Revisiting Postgraduate (PG) Psychiatry Training in India

(Viewpoint

(Transcript of the Panel Discussion Held on 26th October 2018 at Annual Conference of Indian Psychiatric Society South Zonal Branch, Held in Tirupati)

The training that students receive today will have an impact on the professionals and society of tomorrow. To make them better psychiatrists, there should be an ongoing effort to improve the psychiatry training that postgraduates receive. The panel discussion involved three experts from different states and working backgrounds to discuss this important topic.

1. It is frequently pointed out by many that postgraduate training in psychiatry these days is mainly focusing on pharmacotherapy; psychosocial assessment and intervention are ignored; or in many centers, patients are referred to the concerned specialist, and there is little training happening.

Dr. Varghese Punnoose: Before one jumps in for a criticism of the prevailing medical model, it has to be acknowledged that this approach has some definite advantages. It has brought more accuracy in diagnosis and precision in pharmacological management. It has made psychiatry in line with other medical specialties bringing in more respect among peers. It has attracted young medical professionals to psychiatry who otherwise feel burdened by the psychological jargon and turned away by psychotherapeutic skills demanded of them. There is increasing evidence that the medical model has also contributed to stigma reduction. But too much of medical model has made psychiatry less mindful.

During the assessment, contextual factors should be given its due. While emphasizing the primary role of biological factors; psychosocial factors such as causative, precipitating, or perpetuating influences should also be considered. Personal history, family history, and premorbid personality should be thoroughly assessed to understand the person who is under evaluation. The famous adage by William Osler “It is important to know the diagnosis, but it is more important to know the person who has got the diagnosis” is particularly true for psychiatry and should be the guiding principle in training psychiatry residents.

Interventions should not be confined to a prescription of pharmacological agents. Referring the patient to a psychologist and limiting the role of the trainee psychiatrist to pharmacological treatment alone is a sin. Psychological interventions by the trainee psychiatrist should be planned, documented, supervised, and evaluated for every patient. It is an unfortunate situation that many PG training departments do not have a clinical psychologist or a social worker. The reason for this big lacuna is that the Medical Council of India (MCI) regulations do not mandate it. This has to be corrected urgently. The boundary issues with clinical psychologists or Rehabilitation Council of India (RCI) should not be a block for urgent steps in this direction. Till such permanent solutions emerge, the faculty in psychiatry themselves should provide hands-on training for the trainees. Human resource scarcity for psychotherapy training should be tackled by steps like student exchange programs or focused workshops. Feasibility of examining the psychotherapy skills of the trainee in a separate practical examination is worth considering.

Absence or relative lack of psychological approach and interventions by psychiatrists is one of the major reasons for dissatisfaction with psychiatric services. Psychiatrists of the future should be equipped with the skills to meet the expectations of the evolving society.

Dr. Kannan: There have been tremendous strides made in the fields of neurobiology and psychopharmacology. It is natural that psychiatry as a branch of medicine should focus on psychopharmacology. But what we need to understand better is the dynamics between psychiatry and the psychological sciences. The evidence-based medical methods and modern psychiatric classification had over the past few decades removed the psychological model of illnesses and the reliance of psychiatry on social sciences significantly. However, recently there is increasing recognition of the role of psychological-based understanding and therapeutic interventions such as CBT in the management of psychiatric illnesses. A multidisciplinary approach is advocated. The past few decades have seen a gradual recession in the processes of teaching psychotherapeutic techniques. We need to have more systematic programs to restart the processes.
The situation has started to improve, and there is an increased interest in nonpharmacological treatment options now.

**Dr. Ashok:** The number of departments that have introduced PG program in the last decade and the increase in the number of seats mean that there is more than twice the number of PGs now compared to about two decades back. The newer departments also do not have an adequate number of psychologists. The psychologists who do stay on with PG departments are often overburdened with clinical work. And find it harder to focus on supervisory roles and actively participate in PG training. Having them on rounds can be difficult too. This impacts on PG training and builds a vicious cycle of reduced exposure to nonpharmacological interventions. The MCI does not even specify the need for psychologists in the training team. It does specify a social worker (SW), but these posts are often filled with Masters in Social Work (MSWs) who may not actively participate in PG training. The universities recommend but do not make it mandatory to score psychological assessments or psychotherapy notes. There is also a need to get psychologists and psychiatric social workers (PSWs) to get pragmatic and flexible about what should the training in therapies for psychiatry PGs constitute. The teachers have to feel that it is important to focus on the psychological and psychosocial aspects and model for the students. This is the most crucial. The Indian Psychiatric Society (IPS) should encourage and support the newly evolved Indian Teachers of Psychiatry (IToP) group and build groundswell support for bringing such focus in training programs. The faculty should work with universities to develop M.Phil programs in their institutions and help bring about more exposure to psychological aspects through joint programs with psychologists.

2. All of us are seeing more and more child cases in practice; would it be desirable to have a mandatory child case in the final examination.

**Dr. Varghese Punnoose:** One short case from child psychiatry should be mandatory for PG clinical examination. Unless there is an examination, the training in child psychiatry will not be taken in a serious manner by the faculty and trainees. Acquisition of core competencies in assessment and interventions in child patients should be ensured for every candidate.

**Dr. Kannan:** We are witnessing the initial phases of child psychiatry emerging as a separate subspecialty within psychiatry. However, there is a huge need for child psychiatric services which cannot be met by subspecialists. The MCI norms make it mandatory for all teaching centers to have a separate child psychiatry clinic. The Tamil Nadu Dr. MGR Medical University guideline prescribes 4 months of clinical rotation in child psychiatry and also permits students to be posted to higher institutes for specialty training. There is an increasing trend to include one child psychiatry case as part of the short case presentation during examinations even though it is not a mandatory requirement. Objective structured clinical examination (OSCE) scenarios invariably include a child psychiatry station. In this context, it is definitely implementable to include a mandatory child case in the final examination. Such inclusion would not only give a greater legitimacy for candidates to practice child psychiatry but also give a boost to child psychiatry training in India.

**Dr. Ashok:** This is absolutely necessary. Every department should carve out a role in child psychiatry for one of its faculty members and encourage them to gradually take more time on this. They should gradually focus on submitting detailed case summaries and also arranging case conferences in child psychiatry. However, if the numbers of child cases seen are very few, there should be an active liaison with centers where these services are more established. Having a child case in the examinations should be a rule than an exception, and the case needs to be formal child psychiatry case than a purely developmentally impaired child. There has to be a formal evaluation of competency with regard to interviewing children and parents (latter with regard to parenting) in examinations and not just ask a few questions on developmental anomalies to cover child psychiatry topic.

3. De-emphasis of descriptive psychopathology and case taking being more of a checklist exercise.

**Dr. Varghese Punnoose:** The categorical systems of diagnostic classifications (DSM and ICD), use of rating scales, and emphasis on criteria-based diagnosis have taken away the understanding of “what is actually happening in the patient’s mind” from today’s PG training programs. The practice of narrating an exhaustive list of “negative history” at the end of the history of presenting illness is an example of this mechanical symptom checking. The symptom checklist approach deprives the trainee of understanding of the pain suffered by the patient with depression or the appreciation of the devastation of various mental functions in schizophrenia. In short, this leaves the trainee less empathetic. Emphasize on psychopathology should be brought back in training and the candidate’s competence to elicit and describe psychopathology should be given due credit in PG examination.
Dr. Kannan: It is now recognized that the widespread use of classificatory systems and structured protocols has had a deleterious effect on the training of residents in interview techniques and descriptive psychopathology. This has been described in excellent clarity by Anderson where she states that since the publication of DSM-III in 1980, there has been a steady decline in the teaching of careful clinical evaluation that is targeted to the individual person’s problems and social context and that is enriched by a good general knowledge of psychopathology. The simultaneous booming of psychopharmacology and disillusionment with psychoanalysis has also compounded the decline. The currently prominent “diagnose by criteria and treat with medication” approach removes the focus from psychopathology.

We have always maintained that a good and open clinical interview is the gold standard against which structured clinical interviews are tested and designed. But as the use of structured checklists and criteria becomes more widespread among trainees and teachers, there is, unfortunately, a proportionate fall in the soft skill set needed to conduct an open clinical interview, leading to more reliance on superficial approach to criteria-based diagnosis with inadequate phenomenological understanding which becomes a vicious cycle.

Classificatory systems discourage clinicians from getting to know the patient as an individual person because of their dryly empirical approach leading to loss of empathic skills.

Psychopathology precedes nosology. We need a careful description of symptoms and experiences before we can know whether any diagnoses exist, and which ones. Criteria include only some characteristic symptoms of a given disorder. They were never intended to provide a comprehensive description. As greater reliance is placed on criteria-based approaches, students typically do not recognize other potentially important or interesting signs and symptoms that are not included in the criteria. This is reflected in the increased use of Not Otherwise Specified categories and the failure to recognize atypical presentations.

The decline in the use of a diagnostic formulation and increasing use of case summaries are also reflective of these changes. Encouraging trainees to attempt diagnostic formulation exercises could counter the ill effects of overdependence on criteria-based diagnostic approaches. Encouraging use of a biopsychosocial approach or a pluralistic approach in case formulations as suggested by Ghaemi would definitely bring different perspectives into the mind of the trainee while interviewing a patient; enrich doctor–patient communication and treatment alliances.

There is an increasing recognition that the evidence-based medical model may not be well suited for the management of many of the maladies of the 21st century which have their roots in individual lifestyles, societal structures, and economic policies. This has led some to advocate for interpersonal medicine. Greater focus on psychopathology will put us in line with this trend.

Dr. Ashok: One needs to be pragmatic too. At least the weekly case conferences should focus on detailed psychopathological exploration. The PG needs to be formally quizzed on a psychopathological understanding of the case. This training should include comfort in asking questions across domains of functioning, attitude, and clinical negotiations. The skill to match definitions even as one engages in a free-flowing interview with the patient should be continually focused across all three years. IPS should arrange specific workshops in this regard.

4. Future of DPM courses and its current utility.

Dr. Varghese Punnoose: DPM has not lost its relevance in India. There may be logic in discontinuing DPM course in the national institutes, but it should be continued in other medical colleges. The special quota for candidates from general health services may be restricted to these seats. Fresh MD holders with high academic aspirations may not opt for rural and community services and locum jobs. At the same time, there are many in general practice who would like to take up a specialty like psychiatry in the middle of their career. A 2-year full-time clinical training in psychiatry, without the hassles of bringing out a thesis, may attract many such clinicians into the fold of psychiatry. This might be a solution for the relative human resources shortage in rural India.

Dr. Kannan: The diploma courses are the products of a bygone era in medical education. Most countries have shifted to a model where there is a single exit examination after clearing which a particular degree is awarded. Anyone can appear for the exit examination if they have undergone the minimal prescribed clinical training by resident training programs in approved centers. In India, there has been a slow but progressive shift in government policy to discourage diploma courses and encourage degree courses. Initially, the regulations that held that any institute that was approved to admit degree students could admit twice the number of diploma students were withdrawn. The criteria in terms of staffing and infrastructure for both degree and diploma courses
are the same now, thus disincentivizing institutions from beginning new diploma programs. Permissions for new diploma courses are not allowed as per current PG regulations. In addition, the government has now introduced a mechanism for surrendering diploma seats in existing institutes in lieu of degree seats subject to approval.\(^{[10,11]}\) The parliamentary standing committee on health has recently recommended making diplomates with an additional 2 years of experience in teaching colleges eligible for academic promotions provided they have completed a thesis work in accordance with norms.\(^{[12]}\) The ball is now in the court of the MCI to decide on the proposal. It must be noted that a similar request by the government was previously rejected by the MCI on the grounds that the diploma course was shorter and did not involve doing a thesis.\(^{[13]}\)

**Dr. Ashok:** It may need to be retained in order to meet the needs of District Mental Health Program, etc. This can be all government sponsored in each state from among the doctors in service.

**5. MCI PG requirements include museum, fixed and specified specialty clinics, room square feet! But ignoring many important aspects.**

**Dr. Varghese Punnoose:** If the MCI mandates something, it is done. If some facility fails to find a place in the MCI checklist, it is never done. In short, facilities are provided only to serve MCI requirements. Unfortunately, many MCI requirements are anachronistic and illogical. I would like to cite a few such wants in MCI requirements.

- a) MCI does not mandate even a single clinical psychologist in PG training departments. The managements, including governments, do not appoint a psychologist unless mandated by MCI. This results in a situation where a candidate can become a psychiatrist without ever being exposed to clinical psychological assessments and interventions.\(^{[14]}\)

- b) MCI has some requirements like “psychomotor clinic.” Nobody knows what it is! (Maybe a clerical error for the psychosomatic clinic)

- c) MCI should revise its requirements to keep with advances in the field of psychiatry. There should be more emphasis on ensuring the qualitative aspect of PG training than its obsession with physical requirements.\(^{[15]}\)

**Dr. Kannan:** The UG and PG training subcommittees of the IPS can work to produce a model curriculum, examination system, and minimum requirements for postgraduate training that is more appropriate for psychiatric training. One must recognize that the requirement of a museum though seemingly absurd is very much applicable for courses like anatomy and pathology. Therefore, any recommendation that is made must be in the language of extant government regulations. Special clinics are envisaged as a means of imparting specialized training to postgraduates. It is advisable to have functioning clinics for de-addiction, suicide prevention, family counseling, child psychiatry services, geriatric, and neuropsychiatry in all teaching hospitals. Governmental agencies are associated with red tape and only sustained liaison efforts and advocacy by professional bodies can be effective in changing policy.

**Dr. Ashok:** The MCI not only emphasizes poorly defined requirements but also omits specifications with regard to key issues such as forensic psychiatry training, exposure to child cases, and negotiations. There is a clear need for recommending changes to the MCI. The IPS has to take such issues on priority. Having a psychiatrist as a key person in the MCI system currently is a great opportunity to move things forward.

**6. Neurology training is on the decline and consultation liaison training is picking up. Your views.**

**Dr. Varghese Punnoose:** The conventional neurology training can be of little help to the future psychiatrists. The typical neurology case for PG examination is stroke. The focus in neurology training and neurological examination should shift to cognitive assessment, skills to interpret neuroimaging and EEG, and rehabilitation. The core competencies needed for psychiatrists practicing in general hospital settings, private practice, and community are different. They should have the skills needed to assess, manage, and engage in useful liaison with internists, gastroenterologists, cardiologists, rheumatologists, orthopedicians, dermatologists, and so on. So the training should focus more on liaison psychiatry than conventional neurology.

**Dr. Kannan:** The recent decades have seen a general decline in interspecialty interaction and different specialties' function as islands. The advent of high-resolution neuroimaging has in many ways lessened the need for achieving a high competence in clinical neurology not only for psychiatrists but also for physicians and even neurologists themselves. Within neurology, there is a comparatively greater focus on basic CNS pathology and lesser focus on higher mental functions and soft signs which is of more interest to psychiatrists. Wherever there is a possibility of organicity, imaging is done, and both psychiatric and neurologic consultations are obtained. This is more in line with western trends. However, one must remember that the World Psychiatric Association
institutional program on the core training curriculum for psychiatry recommends a minimum of 6 months of rotation in clinical neurology and medicine for trainees.[16] A 6-month training is also required by certain international fellowship examinations.

Though there is lesser training in other disciplines, the culture of today with increased accountability and medico-legal risk has ensured that specialists stick to their own discipline and obtain a liaison consultation even though they may be competent in another field. This has, in turn, led to increased liaison consultations in the management of delirium, fitness, detoxification, and toxicology.

Dr. Ashok: There is a general decline in neurology training of psychiatrists. The replacement of neurologists with psychiatrists themselves for the examinations has certainly had its downstream impact on the approach to training. Consultation-liaison psychiatry training needs to get much more specific in its approaches. Liaison rounds may be more relevant than didactic lectures. Here again, undue focus on MRI and EEG should be replaced by clarity in differentiating organic from other psychiatric syndromes. Collective involvement of neurology in psychiatry services is more important than postings to neurology alone. Such initiatives need to be taken by all psychiatrists in medical colleges. Challenges around this have to be directly explored and academic responses generated under the aegis of the IPS.

7. Do we need to change the assessment methods for the postgraduates?

Dr. Varghese Punnoose: The current pattern of PG examination has no uniformity across the country. The emphasis on the long case in psychiatry is perhaps the only unifying aspect. I would like to make the following suggestions:

a) The number of candidates examined in a single day should not exceed four

b) There should be uniformity across the nation – regarding the number of long and short cases, the relative marks awarded, OSCEs, ward rounds, pedagogue sessions, and viva

Dr. Varghese Punnoose: The research training in centers other than big institutes are far from satisfactory. The faculty who are guiding the research work of the trainees themselves must undergo continuous training and certification. There should

Dr. Ashok: I do feel a more dynamic year-round performance record with regular feedbacks should become a larger portion of the certification process. IPS can mandate how often peers should evaluate the candidate during his/her training. This can be through city/district-wide conferences or even on invitation. The sanitized assessment headings for scoring in the MD exams (IPS PG guidelines) – history/Mental State Examination/physical findings and so on need to be superseded by clearer processes such as clarity of reasoning, sensitivity in interviewing patients, ability to integrate information, technical knowledge, and ethical planning of interventions. IPS can help prepare a system on training teachers in such evaluations in collaboration with Departments of Medical Education.

8. Thoughts on research training to our postgraduates.

Dr. Varghese Punnoose: The research training has no uniformity across the country. The emphasis on the long case in psychiatry is perhaps the only unifying aspect. I would like to make the following suggestions:

a) More objectivity should be brought in the division and award of marks in the practical examination so that the candidate should not be a victim of the examiner idiosyncrasies.

Dr. Kannan: All over the world, there is a shift from case presentation and other unstructured methods like viva to continuous performance evaluation protocols and OSCE settings for assessing the achievement of competency in medical training. The key to the accurate implementation of OSCE is the simulated patient. Trained actors or recruited patients are used for this purpose. Similarly, examiners must also be familiarised with OSCE protocols.

Unstructured examination settings like case discussion can provide an index of the depth of clinical knowledge of a candidate in a particular case, while OSCE can be used to compare the performance of different candidates in the same setting. Conventional examination patterns may be suited for postgraduate examination, whereas OSCE is better suited for undergraduate-level assessments. Soft skills like communication can be tested in OSCE settings. Balanced examination protocols with equal weightage for both unstructured and structured sections and a prescribed passing minimum in each section would be ideal. The long case and viva can constitute the unstructured section. Spotters may be incorporated into the viva or eliminated. The short case can be incorporated into the OSCE with at least 10 stations allowing competencies in multiple domains to be tested.

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8. Thoughts on research training to our postgraduates.

Dr. Varghese Punnoose: The research training...
be a research methodology training workshop after the first 3 months of PG training; then only the candidates should be required to submit their protocol. There should be ongoing supervision of the research project.

**Dr. Kannan:** There is an increased focus on research as part of training in postgraduation. In addition to thesis work, presentation in conferences and publications has been made mandatory. Training in basic sciences also includes biostatistics. Additional training in statistics and statistical software could be provided in a workshop format to all trainees. Departments must have regular research review meetings to monitor progress and provide inputs.

**Dr. Ashok:** Overall, the structure is adequate because of the dissertation. Only a few institutions have courses on research methodology, ethics of research, and so on around the time of synopsis submissions. IPS can step in here and make such for a more widely available. Protocols with timelines for the dissertations should be developed by each department to reduce chances of late submissions. Taking part in another study may be encouraged. Students should be encouraged to publish their own dissertation data without waiting for final examinations.

9. **The number of faculties has been reduced by the MCI. Colleges are sticking to the minimum standard. How is it affecting the functioning?**

**Dr. Varghese Punnoose:** The managements (including government) make sure that the faculty should not exceed the minimum stipulated by MCI. Any additional faculty is considered as a luxury. In psychiatry, the most important resource needed for training is experienced faculty. The quality of psychiatric services and training can be ensured only if adequate faculties are there to provide quality services (clinical and teaching). So the number of faculty should be revised depending on the workload – the number of out-patients (OP), in-patients (IP) strength, consultation work, specialty clinics, medico-legal work, teaching activities, and research projects. This important point has to be driven to the decision-makers in MCI/managements/governments.

**Dr. Kannan:** The number of minimum faculty required for UG and PG courses has been decreased for all specialities. The justification cited is that this is inevitable in view of staff shortage in the country. The implementation of these changes at a time when the flow of specialists is increasing raises doubts about lobbying by private medical training centers. Adverse staffing ratios will definitely impact on both patient care and level of supervision and training. Emphasis on quantity and dilution of norms will definitely lead to erosion of quality.

**Dr. Ashok:** The minimum standards are with regard to teacher–student ratios. This is necessary to increase mental health professionals. However, the teachers can use this opportunity to emphasize more detailed assessments and discuss them, as there would be more residents in the department. With more working residents, the department can organize more postings for them in places where complementing facilities are available (outside the campus). Otherwise, the model of doing minimal clinical work (with more residents) and just reading from books will get strengthened inadvertently.

10. **Having a separate psychiatry paper in MBBS; will it help doctors take up psychiatry as postgraduation and change the mental health treatment scenario in the country?**

**Dr. Varghese Punnoose:** Psychiatry should be a separate paper in the MBBS curriculum with a separate examination – theory and practical. The posting in psychiatry in UG course should be at least 6 weeks. Till such decisions are taken by the MCI, the following interim measures can be considered:

a) In addition to the existing 2 weeks’ training in the 4th semester, an additional 2 weeks’ training may be given in the 7th semester

b) Vertical integration with physiology, community medicine, forensic, pediatrics, and pharmacology lecture classes in the respective semesters

c) At least four general clinics in the final year

d) Minimum 80% attendance in psychiatry posting (for all specialty postings) should be mandatory to appear for university examination

e) The marks obtained in the end posting examination in the 4th semester and the 7th semester should be considered for calculating the internal assessment mark in general medicine.

**Dr. Kannan:** This issue has been discussed *ad hominem*, and there is no doubt that including a separate paper for psychiatry is definitely required. The same has been recommended by many authors. The recently revised MBBS curriculum for 2019 does not make that shift; however, many common mental illnesses go undiagnosed. Primary care physicians trained in psychiatry are the way forward. Greater exposure to psychiatry during undergraduate will kindle interest in some students to take up the field.

**Dr. Ashok:** This is an ongoing issue. A report on undergraduate (UG) psychiatry training held under
national IPS is being prepared. By and large, there is a need to actively engage UGs in psychiatry training, and much depends on the available faculty and their skill sets. By encouraging the UG teachers of psychiatry group that has been evolving, IPS can build a bottom-up support for training UG teachers in carrying out their training roles more effectively.

CONCLUDING REMARKS

Many important aspects of psychiatry training in India have been covered in the discussions.

- To give importance to psychosocial assessment and management along with the growing interest in neurobiology
- Child psychiatry training needs improvement
- Descriptive psychopathology and interviewing skills should not be sidelined
- There seems to be still some scope to continue with DPM course
- MCI regulations and requirements should be more practical
- Neurology training of psychiatry postgraduates is on the decline
- There is a need for continuous assessment
- Research training has to be enhanced
- A separate paper of psychiatry for MBBS would help in providing better mental health services.

Our training program needs to be constantly evaluated and improved in view of the constant changes in social, economic, legal, and technological areas. Rules when formed should include all major stakeholders especially the teachers. Evaluation needs to be more structured and objective. A uniform pattern of training and examination for the entire country would remove many inequalities.

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