alienation was part of medicine. However, mental diseases were of such a nature that it was not possible to treat the 'insane' in the same conditions as patients affected by other diseases. Their most obvious manifestations had social consequences. According to the prevailing philosophical view, the

mentally ill were deprived of free will by their illness. In practice, they were unable to participate in the normal life of the society and were often considered as potentially dangerous. Because of this they had generally been confined in 'madhouses' of various kinds. Philippe Pinel, a French psychiatrist constitutes a turning point. He is known worldwide as the physician who 'liberated the insane from their chains'. As a result, we are now treating our patients in general hospital psychiatry unit.

In most countries, psychiatry is now practiced in the community rather than in institutions and it has converted patients from passive recipients of care to active participants with individual needs and preferences. Psychiatrists are now involved in the planning, provision, and evaluation of services for whole communities. Care in the community has also drawn attention to the many people with psychiatric disorder who are treated in primary care, and has led to new ways of working between psychiatrists and physicians. At the same time, psychiatrists are working now more in general hospitals, helping patients with both medical and psychiatric problems.

This is worth mentioning that in treating mentally disordered patients biological, psychological, and social factors interact and much stigma is attached to mental disorders. But we should keep in our mind that scientific treatment in this field exists and very much effective. With the advent of new generation drugs and researches prognosis of psychiatric disorders became much better now-a-days.

Advances in genetics and in the neurosciences have already increased knowledge of the basic mechanisms of the brain and are beginning to uncover the neurobiological mechanisms involved in psychiatric disorder. Striking progress has been achieved in the understanding of Alzheimer's disease, for example, and there are indications that similar progress will

follow in uncovering the causes of mood disorder, schizophrenia, and autism. Psychological and social sciences and epidemiology are also essential methods of investigation in psychiatry. Although the pace of advance in these sciences may not be as great as in the neurosciences, the findings generally have a more direct relation to clinical phenomena. Moreover, the mechanisms by which psychological and social factors interact with genetic, biochemical, and structural ones still continue to be important however great the progress in these other sciences.

Regarding psychiatric disorders, mostly the major psychiatric diseases come forward in discussion, presentation even in different social and medical concern. But the prevalence and existence of other psychiatric problems (also known as: The minor psychiatric disorders) are much higher in all set up, all around the world, that not been properly recognized. These minor disorders deserve to get sufficient concentration in the academic curriculum to improve quality mental health service and making quality psychiatrists.

The field of psychiatry itself can be divided into various subspecialties. These include: Adult psychiatry, Child and Adolescent psychiatry, Psychotherapy, Addiction psychiatry, Cross-Cultural Psychiatry, Forensic psychiatry, Neuropsychiatry, Psychosomatic medicine, Cognitive disorders as in various forms of dementia etc.

1.1. Psychiatry Residency Programme:

All the selected Residents in the programme will act and named as resident. Their job description shall be as per job description of a resident of the University. The Residents must at all times participate in clinical placements that offer appropriate experience, namely direct contact with and supervised responsibility of patients. Training placement will be made as Block that consists of three months. All training placements must include direct clinical care of patients. The Residents will

undergo the residency training in wide spectrum in psychiatry. General adult psychiatry is at the core of basic training although all residents are expected to gain experience in the specialties of psychiatry. The Residents will also undergo residency training in Medicine relevant to psychiatry, other disciplines relevant to hospital liaison psychiatry etc. The training scheme must provide an overall balance of hospital and community experience. The programme must ensure that the rotation plan for an individual trainee enables them to gain the breadth of experience required. Trainees will need to monitor the scheme through their portfolio and will be monitored themselves by the scheme through its quality management processes. The designated supervisor with the aim of ensuring high quality training will carry out the evaluation of performance of a trainee periodically. In addition; residents will receive theoretical knowledge on customized ways during this residency-training period to make the training sensible and meaningful.

Components for structured training:

A. Working with patients in ward
B. Morning session/ journal club/ topic discussion/ case presentation/ grand round/group discussion/ research related discussion etc.
C. Working in Out Patient Department
D. Encouragement of group learning, self directed learning and sharing session with trainers and other trainees.
E. To Ensure protected study time.
F. Community Orientation: sending trainees to different outreach centres community orientation.
G. The training will be assessed regularly and in end-block assessment. Satisfactory performance is required in above components for appearing at the summative assessment.

2. Objectives:

The candidates in the program shall achieve the diverse competencies/objectives are as followings:

- **Clinical expertise:** to assess cases, establish diagnoses, formulate and implement treatment plan, work in a team and proper documentation.
- **Health advocacy**: to apply appropriate determinants consequences of mental health, mental health promotion and prevention.
- **Academic perspectives**: to create a life-long programme for continuous medical education, read, interpret and apply new findings, integrate and apply new knowledge and technology. To enhance critical thinking, self-learning, and interest in research and development of patient-care service.
- **Collaborative capacities:** to establish treatment plan, work efficiently with other health care professionals and work collaboratively with relevant agencies.
- **Administrative capacity:** to develop cost effective treatment plan, and mental health services, utilize resources effectively and conduct multidisciplinary work. To enhance sensitivity and responsiveness to community needs and the economics of health care delivery.
- **Effective communication:** to establish therapeutic alliance with patients and relatives/caregivers, educate patient, families, teachers, other health and social service professionals, and public and communicate effectively with teachers, prison health care staff, law and law enforcing personnel.
- **Professionalism:** to abide by ethical principles and profession; respect patient rights and broader human rights; support patient autonomy and dignity and respect patient patient's culture, beliefs and values. Achieve the professional requirements for specialty-specific training (Phase B).

- **Professional attitude:** To cultivate the correct professional attitude and enhance communication skill towards patients, their families and other healthcare professionals.

3. Admission Requirements:

This shall be according to the general rules of admission of respective faculty of the University. Medical graduate with successful completion of internship and with full registration with the BMDC will be selected by competitive admission test.

***A**. Pre-requisites for admission in Phase-A*

a) MBBS or equivalent degree as recognized by BMDC
b) One year of internship / in-service training
c) Completion of one year after internship / in-service training
d) BMDC registration

***B**. The applicants should not be above 45 years of age on enrolment.*

3.1. Methods of selection of candidates for the Programme:

A. Candidate will be selected for the programme strictly based on competitive Examination and merit in admission test. Candidates for residency have to sit for a written MCQ-based admission test on Basic Medical Sciences and faculty-based topics. The selection of the candidate will be based on above the cut-off point of obtained marks as per decided by the University.
B. Government doctors will be on deputation.
C. Private candidates may also apply for admission in the programme if they are eligible under clause 2 (eligibility for admission).
D. Applicants who are eligible under clause 2 will be selected through a competitive assessment procedure by a screening board.

4. The Curriculum Content- knowledge, skills and attitude

The Curriculum Content of psychiatry covers three broad areas-knowledge, skills and attitude. The residents shall undergo through active and integrated learning process in the following three areas to acquire intended learning outcomes that have been set to achieving the programme objectives:

A. Knowledge
B. Skills
C. Attitudes demonstrated through behavior

A. Knowledge:

- The knowledge of psychiatry includes psychiatric symptoms and syndromes, psychological aspects of medical disorders and psychosocial issues. Psychiatric symptoms, syndromes and their treatment are to be learned in the context of an integrated biological, psychological and social approach.
- Knowledge about--diagnosis, aetiology, comorbidity, complications, management, prevention of Specific conditions like: Delirium and Dementia, Alcohol and Drug Abuse and Dependence, Schizophrenia, Depression and Bipolar Affective Disorder, Post Traumatic Stress Disorder, Acute Stress Disorder and Adjustment Disorder, Anxiety Disorders and Obsessive Compulsive Disorder, Somatoform Disorder, Hypochondriasis and Psychological Factors Affecting Medical Conditions, Eating Disorder, Sleep and Sexual Disorders, Personality Disorders, A conceptual understanding and their influence on physical and mental disorders etc.
- Knowledge about Special areas of importance:-
  - Recovery – an understanding of recovery principles with people who have mental disorders.

- Pharmacology – Treatments of major and minor mental disorders including side effects of treatment.
- Psychotherapy – Basic Principles of interpersonal and cognitive behavioural psychotherapies and psycho-education in the treatment of mental disorders.
- Rehabilitation – Concepts of long term management of people with long term mental illness.
- Risk Assessment –Recognition and basic management of dangerousness to self or others.
- Ethical Issues – General Principle and their application to psychiatry including confidentiality, competency, informed consent, autonomy and beneficence.
- Legal Issues – Basic knowledge of the Mental Health Act.

B. Skills:

Communication Skills:-

- Learn to take a formal psychiatric history including incorporating information from other sources
- Be able to take a drug and alcohol history
- Examine all dimensions of the mental state with the expectation that it will be used regularly in the assessment of patients
- Develop a basic understanding of the strong emotional relationship between patient and doctor especially within the realm of psychiatric illness and have the competence to use this to facilitate good communication in the interest of the patient
- Appreciate the importance of forming a therapeutic alliance and the role of empathy
- Be able to engage and interview a patient and their caregiver including any specific cultural issues

- Be able to engage and negotiate treatment with often frightened or resistant patients in non psychiatric settings
- Be able to engage and examine a patient whose mental state is such that compulsory treatment under the mental heath act may be necessary
- Be able to undertake these tasks in a community or hospital setting
- Use principles of recovery in working with patients and their families
- Share information with the patient and family including the implications of diagnosis and benefits and disadvantages of treatment
- Understand how to adapt assessments for different developmental stages.

Information evaluation skills:-

- Select the crucial pieces of information for making a differential diagnosis
- Evaluate the role of the personal and social factors in the patient's presentation.
- Formulate a management plan including when to refer for specialist assistance.

Treatment skills:-

- Encourage adherence to treatment, explore, and eliminate barriers to this.
- Basic prescribing skills especially for psychiatric disorders commonly encountered by non-psychiatrists.
- Recognize adverse effects of treatment and distinguish them from illness.

Learning skills:-

- Sustain self-directed independent learning such that the student will keep up to date with new advances in psychiatry and psychological aspects of medicine throughout their professional life.

Teamwork skills:-

- To cooperate with medical colleagues and other healthcare workers.
- To be aware of patient and family organizations and other community services that support and promote mental health.

C. Attitudes:

It is important that residents develop appropriate attitudes. These attitudes need to be encouraged during the teaching of psychiatry and other disciplines. It is important that teachers model these attitudes and that students have the ability to internalise them. Internalising occurs in the way that students work with patients and members of staff.

Residents should:

- Recognise that the profession of medicine involves life-long learning
- Show capacity for critical thinking and constructive self-criticism
- Be able to tolerate uncertainty and acknowledge the opinion of others
- Be able to work constructively with other health professions
- Recognise the value of good doctor-patient relationships
- Appreciate the value of the developmental approach to clinical problems emphasizing the stage of the life cycle and longitudinal perspective of the illness

5. Programme Contents of Phase-A:

Residency training and Learning Modules:

Phase A residency programme have two major components:

a) **Residency training** and
b) **Learning modules**

The prorgamme contents are fulltime residency training along need-based updated theoretical knowledge mentioned in the designed learning modules that run side by side through the entire duration of the programme

6. Phase A Residency Training:

The two-year Core Medical Training provides foundation training in Psychiatry which includes components of educational (academic) and training programme in relevant fields of Applied Medical Sciences and General Internal Medicine. This training program will focus on developing core knowledge and skills, providing a foundation for consolidation and further study within advanced specialty-specific training.

6.1. The intended broad learning outcomes for psychiatric training:

- Be able to perform specialist assessment of patients and document relevant history and examination on culturally diverse patients to include:
  - Presenting or main complaint
  - Past medical and psychiatric history
  - Systemic review
  - Family history
  - Socio-cultural history
  - Developmental history
- Demonstrate the ability to construct formulations of patients' problems that include appropriate differential diagnoses.

- Demonstrate the ability to recommend relevant investigation and treatment in the context of the clinical management plan. This will include the ability to develop and document an investigation plan including appropriate medical, laboratory, radiological and psychological investigations and then to construct a comprehensive treatment plan addressing biological, psychological and socio-cultural domains.
- Based on a comprehensive psychiatric assessment, demonstrate the ability to comprehensively assess and document patient's potential for self-harm or harm to others.
- Assessment of risk, knowledge of involuntary treatment standards and procedures, the ability to intervene effectively to minimize risk and the ability to implement prevention methods against self-harm and harm to others. This will be displayed whenever appropriate, including in emergencies
- Based on the full psychiatric assessment, demonstrate the ability to conduct therapeutic interviews; that is to collect and use clinically relevant material. The doctor will also demonstrate the ability to conduct a range of individual, group and family therapies using standard accepted models and to integrate these psychotherapies into everyday treatment, including biological and socio-cultural interventions.
- Demonstrate the ability to concisely, accurately and legibly record appropriate aspects of the clinical assessment and management plan.
- Develop the ability to carry out specialist assessment and treatment of patients with chronic and severe mental disorders and to demonstrate effective management of these disease states.

  Use effective communication with patients, relatives and colleagues. This includes the ability to conduct interviews in a manner that facilitates information gathering and the formation of therapeutic alliances.

- Demonstrate the ability to work effectively with colleagues, including team working.
- Develop appropriate leadership skills
- Demonstrate the knowledge, skills and behaviours to manage time and problems effectively
- Develop the ability to conduct and complete audit in clinical practice
- Develop an understanding of the implementation of clinical governance
- Ensure that you are able to inform and educate patients effectively
- Develop and utilize the ability to teach, assess and appraise
- Develop an understanding of research methodology and critical appraisal of the research literature
- Ensure that you act in a professional manner at all times
- Develop the habits of lifelong learning

6.2. Structure of Training:

Phase A residency programme consist of two years: 1st year and 2nd year.

The training requirements shall be as follows:

First Year: Basic training in Psychiatry:-

This will be full one-year residency training in General Psychiatry in the Department of Psychiatry. This period of training will be on introduction to psychiatry including fundamentals of psychiatry, orientation about disciplines in psychiatry, learning the assessment of cases including psychiatric interview and management of cases. Training in Psychiatry must be comprehensive and structured. Candidates will be expected to be competent in history taking, examination of the mental state, physical assessment, taking of accounts from informants,

consideration of diagnosis and aetiological factors, the identification of further investigations required for the management and the practice of treatment under supervision. Candidates will be able to work with and contribute appropriately to a multidisciplinary team. The level of skill required is that of someone who is able to work independently with access to consultant advice.

Residents must have exposure in OPD clinics, in-patients units, psychiatric emergencies, and hospital liaison psychiatric work. Candidates must complete diagnostic and therapeutic procedures of assigned and supervised cases. The supervisor with the aim of ensuring high quality training will carry out the evaluation of performance of a trainee periodically. In addition, active participation in journal club, topic discussion, seminars, workshops, and clinical case conferences is expected. In addition, residents will complete behavioral science and basic psychiatry module in customized ways in this period.

In addition, residents will complete learning module of Basic Psychiatry and Liaison Psychiatry in customized ways in this period.

Second Year: Training in Liaison Psychiatry:-

This will be full one year supervised residency training in Medicine and Specialties relevant to psychiatry. Of these, six months training in internal medicine and its divisions, endocrinology, rheumatology, three months training in neurology and three months in the disciplines relevant to hospital liaison psychiatry namely, nephrology, gastroenterology, cardiology, pediatrics, intensive care medicine(ICU),Neurosurgery, palliative care, emergency department, radiology and imaging etc. for specific duration as decided by the Department of Psychiatry. Neurology and Medicine training should enable a candidate to deal with neurological and other medical aspects of psychiatric disorders and with physical illnesses causing and/or associated

with psychiatric disorders. Candidates will be expected to have achieved necessary clinical skills to integrate the physical and psychiatric assessment findings.

In addition, residents will complete learning modules related to Liaison Psychiatry in customized ways in this period.

All trainees should receive adequate supervised experience in the assessment and management of psychiatric disorders in general medical conditions, deliberate self-harm, psychiatric emergencies in general, and psychiatric problems in emergency department. Placement of such training will be organized and coordinated by the Department of Psychiatry.

6.3 Training rotations

Total duration: 24 months

- Phase- A training consists of eight Blocks. Duration of each Block is of three months. The last Block (Block-8) will be allotted for eligibility assessment and Phase Final Examination.
- The remaining 7 Blocks are as follows:

BLOCK	SPECIALITY	DURATION (months)
1	Basic Psychiatry	3
2	Basic Psychiatry	3
3	Basic Psychiatry	3
4	Internal Medicine	3
5	Liaison Psychiatry (Internal Medicine plus its divisions, Rheumatology, Endocrinology)	3
6	Other disciplines relevant to liaison Psychiatry	3
7	Neurology	3

Of the seven blocks placement in psychiatry, three blocks are for training in Basic Psychiatry. The last four blocks placements are

in Liaison Psychiatry. Block 4 is for training in Internal Medicine, Block-5 is in Internal medicine and its different divisions/specialized unit, rheumatology & endocrinology Block 6 is in other disciplines relevant to liaison psychiatry and Block 7 is for training in Neurology.

7. Domains of Learning

Below are the lists of some specific knowledge, skills and attitudes to be obtained for clinical competency throughout training in Psychiatry.

1) Clinical history:

Knowledge	Skills	Attitudes demonstrated through behaviours
• To define signs and symptoms found in patients presenting with psychiatric and common medical disorders • To recognize the importance of historical data from multiple sources	• To elicit a complete clinical history, including psychiatric history, that identifies the main or chief complaint, the history of the present illness, the past psychiatric history, medications, general medical history, review of systems, substance abuse history, forensic history, family history, personal, social and developmental history • To overcome difficulties of language,	• Show empathy with patients. • Appreciate the interaction and importance of psychological, social and spiritual factors in patients and their support networks

	physical and sensory impairment • To gather this factual information whilst understanding the meaning these facts hold for the patient and eliciting the patient's narrative of their life experience	

2) Patient examination, including mental state examination & physical examination:

Knowledge	Skills	Attitudes demonstrated through behaviors
• To define the components of mental state examination using established terminology • To recognize physical signs and symptoms that accompany psychiatric disorders • To recognize and identify the different types of mental distress and their phenomenology • To recognise how the stage of cognitive and emotional development	• To perform a reliable and appropriate examination including the ability to obtain historical information from multiple sources, such as family and other members of the patient's social network, community mental health resources, old records. • To elicit and record the components of mental state examination.	• Respect patient's dignity and confidentiality • Acknowledge cultural issues • Appropriately involve family members • Demonstrate an understanding of the importance of working with other Health and Social Care professionals and team working. • Show a willingness to provide explanation to patients of investigations and their possible unwanted effects.

may influence the aetiology, presentation and management of mental health problems	• To make a clear and concise case presentation to assess for the presence of general medical illness. • To recognise and identify the effects of psychotropic medication in the physical examination.	

3) Diagnosis:

Knowledge	Skills	Attitudes demonstrated through behaviours
• State the typical signs and symptoms of common psychiatric disorders including affective disorders; anxiety disorders; disorders of cognitive impairment; psychotic disorders; personality disorders; substance misuse disorders; and organic disorders • To Be familiar with contemporary ICD or DSM diagnostic systems with the	• To Use the diagnostic system to accurately construct a differential diagnosis for common presenting problems • To Use the diagnostic system accurately in identifying specific signs and symptoms that comprise syndromes and disorders across the age range • To Formulate and discuss differential diagnosis	• Show an awareness of the advantages and limitations of using a diagnostic system

ability to discuss the advantages and limitations of each • To State the typical signs and symptoms of psychiatric disorders as they manifest across the age range, including affective disorders; anxiety disorders; disorders of cognitive impairment; psychotic disorders; personality disorders; substance misuse disorders; organic disorders; developmental disorders; and common disorders in childhood.		

4) Formulation:

Knowledge	Skills	Attitudes demonstrated through behaviours
• To describe the various biological, psychological and social factors involved in the predisposition to, the onset of and the maintenance of common psychiatric disorders that affect adult patients	• To integrate information from multiple sources to formulate the case into which relevant predisposing, precipitating, perpetuating and protective factors are highlighted	• To provide explanation to the patient and the family which enables a constructive working relationship

• To Describe the various biological, psychological and social factors involved in the predisposition to, the onset of and the maintenance of psychiatric disorders across the age range		

5) Investigation:

Knowledge	Skills	Attitudes demonstrated through behaviours
• Define the indications for the key investigations that are used in psychiatric practice • Define the risks and benefits of investigations, including those of psychotherapeutic and genetic investigations • Demonstrate knowledge of the cost effectiveness of individual investigations	• Interpret the results of investigations • Liaise and discuss investigations with colleagues in the multi-professional team in order to utilize investigations appropriately	• Provide explanation to the patient and the family which enables a constructive working relationship

6) Treatment Planning:

Knowledge	Skills	Attitudes demonstrated through behaviours
• Explain the evidence base for physical and psychological therapies including all forms of	• Accurately assess the individual patient's needs and whenever possible in agreement with	• Show appropriate behaviour towards patients and their symptoms and be conscious of socio-cultural contexts

psychotherapies, brief therapy, cognitive behavioural therapy, psychodynamic therapy, psychotherapy combined with psychopharmacology, supportive therapy and all delivery systems of psychotherapy (that is individual, group and family) • Show a clear understanding of physical treatments including pharmacotherapy, including pharmacological action, clinical indication, side-effects, drug interactions, toxicities, appropriate prescribing practices, and cost effectiveness; electro-convulsive therapy and light therapy • Show a clear understanding of the doctor/ patient relationship and its impact on illness and its treatment • Apply knowledge of the implications of coexisting medical illnesses to	the patient, formulate a realistic treatment plan for each patient for adult patients with common presenting problems • Be able to do the above with psychiatric problems as they present across the age range Educate patients, careers and other professionals about relevant psychiatric and psychological issues Demonstrate an understanding of how professional and patient perspectives may differ and the impact this may have on assessment and treatment • Explain to patients what is involved in receiving the full range of psychiatric treatments and manage their expectations about these treatments described under knowledge. • Monitor patient's	• Clearly and openly explains treatments and their side effects. • Demonstrate an understanding of the impact of their own feelings and behaviour on assessment and treatment • Show respect for the patient's autonomy and confidentiality while recognizing responsibility towards safeguarding others • Recognise, value and utilize the contribution of peers and multi-disciplinary colleagues to develop the effectiveness of oneself and others • Provide care and treatment that recognises the importance to patients of housing, employment, occupational opportunities, recreational activities, advocacy, social networks and welfare benefits • Ensure that the employment of legal powers for detention (or to enforce treatment)

the treatment of patients who have psychological disorders • Demonstrate knowledge of CPA (Care Programme Approach) processes	clinical progress and re-evaluate diagnostic and management decisions to ensure optimal care • Be skilled in multi-agency working	balances the duty of care to the patient and the protection of others • Be prepared to test out the feasibility and acceptability of decisions

7) All clinical situations (including in emergencies):

Knowledge	Skills	Attitudes demonstrated through behaviours
• Demonstrate knowledge of risk assessment and management	• Comprehensively assess immediate and long-term risks to patients and others during assessment and treatment • Routinely employ safe, effective and collaborative management plans	• Maintain high standards of professional and ethical behaviour at all times.

8) Psychiatric emergencies for all specialties:

Knowledge	Skills	Attitudes demonstrated through behaviours
• Apply the principles of risk assessment and management • Shows awareness of child protection issues when addressing psychiatric	• Resuscitation • Be able consistently to assess risk and utilize the full resources of the available Mental Health Services in the management of high risk	• Be able to work under pressure and to retain professional composure and to think clearly when working in emergency situations • Be able to prioritize work appropriately when confronted with

emergencies. Has basic knowledge of child protection procedures • Know the principles underlying management and prevention of violence, hostage taking, self harm, suicide, escape and recall of a restricted patient • Be familiar with the policy and principles regarding management of seclusion	situations • Be competent in making a clinical assessment with regard to potential dangerousness of an individual to themselves or others • Be able to prioritize what information is needed in urgent situations • Competent in the supervision and management of challenging behaviour and medical complications in relation to the range of clinical conditions presenting as psychiatric emergencies. Shows good judgment in the choice of treatment settings and in referral decisions • Assess and manage a patient involved in an incident • Risk assess situations in which incidents may occur or have occurred and institute appropriate management including	clinical crises • Keep mandatory training up to date • Maintain professionalism in face of considerable clinical and legal pressure • Offer help and support to others patients, staff and careers) • Provision of appropriate documentation of incidents Follow appropriate policies and procedures

	contingency planning, crisis management and de-escalation techniques • Short term control of violence including emergency use of medication, rapid tranquillization, use of restraint and seclusion • Post event management • Assess and manage a patient involved in an incident Provision of reports and documentation relating to incidents • Working with multidisciplinary and multi-agency colleagues to assess and manage incidents • Consider the need for emergency supervision support and feedback for staff, victim, other patients, careers as required	

9) Mental health legislation:

Knowledge	Skills	Attitudes demonstrated through behaviours
• Demonstrate an understanding of the	• Apply the legislation appropriately at	• Act with compassion at all times • Work with attention to

contemporary mental health legislation and its local implementation with regard to assessment and treatment of patients, including mentally disordered offenders • Understand and make appropriate use of the Mental Health Act in relation	all times, with reference to published codes of practice	the detail of the legislation

10) Broader legal framework:

Knowledge	Skills	Attitudes demonstrated through behaviours
• To know the legal responsibilities of psychiatrists with regard, for example, to agencies such as the relevant driving authority	• Apply the legislation appropriately at all times, with reference to published codes of practice	• Act in accordance with contemporary codes of practice • Be sensitive to the potential conflict between legal requirements and the wishes of the patient

11) Psychological therapies:

Knowledge	Skills	Attitudes demonstrated through behaviours
• Apply contemporary knowledge and principles in	• Foster a therapeutic alliance with patients • With appropriate supervision,	• Respond appropriately to supervision

psychological therapies	commence and monitor therapeutic treatment in patients, based on a good understanding of the mechanisms of their actions • Demonstrate the capacity to deliver basic psychological treatments in at least two modalities of therapy and over both longer and shorter durations	

12) Record keeping:

Knowledge	Skills	Attitudes demonstrated through behaviours
• Define the structure, function and legal implications of medical records and medico-legal reports • Demonstrate a knowledge of the relevance of contemporary legislation pertaining to patient confidentiality • Awareness of issues surrounding copying corresponden ce to patients	• Record concisely, accurately, confidentially, and legibly appropriate elements of the history, examination, investigation, differential diagnosis, risk assessment and management plan	• Complete case records and all forms of written clinical information in a consistent, timely and responsible fashion

13) Communication with colleagues:

Knowledge	Skills	Attitudes demonstrated through behaviours
• Write clinical letters, including summaries and reports • Use e-mail, internet and the telephone. • Communicate effectively with members of the multi-professional team • Demonstrate a knowledge of how and when to telephone colleagues, including those in primary care	• Use appropriate language • Select the most appropriate communication methods	• Be prompt and respond courteously and fairly • Show an appreciation of the importance of timely and effective use of all communication methods, including electronic communication • Demonstrate awareness of the need for prompt and accurate communication with primary care and other agencies • Show courtesy towards all members of the Community Mental Health Team and support staff, including medical secretaries and clerical staff

14) Decision making:

Knowledge	Skills	Attitudes demonstrated through behaviours
• Demonstrate a good understanding of clinical priorities	• Analyse and manage clinical problems	• Be flexible and willing to change in the light of changing conditions • Be willing to ask for help

15) Doctor patient relationship:

Knowledge	Skills	Attitudes demonstrated through behaviours
• Demonstrate an understanding of all aspects of professional relationships including the power differential between psychiatrists and patients • Demonstrate an understanding of the boundaries surrounding consultation • Demonstrate an understanding of the rights of patients, careers and the public • Demonstrate an understanding of the factors involved when the doctor-patient relationship ends	• Develop therapeutic relationships that facilitate effective care • Deal with behaviour that falls outside the boundary of the doctor/patient relationship • Demonstrate the management of ending professional relationships with patients using clear and appropriate communications	• Adopt non-discriminatory behaviour to all patients and recognise their individual needs • Respect the patient's autonomy to accept or reject advice and treatment • At all times be open and honest with patients and careers • Ensure that a decision to end a professional relationship with a patient is fair and does not contravene guidance

16) Confidentiality:

Knowledge	Skills	Attitudes demonstrated through behaviours
• Demonstrate an understanding of	• Use and share patient information	• Respect the rights and limitations of

contemporary legislation and practice in relation to patient confidentiality	appropriately • Demonstrate a capacity to limit information sharing appropriately without either undue restriction or disclosure	patient confidentiality

17) Neuropsychiatry assessment:

Knowledge	Skills	Attitudes demonstrated through behaviours
• The behavioural and psychiatric presentation of progressive neurological disorder including impact upon cognition and development • The psychiatric consequences, associations and impact on brain function of acquired brain injury • Understanding of the neurological basis of psychopathology including neuroanatomy, neurophysiology and neuropsychology	• Ability to carry out a psychiatric assessment of child in the context of brain injury or neurological disorder • Ability to liaise with the wider care system including child health colleagues, families, education and social services about psychiatric sequelae of brain disorder	• Respectful behaviour to young people with neuropsychiatric disorders and their careers • Being aware of the limits of one's competence and being ready to seek advice. • Being supportive to parents in coming to terms with a diagnosis for their child in this domain • Willing and able to act as an advocate for a young person whose developmental needs is not being met.

8. Learning Modules in Psychiatry Phase-A:

Residents will receive theoretical knowledge to facilitate their learning in customized fashion. The prorgamme contents are fulltime residency training. The modules that give an indication of the areas need to be covered to facilitate comprehensive training and will be set in both formative and summative assessment. However, knowledge on recent developments is very essential and will be incorporated in the modules.

- **Basic Psychiatry (** Basic Sciences relevant to Psychiatry and Fundamentals in Psychiatry)
- **Liaison Psychiatry (**Psychiatry in Medicine and Neuropsychiatry)

Details of the contents of learning modules are given in the syllabus section.

9. Supervision and Training Monitoring:

The Training will incorporate the principle of gradually increasing responsibility, and provide each trainee with a sufficient scope, volume and variety of experience in a range of settings that include inpatients, outpatients, emergency and intensive care. All elements of work in training rotation will be supervised with the level of supervision varying depending on the experience of the Resident and the clinical exposure. Outpatient and referral supervision must routinely include the opportunity to personally discuss ail cases. As training progresses the Resident should have the opportunity for increasing autonomy, consistent with safe and effective care for the patient. Residents will at all times have a Supervisor, responsible for overseeing their education and training.

Supervisors are responsible for supervision of learning throughout the program to ensure patient safety, service delivery as well as the progress of the resident with learning and performance. They set the lesson plans based on the curriculum,

undertake appraisal, review progress against the curriculum, give feedback on both formative and summative assessments, and ensures proper recording of the and signing the logbook. The residents are made aware of their limitations and are encouraged to seek advice and receive help at all times.

The Course Coordinator of each department coordinates all training and academic activities of the program in collaboration with the **Course Manager(s)**. The **Course Director** of each faculty directs, guides and manages curricular activities under his / her jurisdiction and is the person to be reported to for all events and performances of the residents and the supervisors. Form of training must be comprehensive and structured. Resident shall maintain the training Log Book and designed Portfolio duly signed by the competent person/persons under supervisor/supervisors. Residents are expected to achieve necessary clinical skills to integrate the physical and psychiatric assessments/findings.

Trainees:

1. Must at all times act professionally and take appropriate responsibility for patients under their care and for their training and development.
2. Must ensure they attend the one hour of personal supervision per week, which is focused on discussion of individual training matters and not immediate clinical care. If this personal supervision is not occurring the trainee should discuss the matter with their educational supervisor/tutor or training programme director.
3. Must receive clinical supervision and support with their clinical caseload appropriate to their level of experience and training.
4. Should be aware of and ensure that they have access to a range of learning resources including:

a) local training course (e.g. MD Psychiatry course)
b) local postgraduate academic programme
c) the opportunity (and funding) to attend courses, conferences and meetings relevant to their level of training and experience
d) appropriate library facilities
e) the advice and support of an audit officer or similar
f) supervision and practical support for research with protected research time appropriate to grade

5. With their personal clinical supervisor/trainer to: work to a signed educational contract
   a) maximize the educational benefit of weekly educational supervision sessions
   b) undertake workplace-based assessments, both assessed by their clinical supervisor and other members of the multidisciplinary team
   c) use constructive criticism to improve performance
   d) regularly review the placement to ensure that the necessary experience is being obtained
   e) discuss pastoral issues if necessary
6. Must have regular contact with their Educational Supervisor/tutor to:
   a) agree educational objectives for each post
   b) develop a personal learning and development plan with a signed educational contract
   c) ensure that workplace-based assessments and other means of demonstrating developing competence are appropriately undertaken
   d) review examination and assessment progress
   e) regularly refer to their portfolio to inform discussions about their achievements and training needs
   f) receive advice about wider training issues
   g) have access to long-term career guidance and support

7. Must collaborate with their personal clinical supervisor/trainer to: work to a signed educational contract
   a) maximize the educational benefit of weekly educational supervision sessions
   b) undertake workplace-based assessments, both assessed by their clinical supervisor and other members of the multidisciplinary team
   c) use constructive criticism to improve performance
   d) regularly review the placement to ensure that the necessary experience is being obtained
   e) discuss pastoral issues if necessary
8. Must have regular contact with their Educational Supervisor/tutor to:
   a) agree educational objectives for each post
   b) develop a personal learning and development plan with a signed educational contract
   c) ensure that workplace-based assessments and other means of demonstrating developing competence are appropriately undertaken
   d) review examination and assessment progress
   e) regularly refer to their portfolio to inform discussions about their achievements and training needs
   f) receive advice about wider training issues
   g) have access to long-term career guidance and support
9. Will participate in an Annual Review of Competence Progression (ARCP) or Phase Ending Examination to determine their achievement of competencies and progression to the next phase of training.
10. Should ensure adequate representation on management bodies and committees relevant to their training.
11. Must make themselves aware of local procedures for reporting concerns about their training and personal development and when such concerns arise, they should report them in a timely manner.

12. The formative (continuous) evaluations of residents will be based on
    a. Successful completion of the Log Book
    b. Completing Portfolio frame work
    c. Supervisor's report and course co-coordinators report
    d. In addition, summative assessment of training will be held accordingly.

10. Assessments

The assessment method is comprehensive, integrated and phase-centered attempting to identify attributes expected of specialists for independent practice and lifelong learning and covers cognitive, psychomotor and affective domains. It keeps strict reference to the components, the contents; the competencies and the criteria laid down in the curriculum.

The assessment procedure for Phase A consists of three parts:

1. Formative Assessment
2. Summative Assessment (Phase-A final)

10.1. Formative Assessment:

Formative assessment will be conducted throughout the training phases. It will be carried out for tracking the progress of residents, providing feedback, and preparing them for final assessment (Phase completion exams).

There will be Continuous (day-to-day) and periodic type of formative assessment.

- **Continuous (day-to-day) formative assessment** in classroom and workplace settings provides guide to a resident's learning and a faculty's teaching / learning strategies to ensure formative lesson / training outcomes.
- **Periodic formative assessment** is quasi-formal and is directed to assessing the outcome of a **block placement** or

academic module completion. It is held at the end of Block Placement and Academic Module Completion. The contents of such examinations include **Block Units** of the Training Curriculum and **Academic Module Units** of the Academic Curriculum.

- **End of Block Assessment (EBA):** End of Block Assessment (EBA) is a Periodic Formative assessment. The End Block Assessment will be conducted by the Department of Psychiatry. It is undertaken after completion of each training block, assessing knowledge, skills and attitude of the residents. Components of EBA are written examination, Structured Clinical Assessment (SCA), medical record review, logbook review and portfolio assessment. Incomplete block training must be satisfactorily completed by undergoing further training for the block to be eligible for appearing in the next phase completion examination. The written examination will be short answer questions (SAQ). Number of question will be 10. Duration of examination will be 100 minutes and total mark will be 50. SCA will be held in specific number of stations (5 to 10 stations or more), which may be distributed among – case base focused history taking, clinical examinations, demonstration of clinical skill/procedure, data interpretations, communication skill, patient education, case scenario based management of common emergencies, scenario based situation to assess the managerial cum leadership quality training etc.

Components of Formative Assessment:

Formative assessment will be done at the end of each block. The Course Coordinator(s) of department will organize end of block assessment.

- ***Attendance book***-daily attendance will be recorded in an attendance register the will be supervised by supervisors, course managers and course coordinator

- ***Logbook*** – will be duly signed by the trainers. Assessment is to be reported as: i) Complete-80-100% of the activities/task was completed satisfactorily, ii) Recoverable-60-79% completed satisfactorily, iii) Irrecoverable- <60% completed satisfactorily.
- ***Portfolio***- specially designed portfolio framework should be fulfilled. It contains, presentations by residents in journal club, grand round, clinical meeting, CME/CPD; assignments done by residents in the area of problem solving exercise, reflective case study, quality care plan, contribution to society/science/ university/department e.g. patient education material, drug information brochure, software, algorithms of departmental year book;

Following documents at least one in each Block –

Best case record, best referral note, best referral reply (optional), best discharge summary, one presentation, one assignment;

Following documents at least one in Whole Phase –

Best procedure logs (designated): whenever performed, at least one from each type of presentation, at least one from each type of assignment.

Optional documents for Phase-A are: written/audio record of a communication, Case report, Emergency management report. Other optional documents: Personal development plan (PIP), quality improvement plan (QIP), publications in medical journal, publications in print media, books, documents of other performances. Assessment is to be reported as: i) Up to date- 80-100% of the desired contents are complete and satisfactory, ii) Deficient- <80% of the desired contents is complete; needs to revise the contents.

- **Medical record review –** will be assessed and reported as: i) Satisfactory – 80-100% satisfactorily completed, ii) Unsatisfactory - <80% satisfactorily completed.

- **Performance during formal presentations**– will be assessed with structured format by trainers, peers and other related persons
- **Performance during teaching and research work** - will be assessed with structured format by trainers, peers and other related persons.
- **Working in multi-disciplinary team** – experienced trainers will supervise performance of the trainer in team regularly.
- **Option of peer assessment and evaluation** - will be assessed with structured format.
- **Assessment of trainers by trainees and colleagues** - will be assessed with structured format by trainees, colleagues and other related persons.
- **Competency rating** – will be assessed clinical competency, communication skills, scholarship and professionalism etc.

Satisfactory completion of formative assessment is prerequisite for appearing at the summative assessment.

10.2. Summative Assessment:-

Summative assessment will be held in Phase A examination will be held at the end of second year. Before appearing the examination, candidates must have to complete the Phase- A residency training along with successful completion of the all components of formative assessment.

10.3. Assessment procedure of Phase A Final Examination:

a) Written Examination:

Consisting of two papers: 200 Marks

- **Paper I (Basic Psychiatry)**: Marks-100: SAQs: 20 questions: 3 hours, pass mark 60%
- **Paper II (Liaison Psychiatry)**:Marks-100: SAQs: 20 questions: 3 hours, pass mark 60%

Each paper (Paper I, Paper II) comprises of 100 marks and 20 short essay questions (SAQ) carrying 5 marks for each.

For Paper I, 10 questions will be from Group A and 10 questions will be from Group B.

For Paper II, 15 questions will be from Group A and 5 questions will be from Group-B.

To pass the examination, the candidate will have acquired knowledge in the relevant subjects as described in the learning module, with particular reference to recent advances. The questions will be invited from teachers in psychiatry and relevant subjects. Moderation of papers, examination of scripts, marking system and qualifying marks will be the same as existing rule of the University.

Content: The content of written examination will be as per syllabus (learning modules) of Phase A in the curriculum. Basic elements of the content are:

1) Clinical Methods (knowledge part)
2) Emergency presentations
3) Common symptom-based presentations
4) Problem Solving Skill (History, Physical examinations etc.)
5) Planning Investigation and Interpretation of data
6) Clinical Reasoning Skill/Clinical judgment
7) Synthesis of information/ Interpretation of Medical Literature
8) System Specific Knowledge
9) Ability to judicious diagnostic tests
10) Management skill and Professional Behaviour
11) Disease Prevention

Organization:

Written examination will be completed in two consecutive days

Paper Setters: Sixteen in numbers and they should be Assistant Professor and above and 50% should be external. Each paper

setters will be asked to submit minimum 10 Short Answered Questions as per above guidelines. Paper Setters to be selected from the respective discipline, as well as, from disciplines/services covered during the rotation as per curriculum.

Moderators: Four in numbers and they should be Professor/Associate Professor from respective discipline and among subject specialist 2 should be External. Moderators will select the questions and after finalization of questions they will print and do packaging of examination question sheets. They will prepare Standard Response Outline (SRO).Then they should submit it to the Controller of Examination.

Script Examiners: Four in numbers and they should be Professor/Associate Professor from respective discipline. Script examination has to be done in the University premises in an exclusive enclosure.

Table of the Format and marks of Phase A Final Written Examination:

Subject of studies	Parts of Exam	Marks allotted	Pass Marks
Phase-A			
Paper-I: Basic Psychiatry Group A- Basic Sciences relevant to Psychiatry Group B – Fundamentals in Psychiatry	Written	100 (Group A-50) (Group B-50)	60
Paper-II: Liaison Psychiatry Group A- Psychiatry in Medicine Group B- Neuropsychiatry	Written	100 (Group A-75) (Group B-25)	60

b) Clinical examination: Total Marks- 200

For two papers (Paper-I and Paper-II), there will be four examiners (Associate Professor and above) for clinical and practical examinations.

Residents will be expected to examine- (would it be included in all subjects)

i. A Structured Observed Long Case (One hour): Marks-100

This will be examination of a long case with or without selected investigations reports as per curriculum. There will be one long case and Case taking will be 40minutes for each candidates to examine the case and 20 minutes crossings for the examiners (10 minutes for each) to examine the candidate. There will be Two Examiners per examinee.

ii. Short cases (30 minutes): Marks- 100

- Each candidate will be examined for this period during which the candidate should be able to examine the cases as many as possible (at least four).
- The clinical examination will be based on the relevant learning modules. The main areas of assessment are the candidate's ability to establish a satisfactory relationship with the patient, take a full psychiatric history, carry out an accurate mental state examination, make appropriate deduction from the information available to him, and concluded about the differential diagnosis of the disorder from which the patient is suffering. Basic Psychiatry clinical examination will test basic clinical skills of psychiatric assessment: the ability of relate to the patient, to take a history and examine the mental state and to exercise judgment in bringing the relevant information together to make accurate assessments and management plan. For Liaison psychiatry clinical examination, assessment will also be extended on psychiatric assessment of patients with physical illness, resident's ability to grasp the basic clinical skills in general medicine and other disciplines relevant to liaison psychiatry. Candidate is expected to carry out a physical examination wherever necessary.
- Examination and crossing of case
- Total time is 30 minutes per examinee
- Two Examiners per examinee

c. Structured Clinical Assessment (SCA): Marks-100

- For two papers (Paper-I and Paper-II), there will be 12 stations, of which 2 interactive stations and 10 other stations. Duration of the examination is 70 minutes. The organizational guideline of the stations is as follows:
  1. Communication–1
  2. Management/ Case scenario/Clinical reasoning/ Medical ethics-3
  3. Referral note/Discharge notes/Operation notes/Procedure notes– 1
  4. Data interpretation – 2
  5. Procedures – 2
  6. Images/Photography – 3
  7. Interactive – 2
- 12 stations are to be constructed from the above mentioned categories. Two stations from the Categories of data interpretation, Case Screening, Procedures and Images should be made interactive.
- A total mark of SCA is 100. Of this, 10 mark each for interactive stations (Total 20 marks) and 8 marks each for other stations (Total 80 marks). Pass mark—60%
- The Phase A final Examination will be conducted through a Standard Operation Procedure as per rule of the University. To pass the Examination as a whole, candidates must pass written, clinical & SCA component separately at one setting-component are not transferable or divisible.
- **Station Setters:** Ten in numbers and they should be Associate Professor and above and among subject specialist two should be external. Each will be asked to set minimum 4 stations covering specified areas and to be submitted to the Controller of Examinations.

- **Moderators:** Four in numbers and they should be Professor/Associate Professor from respective discipline and 2 should be External. Moderators will select the stations and after finalization they will print and do packaging and Station planning. They will prepare the lists of requirements and submit it to the Controller of Examination. One of the Moderators will be appointed as Convener of SCA by the Controller of Examinations.
- **Conduction of Examination:** There shall be a Convener from the Department of Psychiatry to conduct the examination. There will be four Observers/Examiners (Associate Professor and above) and Four Assessors (Associate Professor and above) and Four Organizers (Associate Professor and above) Two Tabulators Assistant Professor and above)r requirements. They should be Assistant Professor and above from respective discipline. Stations have to be arranged and examination has to be conducted by the Convener.

A candidate who fails in Phase-A examination may reappear in the subsequent examination according to the rules of the university. A candidate passing in paper(s) in Phase-A examination will not be required to appear in the same paper(s) in a subsequent examination while reappearing in Phase-A examination.

Examination Board for Phase -A Final Examination:

For written and clinical examinations, there will be an examination board. The examination board consists of four members. Among four examiners, two will act as internals (two psychiatrists from the Department of Psychiatry, BSMMU) and two externals who are psychiatrists from any Institute other than BSMMU. The Convener of this examination board shall be from the Department of Psychiatry of BSMMU.

Each examiner shall mark the scripts separately and they will jointly assess clinical examination. For clinical examination, two examiners will examine long case per examinee and two examiners will examine short case per examinee.

For SCA examination, station setters, moderators and examiners including convener, supervisors, assessors/observers, tabulators, and station managers will be selected as per rule of the University.

11. Curriculum Implementation, Review and Updating:

Both Supervisors and Residents are expected to have a good knowledge of the curriculum and should use it as a guide for their training programme. Since Medicine has historically been rapidly changing specialty the need for review and up-dating of curricula is evident. The Curriculum is specifically designed to guide an educational process and will continue to be the subject of active redrafting, to reflect changes in both Medicine and educational theory and practice. Residents and Supervisors are encouraged to discuss the curriculum and to feedback on content and issue regarding implementation with the Course Director. Review will be time tabled to occur annually for any minor changes to the curriculum.

12. Syllabus (of the Learning Modules in Phase-A)

The aim of the syllabus for Phase A training is to guide the Residents to acquire broad based knowledge on Medicine and fundamentals of Psychiatry before entering the Phase B specialty-specific training. Patients present themselves with problems and it is the problem that needs solving. A specialist who has this knowledge will be able to solve the problem in a better way. So the ultimate objective of Phase A training is to produce a knowledgeable, competent, altruistic specialist with up to date background knowledge of Medicine and Basic Psychiatry. Emphasis has been laid on common general medical conditions

associated with psychiatric disorders frequently encountered in this part of the world.

By the end of Phase A Training (Core Medical Training) the Resident should be able to:

a. Assess presenting symptoms and signs
b. Formulate appropriate investigations and accurately interpret investigation reports
c. Communicate the diagnosis and prognosis
d. Institute appropriate treatment recognizing indications, contraindications and side effects of common clinical conditions:

On this background, it is expected that Residents will be able to (i) acquire knowledge [of psychiatric disorders, common medical conditions related with psychiatric disorders, emergencies, & rehabilitations], (ii) acquire skills [diagnostic, clinical and decision making] and (iii) develop attitude [caring, learning, & ethical].

12. 1 Syllabus contents

Paper-I: Basic Psychiatry

- **Group-A: Basic Sciences relevant to Psychiatry**

a) Brain and Behaviour:

I. **Neuroanatomy:** Structure of the nerve, plasma membrane, nerve cell process. The types of cell found within nervous system. Neuronal synapses. The general anatomy of the brain, cranial nerves and spinal cord. Functions of the lobes and some major gyri including prefrontal cortex, cingulate gyrus and limbic system. The anatomy of the basal ganglia. The internal anatomy of the temporal lobes especially hippocampal formation, amygdala and reticular formation, the major white matter pathways, corpus callosum. Papez's circuit and other circuits relevant to integrated behaviour. The major neurochemical pathways.

II. **Neurophysiology:** The basic concepts in the physiology of nervous system, synapses and receptors, including synthesis, release and uptake of transmitters. Basic

knowledge of action potentials, resting potentials, ion fluxes and channels etc. The physiology of nervous system involved in integrated behavior including perception pain, memory, motor function, arousal, drives and the emotions including aggression fear and stress Knowledge of disturbances of their functions with relevance to organic and nonorganic psychiatry. Tin localization of cerebral functions throughout the life span and their relevance to the effects of injury at different ages to the brain and behavior. An understanding of neurodevelopmental models of psychiatric disorders and of cerebral plasticity. A basic knowledge of the physiology of arousal and sleep with particular reference to noradrenergic activity and the locus ceruleus. Nature of dream and its relationship with sleep. The normal EEC and evoked response techniques. Their application in investigation of cerebral pathology, seizure disorders, sleep and psychiatric disorders. The effects of drug and different disorders on EEG.

III. **Neuroendocrinology:** The physiology of nervous and endocrine systems involved in integrated behavior including perception, pain, memory, motor function, arousal, drives and the emotions including aggression, fear and stress. Knowledge of disturbances of their functions with relevance to organic and nonorganic psychiatry. An understanding of the neuroendocrine system, specially the control system of the secretion of hypothalamic and pituitary hormones, and posterior pituitary function. A basic-understanding of neuroendocrine rhythms and their disturbances in psychiatric disorders. General understanding of anatomical considerations, formation, secretion, transport, metabolism, effect and regulation of thyroid hormones, adrenal hormones, gonadal hormones and the hormones of the pancreas Endocrine functions of the kidneys, hear and pineal gland; hyper and hypo functions of these hormones. Endocrine disorders: pathology of endocrine glands including hyperthyroidism, hypothyroidism, hyper-pituitarism, hypo-pituitarism,

hyper- parathyroidism, hypoparathyroidism, hypoadrenalism, hyperadrenalism in relation to psychiatric disorders, diabetes.

IV. **Neurochemistry:** Neurotransmitters: synthesis, storage and release Ion channels and calcium flux in relation to ion channels. Receptors: structures and function in relation to the transmitters listed below in pre-synaptic and post-synaptic receptors. Basic biochemistry of noradrenalin, serotonin, dopamine, GABA, acetylcholine, excitatory amino acids. Neuropeptides: Elementary knowledge of neuropeplides, particularly corticotrophin releasing hormone and cholecystokinin, encephalins and endorphins.Chronobiology.

V. **Neuropathology:** the neuropathology of organic disorders including the dementia, delirium and amnestic disorder. Lobar damage and its dysfunctional presentation. The neuropathology of schizophrenia, obsessive-compulsive disorder (OCD), neuropathology of other psychiatric disorders particularly brain damage related to stress - the 'glucocortioid cascade hypothesis. Conditions associated with mental retardation including inborn errors of metabolism. Pathology of degenerative disorders including Alzheimer's disease, Pick's disease, Huntington's disease. Parkinson's disease and neurochemical pathology of tardive dvskinesia. Association between the localization of gross cerebral lesions and clinical signs (including tumors, trauma, cerebro-vascular disease, infections including slow virus and unconventional agent affections). Psycho-neuroimmunology.

VI. **Behavioural Genetics:** Basic concepts - chromosomes, cell division, gene structure, transcription and translation, normal karyotype, pattern of inheritance. Traditional techniques: Family, twin and adoption studies. Techniques of molecular genetics: restriction enzymes, molecular cloning and gen probes and others. Condition associated with chromosomal abnormalities-cytogenic and Mendelian disorders, disorders with multifactorial

inheritance, Fragile X syndrome. Principal inherited conditions encountered in psychiatric-practice and the genetic contribution to specific psychiatric-disorders. Prenatal identification, Chromosomal and DNA analysis. Genetic counseling. Molecular and genetic heterogeneity. Phenotype/genotype correspondence. Nutritional disorders: protein energy malformation, vitamin deficiency disease and its relation to psychiatric disorders. Pathology of obesity. Human Genom Project.

b) Behavioural Sciences:

I. *Basic Psychology:* Introduction to psychology and it major perspectives: behavioural (learning), developmental, cognitive, and psychoanalytic. Sensation and perception: basic principles of visual and auditory perception. The relevance of perceptual theory of illusions, hallucinations and other psychopathology. The process of perception-organization and perception, interpretation and perception. Motivation: theories of motivation. Classification of needs with emphasis on Maslows's hierarchy of needs. Internal and external sources of motivation. Eating disorders. Human obesity. Important social motives. Emotion: development of emotion, components of emotional response, nature and classification. Theories of emotion. Cognitive appraisal, differentiation and the status of primary. Emotion and performance. Learning: learning theories including classical, operant, observational and cognitive models. The concepts of extinction and reinforcement. Nature and schedules of reinforcement. Learning process and etiological formulation of clinical problems. Escape and avoidance learning. The cognitive approach to learning. Clinical application of reinforcement in behaviour therapy. Use of punishment. Memory: memory systems and information processing. Type of memory process of encoding, storage and

retrieval. The process of forgetting, emotional factors and retrieval. Distribution, inference, schemata and elaboration in retrieval. The relevance of this to memory disorders and their assessment. Improving memory. Memory and brain. Thinking and language: the nature and development of thinking and its relationship with language. Concepts and reasoning. Problem solving strategies. Decision making. Component of spoken language and language development. Theories of language. Intelligence: nature, definition and components of intelligence, concept of IQ and its stability. Intelligence tests, cultural influences, recent advancement in assessing intelligence. Aptitude and achievement tests. Extreme of intelligence. Heredity, environment and intelligence. Personality: different perspectives of personality (psycho-dynamics, trait and type), behavioural and social learning, humanistic and interactions approaches- Personality tests and its constructions. Stress: models of stress, stress reaction-physiological and psychological aspects. Situational factors-life events, conflict and trauma. Vulnerability and invulnerability, type-A behaviour theory. Coping mechanism. Locus of control. Relationship of stress with disorders, concept of behavioral medicine. States of consciousness: arousal. Sleep structure and dreaming. Biorhythms and effects of sleep deprivation. Hypnosis and suggestibility, meditation and trances.

II. *Social Psychology:* Attitudes: Attitude formation and attitude changes Components and measurements of attitude. Cognitive consistency and dissonance. Believe-Attitude-Behavior relationships. Self psychology, self-concepts, self-esteem and self-image. Self-recognition and personal identity. Interpersonal issues: person perception, affiliation and friendship. Attribution theory. Social behaviour in social interactions. Theory of mind and

pervasive developmental disorders. Leadership, social influence, power and obedience: types, characteristics and behaviour of leaders. Types of social power. Influences operating in small and large groups. Conformity, polarization and group thinking. Gang and deindividualization. Communicative control in relationships. Inter-group behaviour: prejudice, stereotypes and inter-group hostility Social identity and group membership. Aggression: theories of aggression. Factors influencing aggression. Family and social background of aggressive individuals. Altruism: social exchange theory and helping relationships. Interpersonal cooperation. Masculinity and feminity: psychology of man and psychology of woman. Psychology of institution/organization. Management consultancy, introduction of system theories.

III. *Developmental Psychology:* Basic framework for conceptualizing the development: nature and nurture, stage theories, maturational tasks, maturity. Examination of gene-environment interactions. Relative influence of early reasons and later adversities. Impact of specific adversities such as trauma/abuse on development. Historical models - Freud and Neo-Freudians, Social learning, Piaget. Attachment: theories of attachment and its relevance to development. Classification and outcome of attachment. Maternal deprivation and its consequences. Brief consideration of neonatal/infantile-maternal bonding. Adult attachment behaviour. Family: family relationship and parenting practice: Influence of parental attitudes compared with parenting practice. Some aspects of distorted family function e.g. discord, overprotection, rejection, enmeshment, and disengagement. The impact of family factors n subsequent, development of the child. Family structure and influence on development. Temperament: individual temperamental difference and their impact on parent child relationships. Origins, types and stability of temperament and the evolution of character and

personality. Childhood vulnerability and protective factors with respect to mental health. Developmental theories. Cognitive development: Piaget's model and its advancement. Hypothesis of intrauterine cognitive development. Language development: basic outline theories with special reference to environmental influences and communicative competence. Social development: social competence, peer relationships. Components of peer popularity and unpopularity, bully victim problems. Moral development: criteria reference to Kohlberg's stag theory. Egocentricism in adolescence. Development and maintenance of fears: in childhood and adolescence with reference to age. Sexual development: factors in the development of sexual identity and preference. Gender role. Adolescence as a developmental phase: Identity formation and role confirmation, and adolescence crisis with special emphasis on works of Bell, Kohut and Erickson. Adulthood: adaptations such as pairing, parenting, illness, bereavement and loss. Job and careers. Conception, pregnancy and childbirth: stresses related with rearing responsibilities, and their implications in the development of infant. Middle age: adoption to physical change, mid-life crisis. Normal aging: changes of normal aging and its impact on physical, social, cognitive and emotional aspects of individual functioning. Social changes accompanying old age. Stage of bereavement. Disability and pain xvii) Death and dying: adjustment with dying and its phases. Methodology of studying development: cross sectional, cohort and individual studies.

IV. *Identification and evaluation of influences on development.*

V. *Sociology and Anthropology:* Description and terms: Social class, socio-economic status and their relevance to psychiatric disorder and health care delivery. Social role of doctors: Doctor-patient – relationship. Sick role and illness behaviour.Formation of group, clan and family. Family cycle: family factors and psychiatric disorders.

Social factors and specific mental health issues: Life events, and their subjective and contextual issues. Sociology of residential institutions. Basic principles of criminology and penology. Culture and its influence on psychiatric disorders. Stigma and prejudice. Ethnicity: types, ethnic minorities. Adoption and mental health. Anthropological studies, methodology, surveys, social anthropological approaches, and ethnography. Interrelationship between professional groups: team formation, patient care. Characteristics of professions. Development of self-sociological and anthropological perspectives

VI. *Neuropsychology:* Brain organization in relation to memory, language, perception, attention-concentration, Visio-spatial ability and frontal lobe functions.

VII. *Psychometrics:* Psychological testing: knowledge about different psycho-logical tests and clinical implications, special emphasis on tests for intelligence, personality and developmental assessments. Neuropsychological testing: application of neuropsycho-logical rests particularly to measure cognitive impairments in organic disorders especially dementia. Comprehensive test batteries and specialized approaches.

C. Psychopharmacology:

I. General principles: a brief historical review of the development of psychotropic drugs and classification of psycho tropics. The principles of rational prescribing of psychotropics. Pharmacokinetics: general principles of absorption, distribution, metabolism and elimination. Comparison of different routes of administration as they affect drug availability, elimination and access to the brain through blood-brain barrier. Relationship between plasma drug level and therapeutic response. Pharmacodynamics: synaptic receptor complexity, subtypes of receptors, phenomenon of receptor up/down regulation. The principal CNS pharmacology of psycho tropics with particular attention to their postulated mechanism of

action in achieving therapeutic effect at both synaptic, molecular and system levels. These groups mainly include antipsychotics, mood stabilizing agents, antidepressants, anxiolytics, hypnotics, psycho stimulants, and antiepileptic agents. Knowledge about advancement of psychotropics. Adverse effects: understanding dose related adverse reactions associated with main groups of drugs used in psychiatry with appropriate corrective action. Evaluation of risks and benefits of psychotropic drugs in acute, short and long term use including effects of withdrawal. Evaluation of drugs: research methodology for drug trials including principles of design, randomization, blindness (double-blind technique), statistical power, duration, rating scales, exclusion criteria.

Group-B: Fundamentals in Psychiatry:

I. Phenomenology and Psychopathology
II. Disease concept in psychiatry: Evolution of concept of mental disorders. "Medical Model" in its present status. Guiding principles of abnormal behaviour.Criteria of mental disorder
III. Classification of psychiatric disorders: History and development of classification. Current approaches to Classifications. ICD and DSM Classification. Clinical features of disorders
IV. Aetiology of psychiatric disorders: Evolution of aetiological concepts with deferent perspectives. Multifactorial aetiological aspects - biopsychosocial model. Biological-genetic, neurostructural, neurobiochemical, Psychosocial-behavioural, cognitive, stress and stressors
V. Assessment of psychiatric disorders: Principles of assessment. The psychiatric interview, clinical examination and record keeping. Neuroimaging & laboratory investigations. Measurements in psychiatry. Neuropsychological tests- rating scales and measures
VI. Management of psychiatric disorders: Principles of management- Multimodal aspects and Multidisciplinary team

VII. Biological treatment: Psychotropics and psychotherapeutics, ECT and its application. Neurological effects of ECT, Other forms of biological treatments.
VIII. Psychological treatment: Fundamentals of Counseling and Psychotherapy, Different modes of therapy and principles of assessment
IX. Social treatment: Principles and approaches of social therapy. Different social therapies and its applications
X. Psychiatry services: Evolution of Psychiatry services. Services delivery systems. Primary Care Psychiatry services, General Hospital Psychiatry services. Community psychiatry services. Services with special settings. Need -based service delivery and feasible service development. Service evaluation.

Paper- II: Liaison Psychiatry

- **Group-A: Psychiatry in Medicine**
- **Group-B: Neuropsychiatry**

♦ **Group-A: Psychiatry in Medicine**

I. Basic understanding of ward dynamics including doctor-patient-nurse-care givers relationship.
II. Referrals: dynamics, relationship with referrers.
III. Communications skills.
IV. Psychiatric assessment of patients with physical illnesses.
V. Clinical and theoretical aspects of acute and chronic pain and its management.
VI. Assessment and management of patients who have harmed or threatened to harm themselves.
VII. Medical treatment, its complications and their management with special emphasis on drug interaction.
VIII. Theoretical and clinical aspects of psychiatric presentations in physical diseases.
IX. Recognition and management of medical conditions associated with HIV infection and other STDs including their psychiatric manifestations.
X. Course and management of liver, renal and cardiac disease, diabetes, respiratory disorders, cancer relevant to psychiatry.

XI. Endocrinology as relevant to psychiatry.
XII. General medicine and geriatric medicine as relevant to psychiatry.
XIII. Pediatric medicine relevant to psychiatry.
XIV. Chronic physical diseases, psychiatric sequelae and their management.
XV. Terminal illness: management of dying patients and their families.

Group-B: Neuropsychiatry:

I. Clinical knowledge of neurology: physical examination of nervous system, diagnosis, investigation and treatment of common conditions.
II. Disorders affecting cranial nerves, spinal cord, peripheral nerves and demyelinating diseases.
III. Infection of the nervous system: bacterial, viral including slow viral diseases.
IV. Psychiatric consequences and associations of brain diseases, damage and dysfunctions.
V. Brain degeneration process including degenerative disorders and its psychiatric consequences including organic psychiatric conditions.
VI. Psychiatric aspects of head injury and stroke and psychiatric conditions associated with them and the rehabilitation strategies.
VII. Seizure disorders, epilepsy, their management and psychiatric conditions associated with them and the rehabilitative strategies.
VIII. Neurological disorders presenting as psychiatric problems.
IX. Specific conditions like headache, migraine, facial pain, neuralgias.
X. Neuro-imaging techniques: structural and functional imaging including X-ray, CT, MRI, EEC, SPECT, PET, MRS, Fusion imaging.

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