"This prospectus is made under the provisions of the Universities Act, the Postgraduate Institute of Medicine Ordinance, and the General By-Laws No. 1 of 2016 and By-Laws No. 2 of 2016 for Degree of Doctor of Medicine(MD) and Board Certification as a Specialist"

POSTGRADUATE INSTITUTE OF MEDICINE
UNIVERSITY OF COLOMBO, SRI LANKA

PROSPECTUS

MD PSYCHIATRY
AND
BOARD CERTIFICATION
IN PSYCHIATRY

2013

BOARD OF STUDY IN PSYCHIATRY

Contents

PROSPECTUS-DOCTOR OF MEDICINE (MD) IN PSYCHIATRY

1. INTRODUCTION AND JUSTIFICATION FOR AMENDMENTS

The Board of Study in Psychiatry of the Postgraduate Institute of Medicine (PGIM) will conduct a training programme in psychiatry and an examination, the Doctor of Medicine (MD) in Psychiatry examination. The successful completion of this programme will lead to board certification as a specialist in psychiatry in Sri Lanka. This prospectus provides information regarding the regulations and guidelines formulated by the PGIM and the Board of Study (BoS) in Psychiatry pertaining to the structure of this training programme and the examinations.
The previous prospectus dates from 2008 and is in need of revision. Three batches of students have been trained under this prospectus and in the light of experience gained the BOS in Psychiatry has felt it necessary to introduce changes to update and enhance the effectiveness of the programme.

2. TRAINING OUTCOMES

The training outcomes expected of the trainee is competence in the following roles.

1. Medical expert – The trainee should have knowledge and understanding of the basic and clinical sciences relevant to psychiatry and the necessary skills and ability to recognise and manage a wide range of psychiatric disorders in a variety of clinical contexts. They should know the principles of psychiatric rehabilitation and management of mental health problems in the community.

2. Communicator – The trainee should be able to listen effectively, convey to patients and families an accurate and coherent understanding of their illness, discuss appropriate information with health care teams and prepare accurate documents.

3. Collaborator – The trainee should be able to consult effectively with other psychiatrists and health care professional, teach colleagues and learn from them. They should be able to work collaboratively with other members of the multidisciplinary team and facilitate the learning of patients, students and other mental health care professionals.

4. Health Advocate – The trainee should be aware of the structures of governance (regional, national and international) in mental health care. They should be able to identify and understand the determinants of mental health as it affects patients and communities. They should be able to work with relevant health care services and other agencies to promote mental health and mental wellbeing of communities and prevent mental illness.

5. Manager – The trainee should be able to make effective use of resources to optimise patient care. They should be able to prioritize their work and manage their time effectively. They should be able to coordinate, manage and provide leadership to a multidisciplinary team.

6. Scholar – The trainees should be able to commit to lifelong learning, be able to critically appraise medical literature and information , help others learn and give constructive feedback. They should be aware of research principles and their application in clinical practice.

7. Professional – The trainees should show integrity, compassion and respect diversity. They should know the medical, legal and professional obligations of a psychiatrist and be responsible, dependable and punctual. They should accept constructive feedback, be aware of ethical principles. They should have self-awareness of personal limitations and be able to take appropriate action to overcome or correct these limitations.

3. TRAINING CONTENTS/CURRICULUM

The content of the curriculum for the Selection Examination is given in **Annexure 1**.
The details of the training program are given in **Annexure 2**.

4. DURATION OF THE TRAING PROGRAMME

4.1 – Pre-MD. The duration of training shall be 36 months.
4.2 – Post MD. The minimum duration of training shall be 24 months.

5. ELIGIBILITY CRITERIA

Prospective applicants who intend to join the MD (Psychiatry) training programme must satisfy the following requirements:

(a) A medical degree registered with the Sri Lanka Medical Council*

(b) Satisfactory completion of internship acceptable to the Sri Lanka Medical Council

(c) Satisfactory completion of one year of post-internship service in a university/public sector/private sector institution in Sri Lanka acceptable to the PGIM

(d) The criteria prescribed in paragraph (a) to (c) must have been satisfied by the applicant at the date of closure of applications for the selection examination in psychiatry.

(e) Where a shortfall has occurred due to any reason including sickness, maternity or other leave, the applicant should complete such shortfall to become eligible to apply for the selection examination in psychiatry.

(f) Any other requirements stipulated by the Board of Study in Psychiatry that have been approved by the Board of Management (BoM) of the PGIM

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* Sri Lankans in the non-state sector will be selected based on "Guidelines for enrolment of non-state sector candidates for training programmes - 2011. The decision of the Board of Management will be final in all such applications. The quota for the non-state sector is determined for each year by the BOS and same will be included in the advertisement.

Foreign nationals who seek to apply to register for the selection examination should possess a medical degree registrable with the Sri Lanka Medical Council. They will be selected based on "Guidelines for enrolment of non-state sector candidates for training programmes - 2011. The decision of the Board of Management will be final in all such applications.

6. MD (PSYCHIATRY) SELECTION EXAMINATION

6.1. Introduction

Successful completion of the MD (Psychiatry) selection examination is the requirement needed to be considered for entry into the training programme in psychiatry.
The content of the curriculum is given in **Annexure 1**

6.2. Examination Format

The selection examination shall consist of the following components

1. A Multiple Choice Question (MCQ) paper consisting of sixty (60) questions five (five responses each of the multiple true false type to be answered in two hours). There will be negative marking within each question. Of a maximum mark of 300 only candidates who obtain a minimum of 150 marks (50%) will be eligible to sit the structured essay paper.
2. A Structured Essay Question (SEQ) paper consisting of 10 questions to be answered in three hours. Each question will be marked by two examiners independently.

6.3. Requirements to Pass the Selection Examination

Candidates who obtain minimum of 50% in each component ie, the MCQ paper and SEQ Paper will be considered to have successfully completed the MD (Psychiatry) selection examination. However, the number of training placements available each year shall be decided by the PGIM and included in the relevant circulars.

6.4. Number of attempts

The number of attempts allowed for a candidate to sit the MD (Psychiatry) selection examination will be in accordance with the general regulations of the PGIM.

6.5. Exemptions from the selection examination

Candidates who possess a postgraduate qualification in psychiatry awarded by a foreign university or professional body recognized by the Board of Study **with certification to practice as a consultant** (CCST) by the relevant regulatory council or professional body may apply to the Director, PGIM with supporting documentation seeking exemption from the selection examination. The BoM, PGIM may grant such exemption on the recommendation of the Board of Study in Psychiatry for such applicants to be enrolled for training, subject to the general rules and regulations of the PGIM governing lateral entry to training programmes (See Section 4.7)

6.6. Out of those who have passed the selection examination candidates will be enrolled into the MD (Psychiatry) training programme based on their merit position in the selection exam and the number of training opportunities available.

7. THE MD (PSYCHIATRY) TRAINING PROGRAMME-

STAGE 1 - PRE MD TRAINING AND COMPLETION OF MD (PSYCHIATRY) EXAMINATION

7.1. Overview

Stage I of the training programme comprises 36 months of structured, supervised basic specialty training leading to the MD (Psychiatry) examination.

Training will be provided through registrar placements in training centres including the National Institute of Mental Health, psychiatry units of the NHSL, general hospital psychiatry units and university psychiatry units which have been approved by the Board of Study in Psychiatry.

7.2. Allocation of trainees

Allocation of trainees to training units will be at the discretion of the Board of Study in Psychiatry which will appoint an allocation sub-committee for this purpose. The training placements will be decided by the Board of Study where service needs and the availability of placements will be taken into consideration. In allocating placements, the primary consideration will be the order of merit at the MD (Psychiatry) selection examination.

7.3. Structure of Training

The training programme consists of:

Year 1: Training in General Adult Psychiatry - 12 months

Year 2: Training in General Adult Psychiatry - 6 months
Training in Child Psychiatry - 3 months
Training in Forensic Psychiatry - 3 months

Year 3: Training in General Adult Psychiatry and other subspecialties- 12 months

The opportunities for training in the subspecialities mentioned below will be provided in the third year of training while the trainees are undergoing their training in general adult psychiatry placements, based on set educational guidelines and objectives of that subspecialty:

Addiction Psychiatry
Community and Rehabilitation Psychiatry
Liaison Psychiatry
Old Age Psychiatry
Psychotherapy

Neurology-The trainees would be released for a period of 2 weeks from their general adult psychiatry placements during the third year.

7.4. Requirements in training

7.4.1. Training requirements

A trainee should complete the specified duration of training given below.

i. Training at the National Institute of Mental Health - 6 months
ii. Training in a general hospital/NHSL psychiatry unit - 6 months
iii. Training in Child Psychiatry - 3 months
iv. Training in Forensic Psychiatry - 3 months

A trainee would be considered to have successfully completed a training placement by fulfilling the 80% attendance requirement and when the trainee is certified by the

supervising consultant has having performed satisfactorily during the placement in the Record of Training.

7.4.2. Attendance requirements

Trainees are required to fulfil the PGIM requirement of 80% attendance in each major component of training, i.e. General Adult Psychiatry, Child Psychiatry and Forensic Psychiatry for the successful completion of Stage I of the training programme.

7.4.3. Leave of absence

Trainees, who wish to avail themselves of an extended period of leave, including sick, maternity or other leave, are required to inform the Board of Study in Psychiatry and obtain approval for such leave at the earliest available opportunity.

Trainees availing themselves of such leave will be required to fulfil the PGIM requirement of 80% attendance in each major component of training, i.e. General Adult Psychiatry, Child Psychiatry and Forensic Psychiatry and any other component as determined by the BOS, to be considered as having successfully completed Stage I of the training programme.

7.4.4. Exemptions from Stage I of the training programme

7.4.4.1. Diploma in Psychiatry

All postgraduate diploma holders in psychiatry who wish to enter the MD (Psychiatry) training programme must pass the selection examination in psychiatry.

Those who have completed four years of service after obtaining the Diploma in psychiatry and who have been successful in selection examination in psychiatry, will be required to undergo only 24 months of training in Stage I out of which **6 months** will be in General Adult Psychiatry. They will need to fulfil the other compulsory requirements as set out in Section 7.4.

7.4.4.2. Other post-graduate qualifications in Psychiatry:

Candidates who possess a post-graduate qualification in Psychiatry and CCST recognized by the Board of Study and who have obtained an exemption from the MD (Psychiatry) selection examination under Section 6.5 will be required by the Board of Study to undergo a specified period of training, depending on their training and experience, subject to the general PGIM guidelines, to be considered eligible to sit the MD (Psychiatry) examination.

8. PERIODIC APPRAISALS (Pre MD Training Programme)

8.1. Progress Reports

At the conclusion of each placement including placements in the subspecialties, the supervising consultant shall complete a Progress Report for the trainee, indicating whether the trainee has satisfactorily completed that placement.

Areas of concern regarding the trainee, if any, which would include any leave of absence from the training programme, should also be recorded. If the supervisor is not satisfied

with the trainee's performance, this should be referred to the Board of Study for appropriate action.
The trainee shall submit the Progress Reports from all training placements to the PGIM within two weeks of completion of each placement. Progress reports of all placements must be submitted to the PGIM prior to sitting the MD examination.
In the event that one or more progress reports are not satisfactory, trainer should bring this to the attention of the BoS with suggestions for remedial actions. The Board shall decide on the course of action subject to the general guidelines of the PGIM.
Please see annexure 3 for specimen form

8.2. OSCE Examination

After the first 12 months of training in Stage I, trainees will be required to sit an Objective Structured Clinical Examination (OSCE). Trainees are required to obtain a pass grade (a minimum of 50% marks) in the OSCE to be eligible to sit the MD (Psychiatry) examination. The OSCE examination will be conducted approximately at 6 monthly intervals.

8.3. Case book

The trainee should submit a case book of ten case discussions on patients seen during the first 24 months of training. The case book should be submitted for assessment 12 months before the date of the MD examination and will be assessed by an examiner appointed by the Board of Study in Psychiatry. Acceptance of the case book by the BoS is a prerequisite to sit the MD (Psychiatry) examination.

Please see annexure 4: Guidelines for preparation of the case book

9. THE MD (PSYCHIATRY) EXAMINATION

9.1. ELIGIBILITY

Applicants who have satisfied the following requirements will be considered as eligible to sit the MD (Psychiatry) examination:

(a) Satisfactory completion of Stage I of the training programme with satisfactory progress reports and attendance acceptable to the BoS.
(b) A pass grade at the OSCE examination
(c) Acceptance of the case book

The above criteria must be satisfied before the date of closure of applications for the MD (Psychiatry) Examination

9.2. Examination Format

The MD (Psychiatry) examination shall consist of the following components:
The total marks of the examination shall be 1000 marks of which 400 marks will be for the theory component and 600 marks will be for the clinical component. The pass marks will be minimum of 50% for the theory (200 Marks) and for the clinical (300) components separately.

Theory component

9.2.1 A Multiple Choice Question (MCQ) paper : 200 marks
9.2.2 A Structured Essay Question(SEQ) paper :150 marks
9.2.3 An essay paper (choice of one out of three questions; one hour) : 50 marks

The MCQ paper will consist of 60 questions of five responses each of the multiple true false type to be answered in two hours. There will be negative marking within each question.

The SEQ paper will consist of 10 questions to be answered in three hours. Each question will be independently marked by two examiners.

In the Essay paper the candidate will be required to write an essay on one out of three given topics during one hour. The marking will be done independently by two examiners.

Clinical component:

9.2.4 One long case : 300 marks
9.2.5 Two short cases : 200 marks
9.2.6 Viva voce examination on patient management problems : 100 marks

Long Case

The candidate is allowed one hour with the patient and is required to take a history, carry out a mental state examination and a relevant physical examination. The candidate is examined thereafter for 30 minutes. The examination panel will consist of two examiners.

Short Cases

The candidate assesses two patients (15 minutes for each patient) and is then examined for 30 minutes. The examination panel will consist of two examiners.

Viva Voce examination

The viva will be of 20 minutes duration and will consist of Patient Management Problems (PMP's). The examination panel will consist of two examiners.

9.3. Requirements to Pass the MD Examination:

The trainee should obtain a minimum of 50% marks from each of the two components (i.e. theory component and clinical component) to pass the MD (Psychiatry) examination.

9.4. Examiners

Every component will be examined by two examiners, either local and foreign or both local.
Examiners will be selected by the BoS in psychiatry.

9.5. Number of attempts

General PGIM regulations, subject to amendments periodically, will apply with regard to the maximum number of attempts allowed to a trainee at the MD (Psychiatry) examination. At present it is six attempts within a period of eight years from the first attempt.

9.6. The Professor Andrew Sims gold medal

The candidate obtaining the highest mark at the first attempt of the MD (Psychiatry) examination will be awarded the Professor Andrew Sims gold medal, provided the candidate obtains a minimum total mark of 65% at the examination. The gold medal shall be awarded only to a candidate sitting MD (Psychiatry) examination for the first time.

10. THE POST MD (PSYCHIATRY) TRAINING PROGRAMME- STAGE II

10.1. OVERVIEW

The trainees who pass the MD (Psychiatry) Examination will be eligible to receive the MD (Psychiatry) degree. They will be eligible to continue in to the rest of the training programme ending up in Board Certification as a specialist in Psychiatry.
OR
They may select to follow one of the programme in the following subspecialities

Child and adolescent psychiatry	-3 years
Forensic Psychiatry	-3 years

Please refer to the relevant Stage II prospectus of the relevant subspeciality for details.
Stage II of the training programme comprises of further structured, supervised higher specialty training and the submission of a dissertation and a portfolio leading to Board Certification.
Training will be provided through senior registrar placements in training centres including the National Institute of Mental Health, NHSL/ general hospital psychiatry units, university psychiatry units and other recognized overseas training centres which have been approved by the Board of Study in Psychiatry and recommended to the Board of Management for accreditation as training units.

10.2. ALLOCATION OF TRAINEES

Allocation of trainees to training units will be at the discretion of the Board of Study in Psychiatry which will appoint an allocation sub-committee for this purpose. The training placements will be decided by the Board of Study where service needs and the availability of training placements will be taken into consideration. In allocating placements, the primary consideration will be the order of merit at the MD (Psychiatry) examination. Training placements will be for a period of one year each.

10.3. STRUCTURE OF TRAINING:

Training for senior registrar trainees in Stage II of the training programme will be structured as follows:

(a) one year of training in General Adult Psychiatry in Sri Lanka
(b) one year of training in General Adult Psychiatry overseas or in Sri Lanka

The option to do the 2nd year in Sri Lanka is also available. In the event of a trainee opting to undertake the entire period of training of Stage II in Sri Lanka, the trainee should inform the Board at the end of twelve months of training at the latest that this option is being pursued. In such an event the trainee will be allocated a different training centre for the second year of training.

10.4. Requirements in training

Please see **Annexure 5**

10.4.1. Minimum training requirements

Trainees specialising in Psychiatry who opt to complete the entire Stage II of the training programme in Sri Lanka are required, during their second year of training, to satisfactorily complete **one** of the following:

(a) Development of a new service component in relation to improvement of psychiatric services in Sri Lanka. The trainee needs to obtain prior approval of the BoS.
(b) Development of a new training module relevant to Psychiatry for undergraduate, Postgraduate Diploma or MD (Psychiatry) training programme.
(c) Publication of an research article or review article in a peer reviewed journal during Stage II of training.

10.4.2. Attendance requirements

A trainee would be considered to have successfully completed each training placement by fulfilling the 80% attendance requirement and is certified by the supervising consultant as having performed satisfactorily during the placement in the Progress Reports.

10.5. Portfolio

Upon starting Stage II training the trainees are required to maintain a portfolio. The portfolio will form the basis of the Pre-Board Certification Assessment (PBCA) that is a PGIM pre-requisite for Board Certification as a specialist (See Section 11.1).

Please see Annexure 5 for guidelines for preparing the Portfolio

10.6. Dissertation

All trainees in Stage II of the training programme are required to complete a research project and submit a dissertation based on the project. Prior to starting on their dissertations the candidates are required to submit a research project to the BoS. The Board will appoint an examiner for the protocol. The candidate should begin their research only after approval by the BOS.

The dissertation will be examined by a panel of two examiners appointed by the Board of Study in Psychiatry which may accept the dissertation, suggest suitable amendments before acceptance or reject the dissertation. Trainees should have their dissertations accepted by the Board of Study to be eligible to apply for Board Certification.

Please see Annexure 6 for Guidance on the preparation of a research project and Annexure 7 for Guidelines for writing of the dissertation

10.7. Progress Reports (Record of Training)

At the conclusion of each training placement in Stage II of the training programme, the supervising consultant shall complete a Progress Report for the trainee, indicating whether the trainee has satisfactorily completed that placement. Areas of concern regarding the trainee, if any, which would include any leave of absence from the training programme, should also be recorded. If the supervisor is not satisfied with the trainee's performance, this should be referred to the Board of Study early for appropriate action.

The trainee shall submit the Progress Reports from all training placements, two weeks after the completion of each placement. All progress reports must be submitted to the PGIM prior to application for Board Certification.

10.8. Leave of absence

Trainees, who wish to avail themselves of an extended period of leave, including sick, maternity or other leave, are required to inform the Board of Study in Psychiatry and obtain approval for such leave at the earliest available opportunity.

Trainees availing themselves of such leave will be required to fulfil the PGIM requirement of 80% attendance in each training placement to be considered as having successfully completed Stage II of the training programme.

11. BOARD CERTIFICATION

11.1. ELIGIBILITY

Prospective applicants must satisfy the following requirements

(a) Passed the MD (Psychiatry) examination
(b) Satisfactory completion of Stage II of the training programme, fulfilling the requirements set out in Section 10.4.
(c) Acceptance of the Dissertation
(d) Acceptance of the Portfolio

11.2. APPLICATION PROCEDURE

A trainee who has fulfilled all criteria listed in Section 11.1. may apply in writing to the Board of Study in Psychiatry seeking board certification as a specialist in Psychiatry

11.2.1. Portfolio Viva

Upon receiving such an application the Board of Study will appoint a panel of examiners who will schedule a Pre-Board Certification Assessment (PBCA) as required by the PGIM. Assessment of the trainee's portfolio at a viva will constitute the PBCA in Psychiatry.

The panel of examiners appointed by the Board of Study may accept the portfolio or suggest suitable amendments before acceptance.

11.2.2. Oral presentation

In addition to the portfolio viva the trainee should also make a presentation of 20-30 minutes duration to the BoS indicating the details of the Stage II training and his/her future vision in improvement of Psychiatric Services in Sri Lanka.

Upon successful completion of 11.2.1 and 11.2.2 above the Board of Study shall recommend to the BoM that the trainee be Board Certified as a Psychiatrist.

ANNEX 1
SYLLABUS FOR THE PSYCHIATRY SELECTION EXAMINATION

Questions could be set from areas outside those stated in these guidelines.

Neuroanatomy

1) The general anatomy of the brain and functions of the lobes and some of the main gyri including the prefrontal cortex, cingulated gyrus and limbic system. Basic knowledge of the cranial nerves and spinal cord
2) The anatomy of the basal ganglia.
3) The internal anatomy of the temporal lobes, i.e hippocampal formation and amygdala.
4) The major white matter pathways, e.g. corpus callosum, fornix, Papez s circuit, and other circuits relevant to integrated behaviour.
5) The types of cell found within the nervous system.
6) The major neurochemical pathways, including the nigrostriatal , mesolimbic and mesocortical dopamine pathways, the ascending noradrenergic pathway from the locus coeruleus, the basal forebrain cholinergic pathway, the brain stem cholinergic pathway, the corticofugal glutamate system and serotonin pathway.

Neurophysiology

1) The basic concepts in the physiology of neurons, synapses and receptors, including synthesis, release, and uptake of transmitters. A basic knowledge of action potentials, resting potentials, ion fluxes and channels etc.
2) The physiology and anatomical pathways of the neural and endocrine systems involved in integrated behaviour including perception, pain, memory, motor function, arousal, drives (sexual behaviour, hunger, and thirst), motivation and the emotions, including aggression, fear, and stress,. Knowledge of disturbances of these functions with relevance to organic and non-organic (functional) psychiatry.
3) The development and location of cerebral functions throughout the life span from the foetal stages onwards and their relevance to the effects of injury at different ages to the brain and to mental function. An understanding of neurodevelopmental models of psychiatric disorders and of cerebral plasticity.
4) An understanding of the neuroendocrine system, in particular, the control of the secretion of hypothalamic and pituitary hormones (by releasing factors and by feedback control) and posterior pituitary function. A basic understanding of the main hormonal changes in psychiatric disorders and neuroendocrine rhythms and their disturbance in psychiatric disorders.
5) A basic knowledge of the physiology of arousal and sleep and particular references to noradrenergic activity and the locus coeruleus.
6) The normal EEG (including frequency bands) and evoked response techniques. Their applications to investigation of cerebral pathology, seizure disorders , sleep and psychiatric disorders. The effects of drugs on the EEG.

Neurochemistry

1) Transmitter synthesis, storage and release, Ion channels and calcium flux in relation to this.
2) Knowledge of receptor structure and function in relation to the transmitters listed below. Presynaptic and post– synaptic receptors.
3) Basic pharmacology of noradrenaline, serotonin, dopamine, GABA, acetylcholine, excitatory amino acids.

4) Elementary knowledge of neuropeptides, particularly corticotrophin releasing hormone and cholecystokinin and the encephalin / endorphins.

Psychopathology

1) Descriptive Psychopathology.
2) The psychoanalytic theories of Freud, Jung and Klein with special reference to the structure of the mind, the process of development and responses to adversity.
3) Defense mechanisms in intra psychic and interpersonal terms.

Neuropsychology

Brain organization in relation to memory, language, perception.
Visuo-spatial ability and frontal lobe functions.

Psychological Assessment

Principles of measurement: scaling, ratios, norm - referenced and criterion - referenced approaches.
Intelligence: definition and components (general and specific abilities), concept of IQ and its stability, measurement of intelligence using specific tests. Cultural influences.
Overview of techniques in neuropsychological assessment with particular reference to clinical practice.

Psychopharmacology

General Principles

A brief historical overview of the development of psychotropic drugs. Their classification. Optimizing patient compliance. Knowledge of the placebo effect and importance of controlling for it. The principle of rational prescribing of psychoactive drug.

Pharmacokinetcs

General principles of absoption, distribution, metabolism and elimination. Particular reference to comparison of oral , intramuscular, and intravenous routes of administration as they affect drug availability. Elimination as they affect the life of the drug in the body and access to the brain through the' blood brain barrier'. Application of these to choice of administrative route and timing of doses.
Relationships between plasma drug level and therapeutic response: the possibilities and limitations of this concept with specific examples such as lithium, antidepressants and anticonvulsants.

Pharmacodynamics

Synaptic receptor complexity, main receptor sub types, phenomena of receptor up and down regulation.
The principle CNS pharmacology of the main group of drugs used in psychiatry with particular attention to their postulated modes of action in achieving therapeutic affect: at both molecular /synaptic and system levels.
These groups would include "anti-psychotic" agents, drugs
used in the treatment of affective disorder (both mood altering and stabilizing), anxiolytics, hypnotics and ant-epileptic agents.

Neurochemical effects of ECT.

Adverse Drug Reactions (ADRs)
Understanding of dose-related as distinct from "idiosyncratic" ADRs.
The major categories of ADRs associated with the main groups of drugs used in psychiatry and those associated with appropriate corrective action.

Evaluation of drugs
Research methodology for drug trials including principles of design, randomization, blindness, statistical power , duration, rating scales, exclusion criteria.

Statistics
Types of research study, observational and intervention studies. Case control, prospective, retrospective. clinical trials.
Sampling methods –simple random, stratified, cluster sampling,
Concepts of scale of measurement, frequency and probability distributions. Summary statistics and graphs, type of data eg; categorical, ordinal, continuous.
Descriptive statistics-mean, median, mode, standard deviation, proportions, variance, normal distribution
Inferential statistics. Hypothesis testing, type 1 and type 11 errors. Significance tests, estimation and confidence intervals. The advantage of confidence intervals over p values. Odds ratio, relative risk, sensitivity, specificity
Specific tests; Parametric and non parametric tests, particularly t-tests, chi– square test, correlation, ANOVA, confidence intervals for difference between means, and medians.
Clinical trials – Basic design of RCT, the advantages of randomized trials, interpretation of findings
A brief introduction to more complex methods such as factor analysis - no more than a description of what the techniques aim to achieve.
Problems of measurement in psychiatry, use of scales. Validation.
Ideas of reliability and validity, sensitivity, specificity and predictive values of research measures. Bias.
Basic principles of systematic review and metanalysis.
Qualitative research techniques
Principles of Evidence Based Medicine

Basic Psychology

Learning theory: Classical, operant, observational and cognitive models. The concept of extinction and reinforcement. Learning processes and aetiological formulation of clinical problems, including the concepts of generalization, secondary reinforcement, incubation and stimulus preparedness. Escape and avoidance conditioning. Clinical applications in behaviuoral treatments. Reciprocal inhibition, habituation, chaining, shaping cueing. The impact of various reinforcement schedules. The psychology of punishment. Optimal conditions for observational learning.

Basic principals of visual and auditory perception:
Figure ground differentiation, object constancy, set and other aspects of perceptual organization. Perception as an active process. The relevance of perceptual theory to illusions, hallucinations, and other psychopathology. The development of visual perception as an illustration of constitutional/ environmental interaction.

Information processing and attention. The application of these to the study of schizophrenia.

Memory: Influences upon and optimal conditions for encoding. Storage and retrieval. Primary/working memory storage capacity and the principle of chunking. Semantic, episodic and skills memories and other aspects of the organisation of long term/secondary memory. The process of forgetting. Emotional factors and retrieval. Distortion, inference, schemata and elaboration in retrieval. The relevance of this memory disorders and their assessment.

Thought: The possible relationship with language. Concepts, prototypes and cores. Deductive and inductive reasoning. Problem solving strategies, algorithms and heuristics.

Personality: derivation of nomothetic and radiographic theories. Trait and type approaches and elementary personal Construct theory. Resume of principles underlying psychoanalytic and humanistic approaches. The interactionist approach. Construction and use of inventories, rating scales, grids and Q– sort.

Motivation: needs and drives. Extrinsic theories (based on primary and secondary drive reduction) and homeostasis. Hypothalamic systems and satiety. Intrinsic theories , curiosity and optimal levels of arousal. Limitations of each approach and attempts to integrate. Cognitive consistency: Need for achievement, Maslow's hierarchy of needs.

Emotion: components of emotional response. Critical appraisal of James– Lange and Cannon-Bard theories. Cognitive appraisal, differentiation and the status of primary emotions. Emotion and performance.

Stress: physiological and psychological aspects. Situational factors: life events, daily hassles/uplifts, conflicts mad trauma. Vulnerability and invulnerability, type A behaviour theory. Coping mechanisms, Locus of control, learned helplessness and earned resourcefulness.

States and level of awareness: level of consciousness and evidence for unconscious processing. Arousal, attention and alertness. Sleep structure and dreaming. Parasomnias. Biorhythms and effects of sleep deprivation. Hypnosis and suggestibility. Meditation and

Social Psychology

Attitudes : components and measurement by Thurstone, Likert and semantic differential scales. Attitude change and persuasive communication. Cognitive consistency and dissonance. Attitude– behaviour relationships.

Self psychology: self concept, 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' as it might apply to pervasive developmental disorders. Elemental linguistics as applied to interpersonal communication.

Leadership, social influence, power and obedience. Types of social power. Influence operating in small and large groups or crowds: conformity , polarization and 'groupthink '. Deindividuation. Communicative control in relationships.

Aggression: explanations according to social learning theory. Operant conditioning. Ethology, frustration and arousal concepts. The influence of television and other media. Family and social backgrounds of aggressive individuals.

Altruism. social exchange theory and helping relationships. Interpersonal co-operation.

Human development

Basic frameworks for conceptualizing development: nature and nurture, stage theories, maturational tasks. Possible definitions of maturity. Examination of gene environment interactions with specific reference to intelligence. Relative influence of early versus later adversities. The relevance of developmental framework for understanding the impact of specific adversities such as traumata. Very brief mention of historical models: Freud and general psychoanalytic. Social learning, Piaget.

Methodology of studying development: cross sectional, cohort and individual studies. Identification and evaluation, of influences.

Bowlby attachment theory and its relevance to emotional development, affect regulation and human relationships in childhood and later on. Conditions for secure attachment. Types and clinical relevance of insecure attachment. Early separation and its consequences. Consequences of failure to develop selective attachments. Brief consideration of neonatal maternal 'bonding'.

Cognitive development with critical reference to Piaget's model. The relevance of pre-operational and formal operational thought to communication with children and adults.
Basic outline of language development in childhood with special reference to environmental influences and communicative competence.

Development of social competence and relationships with peers: acceptance, group formation, co-operation. Friendships, isolation and rejection. The components of popularity.
Moral development with critical reference to Kohlberg's stage theory. Relationship to development of social perspective taking Development of fears in childhood and adolescence with reference to age. Possible aetiological and maintenance mechanisms.

Sexual development including the development of sexual identity and preferences.
Death and dying.

Genetics
Basic concepts: chromosomes, cell division, gene structure, transcription and translation, structure of the human genome. Patterns of inheritance.
Conditions associates with chromosome abnormalities.
Genetic studies– traditional techniques: *family*, twin and adoption studies.
Techniques in molecular genetics: restriction enzymes, molecular cloning and gene probes. Southern blotting, restriction fragment length polymorphisms, recombination.
Distinction between direct gene analysis and gene tracking. Genetic markers. linkage studies.
Principal inherited conditions encountered in psychiatric practice and the genetic contribution to specific psychiatric disorders.
Prenatal identification. Genetic counseling. The organisation of clinical genetic services.
DNA banks.

Medicine in relation to psychiatry

Neurology in relation to Psychiatry

Head injury- acute effects, chronic sequelae, cognitive impairment, change in personality,
Cerebral tumors-pathology clinical features, psychiatric symptoms, investigation
Cerebrovascular accidents, - Subarachnoid haemorrhage, subdural haematoma, vasculitis
The neuropathology of schizophrenia.
Conditions associated with mental retardation including autism.

Movement disorders- including detailed knowledge of Parkinson's disease. Huntington disease and the neurochemical pathology of the tardive dyskinesias. dystonias, Gilles de la Tourette's syndrome
Association between the localisation of gross cerebral lesions and clinical signs.– disorders of memory, language, apraxias and related executive disorders, agnosias and related disorders of perception, disorders of body image, regional brain dysfunction.

Neuro imaging techniques : X– ray, CT, PET, SPECT and MRI.

Intracranial infections– syphilis, encephalitis, meningitis, cerebral abscess, psychiatric presentations of HIV infection.

Epilepsy- classification of epilepsy, aura, complex partial seizures, post ictal disorders, investigation and treatment of epilepsy- EEG

Delirium- investigation and treatment
Narcolopsy and other Sleep disorders

Multiple sclerosis, neurofibromatosis, motor neurone disease, myasthenia gravis,

Endocrinology
-hyperthyroidism, hypothyroidism, Cushing's syndrome, Addisons disease, Phaeochromocytoma, hyperprolactinaemia, hypopituirism, diabetes mellitus, diabetes insipidus, hyper and hypoparathyroidism

Basic psychopharmacology of tobacco, alcohol, amphetamine, cocaine, hallucinogens, solvents, ecstacy and related substances, benzodiazepines, barbiturates and opiates.

Medical and psychiatric complications of alcohol and other psychoactive substance use. Management of poisoning

Management of the unconscious patient.

Diabetes Mellitus

Hypertension

Metabolic syndrome

SLE
Liver failure, renal failure
Ischaemic heart disease, arrhythmias- clinical features investigation and treatment

Suggested Reading

Basic sciences
Sciences Basic to Psychiatry—Basant K.Puri, Peter Tyrer

Neuroanatomy
Snell

Neurophysiology
Ganong

Pharmacology
Essential Psychopharmacology - Stephen M. Stahl 3rd Edition

Medicine/Neurology
Clinical Medicine- Kumar & Clark

Psychiatry
Oxford Textbook of Psychiatry

Organic Psychiatry *–The Psychological Consequences of Cerebral Disorders* W.A. Lishman, Third Edition, Blackwell Science

Psychopathology
Fish's Clinical Psychopathology
Symptoms in the mind - Andrew Sims

Statistics
Statistics at square one - TDV Swinscow

Psychology
Introduction to Psychology - Atkinson & Atkinson

ANNEX 2
SYLLABUS FOR THE MD IN PSYCHIATRY EXAMINATION

Objective 1 - Psychiatric disorders

Knowledge
The trainee should know in detail the epidemiology, aetiology, clinical features, treatment and prognosis of the following.

- Dementia, delirium and other neuropsychiatric disorders
- Disorders due to reactions to stressful experiences
- Anxiety and obsessive-compulsive disorders
- Somatoform and dissociative disorders
- Mood disorders
- Schizophrenia
- Delusional Disorders
- Personality disorders
- Eating and sleep disorders
- Substance use disorders including alcohol
- Suicide and deliberate self-harm

Skills
The trainee should be able to:

- Take a comprehensive psychiatric history
- Perform a diagnostic mental state examination
- Do a screening neurological examination
- Develop an appropriate ICD 10 differential diagnosis
- Do a case formulation
- Plan relevant laboratory and imaging investigations.
- Make a comprehensive treatment plan incorporating biological, psychological and social aspects.
- Collaborate with other mental health professionals and primary health care team including general practitioners in providing continuous care for patients needing long term treatment
- Implement strategies to enhance treatment compliance

Objective 2 - Risk assessment and management

Knowledge
The trainee should know involuntary treatment standards and procedures, methods of minimizing and preventing risk.

Skills
The trainee should be able to assess a patient's potential for harm to self and others.

Objective 3 - Psychological aspects of Management

Knowledge
The trainee should know the principles of:

- Communication skills

- Supportive psychotherapy
- Problem solving
- Breaking bad news

Skills
The trainee should be able to carry out therapeutic interviews using communication skills, supportive and problem solving therapy skills.

Objective 4 - Pharmacological aspects of Management

Knowledge
The trainee should know the psychopharmacology of the:

a. antidepressants
b. antipsychotics
c. anxiolytics
d. mood stabilizers
e. hypnotics
f. stimulants
g. drugs used in dementia

The trainee should know the:

a. pharmacological actions
b. clinical indications
c. side effects
d. drug interactions
e. toxic effects
f. appropriate doses and prescribing practices
g. cost- effectiveness

Skills
The trainee should be competent in pharmacotherapy.

Objective 5 - Electroconvulsive therapy (ECT)

Knowledge
The trainee should know the theory, background and practical aspects of ECT

Skills
The trainee should be competent in ECT and be able to:

- Prepare patients for ECT
- Explain to patients and relatives about ECT and administer ECT without direct supervision
- Monitor a patient's mental state and cognitive functioning during a course of ECT

Objective 6 – Management of psychiatric emergencies

Knowledge
The trainee should know the causes of violent behaviour be able to formulate a differential diagnosis of such situations and be knowledgeable of methods to contain and manage such behaviours.

Skills
The trainee should be competent in managing problems related to attempted suicide, homicide and violent behaviours.

Objective 7 – Addiction psychiatry

Knowledge
The trainee should know:

- The pharmacological actions of alcohol and other substances of abuse, the symptoms of toxicity and withdrawal, principles of treatment and prevention.
- Other strategies used in public health sector for prevention and harm minimisation.

Skills
The trainee should be able:

- To manage toxicity and withdrawal effects of alcohol and other substances of abuse
- To use non pharmacological strategies such as motivational interviewing and cognitive behaviour therapy in changing substance use behaviours

Objective 8 – Neuropsychiatry

Knowledge
The trainee should know the:

- Pathophysiology, epidemiology, diagnostic criteria, and clinical course for common neurological disorders.
- The pharmacology of major medications used in neurology such anticonvulsants and antiparkinson agents.

Skills

- The trainee should be able to diagnose common neurological problems such as Parkinson's disease, stroke, dementia, and epilepsy.
- They should be able to identify neurological symptoms of psychiatric disorders and psychiatric symptoms of common neurological disorders
- They should be able to identify common abnormalities in an EEG.

Objective 9 – Consultation Liaison Psychiatry

Knowledge
The trainees should have relevant knowledge in general medicine, neurology and psychiatry

Skills
The trainee should be competent in managing the following.

- Delirium/dementia and other psychiatric disorders with organic causation;
- Somatisation;
- Depression and anxiety in medically ill patients;
- Suicide/self-harm (with special emphasis on the management of a medical unit issues);
- Addiction problems in medical settings;
- Abnormal illness behaviour in somatically ill patients;
- Coping with chronic disease and terminal illness;

- Chronic pain;
- Puerperal disorders
- Sexual dysfunction in medically ill patients, and sexual abuse in specific patient populations (e.g., somatoform disorder and chronic pain);
- Management of patients with psychiatric disorders (e.g., psychotic and bipolar) in need of medical/surgical treatment.

The trainee should be able clearly communicate the findings and the management plan to the other health professionals involved in the treatment.

Objective 10 - Forensic Psychiatry

Knowledge
The trainee should have knowledge of
- The role of the forensic psychiatrist, crime & mental disorder, criminal justice system, psychiatry in prisons, psychiatry & civil law, mental health legislation, ethical issues
- Criminal behaviour with regard to nature & classification of crime, homicide, child abuse and sexual offences
- Mental disorder related to crime including schizophrenia, affective disorders, antisocial personality disorder, mental retardation, organic mental disorders and substance use disorders and special issues of morbid jealousy, infanticide and malingering

Skills
- Assessment of risk
- Ability to minimize risk
- Conduct a forensic evaluation:
  Fitness to plead
  Fitness to stand trial
  Criminal responsibility
  Testamentary capacity
- Assimilate information from various sources including lay informants, medical and legal personnel
- Evaluate relevance and judge reliability of information
- Communicate in written format using non-technical words

Objective 11 – Child and Adolescent Psychiatry

Knowledge
The trainee should have the knowledge of the:
- Developmental milestones and the relevance of developmental stage in psychiatric assessment
- Impact of psychiatric conditions on development of children and adolescents
- Services available that are involved in provision of services to children in general and for children with special needs

Skills
The trainee should be able to:
- Assess children and adolescents using various methods
- Assess developmental stage, mental age, cognitive level and scholastic skills.
- Involve the family in management

- Liaise with other team members and external agencies in delivering psychosocial management

Objective 12 - Rehabilitation Psychiatry

Knowledge
The trainee should know the principles of psychosocial rehabilitation.

Skills
The trainee should be able to:

- Obtain information from patients, their families and other relevant sources relevant to psychosocial functioning
- Assess a patient's strengths, disabilities, risks and vulnerabilities.
- Use structured tools used in the assessment of psychosis, disability, social function, quality of life and monitor change
- Apply in practice the principles of assessment of disability in primary and secondary impairment and tertiary handicap
- Assess change in social function and predict capability
- Rehabilitate a patient with mental illness

Objective 13 - Community Psychiatry

Knowledge
Trainee should know:

- The different models of community care
- Treatment settings in the community, which include ambulatory, consulting, acute care, partial hospital, skilled care, rehabilitation, and substance abuse facilities; halfway houses; nursing homes and home care; and hospice organizations.
- The organization of care in each relevant delivery setting

Skills
The trainee should:

- Have the ability to access community, national, and allied health professional resources to enhance the quality of life of patients with psychiatric illnesses
- Demonstrate the ability to lead and work within healthcare teams needed to provide comprehensive care for patients with psychiatric disease and respect professional boundaries
- Have skills for the practice of ambulatory medicine, including time management, clinical scheduling, and efficient communication with referring physicians
- Able to use appropriate consultation and referral mechanisms for the optimal clinical management of patients with complicated medical illness
- Be able to engage in prevention and mental health promotion

Objective 14 – Geriatric Psychiatry

Knowledge
The trainee should have the knowledge of the:

- Assessment and management of elderly people

- Significance of underlying medical conditions and their treatment in psychiatric manifestations and management
- Common social issues faced by elderly people
- Community resources available to provide services to elderly people

Skills
Trainees should be able to:
- Assess mental state and extended cognitive functions of elderly people
- Assess competency regarding specific issues
- Assess testamentary capacity
- Engage the family in management actively

Objective 15 – Psychotherapy

Knowledge
The trainee should know the theoretical basis of basic psychotherapies, behavioural therapies and cognitive therapy

Skills
They should be able to carry the following psychotherapies
- Counselling
- Supportive psychotherapy
- Problem solving therapy
- Brief psychotherapy
- Cognitive therapy for depression, anxiety disorders, obsessive compulsive disorder and somatisation
- Grief therapy

They should be competent in carrying out the following behaviour therapies
- Relaxation
- Graded exposure
- Cue exposure and response prevention

The trainee should be able to carry out the above in an individual as well as group setting.

Objective 16 – Sexual problems

Knowledge
The trainee should know the:
- The normal sexual response
- The classification and aetiology of common sexual problems
- The treatment options available and the management of sexual problems

Skills
The trainee should be able to assess and manage the following psychosexual problems.
- Premature ejaculation
- Erectile dysfunction
- Vaginismus
- Reduced libido

Objective 17 - Cultural and Social aspects of Management

Knowledge
The trainee should have knowledge of the:

- Common cultural and religious beliefs in the community which are relevant to mental illness
- Occult practices and alternative systems of medicine used by mentally ill patients in the community
- Impact of stigma at different levels

Skills
The trainee should demonstrate the ability to

- Assess and manage patients with different cultural and religious backgrounds
- Identify and help patients and carers to deal with stigma related issues

Objective 18 - Working with carers, NGOs and other agencies

Knowledge
The trainee should have knowledge of the:

- Impact of mental illness on the carers
- Available non-governmental and governmental agencies which provide services for the mentally ill patients

Skills
The trainee should demonstrate the ability to:

- Involve the carers in the management of the patients
- Identify emotional issues and provide necessary psychological support to the carers
- Liaise with other agencies in delivering holistic care for the patient

Objective 19 - Statistics and research

Knowledge
The trainee should have a working knowledge of:

- Different designs for studies including investigative studies, case–control and cohort studies
- Procedures involved in clinical trials, including the use of controls, randomisation, blinding, comparison and placebo groups
- Statistics relevant for research

Skills
Trainees should be able to:

- Construct a basic research protocol
- Critically appraise research studies
- Understand evidence based clinical practice

Objective 20 – Computer Literacy

Knowledge
The training should have a basic knowledge in IT.

Skills
The trainee should be able to:

- Demonstrate familiarity with a computer
- Use a word processing package
- Manipulate data using a spread sheet
- Search a simple database
- Undertake searches and access relevant sites on the internet
- Make a Power Point presentation

Objective 21 – Medical record keeping

Knowledge
The trainee should have knowledge of medical record keeping and prescription writing including prescriptions for narcotic drugs

Skills
Trainee should have the ability to:

- Maintain up-to-date, legible and comprehensive medical records. (The records should include a comprehensive history, MSE, examination, formulation and management plan)
- Write legible prescriptions.

Objective 22 – Health Education

Knowledge
The trainee should know the basic principles of health education

Skills
The trainee should have the ability to teach medical students, doctors in other specialities and paramedical staff on psychiatry

Objective 23 – Leadership and team management

Knowledge
The trainee should know the principles of leadership and team management

Skills
The trainee should demonstrate the ability to effectively work within a multidisciplinary treatment team, including being able to:

- Listen effectively
- Elicit needed information from team members
- Integrate information from different disciplines
- Clearly communicate an integrated treatment plan
- Manage conflict

Objective 24 – Professionalism, ethical aspects and attitudes

Knowledge
The trainee should know the principles of biomedical ethics including matters of informed consent/assent, professional conduct, and conflict of interest.

Skills
Trainees should:

- Show ethical behaviour, integrity, honesty, compassion, and confidentiality in the delivery of care
- Show respect for patients and their families, and their colleagues as persons
- Show understanding of and sensitivity to end of life care and issues regarding provision of care and clinical competence
- Should be able to review their professional conduct and take corrective action when appropriate.
- Should show awareness of safety issues, including acknowledging and correcting medical errors, should they occur.

Disclaimer – The above syllabus is for guidance only and in no way implies that the trainee would only be tested in the areas listed above.

ANNEX 3
PROGRESS REPORT BY CONSULTANT

Trainee Name:
Speciality:
Consultant:
Period report: From To

Clinical Skills: (e.g. judgement, empathy, history-taking, therapeutic ability, relations with patients/relatives, general standard of care)

Academic Ability: (e.g. interest, knowledge of literature, research interests/endeavours, involvement in case conferences and seminars)

Relations with staff and other agencies: (quality of personal relationships, skills in joint working, communication and consultation with doctors and other agencies)

Administrative ability: (reliability, responsibility, quality of case notes, etc.)

Areas of Progress during placement

Areas of concern

Psychotherapy experience
Specific cases allocated in placement
Modality of therapy
Comments on progress

Receptiveness to feedback

Signed by trainee Date

Signed by consultant Date

ANNEX 4
GUIDELINES FOR PREPARATION OF CASE BOOKS

It is mandatory that all trainees in Psychiatry, prior to sitting the MD (Psychiatry) Part II examination submit a case book of 10 psychiatric patients they have directly managed during their period of training.

The case book should demonstrate the range of patients the trainee has been exposed to and in each instance bring out the depth of understanding the trainee has reached on the disease condition as well as the particular patient as a whole.

Writing up the case histories, in effect could be an extremely useful exercise for the trainee and could contribute immensely to consolidating their knowledge of the subject, improve their presentation and language skills and sharpen their clinical acumen in understanding the patient in the context of his disorder.

Find below the general outline for each case history and discussion:

PSYCHIATRIC HISTORY

A psychiatry history should include the following components:

a. Identifying information (age, sex, occupation, marital state, etc.) (coded for confidentiality reasons)
b. Chief complaints
c. History of presenting illness
d. Past psychiatric history
e. Alcohol and substance misuse history
f. Past medical history
g. Family history
h. Personal history
i. Social circumstances
j. Any other relevant information pertaining to the individual patient

MENTAL STATE

A mental state examination should have the following components:

a. Appearance and behaviour
b. Speech: amount and form
c. Thought content and form
d. Mood
e. Abnormal beliefs, delusions
f. Perceptual disturbances
g. Obsessional and compulsive phenomena
h. Cognitive function
i. Insight: attitudes to illness and its treatment

PHYSICAL EXAMINATION

1. The extent of the physical examination has to be judged on a case by case basis, taking into account diagnostic possibilities.

2. However, it is most likely to focus on the examination of the central nervous system and the endocrine system. Physical examination should not, of course, be limited to these systems and all patients should have a full routine examination. Important positive and negative findings should be summarized.

DIAGNOSIS

1. Trainees are expected to know the principles of classification, to have a working knowledge of ICD-10 and to have a more detailed knowledge of either ICD-10 or DSM-IV.
2. They should also be able to apply appropriate multidimensional approach and the concept of natural history of syndromes and disease.
3. They should list in order of probability diagnoses that should be considered and include any disorders which warrants investigation.
4. It is necessary to include any current physical illness that may account for some or all of the phenomena, and to give evidence for and against each diagnosis considered.
5. It is often necessary to consider supplementary diagnoses in addition to the primary diagnosis (Eg: Nicotine dependence).

AETIOLOGY

1. The trainee candidate should be able to discuss aetiological issues including social, psychological and biological aspects.
2. The trainee should be able to address the question "*Why has this patient developed this disorder at this point in their life, in this particular form and with this particular content to their mental state?*".
3. The trainee would need to describe the psychological factors involved.
4. For psychological factors, the trainee should address the relative appropriateness of various frames of psychological reference including psychodynamic and cognitive behavioural formulation.

MANAGEMENT PLAN

1. Safety

What are the current safety concerns? Priority lies with immediate risk to self from suicidality or diminished self cares and risk to others. Be aware of risk factors. Psychiatry has moved away from predicting dangerousness to *managing risk.* Strategies for managing risk include engagement with the individual, frequency of contact and education around early warning signs for illness relapse. Increase in nursing and medical supervision, respite admissions and or acute in-patient hospitalisations are options in managing unwell and unsafe patients. An active plan to address substance abuse issues may be part of managing safety as may attention to environmental stress such as housing stability.

2. Clarifying diagnosis and differential diagnosis

It is surprising how many patients are treated within the system for years with an unclear or inconsistent diagnosis. Management addressing differential diagnosis includes reviewing old notes both psychiatric and medical, obtaining a thorough longitudinal history from the individual and meeting with family members for clarification

3. Cultural issues
The individual and family's cultural identification must be discussed.

4. Biological Management
Pertinent diagnostic tests and examinations. Consideration of the physical health of the individual is essential.
Discussion of the advantages and disadvantages of medication and possible side effects is obligatory in good management. It is also important to discuss the dosing regime, the expected time for effect, the need for any special monitoring and practical issues such as what to do if a dose is missed. There should also be a statement on how often the person will be reviewed.

5. Psychological management
Psycho-education (discussing what the individual's condition is and potential treatment strategies) and exploring the patients coping style and aggravating stressors are components of general psychological management. Additionally specific psychological therapy may be indicated such as cognitive behavioural therapy. Psychological management may include special assessments such as neuropsychological testing.

6. Social and Family issues
A major criticism of mental health services has been the lack of communication with family members. Family members are not only a valuable source of information but are often a major support in the individual's recovery process.

7. Rehabilitation Management
Rehabilitation is not concentrating solely on symptoms but rather looks at the impact of the illness on the individual's ability to function within and as part of the community. Establishing goals with the individual and their family and looking at the steps needed to achieve these are important. A rehabilitation plan identifies areas for skill retrieval, skill development and community integration.

Discussion
End with a discussion of the differential diagnosis, the patient's problems, and the treatment approaches. Discuss anything that is unusual or particularly interesting to you about the case.
In asking the trainees to write case histories, we do not just expect them to be "scribes". We encourage critical thinking and reflection. In this section of the Case History , we want you to comment on the overall management of the case. Were there areas of engagement or treatment that could have improved? Were medication used properly? Was there effort to involve families? Were non-medication treatments utilized? If not, why?

References
Relevant and appropriate references should be quoted within the text, particularly within the management and discussion. They should be in an accepted referencing style – eg. Harvard or Vancouver style.

ANNEX 5
SENIOR REGISTRAR TRAINING

Introduction
During the Senior Registrar training, the trainee is expected to acquire skills that will help them in their work as a consultant psychiatrist after Board Certification. In addition to general clinical training the trainee should become competent in other areas described below.

1. Clinical Training
The Senior Registrar should be competent in

- Conducting a clinical assessment
- Making a diagnostic formulation
- Evaluating risks
- Making appropriate referrals
- Formulating a treatment plan
- Undertaking clinical interventions
- Reviewing and changing treatment as appropriate

She/he should work as a member of the multidisciplinary team and help in drawing up care plans and monitor the improvement in patients.

2. Teaching
Depending on the training carried out in the unit the Senior Registrar would be required to teach undergraduates, supervise registrars and participate in teaching of other medical and non medical staff. The SR Should organise the postgraduate teaching programme in consultation with the trainer and coordinate other teaching programmes in the unit. He/she should participate in journal clubs, case presentations and other academic activities in the unit.

3. Research
The SR is required to undertake a research as a requirement for Board Certification. She/ he should design, undertake and complete a research project during the training period. He could identify a supervisor in the unit or outside the unit.
In addition to the dissertation the SR's are encouraged to carry out other research leading to presentation in scientific meetings and publication in journals. They are encouraged to attend a research methodology course. The SR should be competent in critically appraising new research publications including studies with the following methodologies:
- randomized controlled trial
- case control study
- longitudinal cohort study
- large scale epidemiological study of either prevalence or incidence

The SR could utilise 2 sessions a week for their research activities.

4. Clinical Audit
It is important that the trainee is exposed to the process of analysing practice, setting standards and auditing practice against these standards. The trainee should undertake a clinical audit and present findings at an audit meeting.

5. Information Technology
The trainee should be competent in the use of computers and information technology to help in their clinical practise. They could enrol in courses organised by the PGIM and use facilities available in the unit to upgrade their knowledge.

6. Management
SRs should obtain management experience. This should begin with simple tasks in the clinical and teaching work of the unit. The SR should be able to clarify roles, responsibilities and use authority effectively, allocate and delegate work efficiently, develop objectives and work plans and respond to problems in a team or individual.

7. Service development
The SR should participate in improvement of ongoing services and development of new services. They should participate in planning meetings, contribute to developing project proposals and monitor ongoing activities. The SR could be involved in a wide range of services such as setting up of specialised clinics, initiating new activities in the ward, development of community based services or teaching programmes.

8. Special interest
The SR is encouraged to develop a special interest in an area other than general adult psychiatry such as child, psychiatry, liaison, forensic, old age , drug and alcohol, community psychiatry, psychotherapy or medical education.

9. Supervision
During timetabled supervision difficult clinical issues, personal, managerial and training matters can be discussed.

10. Assessment
The trainer will submit an evaluation of the training period to the PGIM at the end of training. In addition regular feedback sessions should be carried out during the one year period.

ANNEX 6
GUIDELINES FOR PORTFOLIO

A portfolio is a repository of one's personal and professional goals, achievements, and the methods of achieving those goals. It is a collection of materials made by a professional that records and reflects key events, learning experiences and processes in that professional career. The Portfolio is an important tool for assessment of Trainee Performance and Learning Processes. The "Portfolio Method" will be used as an assessment criterion for the Training Programme. It is a key document in the formative assessment of the trainee during the training programme.
Reflection is an important concept in personal development. It is a deliberate and purposeful activity. The fundamental basis of Portfolio maintenance is Reflective Practice, which is an important tool in postgraduate training.

Reflective practice consists of -

a) focused self-assessment
b) reflecting on experience
c) reflecting on strengths, weaknesses and areas for development
d) design of own strategies that leads to improvement in practice

Using such a process, there is improved training by self-identification of strengths and weaknesses, which is expected to promote deep learning, document what the trainee already knows, identify areas for improvement and help in planning helps in planning further learning. This approach promotes self-directed learning and critical thinking skills

The objective of maintaining a Portfolio is

- To help the trainee to record his or her training in brief so that the experience acquired can be assessed and deficiencies identified and remedied.
  And
- To help supervisors and assessors to evaluate the overall training and provide guidance in areas where it is needed.

The components of the Portfolio

- Documentation of all aspects of training and learning experienced by the trainee. This should include a minimum of ten case records and a minimum of ten procedures and practical skills.
- Regular reflective entrees on all aspects of patient care and professional training
- Exposure to new technologies. A minimum of ten technologies.
- Details of Continuing Professional Development activities. Minimum of twenty.
- Records of Scientific Presentations made. A minimum of five.
- Direct Observation of Practical Skill (DOPS). A minimum of ten.
- Case Based Discussions (CBD). A minimum of five.
- Mini-Clinical Examination (Mini-CEX). A minimum of five.
- A record of individual activity-based entrees on the trainee's own experience
- Two clinical audits

The portfolio should be maintained in separate sections to conform to the above format. Entries in the Portfolio should be made by the trainee at the time of acquiring the skill and authorized by the trainer or supervisor.

The trainee is expected to keep it updated regularly. The trainers and supervisors will use the portfolio to assess the progress of the trainee and to provide a feedback at regular intervals during the training period. The trainers and supervisors are expected to assess the level of competencies in different areas of training and

Provide advice and assistance to the trainees to achieve the expected levels of skills empowerment.
It is the responsibility of the trainees, the trainers and the supervisors to ensure that the entries in the Portfolio are authentic and made regularly. It is essential to provide the trainee with accurate feedback on his or her views about his or her performance during the training period.

The Board of Study expects the Trainee and the Trainers to make the best use of the Portfolio in order to achieve the objectives of the training programme. The portfolio should be kept as a ring binder document which will allow easy insertions by the Trainee.

Assessment of the Portfolio

- Different components of the portfolio may be assessed by the trainer or another trainer appointed by the BOS at 3-6 monthly intervals to ensure completion/achievement of set goals of identified component/s and to take remedial action if any deficiencies are observed.
- The completed portfolio should be submitted after completion of training (including the overseas) for the purpose of Pre Board Certificate Assessment (PBSA). It will be assessed by a panel of two examiners appointed by the BOSP. The panel will sit at a formal discussion with the trainee and evaluate the portfolio over a period of 45 minutes.
  At the 45 minute portfolio *viva* voce the performance of the trainee will be marked by the examiners using the following rating scale:

Rating Scale

Grading	Closed Mark
Bad Failure	7
Borderline failure	8
Pass	**9**
Good pass	**10**
Excellent pass	**11**

It is mandatory to obtain a minimum mark of 9. A trainee who would score a closed mark of less than 9 will be advised by the panel on exactly how the portfolio could be improved to achieve a closed mark of 9 or more. In such a case, the necessary corrections and amendments have to be made by the trainee and the portfolio submitted to the same panel of examiners for a second evaluation. If a closed mark of 9 or more is not obtained, a third evaluation by the same panel of examiners will become necessary.

The completed portfolio, its satisfactory assessment by the BOS and a minimum pass grading at the PBSA is necessary for the trainee to be eligible for Board Certification.

ANNEX 7
GUIDELINES FOR PREPARATION OF A RESEARCH PROTOCOL

Your difficulties can be minimized by embarking on a simple research project.
Conducting the research work with your commitments should be feasible. The resources should be available.
Choosing an idea is very important. The work may be an original work or a replication of another work. When selecting an idea, you may review the available work. Your enthusiasm can be maintained if you select an area which is of personal interest to you.

The difference of a research work from an audit

Audit and research, both are generally concerned about the quality of care. Research decides what constitutes good care. Audit determines whether good care is being practiced *(Jacyna et al)*. The methodology of audit is generally similar to research work eg. Application of valid and unbiased measures, analysis of data, use of objective scrutiny. Audit must be as good as proper research work.
You may shape your idea after reviewing the literature and/or discussing with your supervisor.
When explaining/defining what to be studied, don't have too many categories and try to collect too many information. It is known that narrower the area of questioning the more viable the research work.
Literature survey can be done using Medline, Google search, CD Rom, Dissertations, Conference proceedings, books and websites through libraries.

Funnel Approach

Funnel approach can be used when choosing a research question. Choose a specialty eg. General Adult Psychiatry. Choose a broad topic, eg. Treatment. Specify further eg. Chemotherapy. Choose a specific method of treatment eg. Depot medication. Choose a specific aspect of depot medication eg. Compliance. Then develop a hypothesis – Poor compliance even of depot medication leads to relapses.
You need to get familiarized with the basic methodology and statistics in addition.

The essential elements in the Protocol

Protocol is the vital component of any research work and writing a good / sound protocol is an essential element in carrying out the study. Protocol should be a complete document which provides details of research work from the objectives to the final report.
Discuss the protocol with your supervisor to improve the shortcomings.
You may need to rewrite the protocol several times in order to improve the quality and to minimize the problems.
Title should be relevant, appropriate and catchy.
Investigators, collaborators, supervisors should be included properly. Their names, and if necessary, qualifications, positions, address and contact details should be included.

Introduction / background / literature survey

Introduction/background/literature survey needs to be properly highlighted. Your work, the benefits of your work and the outcome of your work for the advancement of clinical care needs to be justified.

Objectives and hypothesis

There may be broad objectives and then specific objectives.

They should be clear and sufficiently addressed. Hypothesis should be clear and understandable.

Methodology

The next step is the methodology. Study design should be sound. Inclusion, exclusion and diagnostic criteria should be included.

Sample selection, recruitment, sample size and content should be appropriate and sound.

Randomization and stratification procedures, masking procedures, administration of treatment and monitoring should be clear and sound.

It is necessary to mention the assessment tools/scales and whether they are validated for the local setting etc.

Subjects

Plans for longer term follow up and referral to appropriate places when indicated should be mentioned.

Statistics and Data handling

Data handling and statistical procedures should be sound and appropriate. Advice and opinion from a statistician may be sought.

Data analysis, dissemination of knowledge and plans for publication may be included.

You may incorporate a study time table which will facilitate smooth running of the work.

Logistics and funding

The cost and funding and the reasons for funding may have to be included.

Ethical issues

The need to obtain consent and maintain confidentiality has to be highlighted. Use of consent forms is encouraged. Approval from a recognized ethical committee has to be obtained.

References

References should be properly included / listed (eg. Harvard system)

Appendix

Forms used

l. Data collection forms
2. Consent forms
3. Rating scales
4. Any other assessment tools

Should be attached.

References

1. Jacyna M.R., de Lacy G., Chapman E.J. (1992) How does medical audit differ from research? How necessary are the computers? *Hospital update*, **18**, 592-596.
2. Stephen Curran & Christopher J. Williams Clinical Research in Psychiatry; A Practical Guide 1999, Reed educational and professional publishing Ltd.

ANNEX 8
GUIDELINES FOR DISSERTATION

Introduction
This document gives important information about the MD Psychiatry Dissertation
It discusses the

- Aims and objectives
- The formal requirements of the dissertation
- The dissertation structure and presentation
- The criteria used by examiners in assessment
- The roles and duties of the supervisor

What is a dissertation?

- A dissertation is a long piece of written work
- It should have a minimum of 10,000 words
- It is an analytical work and not a descriptive account of the subject
- It is not a review of books or articles read.
- Compared to an essay it is an more in depth study of the subject with greater analysis and more reference to sources

Aims and objectives
The dissertation is required as part fulfilment for the MD in Psychiatry. A trainee is required to submit the dissertation prior to Board Certification in the speciality.
The Aim of the dissertation is to enable students to:

- advance their knowledge of the field
- develop their ability to undertake sustained critical analysis
- develop and improve their research (especially quantitative) skills
- improve their scientific writing and presentation skills

Guidelines
The dissertation should:

- address a well-defined research question
- present a logically developed argument supported by evidence
- have a significant quantitative research component
- not be a purely qualitative study

The dissertation should demonstrate that the trainee while collecting detailed data on a particular topic is also capable of understanding how the works of other authors relate to his or her work.

Choosing a topic
Start thinking about a topic during your clinical work as a registrar. You may get ideas from the published literature and dissertations available in the PGIM library. Select an area that interests you. The topic must be feasible, practical in terms of access to needed resources as well as time.
An adequate research design for a dissertation will allow the trainee proposing the research to:

- specify the question that is being asked
- explain why answering the question is important
- explain why the design chosen is the best way of trying to answer the question

- explain what will be done and for what purpose
- explain how the data will be analysed and why those procedures were chosen
- offer a defensible way of interpreting the data, regardless of what is found.

Structure
A dissertation typically consists of several parts which should be formally indicated by section breaks or chapters. The following format is suggested.

Title
- The title must not promise more than the paper can deliver
- Ensure that the title is succinct and avoid redundant phrases

Abstract/summary
- Should be around 500 words
- Use the correct structured abstract format(background, aims, method, results, conclusions)
- Clearly state the aims
- State the sampling strategy, sample size, response rate and main sample characteristics
- Describe the design
- Summarise the measures used
- Describe the intervention(s) if present and the control if there is one
- Summarise the main findings as they relate to the aims
- Clearly state the conclusions, avoiding phrases such as 'The results are discussed' and avoiding just repeating the summary of results

Introduction
- Begin with a statement of the main issues being addressed
- Make a clear case as to why the study was needed
- Describe any necessary background information about the setting for the study
- Justify the choice of measures and the sampling strategy
- Clearly state the research questions/hypotheses. This can be done with a bulleted or numbered list.

Literature Review
The topic is placed in its academic context by reviewing the relevant scholarly literature and relating the research question to academic debates. Refer to relevant literature only. Relevant if it shows why the research questions are important or gives an indication of how the result may turn out. It is essential to search for and give due credit to studies of a similar nature wherever they originate and whatever their conclusions. Selective citation is a common source of bias.

Methods
- Describe the study design and setting
- Show the sample size calculation
- Clearly state the total number of participants and the numbers in each group if there are groups
- Describe the inclusion and exclusion criteria
- Clearly state the response rate

- Describe the sample in terms of age, sex breakdown, social class or other relevant properties
- Clearly state how the sample was obtained in such a way as to be able to judge its representativeness
- Clearly list the measures used, indicating where possible indices of validity and reliability or giving a citation where these can be found
- Describe the intervention(s) if appropriate and any control conditions if present
- described statistical methods used
- Describe how consent is obtained and confidentiality is maintained.
- State how ethical approval was obtained

Results

- Describe the results in terms of the answers to the questions/aims presented at the end of the introduction in the same order as they were presented then
- Avoid phrases such as 'The result was not significant'? (Only differences and associations can be statistically significant, not 'results')
- Always use meaningful labels when referring to results from individual questionnaire items (rather than just the question number)
- Avoid repeating material in both tables/graphs and text. The text should just summarise the data presented in tables or graphs.
- Ensure that all tables and figures have titles using a consistent format and are numbered consecutively
- Cite all tables and figures in the text using a phrase such as 'Table 1 shows that ...'?
- State the test statistics (e.g. t value, F value or chi squared value), degrees of freedom and p values? Even for p values greater than .05 it is helpful to show the exact p value to aid any subsequent meta-analysis.
- Clearly state the Ns for every mean, correlation, proportion or other analyses. Always give the Ns corresponding to percentages.
- Avoid using p=0 or p=0.000 or p<.0000 (despite these being given in SPSS printouts)? Use p<.001 or p<.0001 instead.

Discussion

- Begin the discussion with a summary of the main findings
- Relate the findings to previous research in terms of whether they support or fail to support the conclusions of that research
- Explain how the findings reflect on theory, practice or policy formulation
- Examine the limitations of the study, addressing issues such as sample size, sample representativeness, measurement error, measurement bias, whether any intervention was successfully implemented, whether there was contamination between different intervention conditions and ability to generalise from the findings
- Attempt to explain apparently anomalous findings
- Avoid reporting results in the discussion section that have not been mentioned in the results section
- Do not use tables and figures in the discussion
- Finish with a paragraph summarising the main conclusions

References

- Ensure that your citations and references follow a consistent format. The trainee follow the Vancouver or Harvard System.

- Ensure that your references are complete and match the citations in the paper
- avoid citing unpublished work, especially work reporting substantive findings
- ensure that the references are in the required order

Appendix

- Ethical clearance form
- Questionnaires and scales used in the study
- Consent form

General

- Include an acknowledgements section stating the source of funding and thanking relevant people for their assistance
- Indicate any conflicts of interest
- Ensure that your formatting is consistent and appropriate
- Ensured that tables and figures are always cited in the text and all have numbers and titles
- Use the past tense when describing other people's findings, and your own methods and results
- Avoid colloquial expressions
- Use Arabic numerals (e.g. '12', '34') except for numbers below 10 and those beginning a sentence, in which cases you spell the numbers out (e.g. 'three')?
- Ensure that all abbreviations are spelled out in full the first time they are used
- Avoid using shortenings such as "don't" and "it's"?
- Discussion should be broken up into sections and sub-sections, but excessive fragmentation should be avoided.
- Organise the discussion into paragraphs and avoid bullet points.
- Present data with graphic illustrations (graphs, tables, charts, diagrams, flowcharts) where appropriate.
- Make sure that the text explains and discusses the data.
- Do not consign important information to appendices; wherever possible, integrate it into the text. All graphics must be clearly presented, be a reasonable size, have relevant headings and acknowledge sources.
- Ensured that the author has read through the manuscript carefully to check it over
- Remember that writing takes a long time, far longer than you may anticipate, so plan carefully and leave plenty of time for re-drafting and a final proof-reading before the submission deadline.

Plagiarism

The dissertation must be your own work. Plagiarism - the presentation of another person's thoughts or words as one's own - in the dissertation constitutes grounds for failing the dissertation; more serious sanctions may be also applied if circumstances warrant them. It is your responsibility to understand the concept of plagiarism and why it should be avoided.

3. Assessment criteria

The dissertation is assessed according to the following criteria, with credit given to the extent that:

- the research question is well-defined, and contextualised;
- relevant sources have been consulted;
- knowledge of relevant literature, issues and debates is demonstrated

- an argument is specified, coherently presented and supported by evidence
- alternative arguments are analysed
- the approach is critical, not descriptive
- a relevant methodology is employed
- the style and presentation is clear and careful, and appropriate academic conventions have been observed.

Dissertations are marked according to the following schema:
0-29: A very poor dissertation, which does not specify a research question, fails to present an argument, is largely descriptive, shows little or no knowledge of the topic, or its intellectual context, does not refer adequately to the relevant literature, fails to follow an appropriate methodology, and is shoddily presented

30-39: A poor dissertation, which fails to identify a research question adequately, does not present a clear argument, includes some relevant material, but does not evidence of sufficient reading and is overly descriptive

40-49: An inadequate dissertation, which identifies a research question, states an argument, shows some knowledge of the literature and addresses the question, but does not sustain the argument, is overly descriptive, and lacks originality, sufficient knowledge of the relevant literature, issues and debates, and organisation.

50-59: A satisfactory dissertation, which defines a research question adequately, makes an argument, shows an awareness of the major issues, shows some knowledge of the sources and of alternative approaches to the subject, but does not adequately develop or sustain the argument, does not show a clear understanding of alternative arguments, and makes uncritical use of sources.

60-69: A good dissertation, which offers a precise specification of the research question, presents a clear and coherent argument that is well-substantiated by evidence, treats the issues in a critical and balanced way, shows an awareness of context, sources and different explanations, and achieves a high standard of presentation

70-100: A dissertation of distinction quality, which addresses a well-defined research question, displays exceptional knowledge of the literature and/or a substantial measure of originality, and achieves a high standard of presentation

Action suggested
0-29 – The dissertation is rejected and the trainee will need to redo the project
30-39 – Resubmit after extensive revision. The trainee should not resubmit the dissertation before three months. The dissertation would need to be re-examined
40-49 Resubmit after corrections suggested by the examiners. It need not be re- examined
50> Accepted with no corrections

What to avoid in a dissertation
Most dissertations fail due to carelessness, sloppy or lack of work and poor attention to detail. Sometimes candidates who work hard sometimes produce weak dissertations. There are four common reasons

- **Excessive description** – the dissertation should be analytical and not merely descriptive.
- **Poor definition of the question** – Unlike an essay it is up to the trainee to define the research question. It is the most important task in a dissertation. If the question is unclear the dissertation would be weak.
- **Poor integration of theory and empirical (observed material)** – the theoretical discussion should not stand in isolation but inform the analysis of the material under study.
- **Poor contextualisation** – The dissertation should show that the trainee understands how the topic relates to work done by others in the same field.
- **Uncritical use of sources** – all studies or publications do not have equal merit or meaning. A good literature review must separate the good from the bad and give greater attention to those studies having the best designs and the most defensible conclusions

The role of the supervisor

The dissertation is intended to provide an opportunity for trainees to pursue a research project independently. Trainees are entirely responsible for the work for their dissertation. The role of the supervisor is to offer advice and guidance, not to direct the research. Your supervisor will help you to identify a topic, to draw up a suitable preliminary bibliography and to plan the primary and secondary research you will need to do for the dissertation. He/she will be available to advise you on approach, coverage, questions to be asked and the outline structure and research design.

When selecting a supervisor, choose on the basis of their expertise on the subject. Do not select a supervisor simply because he/she is your current consultant or head of department.

More specifically, the supervisor is expected to:

- assist you in the definition and organisation of your project in the early stages of preparation;
- offer you advice about sources;
- advise you on the feasibility of what you plan to do; and
- Approve your dissertation proposal.

The supervisor is under **no obligation** to:

- find you a suitable topic for the dissertation;
- read preliminary drafts of your work;
- offer you guidance or assistance after the end of the summer term; or
- Proof read your final draft.

You should have at least three meetings with your supervisor.

- an initial discussion to identify the topic, questions and methodology and sketch out an initial action plan and bibliography;
- an intermediate meeting to assess progress on the dissertation and discuss the likely structure of the first draft; and
- a final 'trouble-shooting' meeting before submission.

Formal requirements

Length

The length of the dissertation should be a minimum of 10,000 words inclusive of appendices and references. A dissertation which is shorter will be penalised by the examiners. The number of words in the dissertation should be recorded on the cover page.

Form

The dissertation should be typed or word-processed, and bound. The paper should be of A4 size, of adequate quality, with clear printing, a type face of adequate size (usually font size 12), 1.5 line spacing, on one side of the page, with margins of 30cm on the binding edge and at least 20mm on the rest. Candidates are required to submit two copies with one cover sheet for each copy.

The cover sheet must state the following:

- Title of dissertation
- The name the candidate
- The degree for which the dissertation is submitted
- The month and year of submission
- The following sentence as footer: Dissertation submitted in partial fulfilment of the requirement for the MD in Psychiatry.

The page following the title page shall carry a declaration by the candidate that the work presented in the dissertation is his or her own, and that no part of this dissertation has been submitted earlier or concurrently for any other **degree**. (The trainee may submit the research findings for publication in journals). The declaration must be signed by the supervisor.

The page following the title page will be the table of contents followed by the abstract of not more than 500 words. Pages should be numbered consecutively, beginning with the page containing the abstract using numerals on the upper or lower right-hand corner of each page.

Once the thesis is approved by the examination board two bound copies should be submitted to the PGIM.

Typographic spelling and other technical errors should be avoided by leaving sufficient time for proof-reading the final draft. Particular care should be taken with figures, statistics, diagrams and tables, ensuring that the information presented is clear, that headings and captions are fully self-explanatory, and those sources are correctly attributed.

Students must complete and sign the declaration on plagiarism provided by the PGIM and submit one copy with their dissertation.

Further guidance

In addition to these written guidelines and your meetings with your supervisor, you are required to attend the workshops on research training conducted by the PGIM. These workshops would be conducted when you start your SR training. These will provide an opportunity to raise general questions about the dissertation and also more extensive guidance concerning various possible research methods and models of dissertation design.

You are advised to start developing ideas for your dissertation during your registrar training and discuss these in the research training forums in your training units.

The trainee could refer the following BMA link to access information on reference styles

http://www.bma.org.uk/library_medline/electronic_resources/factsheets/LIBReferenceStyles.jsp