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The importance of psychiatry in undergraduate medical education in India

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"It is impossible for the part to be well, if the whole is not well"

- Socrates

What Socrates said several centuries ago has become even more relevant in this era of specialization and super-specialization in medicine. While several medical specialities have made spectacular advances in various areas within their domain, humanism has often got neglected and forgotten. We all recognize that mental health is essential to overall health and the well-being of individuals and societies. Mental health affects the individual's ability to function, to be productive, to establish and maintain positive relationships, and to experience a state of well-being. This is the reason we say, "There is no health without mental health."

Indian J Psychiatry

About 14% of the global burden of disease has been attributed to neuropsychiatric disorders, mostly due to the chronically disabling nature of depression and other common mental disorders, alcohol-use and substance-use disorders, and psychoses. Such estimates have drawn attention to the importance of mental disorders for public health. The burden of mental disorders is likely to have been underestimated because of inadequate appreciation of the connectedness between mental illness and other health conditions. Because these interactions are protean, there can be no health without mental health. Mental disorders increase the risk for communicable and non-communicable diseases, and contribute to unintentional and intentional injury. Conversely, many health conditions increase the risk for mental disorder, and comorbidity complicates help-seeking, diagnosis, and treatment, and influences prognosis.[1] Mental disorders, a highly prevalent group of non-communicable diseases, affect the lives of 1 out of 5 persons each year. They represent 20–40% of the burden of disability. Factors related to mental illness can interfere with the treatment of other illnesses and frequently co-occur with CVS, diabetes, cancer, and other non-communicable diseases (Eliot and Sacher, 2011).[2]

Health systems across the world remain significantly fragmented, affecting access, quality, and costs of the care delivered. Strengthening health systems is a global health challenge for all countries: low, middle, and high income. According to the World Health Organization, the key components of a well-functioning health system, namely, leadership and governance, health information systems, health financing, human resources for health, essential medical products and technologies, and services delivery are *sine qua non* for health system's functioning and strengthening. [3]

The development of mental health care all over the world is best described as a developing process. The World Health Report (2001)[4] described the changes over the last two centuries as follows: “Over the past half century, the model for mental health care has changed from the institutionalization of individuals suffering from mental disorders to a community care approach backed by the availability of beds in general hospitals for acute cases. This change is based both on respect for the human rights of

individuals with mental disorders and on the use of updated interventions and techniques. The care of people with mental and behavioural disorders has always reflected prevailing social values related to the social perception of mental illness."

At the time of Indian Independence, the Bhore Committee, 1946,[5] emphasized the need for training in the social aspects of medicine to boost India's meager mental health resources (19 hospitals with 10,181 beds and a few general hospital psychiatric units). It also recommended setting up of psychiatry departments in every general hospital to review and enhance the existing curriculum and training in Psychiatry for medical undergraduates.

It is now realized that training of Psychiatry to undergraduate medical students is very vital. Knowledge of Psychiatry, Mental health, and Behavioral Sciences equips the students to deal with various difficult and complex situations during medical practice. This will in turn help them to develop proper communication skills and to empathize with their patients and their suffering. It instils humanistic values in them, further empowering them to establish and maintain fruitful professional relationships with their patients. Moreover, since psychiatric problems are common among patients seen in general practice (about 25%) and specialty clinics (about 15%),[6] a proper training in Psychiatry during UG course makes the student a better doctor.

DEVELOPMENT OF MENTAL HEALTH SERVICES IN INDIA

Go to:

Since mental health services were grossly inadequate at the time of Indian independence, the initial period of 1947–1966 focussed on doubling of the psychiatric beds,[7,8] along with development of training centers to train psychiatrists, clinical psychologists, psychiatric social workers, and psychiatric nurses. This was followed by the establishment of general hospital psychiatric units at several centers in the 1960s and 1970s.[9] The adoption of National Mental Health Programme (NMHP) in August 1982[10] can be considered the landmark in the development of community psychiatry.

General hospital psychiatry and medical education

Indian J Psychiatry
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In nearly one-and-a-half decades after independence, mental hospital beds were doubled to 20,000 in India. The first General Hospital Psychiatry units (GHPUs) were established at Calcutta and Mumbai before independence. In the 1960s, such units were established in Chandigarh, Delhi, Madurai, and Lucknow. The first GHPU in Kerala was started at Medical College Kottayam in 1967.

The twin challenges of the 1960s and 1970s were of moving mental health care beyond the isolated mental hospitals and bringing mental health care to the general medical care settings (liaison psychiatry). These in turn led to the development of GHPUs which have contributed immensely to the development of liaison psychiatry[11–15] and to training of psychiatrists and research. General Hospital Psychiatry (GHP) has been one of the biggest silent revolutions in mental health delivery and psychiatric education in India. Several new medical colleges were started, which also had psychiatric units, which were part of teaching requirements. Also, during the last one or two decades, psychiatric units in most major hospitals have become a reality. This shifting of the place of care to the general hospital setting has contributed significantly to the process of destigmatization of psychiatric illnesses and psychiatric care.[16]

WHY TEACHING PSYCHIATRY TO UNDERGRADUATES IS IMPORTANT IN INDIA?

Go to:

Mental disorders are widely prevalent in India

Several epidemiological studies have demonstrated the existence of a wide variety of mental disorders in the community in India. The World Health Survey,[17] which also covered six states in India (Assam, Karnataka, Maharashtra, Rajasthan,Uttar Pradesh, and West Bengal), gives valuable information about “psychosis” in the community. It showed that the prevalence rates of depression were higher than those of psychoses, but the rates treated were far lower, which pointed to the limited awareness about depression in the community.

The “unmet need” for mental health care in the community

The WHO Atlas[18] and a recent state-wise analysis of

psychiatrists[19] highlights the low numbers of mental health professionals in India. The number of psychiatrists is far too inadequate in India. Besides, most of the psychiatrists are concentrated in urban areas. Chandigarh, Delhi, Goa, Pondicherry, Kerala, and Maharashtra are the states/union territories where the number of psychiatrists is adequate or near adequate, although even here, there is regional imbalance. The number of psychologists, social workers, and psychiatric nurses is also quite inadequate. Since nearly 70% of psychiatrists are working in private sector, there is urgent need for private sector-public sector collaboration in implementing various national and state mental health programs.

Stigma about mental illness

There is widespread stigma about mental illness and psychiatric services in India. Films, newspaper reports, and magazines often depict mental illness as chronic, incurable, and as a subject matter of ridicule. Mental hospitals formed the mainstay of treatment until few years ago and this has led to strong negative attitudes among the lay public, increasing the stigma. National Human Rights Commission in India had undertaken reviews of the functioning of the mental hospitals in 1998 and 2008[20,21] and had highlighted several inadequacies.

Poor utilization of the psychiatric services

It is well known that we have poor mental health infrastructure in India. Besides, even the existing facilities are not adequately utilized. Many do not seek modern psychiatric care. Even those who avail these services often come late for treatment. Many patients have to commute long distances to come to the nearest psychiatric facility. They often need someone to accompany them. Even then, drugs may not be available in the government-run hospital. Lack of rehabilitation centers and difficulties to avail welfare benefits are the other problems. Community involvement in mental health care can be an answer to this problem.[22,23] The implementation of the District Mental Health Program in many districts has given positive results. Literacy also plays an important role in utilization of psychiatric services as evidenced in states like Kerala. With a very high literacy level, there is much wider acceptability and utilization of psychiatric

services here.

Seeking primary care

More than 70% of India's population live in rural areas. A large majority of them avail treatment from primary health centers, especially for financial reasons. If the medical officers in these primary care facilities have adequate knowledge in Psychiatry, it will be a great gain for mental health. Imparting this knowledge to primary health centre doctors is best achieved through adequate training in Psychiatry during their MBBS course.

Mental health care through primary health care

Primary care facilities are well organized in India. Delivering mental health care through primary care will be cost-effective, possible, and practical.

Inadequate number of mental health professionals

The number of psychiatrists in India is only about 4000 for 1.2 billion population, i.e. 1 psychiatrist for 300,000 people. This is grossly inadequate. The number of psychiatrists should be tripled if we have to achieve a minimum ratio of 1 psychiatrist for 100,000 people. Even this is not conceivable now. Only medical graduates, having at least basic training in Psychiatry, can fill up this huge vacuum.

Poor understanding about psychological distress

There is poor understanding of the psychological distress as requiring medical intervention in the general population. Poor literacy is one factor which leads to lack of awareness regarding mental disorders. Stigma is another important barrier to mental health care.

Treatment gaps and need for collaboration

It has been observed that there are large treatment gaps and treatment delays in India. Studies have shown that about half of the patients of schizophrenia are living in the community without treatment. Community involvement is crucial to mental health. Although it is

not advisable to mix up various systems of medicine in India, opening up of a dialogue and exploring collaboration may be very helpful.

Community psychiatry as part of community medicine

In delivering mental health care, community psychiatry is a suitable model not only in rich countries but also in low- and middle-income (LAMI) countries. Setting up of special institutions for the care of the persons with mental disorders (asylums), the humane treatment of the ill persons, deinstitutionalization, and recognition of the rights of the ill persons with mental disorders[4] are some of the phases through which Community Psychiatry has developed in the world. Community Psychiatry in India is nearly six decades old.[16,23] Psychiatry can be effectively integrated into Community Medicine in medical education.

INTERNATIONAL SITUATION

Go to:

In the USA, Behavioral Sciences are taught in the first year of undergraduate studies. During the first 2 years, there are about 60 h of teaching in various psychosocial areas. In the third year, 30 h are devoted to practical teaching of Psychiatry. In the fourth year, there is a full-time posting of 8 weeks of Psychiatry clerkship compared to 8 weeks each allotted for Obstetrics and Pediatrics and 12 weeks for both Medicine and Surgery.

In Denmark, the teaching of mental disorders started in 1902 and was well established in 1912. During the fifties, it acquired the status of a major clinical subject, rising to third place after Surgery and Medicine and ahead of Pediatrics and Obstetrics and Gynecology. Now, there are approximately 240 h of Psychiatry teaching in a 6-year course, comprising about 7% of the total time. It is a major clinical discipline with a qualifying examination at the end of the course.

In Britain, Psychiatry established its place in medical education in the forties. However, it went through major changes in the seventies following the General Medical Council's recommendations in 1967 regarding medical education, which re-emphasized the importance of Behavioral Sciences and Psychiatry in medical teaching and

Indian J Psychiatry
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practice. Currently, 80 h are devoted to the behavioral science course during basic medical science teaching. During the clinical course, students first learn interview skills and psychiatry history taking once a day during the 36 weeks and then attend a full-time Psychiatry clerkship for 3 months. This is usually followed by a university examination as in other subjects.

In South Asia, both Sri Lanka and Nepal give prominence to Psychiatry and medical students need to pass examination in Psychiatry to qualify for medical degree.

WORLD PSYCHIATRIC ASSOCIATION RECOMMENDATIONS

Go to:

In 1998, the World Psychiatric association (WPA), along with the World Federation of Medical Education (WFME)[24] through a core curriculum committee, developed detailed guidelines for the "Core Curriculum in Psychiatry for Medical Students." The main recommendation that Psychiatry should occupy a major part in the medical curriculum is now generally agreed. There are three reasons for this agreement. First, the general approach of Psychiatry which stresses the unity of body and mind is important in the whole of medical practice. Secondly, skills that are learned in Psychiatry are important for all doctors: for example, the ability to form a good relationship with a patient, to assess the mental state, and to convey distressing information. Thirdly, psychiatric problems are common among patients seen by doctors working in all branches of medicine. For example, it is known that among the outpatients attending specialist clinics, about 15% of those given a diagnosis have an associated psychiatric disorder and an average of 20–30% of those given no medical diagnosis have a psychiatric disorder. Psychiatric disorders are even more frequent among patients attending general practice. Therefore, all future doctors must know about these psychiatric problems, not only because they are common but also because their management involves much medical time and resources and gives rise to many serious incidents.[25]

THE PROPOSED CURRICULUM

Go to:

The core component in Psychiatry in the curriculum described in the WPA/WFME report is the minimum that is required by medical

Indian J Psychiatry

students who, after qualification, will enter further training whether they are to work as specialists or in primary care. In many countries, doctors who have chosen a career in primary care (general practice) receive a further period of training after graduation; and in most of these countries, this training extends their psychiatric skills.

UG TEACHING IN PSYCHIATRY: INITIATIVES OF INDIAN PSYCHIATRIC SOCIETY

Go to:

Strengthening undergraduate training in Psychiatry and having an examination on the subject at the university level had been an agenda of Indian Psychiatric Society (IPS) for the last half a century. IPS sub-committee on UG teaching in Psychiatry with KR Masani, KC Dube, VN Bagadia, SS Syalee, and JS Neki (1965) said, "In India, the principal need is for physicians to take charge of rural areas, in which they must be, in large measure, self-sufficient. When about one half of the clientele of a GP anywhere consists of such patients who require psychiatric help, it is only essential that the general medical practitioner be properly equipped to deal with them. Unless we teach our future practitioners to see psychiatric problems and to deal with them and unless we attract by our teaching and our example, a sufficient number of bright students into Psychiatry, we shall succeed neither in training a good "basic doctor" nor in elevating the standard of Psychiatry." And in their recommendation, they had strongly suggested a compulsory examination in Psychiatry.

In an editorial in *Indian Journal of Psychiatry*, BB Sethi (1978)[26] pleaded for a better deal for training in Psychiatry at undergraduate level. As chairman of the IPS UG Psychiatric Education Committee, Bhaskaran (1990)[27] in another editorial in our journal said, "There is general agreement among mental health professionals that undergraduate training in Psychiatry and Behavioural Sciences in most of the medical colleges in the country is unsatisfactory. Training teachers of Psychiatry and Behavioural Sciences in our medical colleges should engage our active attention much more than it has done so far. Apart from the reasons cited above, there are other compelling reasons for such a training, with special reference to our country." He also lamented that the influence of cultural factors in determining attitudes to health and illness, and doctor–

Indian J Psychiatry

patient relationship are not adequately stressed, though they are important in understanding the behavior of the patient at the time he does become a patient. He also stressed the need for experiential component to the student in the form of a field visit to a village and surveying the attitudes of people to nutrition, beliefs about health and illness, or a visit to a family. He also noted that there was absence of provision for examination in Psychiatry, which led to the neglect of the subject.

A workshop and teachers' training program was held in NIMHANS in 1989 on UG teaching in Psychiatry for teachers from 10 medical colleges, which identified the necessary steps to improve UG teaching. This meeting made several recommendations to Medical Council of India (MCI), the most important of which was giving Psychiatry a status of full-fledged subject at MBBS level. It was expected that other centers too will take up similar training programs. Sadly this has not happened. We need a renewed effort on this.

The recommendations of the NMHP (1982)[10] noted that the amount and type of mental health training to medical undergraduates in our country is grossly inadequate. The NMHP saw the potential of using these future medical doctors as agents of a new and better mental health service system for our country. The working committee of NMHP also stressed that the amount and content of undergraduate psychiatric training be altered to address the mental health needs of our country.

In yet another editorial in the *Indian Journal of Psychiatry*, Trivedi JK (1998) said, "The basic purpose of teaching and training at undergraduate level is to prepare medical graduates to serve better at primary health care level. The patients with physical illness have concomitant emotional problems requiring professional handling, therefore teaching of Psychiatry at undergraduate level becomes even more relevant and essential."

IPS in 2010[28] submitted a document to the MCI, prepared by its Psychiatric Education Committee. It stated that a medical student on graduation should be able to deliver mental health services at primary care level and listed the following main objectives.

1. Able to identify signs and symptoms of common psychiatric illnesses
2. Able to identify developmental delays including cognitive delays
3. Able to understand the nature and development of normal human behavior
4. Able to appreciate the interplay between psychological and physical factors in medical presentations
5. Aware of common psychopharmacological interventions in clinical practice of psychiatry
6. Able to apply basic counseling skills and comfort in discussing common psychiatric issues with the patient or the relative
7. Aware of statutory and educational provisions with regard to psychiatric illnesses and disability
8. Able to develop helpful and humane attitude toward psychological, psychiatric, and behavioral difficulties
9. Able to deliver mental health services at primary care level

A detailed course content was also enlisted:

S. no.	Topics	Must know	Desirable to know
1.	Signs and symptoms of common mental disorders: Depression and anxiety disorders. Ask about depression, anxiety, somatization disorders including conversion disorders, psychoses, and dementia. Diagnose depression, assess suicidal risk, educate and advise, prescribe rationally the antidepressants and tranquilizers, and refer appropriately	Yes	
2.	Unexplained physical complaints: Identify physical symptoms without apparent physical cause, interplay of physical and psychological aspects in medical presentations, elicit stress and coping, educate, reassure, and refer	Yes	
3.	Cognitive delays: Identify	Yes	

Indian J Psychiatry

	developmental delay, basic education and advice, referral		
4.	Substance abuse: Ask about alcohol or drug use, identify problem drinking, educate and advise, refer appropriately, signs and symptoms of alcohol dependence, its medical and psychosocial impact, treatments available	Yes	
5.	Sleep education: Sleep hygiene, prescribe rationally, look for other physical possibilities	Yes	
6.	Mental functions: Primary and higher, elicit signs and symptoms of delirium, identify early cognitive decline, educate family, plan referral	Yes	
7.	Agitated/violent patient: Emergency management, forensic and transportation needs, procedural knowledge for hospitalization	Yes	
8.	Psychoses: Identify, provide immediate care, and refer, educate family regarding the nature of illness	Yes	
9.	Concept of mental hygiene and mental health: Promotional issues related to death and dying, breaking bad news, eliciting reaction and providing support, prevalent social and psychological concepts around death and dying	Yes	
10.	Common causes of delirium: Behavioral management of delirium, safe sedation methods	Yes	
11.	Child development: Common developmental disorders	Yes	
12.	Forensic aspects of violence, attempted suicide, and suicide	Yes	
13.	Chronic organic brain syndrome: Dementia and mental health issues in old age		Yes
14.	Mass hysteria, PTSD		Yes
15.	Stress management	Yes	
16.	Basic counseling principles	Yes	
17.	Principles of psycho-education		Yes
18.	Basic psychotherapeutic skills		Yes
19.	Psycho-social barriers in help seeking in mentally ill		Yes
20.	WHO Primary Care Classification of		Yes

	Mental Disorders	
21.	Knowledge about NMHP and Mental Health Act	Yes

The following learning skills were stated as necessary.

Skills to be acquired	Perform indepen--dently	Perform under supervision	Assist the expert	Observe
Psychiatric history taking	Yes			
Mental state examination (primary mental functions)	Yes			
Mental state examination (higher mental functions)	Yes			
Diagnosis of common mental disorders	Yes			
Dealing with PTSD		Yes		
Dealing with mass hysteria				
Mental hygiene	Yes			
Sleep hygiene	Yes			
Developmental delay assessment		Yes		
Physical methods of treatment (electroconvulsive therapy)				Yes
Use of psychotropic medication, knowledge of their indication, adverse effects, therapeutic dosage	Yes			
Abreaction				Yes
Brief psychotherapy		Yes		
Counseling	Yes			
Referral of potential cases	Yes			

Indian J Psychiatry

to neurologist or psychiatrist		
Behavioral and psychological analysis of self-destructive behavior	Yes	
Child psychiatric history taking		Yes
Child and adolescent mental state examination		Yes
Geriatric history taking		Yes
Geriatric mental state examination		Yes
Initial and primary care for the children and adolescents and referral to the specialist	Yes	
Terminal care		Yes
Exercising empathy, compassion, and establishing rapport and maintaining rapport which is a must for all psychiatric interventions	Yes	
Psychotherapeutic and behavior modification approach		Yes

MCI on UG psychiatry training

In their letter dated 20 August 2011 addressed to the Ministry of Health and Family Welfare, Government of India, MCI referred to the discussion with IPS held at MCI on 13 May 2011. MCI said the following have been incorporated into the curriculum of Psychiatry, for the undergraduate MBBS course:

1. The teaching hours in Psychiatry are increased from 20 to 40 h
2. The clinical posting in Psychiatry has been increased from 2 weeks to 4 weeks
3. The doubling of the marks to 20 in the theory paper for medicine and it was agreed that the questions of Psychiatry would be made mandatory
4. Internal assessment in Psychiatry to be made mandatory for final examination
5. Psychiatry posting in internship has been made mandatory, instead of elective posting
6. The subject to be taught in an integrated manner, especially in Community Medicine.

Undoubtedly, all the above measures are progressive and are to be welcomed. Unfortunately, except for the decision on internship, all other decisions are yet to be implemented. The MCI's decision on compulsory internship for MBBS graduates is a significant step forward.

The general attitude among medical students is that they will not take a subject seriously unless there is an exam on that subject. It is very sad that the MCI has not responded positively to this urgent need for examination in Psychiatry. In the above letter, MCI said, “Similar representations for considering their subject as a separate examining paper have been placed by Orthopaedics, Palliative Medicine, Oncology, Medical Virology, ENT, Ophthalmology, Dermatology and Sleep Medicine. Due to the constraint of the council to restricting the burden of examination on medical students, additional paper in Psychiatry and other subjects cannot be considered.”

We can conclude that the MCI's assessment was wrong for the following reasons:

1. Orthopedics and ENT are already examination subjects.
2. Palliative Medicine, Oncology, Medical Virology, Sleep Medicine, etc. are sub-specialities and are in no way comparable to a major branch like Psychiatry.
3. Major public health problems like depression, suicides, alcohol and substance use, and adolescent psychiatric

Indian J Psychiatry

problems have been completely ignored.

On receiving this reply, IPS took up the matter again with the Government of India. On 2nd September 2011, a delegation of M Thirunavukarasu, Roy Abraham Kallivayalil, Rakesh Chadda, and UC Garg met the Ministry of Health officials and later Sri. Ghulam Nabi Azad, Union Minister of Health, and explained to them in detail regarding the importance of Psychiatry in UG medical education. Soon there was change in the Board of Governors in MCI. Hence, on 23 November 2011, an IPS delegation of Roy Abraham Kallivayalil and UC Garg met the officials of the Ministry of Health, Government of India, and requested them to once again take the matter of UG training and examination in Psychiatry with the new Board of Governors at the MCI. We believe these concerted efforts for a just cause have convinced the Government of India on the matter. On 25 November 2011, Additional Secretary, Ministry of Health, wrote to the Chairman, MCI, thus: "Given the prevalence of mental health problems in the country, more needs to be done than just making the students familiar with the subject at the undergraduate level. Moreover, as in the case of other specialities, there should be a separate exam and evaluation of Psychiatry as a subject".

A COMPARISON OF THE CURRENT MEDICAL CURRICULA

Go to:

We may compare an MCI-based curriculum and a progressive curriculum in an autonomous institute in the country. The Kerala curriculum is a prototype of an MCI-recommended curriculum. The other is of the curriculum at India's premier medical institution, AIIMS, New Delhi.

MBBS curriculum in Kerala (2009):[29] Has been prepared by the Director of Medical Education as per "Regulations on Graduate Medical Education, 1997" and revision 2007 MCI (modified up to 2009).

The highlights regarding Psychiatry are:

2 weeks clinical posting and 20 theory classes

Examination

Medicine theory: 150 marks (60 + 60 + 30) (2 papers of 3 h

duration, each 60 marks)

Paper I: General Medicine

Paper II: Sec. A: TB and Emergency Medicine

Sec. B: Dermatology and Psychiatry

Internal Assessment: 30 marks

(15 marks in Psychiatry out of 150 can be presumed)

Practicals: 150 marks (60 + 60 + 30)

OSCE: 2 stations of 5 marks each in Psychiatry

Marks for Psychiatry: 10/150

Total marks for Psychiatry: 25/300

Main drawbacks are:

1. Question paper is set by Department of Medicine. Psychiatry faculty has no role in it.
2. No Psychiatry teacher as examiner.
3. Proper evaluation of answers cannot be assured.
4. No requirement to score any minimum marks in Psychiatry.
5. Psychiatry may not be considered for Internal Assessment.

Curriculum in AIIMS, New Delhi[6]

9 weeks clinical posting including Rural Health Services Project

Compulsory log book

Examination: 13 marks for theory and 12 marks for practicals (total 25/225)

Although there is not much variation in the marks awarded for Psychiatry, the 9 weeks clinical posting, rural posting, compulsory log book, evaluation by Psychiatry, and Internal Assessment marks for Psychiatry make this a unique model, different from the MCI prescribed one.

PROPOSALS FOR THE FUTURE IN UG TEACHING OF PSYCHIATRY

Go to:

Indian J Psychiatry

Considering our constraints in most states, there should be at least 30 beds in Psychiatry and a minimum faculty consisting of one professor, one associate professor, and two assistant professors/lecturers and residents in all the medical colleges in the country. The minimum requirements are as follows.

a. Psychiatry should be a compulsory subject with university examination for the MBBS students
b. There should be a separate theory paper, clinical exam, and viva voce, as for other subjects
c. The examiners shall be from Psychiatry faculty only
d. There should be minimum 8 weeks clinical posting and 100 lectures
e. There should be compulsory posting in Psychiatry during internship for at least 15 days (already implemented)
f. Few lectures in Psychiatry may be included in the first or second semester for orientation.

Psychiatry departments in all medical colleges should be strengthened with adequate beds and faculty.

In India, the following initiatives are required in future.

Revising the curriculum and enhancing the quality of training

In parallel with increasing the time allocated to Psychiatry teaching, a greater need has been felt of introducing social and behavioral sciences in the training of medical undergraduates to make them more socially aware and responsive and develop a holistic community-oriented approach.

General epidemiological surveys in primary care setting have indicated that as many as 30% of patients attend health services primarily for a mental health problem. General practitioners are already sharing the burden of mental health problems. However, to increase their effectiveness in identifying and managing common mental and behavioral health problems in the community, including screening and early intervention for tobacco, alcohol, and other drug use, they must be provided quality training at the undergraduate level itself with frequent refresher courses as part of continuing medical education subsequently.

The training curriculum should also include application of evidence-based psychosocial strategies, skill-building in the areas of administration and management, policy development, and research methods.

Strengthening faculty of Psychiatry

Technological revolution has been sweeping the world, bringing rapid changes in our knowledge and beliefs. Medical sciences too have witnessed such a revolution, demanding rapid changes in the content as well as method of its delivery. This may put a greater stress on the teachers who, in a typical Indian medical college, may already be burdened with high clinical workload and administrative responsibilities. Teachers must be involved regularly in workshops, etc. to enhance their teaching skills by application of newer technologies like audiovisual media, computers, internet, and other tools of information technology.

Research in mental health care

Most of the research to date has been generated in the developed countries (WHR, 2001). Research is needed in the developing countries to generalize evidence and then guide reforms in mental health care. We need to strengthen the undergraduate teaching of Psychiatry toward this goal.

AN ACTION PLAN

Go to:

1. Biggest hindrance to include psychiatry in the UG curriculum as a subject with examination are clinicians, who think that psychiatry is not important. This can be overcome by working closely with them.
2. How to convince psychiatry is important to policy makers? By providing epidemiological data that psychiatric disorders are common, they are commonly missed due to lack of training, psychiatric disorders are eminently treatable, treatment is cost-effective, and not identifying and not treating psychiatric disorders contributes to poor quality of life (QoL), excessive resource utilization, and complications like suicide. Also, to educate policy makers that problems which are

Indian J Psychiatry

superficially considered as social problems like alcoholism, suicidal behavior, school dropouts, etc. are in fact mental health problems.

3. To convince students that they need Psychiatry for their professional and personal development. Start from the days of Physiology and Anatomy (Sem I and II) and link brain areas and circuits to emotions and behavior. Firm footing in neuroscience Is very helpful. Emphasize that higher functions of brain are influenced by environmental influences.
4. Make clinical postings interesting by new teaching methods, giving more importance for anxiety disorders, depressive disorders, substance use disorders, medically unexplained somatic symptoms, psychosomatic symptoms, suicidal behavior, etc. than schizophrenia or mania.
5. Emphasize more on Consultation Liaison Psychiatry and GH Psychiatry than on hardcore Psychiatry.
6. Uniformity in training and examination – schedule and module, OSCE – rather than personal idiosyncrasies.
7. MBBS without psychiatry is a handicap (not learning the most advanced function of the most complex organ system in the body).
8. Integrating psychiatry teaching with other clinical subjects like general medicine (to demonstrate a case of depression or somatoform disorder) and specialities like dermatology (e.g. a case of OCD/trichotillomania/delusional parasitosis), cardiology (to demonstrate a case of panic disorder or depression), gastroenterology (to demonstrate a case of psychosomatic disorder), surgery (to demonstrate a case of delirium), neurology (demonstrate a case of dissociative convulsions), and pediatrics (a case of OCD/ADHD? dyslexia) may make postings more interesting.
9. Encourage humanities in medicine – arts, literature – person-centered approach.
10. Soft skills like communication skills, stress management, study techniques, etc. which may help personal development may be included in training.

CONCLUSION

Go to:

Engel (1982) contends that though psychiatrists talk about the need to adopt a bio-psycho-social approach to patient assessment and patient care, in actual practice, they do not necessarily operate within the frame work of such a model. There is no doubt that our system of medical education contributes to this. According to Bhaskaran (1990), "Psychiatrists undergo the same strictly bio-medical education as all other physicians and are products of the same scientific culture. Indeed, many psychiatrists are not less dualist and reductionistic than their non-psychiatrist colleagues. Widely shared are deep commitments to single system causal explanations – whether they are social, behavioural, psychogenic or molecular – for psychiatric disorders. Especially compromised are psychiatrists whose longing to be accepted as 'real' physicians leads them to embrace the bio-medical model uncritically despite its obvious incapacity to deal scientifically with the psychological and the social." These criticisms are very much valid today. It is no doubt that the teacher's orientation and his example greatly influences undergraduate students. As teachers, we need to keep our minds and hearts open to emerging changes in the modern world.

Primary health care is the cornerstone of healthcare delivery, especially in the developing world.[30] Hence, medical curricula at both the undergraduate and postgraduate levels should adapt and evolve to produce professionals with a person-centered approach. This requires a change in policy on the selection of students to medical school and the content of medical curricula and examinations.[31]

It is worthwhile to note many countries like Sri Lanka give much greater importance to Psychiatry in UG teaching. India has to lead the way and regional co-operation in South Asia will be very helpful.[32–34]

Reaching the unreached should be our goal.[35] Training should also involve knowledge and understanding of our culture.[36] The resource constraints in mental health are well documented,[37] and hence equipping our young medical graduates with a sound knowledge of Psychiatry is the only option available to us at present. The social factors in training are also very important.[38]

Indian J Psychiatry

Good training in Psychiatry during UG will help the general practitioners to be well equipped and the specialists to consider psychiatric and psychological factors from the outset, which will reduce mortality and morbidity due to psychiatric illness and provide cost-effective and cost-efficient treatments avoiding unnecessary investigations. This will lead to person-centered and people-centered care based on humanistic principles[39] and it will prove that "There is no health without mental health."

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REFERENCES

Go to:

1. Prince M, Patel V, Saxena S, Maj M, Maselko J, Phillips MR, et al. No health without mental health. Lancet. 2007;370:859–77. [PubMed]

2. Sorel E, Satcher D. The U.N.'s unfortunate exclusion. Psychiatr News Bulletin. 2011:8.

3. Geneva: WHO; 2010. [Last cited in 2010]. World Health Organization; mhGAP Intervention Guide for mental, neurological and substance use disorders in non.specialized health settings. Available from: http://www.who.int/mental_health/evidence/mhGAP_intervention_ . [PubMed]

4. World Health Organisation; World Health Report 2001. Mental Health. new understanding, new hope. Geneva: WHO; 2001.

5. II. Delhi: The Manager of Publications; 1946. [Last cited in 1946]. Government of India. Report of the health survey and development committee. Available from: http://nihfw.org/NDC/DocumentationServices/Reports/Bhore%20Committee%20Report%20.%20Vol%20II.pdf .

6. Sood M, Sharan S. A pragmatic approach to integrating mental health in understanding training: The AIIMS experience and work in progress. Natl Med J India. 2011;24:108–10. [PubMed]

7. Dube KC. Unlocking of wards-an Agra Experiment. Indian J Psychiatry. 1963;5:2–7.

8. Sharma S. Mental hospitals in India. New Delhi: Director General of Health Services; 1990.

9. Wig NN. General hospital psychiatry units: Right time for evaluation. Indian J Psychiatry. 1978;20:1–3.

10. Director General of Health Services: National Mental Health Programme for India. New Delhi: Ministry of Health and Family Welfare; 1982.

11. Neki JS. Report of the sub-committee of the Indian Psychiatric Society on public education in psychiatry and teaching standards in psychiatry in India. Indian J Psychiatry. 1964;6:81–7.

12. Indian Psychiatric Society. First Report of the subcommittee on undergraduate teaching in psychiatry. Indian J Psychiatry. 1965;7:63–72.

13. Indian Psychiatric Society. Second report of the committee on undergraduate teaching in psychiatry, staff circular and other requirements. Indian J Psychiatry. 1965;7:73–9.

14. Garg KL, Wig NN, Chugh KS, Wahi PL, Menon DK. Psychiatric aspects of hemodialysis. J Assoc Physicians India. 1976;24:483–9. [PubMed]

15. Garg KL, Wig NN, Chugh KS, Verma SK. Psychiatric aspects of chronic uremia. Indian J Psychiatry. 1978;20:43–37.

16. Agarwaal SP, Goel DS, Ichhpujani RL, Salhan RN, Shrivatsava S. Mental health- an Indian perspective (1946-2003) New Delhi: Directorate General of Health Services, Ministry of Health and Family Welfare; 2004.

17. Health system Performance Assessment. Mumbai, New Delhi, Geneva: International Institute for Population Sciences (IIPS), World Health Organisation, World Health Organisation-India-WR office; 2006. World Health Survey, India, 2003.

18. WHO: Mental Health Atlas. Geneva, Switzerland: WHO; 2005.

19. Thiruvanakarasu M, Thiruvanakarasu P. Training and national

Indian J Psychiatry

deficit in psychiatrists- a critical analysis. Indian J Psychiatry. 2010;52:S83–8. [PMC free article] [PubMed]

20. Quality assurance in mental health. New Delhi: NHRC; 1999. National Human Rights Commission.

21. Nagaraja D, Murthy P, editors. Mental health care and human rights. New Delhi: NHRC-NIMHANS; 2008. National Human Rights Commission (NHRC)

22. Srinivasa Murthy R, Wig NN. The WHO Collaborative study on strategies for extending mental health care, IV: A training approach to enhancing the availability of mental health manpower in a developing country. Am J Psychiatry. 140:1486–90. [PubMed]

23. Srinivasa Murthy R. Mental health services in low and middle income countries. Chapter 39. In: Thornicroft G, Szmukler G, editors. Oxford Textbook of Community Psychiatry. Oxford: Oxford University Press; 2011. pp. 325–36.

24. New York: World Psychiatric Association and World Federation for Medical Education; 1998. [Last cited in 1998]. World Psychiatric Association. WPA core curriculum in psychiatry for medical students. Available from: http://www.wpanet.org/sectorial/edu5.1.html .

25. Murthy RS, Khandelwal S. Undergraduate training in psychiatry: World perspective. Indian J Psychiatry. 2007;49:169–74. [PMC free article] [PubMed]

26. Sethi BB. Undergraduate psychiatry. Indian J Psychiatry. 1978;20:197.

27. Bhaskaran K. Undergraduate training in psychiatry and behavioural sciences—The need to train the trainers. Indian J Psychiatry. 1990;32:1–3. [PMC free article] [PubMed]

28. Indian Psychiatric Society: Recommendations for Under-graduate (MBBS) syllabus in Psychiatry. Report prepared by the Psychiatric Education Committee of Indian Psychiatric Society chaired by RC Jiloha. 2010

29. Director of Medical Education, Kerala: MBBS Curriculam & Academic Calendar 2009-2015. Trivandrum: Directorate of

Medical Education; 2009.

30. Issac MK, Chandrasekar CR, Srinivasa Murthy R. Mental health care by primary care doctors. Bangalore: National Institute of Mental Health and Neurosciences; 1994.

31. Kallivayalil RA, Punnoose VP. Person-centered medicine and primary healthcare: Academic perspectives. Int J Pers Cent Med. 2011;1:433–4.

32. Trivedi JK, Goel D, Kallivayalil RA, Issac M, Shrestha DM, Gambheera HC. Regional co-operation in South Asia in the field of mental health. World Psychiatry. 2007;6:57–9. [PMC free article] [PubMed]

33. Kallivayalil RA, Trivedi JK, Tripathi A. Social factors and forensic psychiatry in India. Curr Opin Psychiatry. 2009;22:482–7. [PubMed]

34. Kallivayalil RA, Punnoose VP. Editorial in suicide prevention-a handbook for community gatekeepers. Kottayam: National Alliance for Mental Health; 2009.

35. Srinivasa Murthy R. Reaching the unreached. Lancet. 2000;356:39.

36. Rao AV. Culture, philosophy, mental health. Mumbai: Bharatiya Vidya Bhavan; 1997.

37. Saxena S, Thornicroft G, Knapp M, Whiteford H. Resources for mental health: Scarcity, inequity, and inefficiency. Lancet. 2007;370:878–89. [PubMed]

38. Varma VK, Kulhara P, Masserman CW, Malhotra A, Malik SC, editors. Social psychiatry: A global perspective. Delhi: Macmillan India Ltd; 1998.

39. Mezzich JE. Psychiatry for the Person: Articulating science and humanism. World Psychiatry. 2007;6:1–3. [PMC free article] [PubMed]

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