Oman Medical Specialty Board المجلس العماني للإختصاصات الطبية

PSYCHIATRY

Residency Program

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PSYCHIATRY CURRICULUM

(a) Introduction

Mental illnesses are universally looked upon as object of stigma and more so in our part of the world. Various folklore beliefs have been used to explain the factors triggering mental illness. In the Orient and the Middle East the age old beliefs include possessions by witches, 'Jinn', spirits and various magical or mystical influences are still generally thought to cause mental illnesses. Even for post-renaissance societies, many people in the Western World also believe in possession states and some believe in the influences of aliens and disembodied intelligence. In traditional society around, many people still hold a view that anthropomorphic being may be operative in at least some of the cases with mental illness. This results in social discrimination, stigma and ostracism that often results in delayed or refused treatment for mental illness all over the world.

Within the past decades, psychiatry and its allied field have made more progress than the last 500 years. This is partly because of technological developments used to quantify what previously was thought to be an ethereal aspect of the human mind. With advancements in molecular and genetic science showing a functional relationship between the human 'psyche' and cellular activity, psychological phenomena have become the latest frontier in our scientific quest

Over the last 100 years, a wealth of modern research has brought enlightenment and psychiatry now forms the scientific basis of the understanding of the biological, psychological, and socio-cultural components of mental illness. More recently, it has becoming clear eclectic approach using both biological, social-cultural and psychological techniques improve the quality of life of people with mental illness that were deemed unfathomable just two decades ago. The most effective channels to dispense such services is to trained psychiatrists.

Psychiatrists are medical doctors who are additionally qualified to correctly diagnose, fully evaluate, appropriately investigate, and prescribe the best therapies; including medications, psychotherapy and other treatment and psychotherapeutic modalities. They are vital and pivotal members of the therapeutic team that manages the mental, psychological, interpersonal, emotional, and quality of life problems, suffered by people with psychiatric problems. Strict research criteria and demonstrable efficacy forms the basis of the treatments used. This scientific basis is now universally recognized. Properly trained and enlightened doctors and psychiatric trainees are of prime importance in rehabilitating and improving the quality of life of people afflicted with mental illness. Through this Psychiatric Residency Programme the future Omani Psychiatrists will be trained to deliver the highest quality of modern holistic psychiatric care for all mental health problems and also be able to prevent/reduce disability provide the best quality of life for their patients. Evidence-based amelioration of mental illness using modern psychiatric services has been shown to be essential mechanism to mitigate the stigma and discrimination of people with mental illness.

Rapid social changes are taking place all over the world and in our country, the Sultanate of Oman; this speed of this socio-cultural change has been very dramatic with rapid urbanisation, modernisation, industrialisation, high levels of education and a shift towards nuclear families that have changed the demographics of the country within 30 to 35 years. These rapid social changes have not only altered the structure of the communities', families' and the individual's psychological well being but the globalisation has added social disorganisation that give rise to problems like juvenile delinquency, alcohol and other substance abuse, traumatising industrial and traffic accidents. Other factors like malnutrition, metabolic and life-style diseases as well as infections also adversely influence mental health; hence there is an increasing need for community education programs.

Improving quality of life and promoting the understanding for proper meaningful preventive, therapeutic and rehabilitative programs are essential. Central to this concept is the development of local specialised manpower to deliver the best results. The training of local doctors will give the trainees more insight in understanding the cultural factors and their effect on mental health. It is more cost-effective, efficient, and directed to more rapid community based specialised interventions.

(b) General Objectives

The program is designed to produce specialists in General Psychiatry with adequate knowledge and competency of the subspecialties including child and adolescent psychiatry, substance misuse, geriatric psychiatry, forensic psychiatry, etc., who will be the future consultants in psychiatry.

(c) Specific Objectives

1. To produce highly skilled, competent and ethical psychiatrists, to deal with most of the psychiatric problems and to have the right attitude to deal with patients and their families.

2. To promote research orientation and environment for academic research.

(d) Admission Criteria

1. Applicant should have B.Sc., or equivalent in Medical Sciences from a recognised medical training programme and a minimum grade of 'Good' or 3.00 GPA.
2. One year successful completion of internship
3. One year of G.P. experience in primary health care
4. Two recommendations letters.
5. Letter of sponsorship
6. Successful selection at personal interview and or MCQ Entrance Exam.

(e) Structure of the Training Program

The Psychiatry Residency Training is a four years long conjoint training programme based at the Sultan Qaboos University Hospital and Ibn Sina Hospital. Selected candidates will start at R1. In very special cases, transfers at the second-year postgraduate level (R2) may be permitted from another recognized programme in another country.

1.	General Psychiatry	19 ½ Blocks divided over 4 years
2.	Child and Adolescent Psychiatry	6 ½ Blocks
3.	Misuse and dependency on alcohol and other mind altering substance	6 ½ Blocks
4.	Liaison Psychiatry	6 ½ Blocks
5.	Rehabilitation and day care	3 Blocks + one week
6.	Neurology	3 Blocks + one week
7.	Elective(s)	6 ½ Blocks

Mandatory Subspecialty Rotations:

Substance Misuse (6½ Blocks), Child and Adolescent Psychiatry (6½ Blocks), Neurology (minimum 3½ Blocks), Rehabilitation and Day Care, Old Age Psychiatry (minimum 3½ Blocks)

Elective Subspecialty Rotations:

Old Age Psychiatry (additional 3½ Bocks), Forensic Psychiatry, Liaison Psychiatry, Community Psychiatry, Emergency Psychiatry, Child and Adolescent Psychiatry (additional elective for certification as a Child and Adolescent Psychiatrist).

First year (R1)

Devoted to give the resident a good background in basic general psychiatry (lectures, outpatients care, inpatient care, emergency and on call duties) (Appendix 1). Trainees are expected to also devote time for personal studies in allied basic subjects.

The following objectives must be fulfilled by the trainee:

1. Taking good history (Competence in Psychiatric Interview)
2. Acquiring good knowledge to elicit important psychiatric symptoms and signs and establish clinical diagnoses (psychopathology).
3. To have good experience in the use of psychological and physical examination and relevant investigations
4. To gain good theoretical knowledge in psychopathology and aetiological factors
5. Learning the basic Principles of drug therapy, behavioural, cognitive and psychotherapy.
6. Follow up of stable cases and planning of care.

Second year (R2)

The second year will be taken up by didactic lectures, tutorials, demonstrations, etc., in subjects basic to psychiatry (see Appendix 2). This year will also be devoted to broadening the clinical base of the resident in General Psychiatry and in the sub-specialities. The Residents in R2 are expected to continue personal studies of related disciplines. The specific objectives are:

1. To acquire adequate knowledge about the anatomical, physiological, biochemical and psychological basis of man's behaviour in health and disease.
2. To have enough information about the influence of psychotropic drugs on brain metabolism.
3. To provide the resident with expertise in carrying out a good mental state examination.
4. To provide the resident with experience in interviewing children and adolescents and helping families cope with maladjusted children.
5. To get the experience required in writing psychiatric reports.
6. To develop in the trainee maturity of clinical judgement.

Third year (R3)

Special attention will be given to the sub-specialties of clinical psychiatry. The relationship between mental health and psychosocial factors will be closely examined. The third year resident will be awarded the status of senior resident-after clearing the OMSB Part-I.

Senior resident will perform additional duties as Senior Registrar and will conduct OPD Clinics and attend to patients referred from primary care clinics as well as from the accident and emergency departments.

R3 residents will be second on call for emergencies, including cases who come under Liaison Psychiatric Programme when going through that rotation.
R3 residents will be assigned teaching responsibilities to undergraduate students

Fourth year (R4)

The fourth year is designed to increase the experience of the resident in General Psychiatry and the sub-specialties. Rehabilitation of the disabled, Mental Health Administration and involvement of the Community will receive due emphasis. The resident shall be involved in teaching first and second year residents. During this final year, residents will be encouraged to continue to be involved in ongoing research in the Department as from R2. Part of R4 will be devoted to an approved elective rotation.

EVALUATION

The evaluation of the resident (strengths and weakness) will be a continuous process throughout the four year programme and the following will be considered:

1. Satisfactory completion of each of the clinical rotations with regard to academic knowledge, attitude, clinical competence, maintains patient confidentiality and professional behaviour.
2. Satisfactory attendance and active participation at lecture, tutorials, teaching skills (peers), ability for self directed learning, seminars and other academic activities.
3. Satisfactory evidence of competence to carry out good psychiatric interview including standardized mental state examination, interpretation and differential diagnosis, decision making and management plan, verbal and written communication, provides comprehensive care, ability to manage emergency conditions, consultation skills, physical method of treatment (use of drug and electroconvulsive therapy), individual and group psychotherapy, ability to assess children and adolescents.
4. Performance at annual examinations conducted at the end of each training year, for the first three years written examination. Disciplinary action for unsatisfactory performance or behaviour will be taken according to the rules and regulations of OMSB Psychiatric Residency Board.

Final Fellowship Examination

This examination is held annually. To be eligible for entry for the examination, the candidate must successfully complete the four year programme and pass successfully the annual examinations. The examination will consist of:

Written examination, Clinical examination and Oral examination

The candidate is allowed to re-sit for any of the annual or final examinations for a maximum of three times in three successive years.

Upon successful completion of the four year programme and on passing the final examination, the candidate shall be awarded the Fellowship of Oman Medical Speciality Board in Psychiatry (FOMSB-Psych).

APPENDIX 1

Contents of the Program and Detailed syllabus of the training program

Areas of Core Medical Knowledge Relevant to Residency Training in Psychiatry

History of psychiatry and various psychiatric practices

Mental illnesses, superstitions and traditional beliefs (Mesopotamia, Ancient Egyptian, Greek, Roman, Arab, Modern and Omani beliefs in relation to mental illness).

History of Islamic Medical Renaissance – Therapeutic and humane approach to the mental illness and the role of the correct Islamic beliefs on illness, responsibility and human rights.

History of the development of 'humane psychiatry', 'bed-side manners' and the various therapeutic approaches to mental illness.

Behavioural Sciences

Behavioural science is a term that encompasses all the disciplines that explores behaviour. On its application, behavioural science is a scientific discipline, such as sociology, anthropology, or psychology, in which the actions and reactions of humans (and animals) are studied. It is expected therefore that cadre of fellows Oman Medical Speciality Board in Psychiatry to competent to all competing paradigm relevant to psychiatry.

Contribution of the psychosocial sciences to human behaviour.
Theory of development
Piaget, Attachment theory,
Thanatology,
Learning theories,
Aggression and violence,
Ethology and Sociobiology,
Anthropology and Psychiatry,
Sociology and Psychiatry

Psychology as scientific and human endeavour:
The historical origins of psychology
Nativism versus Empiricism
Structuralism and Functionalism
Behaviourism
Gestalt psychology
Psychoanalysis

Basic principles of perception: Gestalt, figure ground differentiation, object constancy and other aspects of perceptual organisation. Extrasensory perceptions and Perception as an active process. The relevance of perceptual theory to illusions, hallucinations and other psychopathology. The development of visual perceptions, information processing,

attention and the formation of thought: The application of these in schizophrenia and formal thought disorders.

Memory: Memory is central to optimal functioning and quality of life. The complexity of memory would be elucidated including: Three important distinctions of memory/three stage of memory, working memory, long-term memory, implicit memory, Retrospective vs. prospective memory; Disorders of memory including Age-associated memory impairment, Amnesic syndrome and controversial issue in memory including 'repressed memory', 'recovered memory' and 'false-memory syndrome'.

Language and thought: **Language and communication, development of language, concept and categorization, reason.** Deductive and inductive reasoning. Problem-solving strategies, algorithms and heuristics. Rational thought and irrational attitudes.

Personality: Derivation theories, traits and type approaches and elementary personal construct theory. Basic principles underlying psychoanalytic and humanistic approaches. Construction and use of inventories, rating scales, grids, etc.

Motivation and Emotion: Basic motives, theory of motivation, needs and drives. Extrinsic theories and homeostasis. Hypothalamic systems and satiety. **Emotion:** Components of emotional response. Critical appraisal of James-Lange and Cannon-Bard theories. Cognitive appraisal, differentiation and the status of primary emotions. Emotions and performance.

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

Consciousness and Perception: Levels of consciousness and evidence for unconscious processing. Arousal, attention and alertness. Sleep structure and dreaming. Hypnosis, meditation, trances, and suggestibility in managing problems. Parasomnias.Biorhythms and effects of sleep deprivation.

Sociological approach to Psychiatry: Social Psychology

A**ttitudes and behaviour:** Components, 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. 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', de-individuation. Communicative control in relationships.

Intergroup behaviour: Prejudice, stereotypes and intergroup hostility. Social identity and group membership.

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

Altruism: Social exchange theory, helping relationships. Interpersonal co-operation.

Social science & socio-cultural psychiatry: Socio-cultural factors with a specific relationship to mental health issues. Life events and their subjective, contextual evaluation: Stigma and prejudice, Sick role and illness behaviour.
Mental Health Care planning and delivery, Basic principles of forensic psychiatry, criminology and penology, Minority groups, expatriates and transcultural psychiatry: Components, Attitude change and persuasive communication.

Research methods, statistics and evidence-based practice: This should include the basic knowledge of the principles of research methods, statistics, epidemiology, evidence-based practice, scientific analysis and interpretation of psychiatric literature. The Resident should be able to critically appraise and have an overview of intervention studies, clinical trials and meta-analysis. The Resident should understand the advantages of randomised trials and the problems with alternatives such as historical controls, Concepts of incidence (inception), prevalence, population at risk, sampling techniques, case identification, case registers, mortality and morbidity statistics and Epidemiology of specific psychiatric disorders, etc.

Psychopathology and understanding of Rare Psychiatric Syndromes: At the end of R2 the trainee should have a detailed knowledge of the principles of psychopathology and the abnormal processing of thought, behaviour, emotions and perceptions. The R2 should also have a basic concept of the Rare Psychiatric Syndromes. The trainee would be expected to discuss the psychopathology of the various problems, disorders and behaviours.

Human Development

At the completion of training, the psychiatrists should be knowledgeable about normal biological, psychological and social development from infancy to old age and consider:

The stages of normal development in order to determine whether an individual's style of thinking, coping, feeling or behaviour is appropriate for that stage or may be an indication of illness.

The influence of cognitive and emotional development on aetiology, presentation and management of mental health problems.

Factors that may be associated with vulnerability to mental health problems and protective factors associated with resilience.

Developmental issues in relation to the varied cultural and economic backgrounds.

In particular they should be able to demonstrate knowledge of: Basic frameworks for conceptualising development: nature and nurture, stage theories, maturational tasks. Possible definitions of maturity. Examination of gene-environment interactions with specific reference to intelligence. The relevance of developmental framework for

understanding the impact of specific adversities such as traumata. Freud and general psychoanalytic, social-learning, Piaget.

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

Bowlby's 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'.

Other aspects of family relationships and parenting practices.

The influence of parental attitudes compared with parenting practices. Some aspects of distorted family function: e.g., high expressed emotions, discord, overprotection, and rejection. Theories of bereavement, effects of parental divorce and intrafamilial abuse on the subsequent development of the child.

Brief mention of relevance or otherwise of non-orthodox family structure including cultural influences on family and stages of family.

Individual temperamental differences and their impact on parent-child relationships. Origins, typologies and stability of temperament and the evolution of character and personality. Childhood vulnerability and resilience with respect to mental health.

Cognitive development with critical reference to Piaget's model. Pre-operational and formal operational thought to communication with children and adults.

Basic outline of language development in childhood, the 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: Adolescence as a developmental phase with special reference to pubertal changes, task mastery, conflict with parents and authority, affective stability and 'turmoil'. Normal and abnormal adolescent development.

Adaptations in adult life, such as pairing, parenting, illness, bereavement and loss. Pregnancy and childbirth and their stresses both physiological and psychological.

The development of personal (ego-) identity in adolescence and adult life. Work, ethnic, gender and other identities. Mid-life 'crises'.

Normal ageing and its impact on physical, social, cognitive and emotional aspects if individual functioning. Social changes accompanying old age.

BASIC NEUROSCIENCES

The trainee shall demonstrate knowledge of basic neurosciences which underpin the practice of clinical psychiatry. In particular, they will be able to demonstrate knowledge of those aspects of neuroanatomy, neurophysiology, neurochemistry, molecular genetics and other biological sciences which are relevant to understanding mental disorders and their treatment:

Neuroanatomy

The general anatomy of the brain and the functions of the lobes and some of the major gyri including the prefrontal cortex, cingulate gyrus and limbic system. Basic knowledge of the anatomy of the basal ganglia, cranial nerves and spinal cord.

The internal anatomy of the temporal lobes, i.e., hippocampal formation and amygdala.

The major white matter pathways, e.g. corpus callosum, fornix, Papez's circuit, the Limbic System and other circuits relevant to integrated behaviour.

The types of cell found within the nervous system.

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 glutamate system and serotonin pathways.

Neurophysiology

The basic concepts in the physiology of neurones, synapses and receptors, including synthesis, release and uptake of transmitters. A basic knowledge of action potential, resting potential, ion fluxes and channels etc.

Knowledge of 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 and the disturbances of these functions with relevance to organic and non-organic (functional) psychiatry.

The development and localisation 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.

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. The main hormonal changes in psychiatric disorders.

A basic understanding of neuroendocrine rhythms and their disturbance in psychiatric disorders.

A basic knowledge of the physiology of arousal and sleep and with particular reference to noradrenergic activity and the locus coeruleus.

The normal EEG (including frequency bands) and evoked response techniques. The applications to investigation of cerebral pathology, seizure disorders, sleep and psychiatric disorders. The effects of drugs on the EEG.

Neurochemistry

Transmitter synthesis, storage and release. Ion channels and calcium flux.

Knowledge of receptor structure and function in relation to the various neurotransmitters.

Pre-synaptic and post-synaptic receptors.

Basic pharmacology of noradrenaline, serotonin, dopamine, GABA, acetylcholine, excitatory amino acids.

Elementary knowledge of neuropeptides, particularly corticotrophin releasing hormone and cholecystokinin and the encephalins/endorphins.

Molecular Genetics

Basic concepts: chromosomes, cell division, gene structure, transcription and translation, structure of the human genome, patterns of inheritance.

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, lod scores.

Conditions associated with chromosome abnormalities.

Principal inherited conditions encountered in psychiatric practice and the genetic contribution to specific psychiatric disorders.

Prenatal identification. Genetic counselling. The organisation of clinical genetic services, DNA banks.

Molecular and genetic heterogeneity. Phenotype/genotype correspondence.

CLINICAL PSYCHOPHARMACOLOGY

The trainee will demonstrate knowledge of psychopharmacology. This knowledge will include will include pharmacological action, clinical indications, side effects, drug interactions, toxicity and appropriate prescribing practice. In particular trainees will be able to demonstrate knowledge of:

General Principles

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

Pharmacokinetics

General principles of absorption, distribution, metabolism and elimination. Particular reference to a comparison of oral, intramuscular and intravenous routes of administration as they affect drug availability, elimination as it affects the life of the drug in the body and access to the brain through the 'blood-brain barrier'. Applications of these to choice of administrative route and timing of doses. The relationship of culture and ethnicity to pharmacokinetics

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 principal CNS pharmacology of the main groups of drugs used in psychiatry with particular attention to their postulated modes of action in achieving therapeutic affect: at both molecular/synaptic and systems levels. These groups would include 'anti-psychotic' agents, drugs used in the treatment of affective disorder (both mood altering and stabilising), anxiolytics, hypnotics and anti-epileptic agents. The relationship of culture, race and ethnicity to pharmacodynamics.

Neurochemical affects 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.

Classifications of Psychiatric Disorders:

ICD-10 and DSM IV-R classification and diagnostic systems the various biological, psychological and social factors involved in the predisposition to and onset, and maintenance of psychiatric disorder.

The nature and process of psychiatric treatment, including the application of multidisciplinary approaches, the special role of the psychiatrist in treatment and the co-ordination of the various treatment processes involved. Physical, psychological and social treatments and their relevance to the management and treatment of psychiatric disorders. Preventative strategies in psychiatric disorder, where these exist.

The presentation of psychiatric disorder in a range of cultural settings, especially those likely to be encountered in the Middle East.

The assessment of need for psychiatric services within a community and how to set up and administer such services, including some idea of the costs of major elements of such service provision.

Rehabilitation:

Psychiatric assessment of patients with physical illness.

Assessment and management of patients who have harmed or threatened to harm themselves.

Advice to special medical services, such as endocrinology, neurology and neurosurgery, cardiothoracic surgery, nephrology, intensive care wards, special care baby wards, accident and emergency departments, HIV infection, haematology, oncology.

A working knowledge of neurology, including physical examination, diagnosis, investigation, Imaging of the nervous system and treatment of common conditions.

Knowledge of psychiatric aspects of head injury and stroke, and of rehabilitative strategies.

Clinical and theoretical aspects of pain and its management and disorders presenting with symptoms of physical disease.

Care of the dying and the bereaved. Bereavement Counselling.

Knowledge of staff interaction in general hospital services and of advising on this matter.

Emergency Psychiatry

At the completion of training, the trainee will be able to demonstrate competence in the assessment and management of emergencies in psychiatry. This will include:

- All aspects of suicide and attempted suicide including risk assessment and risk management
- Knowledge of the theory and practice of crisis intervention/home treatment
- Differential diagnosis in emergency situations

Psychotherapy

At the completion of training all trainees will be able to understand the principles and techniques of psychosocial therapies sufficient to treat patients using brief and supportive therapies and to know when and how to make a referral that is indicated. Further to this they will be able to explain to a patient prospective treatment if a referral is made. Thus they will be able to:

State the characteristics and techniques of, and common indications for psychodynamic psychotherapy, psychoanalysis, supportive psychotherapy, cognitive and behavioural therapies, group therapies, couples and family therapies and psycho educational interventions.

State the indications for and techniques of combining psychotherapy with psychopharmacology.

Describe behavioural interventions (e.g. relaxation training, assertiveness training, relapse prevention) and know for which problems they are indicated or contraindicated.

The knowledge to be demonstrated will include a variety of therapies and their cultural appropriateness:

Dynamic Psychotherapy

Development of psychodynamic concepts by Freud, the Neo-Freudians Klein, Jung and Winnicott. An understanding of the following: therapeutic alliance; transference; countertransference; resistance; negative therapeutic reaction; acting out; interpretation; insight; working through; defence mechanisms. Indications for brief, long-term and supportive psychotherapy. Therapeutic factors in groups.

Family Therapy

Influence of General Systems Theory. Different models of family therapy: dynamic; structural strategic; psycho educational; behavioural. Goals of treatment.

Cognitive-Behavioural Therapies

Cognitive Therapy: The cognitive model for non-psychotic disorders. The importance of schema, negative automatic thoughts and maladaptive assumptions. These will need to be considered in appropriate cultural contexts:

Appropriateness and effectiveness of psychotherapy, effect of culture and gender on therapy.

Behaviour Therapy: Understanding of systematic desensitisation, operant conditioning, graded and cue exposure, habituation and social skills training. How to conduct a functional analysis, formulate a treatment plan and use measurement to assess change.

Difficulties in defining outcome, understanding of effect size and meta-analysis, specific and non-specific effects in psychotherapy and be aware of contemporary guidelines.

CHILD AND ADOLESCENT PSYCHIATRY

At the completion of training the psychiatrist shall demonstrate a general knowledge of Child and Adolescent Psychiatry. This includes knowledge of the assessment and treatment of children and adolescents, knowledge of disorders that are usually first diagnosed in infancy, childhood or adolescence and developmental disabilities. In particular:

- The effects of adult mental illness on children. The effect of depression and other psychiatric symptomatology on parental functioning, and the impact of this on child development and functioning. An understanding of cultural variations in aetiology and management.
- The effects of early and continuing experience on later child, adolescent, and adult development and functioning. Long-term implications of early insecure attachment. Short and long-term effects of other negative life events on development and functioning e.g. maternal loss, child abuse, chronic or life-threatening illness.
- Classification, Aetiology and epidemiology of child and adolescent psychiatric disorder.
- Child protection. The needs of the developing child and how these change with time. Types of child abuse and their aetiology, recognition and outcome.
- Interaction between psychiatric disorder and physical illness. Physical presentation of psychiatric disorder.
- Knowledge of the prevalence, aetiology, presentation, treatments and outcome of the following conditions:
- Common pre-school problems – oppositional behaviour, temper tantrums, sleeping difficulties, feeding difficulties
- Conduct disorder
- Hyperactivity and attention deficit disorders
- School attendance and performance problems
- Emotional disorders, depression, OCD and schizophrenia specific to children and adolescents.
- Anorexia nervosa and deliberate self-harm in children and adolescents.
- Substance misuse
- Generalised mental handicap, specific delays in speech, language, reading, pervasive developmental disorders e.g. autism and Asperger's Syndrome
- Enuresis and encopresis, Tic disorder

- Family conflict problems.
- Continuation of childhood psychiatric disorder into adulthood.
- Treatment: The basic range of treatment methods: description, indications and contra-indications for different treatment interventions, outcomes. Indications for in-patient and day patient care.
- Description of a typical child psychiatric service. Basic information on different agencies involved in the care of children and their function.

OLD AGE PSYCHIATRY

At the completion of training the psychiatrist will demonstrate knowledge of the particular aspects of psychiatric disorders, their presentation and treatment in late life. This will include:

- Neurobiology of ageing. Psychology of ageing; cognition and age, importance of loss, personality changes with ageing.
- Social and economic factors in old age; attitude, status of the elderly, retirement, income, accommodation, socio-cultural differences.
- Psychopharmacology of old age; pharmacokinetics, pharmacodynamics, drug interactions, practical considerations. Drugs affecting mental functioning.
- Demographic changes. Epidemiology.
- District service provision; need for specialisation, principles of service provision, multidisciplinary working with reference to needs of an older population, relationships with and provision by social services and voluntary bodies. Liaison with geriatricians. Attention to the needs of carers. Appropriate legislation
- Assessment of a referral; psychiatric, physical, psychological and social.O.T. investigation including use of EEG and brain imaging. Use of home visits.
- Psychological aspects of physical disease; particular emphasis on possible psychiatric sequelae of Parkinson's disease, cerebrovascular disease, sensory impairment. Emotional reaction to illness and to chronic ill health. Reversible dementias. Delirium.
- Epidemiology, clinical features, differential diagnosis, aetiology, management and prognosis of the following:
- Dementia disorders
- Affective disorders in old age
- Late paraphrenia and paranoid states
- Anxiety disorders.
- Suicide and attempted suicide in old age.
- Psychiatric aspects of personality in old age.
- Psychotherapy with older adults: adaptations and difference in therapy.

  Transference - counter-transference issues. Common themes.

- Bereavement and adjustment disorders.
- Sleep disorder in later life.
- Alcohol and drug problems in the elderly.
- Psychosexual disorders in old age; including sexuality in physically ill/disabled people, sexuality in institutionalised elderly.
- Medico legal issues in old age psychiatry; abuse of the elderly. Management of property. Testamentary capacity. Driving.

OTHER CLINICAL SUBSPECIALTIES

At the completion of training all psychiatrists are expected to be knowledgeable and competent to a basic degree in sub-specialties of psychiatry. The level of knowledge and practice is to enable the individual doctor to deal with the majority of routine cases and emergencies that may be referred, not the level required to practice as a specialist in the given field

Addictions

Classification of disorders associated with the use and abuse of alcohol and other psychoactive substances:

Basic pharmacology and epidemiology of: alcohol; cannabis: the stimulants (amphetamine, cocaine, phentermine, diethylpropion, pemoline etc.); hallucinogens; solvents and nitrites; Ecstasy and related substances, benzodiazepines and barbiturates; opiates.

The restrictions imposed on doctors by the Royal Decree on and the legal provisions of the laws of Oman in respect of Misuse of Drugs.

Awareness of the arguments for and against the various types of prescribing and treatment modalities.

Cause, consequences and recognition of heavy drinking: the concept of 'problem drinking'; the components of the alcohol dependence syndrome; the nature of alcohol-related disabilities; detoxification procedures for in-patients and out-patients, who uses which drugs and why; reasons for initiating and continuing drug use; how to recognise drug use; the concept of problem drug use; patterns of dependence on different drugs; detoxification procedures for inpatients and outpatients. An understanding of cultural factors in the use and abuse of drugs.

The interaction of drug and alcohol use with psychiatric illness.

Basics of the biological, psychological and socio-cultural explanations of drug and alcohol dependence.

The assessment and management of drug and alcohol misusers.

Culturally appropriate strategies for the prevention of drug and alcohol abuse.

The assessment and management of non-substance addictive behaviours and related syndromes.

Dual diagnosis and co-morbidity (classificatory systems).

Recognition of substance misuse related medical, psychiatric and social complications and their impact on Public Health.

Forensic Psychiatry:

Relationship between crime and mental disorder

Knowledge of the range of offences committed by mentally disordered offenders; specific crimes and their psychiatric relevance particularly homicide, other crimes of violence, sex offences, arson, shoplifting and criminal damage.

The relationship between specific illnesses and crime and Special syndromes:

Morbid jealousy, erotomania, Munchausen and Munchausen by proxy. Mental disorders and offending in special groups: young offenders, females, ethnic minorities; substance misuse and crime; offenders with brain damage, epilepsy, deafness and other physical disabilities.

Psychiatry and the criminal justice system of Oman and other countries:

An outline of the procedures of arrest, prosecution and sentencing. Role of police in arrest of mentally disordered offenders, the assessment of defendants at police stations, false confessions.

Psychiatric defences

Fitness to plead, mutism and deafness, criminal responsibility, diminished responsibility, infanticide, amnesia and automatism. Psychiatric disposals after conviction.

Candidates will not be expected to have detailed knowledge of mental health legislation or psychiatric defences in more than one jurisdiction. They should be able to describe the principles upon which the mental health legislation and psychiatric defence of one particular jurisdiction is based.

Writing reports and giving evidence

Principles of assessing a defendant for the court and preparing a psychiatric court report in a criminal case.

Facilities and treatment (available and those planned):

Elements of a Forensic Psychiatry service, their relationship to each other and other specialties. The use of security in the treatment of psychiatric patients and the arguments for and against seclusion. The long-term management of patients on restriction orders. Care in the community for previously violent patients.

Assessment of Dangerousness

The concept, definitions and situations where assessment is required. Problems in prediction.

Psychiatry in prisons

Knowledge of the prevalence of psychiatric disorder in prison populations, suicide in prisoners, psychiatric treatment in prison settings.

Victims

The psychological sequelae of victimisation, especially anxiety states, anger and aggressive behaviour. Post Traumatic Stress Disorder, Compensation, Compensation Neurosis and other medico-legal issues.

Civil matters

Psychiatric disorder and civil rights including marriage, divorce, custody of children and management of property and affairs. Ethical issues including confidentiality and the implications of 'duty to warn'. Claims of psychiatric damage, for example Post Traumatic Stress Disorder.

Learning Disability (Mental retardation)

The topics suggested should complement those topics which will be covered in other areas of psychiatry, particularly neuropsychiatry and child psychiatry:

Developmental

The neurobiology of brain development and the effects of genetic and environmental factors.

More common learning disability disorders. For example, Down's Syndrome, fragile-X syndrome, foetal alcohol syndrome and the developmental problems of very low birth weight babies.

Specific disorders of development including autism and Asperger's syndrome.

The influence of social factors on intellectual and emotional development.

Classification and Epidemiology

An historical perspective to methods of classification.

Modern systems of classification including ICD-10 and the WHO classification of impairments, disabilities and handicaps. A working knowledge of 'statementing' for special needs education.

The prevalence of intellectual impairment in the general population. The prevalence of superadded behavioural, psychiatric and other impairments within this group. The factors which might account to the observed high rates of psychiatric behavioural disorders in this group.

Clinical characteristics of learning disability and mental handicap:

The presentation, diagnosis and treatment of psychiatric illness and behavioural disorder in people with a learning disability (mental handicap).

Psychological methods of assessment and an understanding of psychological theories as to the cause of problem behaviours. An understanding of relevant behavioural modification techniques.

The application of psychiatric methods of treatment in learning disability (mental handicap) including psychotherapy, drug treatments, behaviour therapy and cognitive therapy.

Specific syndromes and their association with particular psychiatric or behavioural disorders (behavioural phenotypes).

The impact of disability on the family and the psychological consequences of having a child with a disability.

The assessment, management and treatment of offenders with a learning disability (mental handicap).

Other issues:

Service development for people with a learning disability (mental handicap). The change from an institutional to an individualised, needs based approach.

The provision of specialist psychiatric services for people with a learning disability (mental handicap).

APPENDIX 2

Lectures (2-4 P.M)

YEAR 1

Topic	**No. of lectures**
ANATOMY : Neuroanatomy: Brain & CNS The resident will understand the crucial role of the functional anatomy of the brain in the practice of modern psychiatry	10
PHYSIOLOGY: Physiology of the CNS The resident will have an adequate knowledge of the role and physiology of the nerve cell in psychiatric illnesses (especially dementia and other organic brain syndromes). Understand receptors (agonism, antagonism, block, etc., and be cognizant of role of physiology of sleep, sex & appetite in mental illness.	10
GENETICS: Understand the crucial role of Genetics and do genetic counseling for almost all psychiatric illnesses	5
MEDICINE (endocrinology unit) Endocrinology: hormones: mood & behavior: Understand the role played by hormonal disturbances in the occurrence of psychiatric symptoms and co-morbidity	5
RADIOLOGY & NUCLEAR MEDICINE: Radiology & Nuclear medicine: CT scan – MRI- f MRI- PET- SPECT. The future psychiatrists would be able to use, read, & interpret results of modern tools of investigations	5
EPIDEMIOLOGY AND STATISTICS: Develop a good knowledge about statistics is a corner stone for a future psychiatrist who is expected to conduct studies	5
NEUROPHYSIOLOGY: EEG, PSG Basic knowledge and the ability to interpret EEG and PSG	3

At the end of the first year, the candidate should be given a good grounding in medical and basic sciences that will help him in the following years to understand and follow the rapid changes occurring in the field of psychiatry.

The candidate, by the end of the first year is supposed to have refreshed and updated his knowledge about the anatomical and physiological basis of the human behaviour and acquired more skills in dealing with the new tools of investigations modern technology has added to psychiatry.

In addition, the candidate is supposed at the end of this year to have acquired the ability to evaluate researches from a statistical aspect.

YEAR 2

Topic	No. of lectures
Psychology from cultural perspectives: Such course is quite important to relate the future psychiatrist not only to his western view on human nature, but also to that of the patients reflect his or her milieu. The role of culture in coping with psychological stresses is paramount.	1
General Psychology: The processes of consciousness and perception, learning, memory, basic motivation and motives, personality and individuality should constitute integral part of this program. Emotions, thinking, perception, attention, memory, learning, defense mechanisms	8
Schools of Psychology: Psychiatrist ought to be equipped with historical origin of psychology, contemporary psychological perspectives and different psychology paradigm.	8
Personalities: shaping traits & types: The candidate should be able to understand how different types personalities are shaped and factors affecting individuality.	3
Sexuality and gender: development and problems: A quite important subject to know about in order to understand a whole group of psychiatric diseases.	1
Child Psychology: Childhood is a rich period from the psychological aspect. Many of the psychiatric troubles could be traced to experiences and events that happened in childhood. Knowledge about the normal psychological needs of a child would help the future psychiatrist to guide parents to meet these needs.	4
Adolescent Psychology: Adolescence is characterized by physical, cognitive, emotional and behavioral changes. Adolescent turmoil has been documented even though normal adolescents usually do not show serious emotional or behavioral changes, and these problems are now viewed as evidence of disorder.	2
Psychology of the elderly: Development does not end at puberty or during adulthood but it continues from cradle to the grave. With this recognition, changes that occur in normal aging as stress and distress in coming to terms with one increased infirmity.	2
Overview of psychological treatment to psychiatric patients: Complementing pharmacological intervention to mitigate stress and distress, there are various techniques that go under the umbrella of psychotherapy that have been shown to relieve people's distress and improved quality of life. Acquired psychotherapeutic know-how should be integral part of psychiatric intervention. Additionally, some element of psychotherapeutic interaction bear direct relevancy in communication skill and patient-doctor interactions.	10
Psychology (Communication skills)	2

Psychometric: In the absent of correlate of neuropathalogical changes in psychiatric patients, mental health professional often rely heavily on assessment measures to evaluate patients personality, intellectual functioning and other indices of higher cognitive functioning. Such psychometric assist in charting patients' progress and severity of their distress.	3
Cross-cultural psychology: Psychiatric illness are often viewed to be exacerbated by life events which often hinges on cultural teaching. Cross-cultural psychological is a venue for explore what constitute culture-specific behavior or universal human reaction.	2
Social Interventions: A future psychiatrist should learn how do social factors affects mental health, and how social interventions could help.	3

At the end of the second year, the candidate should have understood the basic principles of psychology and psychotherapy and how do social and cultural factors affect the clinical presentation of a patient.

YEAR 3

Topic	**No. of lectures**
History of psychiatry in the Arabic area	1
Communication skills (Out of question that all doctors – not only psychiatrists- should have a minimal threshold of continuously improving communication skills)	2
Interviewing skills (Interviewing psychiatric patients is more or less an art that a future psychiatrist has to be trained on . It is a continuous process. In these lectures we give only the basic rules)	3
Signs & symptoms in psychiatry and Psychopathology	6
Etiology in psychiatry	4
Reaction to stressful events	4
Anxiety disorders	6
Obsessive compulsive disorders	3
Affective disorders	6
Schizophrenia & related disorders	6
Suicide & deliberate self harm	2
Dementias & other organic brain diseases	6

At the end of the third year, the candidate is supposed to have been trained in carrying out a good mental state examination , he should have acquired a good knowledge of etiological factors in psychiatry, an adequate experience in clinical diagnosis using psychiatry interview techniques of adult, children and families as well as a mature clinical judgment.

YEAR 4 - Psychiatry & Medicine

Topic	No. of lectures
Alcohol & drug abuse	8
Psychiatry & Medicine: Psychiatric symptoms as a constitutional part of non psychiatric disorders, Somatic disorders with Psychiatric presentations, Psychosomatic disorders and related disorders	6
Child psychiatry	8
Adolescent psychiatry	4
Drugs & other physical treatments	8
Psychiatric emergencies	10
Psychiatry & law in Oman	4

At the end of the final year, the candidate should have acquired a holistic approach to the human health; relating body to mind ones and vice versa.

He should have acquired a good experience in sub-specialties of clinical psychiatry, with a specific concern about the regional factors that may affect the clinical approach to a case, especially in the fields of child & adolescent psychiatry, and of alcohol & drug abuse.

The candidate is supposed to have given the basic principles of pharmacotherapy as appropriate for the acutely disturbed patients , for those who are in an emergency state, and for those requiring follow up in the outpatients clinics.

EXAMINATION SUB-COMMITTEE

Proposal of the sub-committee for OMSB examinations in Psychiatry:-

The trainees are evaluated during their training in psychiatric OMSB programme through comprehensive assessment methods:

- Rotational assessments by the Educational Supervisor/Consultant, including assessment of knowledge, skills and attitude.
- Annual examination at the end of R1,R2 and R3.
- Final Board examinations, Parts I and II.
- Research* (membership to be awarded after passing final board exams and upon completing a research project).

Each method of assessment is highlighted in the following table:

Method of Assessment	Subjects / Description	Marking	Timing
Rotational Assessments	Aims to assess the candidate's performance during the clinical rotations. It focuses mainly on their knowledge, attitude and skills. The assessment is done through the following tools/ methods (the passing mark will be 60% of the overall examinations collectively): 1. ***Monthly & End of rotation assessments*** (copy attached). 2. ***Case presentation***: 2 comprehensive case presentations per rotation and of satisfactory standard (total 4 cases per year) 3. ***Critical appraisal/journal club presentation;*** one per rotation and of satisfactory standard (total 2 presentations per year)	It constitutes **50%** of the total annual evaluation; divided accordingly: **20%** of total annual marks **20%** of total annual marks **10%** of total annual marks	Monthly and end of each six month's rotation

Annual Exam	The exam aims to assess the knowledge of the candidate at the end of years R1,R2 and R3. It consists of **100 MCQs / EMQs** for two hours. The minimum passing mark is **60%** and it is essential for the candidate to pass the exam in order to progress into the following study year. The candidate has total of **three** attempts to resit for the exam. The fourth attempt may be granted by the Board Trustees.	It constitutes **50%** of the annual evaluation	**End of September** of year (R1,R2,R3). The resit exam to be undertaken every 6 months
Final Board Exam (Part I)	Aims to assess the knowledge of the candidate covering all the basic subjects. It consists of : • ***150 MCQs/EMQs*** for three hours (60%). Each question consisting of **five choices** with only one single correct answer and there is **no** negative marking. • ***15 short essay questions*** for two hours (40%) The candidate is eligible to sit for the exam **only** after passing the second year (R2). The minimum passing mark is **60%**. The candidate has total of **three** attempts to sit for the exam. The fourth attempt may be granted by the Board Trustees. However, passing the Part I exam. Is not considered as mandatory for progress through the third and fourth year of training.	**60%** of the total mark **40%** of the total mark	To be undertaken as from the end of second year (R2) and re-attempted at six – monthly intervals.

Final Board Exam (Part II)	The final examination is a comprehensive exam assessing the knowledge, skills and attitude of the candidate. Candidates will be examined in all subjects (theory and clinical) attained throughout the training years. Candidate is eligible to sit for this exam only after passing the overall annual assessments and Final board Part I exam. The minimum passing mark is **60%** in **each part**. It is divided into three parts: ***1. Theory part*** consisting of : • ***150 MCQs***/***EMQ*** focused on the clinical aspects. It is for three hours. • ***15 short essay*** questions for two hours. • ***Patient management problem*** paper for one hour. It is essential for the candidate to pass the theory exam with minimum 60% of total theory mark in order to proceed into the clinical exam. Theory part is to be re-attempted, maximum of 5 attempts in case the candidate failed the clinical.	**50%** of the total theory mark **30%** of the total theory mark **20%** of the total theory mark Overall THEORY mark will constitute **40%** of the FINAL mark.	**End of R4,** end of October.
	2. Clinical part consisting of : • ***Long case*** for one hour. • ***5-10 OSCE*** stations, average of 10 minutes per station.	(**75%** of overall clinical + oral mark) **50%** of the total clinical mark **50%** of the total clinical mark	

	3. Oral exam: • To be conducted by two committees (minimum of two examiners including one independent/external examiner in each committee). • Each candidate will be examined for 30 minutes in each committee. Maximum of 5 attempts to resit the exam will be allowed.	(**25%** of overall clinical + oral mark) Overall clinical + oral mark will constitute **60%** of the FINAL mark.	

Research:

The research work is a prerequisite for the final board exam. It can be started after R1, and presented at an appropriate time during the residency program, NO LATER than six months prior to the date of final board examination. The topics chosen must be relevant to the Omani population. They can be done for the patients in the hospital (retrospective, prospective or combined), or in the community (schools, different centres) as surveys. The research paper must include:

- Introduction
- Methods
- Results
- Discussion
- Conclusion
- References

Case reports are not considered as research. The research must be:

- presented publicly
- evaluated by three Scientific committee members
- the passing mark is 60%

In case of getting less 60%, a period of six months is given to complete the work and another trial is allowed.

ACCREDITATION SUB-COMMITTEE

Introduction

Accreditation process is a regulatory process to improve the quality of health by ensuring and improving the quality of postgraduate medical education. It strives to develop evaluation methods and processes that are valid, fair, open and ethical.

Objectives of accreditation

1. Improving the quality of postgraduate medical education
2. Providing means for objective assessment of residency programmes
3. Providing guidance in the development of new residency programmes
4. Assisting programme directors in reviewing the conduct and educational quality of their programmes.

To achieve these objectives, essential elements in each aspect of a programme have been identified which must reach established accreditation standards before the programme can be accredited. The role of accreditation subcommittee in psychiatry is to assist OMSB accreditation committee in its work to:

- recommend policies, standards and criteria relating to psychiatric residency programme and training centres.
- review periodically the general accreditation criteria of the OMSB for the programme and training centres.
- review periodically the residents' rotations to ensure that the training objectives are fulfilled and the exit examination criteria are achieved.
- ensure didactic training of residents eg. lecture series, conferences and seminars satisfying the training requirements.
- evaluate any new training centre that is being considered for addition to the training programme.

Accreditation criteria

For the Psychiatric training programme to be accredited by the accreditation committee of OMSB, the following requirements must be fulfilled.

a) Meet the requirements for accreditation as detailed in the OMSB general accreditation requirements

b) Meet the specific accreditation requirements for Psychiatry residency programme and the training centres (psychiatric department of Sultan Qaboos University Hospital and Ibn Sina Psychiatric Hospital)

Specific requirements for psychiatry

Definition

An approved residency program in psychiatry must provide an educational experience designed to ensure that its graduates will possess sound clinical judgment, requisite skills, and a high order of knowledge about the diagnosis, treatment, and prevention of all psychiatric disorders, together with other common medical and neurological disorders that relate to the practice of psychiatry.

Although residents cannot be expected to achieve the highest possible degree of expertise in all of the diagnostic and treatment procedures used in psychiatry in 4 years of training, those individuals who satisfactorily complete residency programs in psychiatry must be competent to render effective professional care to patients. They must, furthermore, have a keen awareness of their own strengths and limitations, and of the necessity for continuing their own professional development.

The didactic and clinical program must be of sufficient breadth and depth to provide residents with a thorough and well-balanced presentation of psychological, socio-cultural, and neurobiological observations, theories and knowledge of major diagnostic and therapeutic procedures in the field of psychiatry. The program must also provide the education and training necessary to understand the major psychiatric literature, to evaluate the reliability and validity of scientific studies, and to incorporate appropriately new knowledge into the practice of medicine.

Programs are expected to operate in accordance with the Principles of Ethics with Special Annotations for Psychiatry", and to ensure that the application and teaching of these principles are an integral part of the educational process.

Duration and Scope of Education

Admission requirements, as specified by OMSB

Length of program- complete psychiatry residency is 48 months.

Program Format by Year of Training as it is outlined in the program curriculum

Accreditation of health institutions as training centres requires that they meet the following requirements:

Institutions

A, Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating institutions.

a) Programs should be conducted under the sponsorship of an institution that meets the Institutional Requirements that apply to residency programs in all specialities.

b) The administration of the sponsoring institution should be understanding of and sympathetic to the attainment of educational goals, and should evidence its willingness and ability to support these goals philosophically and financially. The latter includes a commitment by the institution and by the program that embraces appropriate compensation for faculty and residents, adequate offices and educational facilities, support services, and opportunities for research.

B. Participating Institution

Assignment to an institution must be based on a clear educational rationale, integral to the program curriculum, with clearly-stated activities and objectives. When multiple participating institutions are used, there should be assurance of the continuity of the educational experience.

Assignment to a participating institution requires a letter of agreement with the sponsoring institution. Such a letter of agreement should:

a) identify the faculty who will assume both educational and supervisory responsibilities for residents;
b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;
c) specify the duration and content of the educational experience; and
d) state the policies and procedures that will govern resident education during the assignment.

It is important that each affiliated institution demonstrate significant commitment to the overall program. The educational rationale for including each institution within the program must be stated. The number and distribution of participating training sites must not preclude satisfactory participation by residents in teaching and didactic exercises.
Geographic proximity will be one factor in evaluating program cohesion, continuity, and *critical mass*. Affiliated training-sites will be evaluated on the basis of whether they contribute to a well- integrated educational program, with respect to both didactic and clinical experiences.

Program Curriculum

Each program must offer its residents planned and sufficient educational experiences. These educational experiences should include presentations based on a defined curriculum, journal review, administrative seminars, and research methods. They may include, but are not limited to, problem-based learning, laboratories, and computer-based instruction, as well as joint conferences cosponsored with other disciplines.

The program design and sequencing of educational experiences should be approved by the scientific committee of the OMSB as part of the review process.

The program must possess a written statement that outlines its educational goals with respect to the knowledge, skills, and other attributes of residents for each major assignment and for each level of the program. This statement must be distributed to residents and faculty, and must be reviewed with residents prior to their assignments. All educational components of a residency program should be related to program goals.

The program should have specific training objectives and clear curriculum for each study year.

The program must possess a well-organized and effective curriculum, both didactic and clinical. The curriculum must also provide residents with direct experience in progressive responsibility for patient management.

The didactic and clinical curriculum must be of sufficient breadth and depth to provide residents with a thorough, well-balanced presentation of the generally- accepted theories, schools of thought, and major diagnostic and therapeutic procedures in the field of psychiatry.

Each program must provide an opportunity for residents to participate in research or other scholarly activities, and residents must participate actively in such scholarly activities.

The curriculum must include a significant number of interdisciplinary clinical conferences and didactic seminars for residents in which psychiatric faculty members collaborate with neurologists, internists, and colleagues from other medical specialties and mental health disciplines.

Clinical training must include adequate, regularly scheduled, individual supervision. Each resident must have at least 1-2 hours of individual supervision weekly, in addition to teaching conferences and rounds, except when on non-psychiatric rotations.

Didactic instruction must be systematically organized, thoughtfully integrated, based on sound educational principles, and include prepared lectures, seminars, and assigned readings that are carried out on a regularly- scheduled basis. In a progressive fashion, it should expose residents to topics appropriate to their level of training. Staff meetings, clinical case conferences, journal clubs, and lectures by visiting professors are desirable adjuncts, but must not be used as substitutes for an organized didactic curriculum.

The curriculum must include adequate and systematic instruction in neurobiology; psychopharmacology, and other clinical sciences relevant to psychiatry, child and adult development; major psychological theories, including learning theory, psychodynamic

theory, and appropriate material from the socio-cultural and behavioral sciences such as sociology and anthropology. The curriculum should address development, psychopathology, and topics relevant to treatment modalities employed with patients with severe psychiatric disorders/conditions.

The residency program should provide its residents with instruction about Omani and Arab culture and subcultures, particularly those found in the patient community associated with the training program. This instruction should include such issues as gender, race, ethnicity, socioeconomic status, religion/spirituality, and sexual orientation. Also the curriculum should contain enough instruction about these issues to enable residents to render competent care to patients from various cultural and ethnic backgrounds. Understanding cultural diversity is an essential characteristic of good clinical care. The program must devote sufficient didactic training to residents whose cultural backgrounds are different from those of their patients, and provide a suitable educational program for them as well.

Didactic exercises must include resident presentation and discussion of clinical case material at conferences attended by faculty and fellow residents. This training should involve experiences in integrative case formulation that includes neurobiological, phenomenological, psychological, and socio-cultural issues involved in the diagnosis and management of cases presented.

The clinical services must be so organized that residents have major responsibility for the care of a significant proportion of all patients assigned to them, and have sufficient and ongoing high-quality supervision. The number of patients for which residents have primary responsibility at any one time must be adequate enough to permit them to provide each patient with appropriate treatment, and to have sufficient time for other aspects of their educational program. At the same time, the total number must be large enough to provide an adequate depth and variety of clinical experiences. The amount and type of patient care responsibility a resident assumes must increase as the resident advances in training. Each resident must have major responsibility for the diagnosis and treatment of a reasonable number and adequate variety of patients with both acute and chronic illnesses representing the major psychotic and non psychotic categories of psychiatric diagnoses/conditions. Adequate experience in the diagnosis and management of the medical and neurological disorders encountered in psychiatric practice also must be ensured. Each resident must have supervised experience in the evaluation and treatment of patients of different ages throughout the life cycle and from a variety of ethnic, racial, socio-cultural, and economic backgrounds. It is desirable that residents have didactic learning and supervised experiences in the delivery of psychiatric services in the public sector and in managed care health systems.

The **didactic curriculum** should include:

- critical appraisals of the major theories and viewpoints in psychiatry, together with a thorough grounding in the generally accepted clinical facts;
- presentation of the biological, psychological, socio cultural, economic, ethnic, gender, religious/spiritual, sexual orientation, and family factors that significantly influence physical and psychological development throughout the life cycle;

- presentation of the aetiologies, prevalence, diagnosis, treatment, and prevention of all major psychiatric disorders in the current standard diagnostic statistical manual, including the biological, psychological, socio-cultural, and iatrogenic factors that affect the long-term course and treatment of psychiatric disorders and conditions;
- comprehension of the diagnosis and treatment of neurological disorders commonly encountered in psychiatric practice, such as neoplasm, dementia, headaches, traumatic brain injury, infectious diseases, movement disorders, multiple sclerosis, Parkinson's disease, seizure disorders, stroke, intractable pain, and other related disorders; the use, reliability, and validity of the generally- accepted diagnostic techniques, including physical examination of the patient, laboratory testing, imaging, neurophysiologic and neuropsychological testing, and psychological testing;
- the financing and regulation of psychiatric practice, including information about the structure of public and private organizations that influence mental health care;
- medical ethics as applied to psychiatric practice;
- the history of psychiatry and its relationship to the evolution of medicine;
- the legal aspects of psychiatric practice;
- research methods in the clinical and behavioral sciences related to psychiatry.

Clinical training should provide sufficient experiences in:

- the elements of clinical diagnosis with all age groups (of both sexes, to include some ethnic minorities), such as interviewing; clear and accurate history taking; physical, neurological, and mental status examination; and complete and systematic recording of findings;
- relating history and clinical findings to the relevant biological, psychological, behavioral, and socio-cultural issues associated with aetiology and treatment;
- formulating a differential diagnosis and treatment plan for all psychiatric disorders in the current standard nomenclature, taking into consideration all relevant data;
- the major types of therapy, including short and long-term individual psychotherapy, psychodynamic psychotherapy, family/couples therapy, group therapy, cognitive and behavior therapy, crisis intervention, drug and alcohol detoxification, and pharmacological regimens, including concurrent use of medications and psychotherapy;
- electroconvulsive therapy, a somatic therapy that is viewed as so important that its absence must be justified (Examples of other somatic therapies include biofeedback and phototherapy.);
- providing continuous care for a variety of patients from different age groups, seen regularly and frequently for an extended time, in a variety of treatment modalities;
- psychiatric consultation in a variety of medical and surgical settings;
- providing care and treatment for the chronically- mentally ill with appropriate psychopharmacologic, psychotherapeutic, and social rehabilitative interventions;

- psychiatric administration, especially leadership of interdisciplinary teams, including supervised experience in utilization review, quality assurance and performance improvement;
- providing psychiatric care to patients who are receiving treatment from non medical therapists and coordinating such treatment;
- knowledge of the indications for and limitations of the more common psychological and neuropsychological tests;
- critically appraising the professional and scientific literature; and
- Teaching psychiatry to medical students, residents, and others in the health professions.

Program format by year of training

First Year of Training

Objectives of Training in the first year

The training obtained during the first postgraduate- year should provide residents with medical skills most relevant to psychiatric practice. These include being able to:

- perform a complete initial history and physical examination, including appropriate diagnostic studies;
- diagnose common medical and surgical disorders, and to formulate appropriate initial treatment plans;
- provide limited, but appropriate, continuous care of patients with medical illnesses, and to make appropriate referrals;
- be especially conversant with medical disorders displaying symptoms likely to be regarded as psychiatric, and with psychiatric disorders displaying symptoms likely to be regarded as medical;
- be especially cognizant of the nature of the interactions between psychiatric treatments and medical and surgical treatments; and
- be able to relate to patients and their families, as well as other members of the healthcare team with compassion, respect, and professional integrity.
- The rotation of a psychiatric first postgraduate-year is subjected to the curriculum and clinical rotation approved by curriculum sub-committee. It is suggested to include:
- At least 3 months rotation in internal medicine. This training must be in a clinical setting which provides comprehensive and continuous patient care. Neurology rotations may not be used to fulfil this 3-month requirement.
- One month, but no more, of this requirement may be fulfilled by an emergency medicine or intensive care provided the experience is predominantly with medical evaluation and treatment and not surgical procedures.

- A minimum of 2 months of neurology, or its full-time equivalent on a part- time basis, is required prior to completion of training. It is highly desirable that this experience occurs during a psychiatric first postgraduate year and it may include a maximum of one month of supervised inpatient or outpatient child neurology.
- A psychiatric first postgraduate- year should not include more than 8 months and not less than 6 months in psychiatry.
- The program director of the Department of Psychiatry must maintain contact with residents during the first postgraduate-year while they are on services other than psychiatry.

Second through Fourth Years of Training

Objectives of Training in the second through fourth years

The program must provide a well-planned, high-quality curriculum that includes specific, assessable objectives for program components as well as criteria for graduation. These must be stated in writing and provided to each resident and faculty member. Residents must be taught to conceptualize all illnesses in terms of biological, psychological, and socio cultural factors that determine normal and abnormal behavior. They must be educated to gather and organize data, integrate these data within a comprehensive formulation of the problem to support a well-reasoned differential diagnosis, formulate a treatment plan, and implement treatment and follow- up care as required. The program must provide residents with sufficient opportunities to develop knowledge, clinical skills, sensitivity to cultural diversity, and professional principles.

Although some of the training described below may be offered in the first postgraduate-year, all must be completed prior to graduation from the program.

a) The program must have an explicitly-described educational curriculum which covers the broad spectrum of clinical psychiatry

b) The formal didactic instruction must include regularly scheduled lectures, teaching rounds, seminars, clinical conferences, and required-reading assignments covering the topics identified in the program.

c) There must be an educationally sound balance among time spent in direct patient care, clinical and didactic teaching, and supervision. Formal educational activity shall have high priority in the allotment of the resident's time and energies. Service needs and clinical responsibilities must not prevent the resident from obtaining the requisite didactic educational activities and formal instruction.

d) The program should ensure that residents are relieved of non-emergent clinical duties in order to attend these planned educational experiences. Although release from some off-service rotations may not be possible, the program should require that each resident participate in at least 70% of the planned psychiatry educational experiences offered (excluding vacations). Attendance must be monitored and documented.

Program Personnel

A. Program Director:

There must be a single program director responsible for the program. The person designated with this authority is accountable for the operation of the program. The program director must devote at least one-half of his or her time to the administration and operation of the educational program, including didactic, supervisory, and clinical teaching activities. Programs with multiple institutions, many residents, and/or large clinical populations will require additional time.

The program director, together with the faculty, is responsible for the general administration of the program, including those activities related to the recruitment, selection, instruction, supervision, counselling, evaluation, and advancement of residents, as well as the maintenance of records related to program accreditation, and for the establishment and maintenance of a stable educational environment. Adequate lengths of appointment for both the program director and faculty are essential to maintaining such an appropriate continuity of leadership.

Frequent changes in leadership or long periods of temporary leadership usually have a negative effect on an educational program, and may adversely affect the accreditation status of the program.

Qualifications of the program director must:

a) possess the requisite psychiatry expertise as well as documented educational, clinical, and administrative abilities.
b) be certified in the specialty by a Speciality Board of Psychiatry recognized by OMSB
c) must be appointed in good standing and based at the primary teaching site, and must be licensed to practice Psychiatry in Oman.

Responsibilities of the program director are as follows:

a) Oversee and organize the activities of the educational program in all institutions that participate in the program. This includes selecting and supervising the faculty and other program personnel at each participating institution, appointing a local site director, and monitoring appropriate resident supervision at all participating institutions.

b) Responsible for preparing an accurate statistical and narrative description of the program as requested by OMSB, as well as updating annually both program and resident records through OMSB's Accreditation Data System.

c) Ensure the implementation of fair policies, grievance procedures, and due process, as established by the sponsoring institution and in compliance with the Institutional Requirements.

d) Seek the prior approval of OMSB for any changes in the program that may significantly alter the educational experience of the residents, in order to determine if an adequate educational environment exists to support these changes and if the program's clinical and academic resources are adequate to support these changes. Such changes, for example, include:

   1. the addition or deletion of a participating institution;
   2. a change in the format of the educational program, or the addition of any rotation of 6 months' full-time equivalent or longer;
   3. a change in the approved resident complement for those specialties that approve resident complement;
   4. any change in the total length of the program. On review of a proposal for any such major change in a program, OMSB may determine that a site visit is necessary.

e) The program director must make resident appointments and assignments in accordance with institutional and departmental policies and procedures.

f) Supervise residents through explicit written descriptions of supervisory lines of responsibility for the care of patients. Such guidelines must be communicated to all members of the program staff.

g) Regularly evaluate residents' knowledge, skills, and overall performance, including the development of professional attitudes consistent with being a physician.

h) Provide written information to applicants and residents regarding financial compensation, liability coverage, and the policies regarding vacations, sick leave, parental leave, and other special leaves.

i) Monitor residents' stress, including physical or emotional conditions which inhibit performance or learning, as well as drug or alcohol-related dysfunction. Program directors and teaching staff should be sensitive to the need for timely provision of confidential counselling and psychological support services to residents. Training situations that consistently produce undesirable stress on residents must be evaluated and modified.

j) Maintain a permanent record of evaluation for each resident that is accessible to the resident and other authorized personnel. These records will be made available on review of the program.

k) Notify the Executive Director of OMSB in writing within 60 days of any major change in the program that may significantly alter the educational experience for the residents, including:

   1. changes in leadership of the department or the program;
   2. changes in administrative structure, such as an alteration in the hierarchical status of the program/department within the institution; and
   3. changes in the resident complement that would bring the number of residents below the required critical mass of 3 residents per year for 2 consecutive years.

B. The Training Faculty:

The training faculty is the consultants and specialists who work in the health institutions and who are qualified to train and educate residents in the specific specialty.

1. At each participating institution, there must be a sufficient number of faculties with documented qualifications to instruct and supervise adequately all residents in the program.

2. The faculty, furthermore, must devote sufficient time to the educational program to fulfil their supervisory and teaching responsibilities. They must demonstrate a strong interest in the education of residents, sound clinical and teaching abilities, commitment to their own continuing medical education, participation in scholarly activities, and must support the goals and objectives of the educational program of which they are a member.

3. Qualifications of the physician faculty are as follows:

   a) The physician faculty must possess the requisite specialty expertise and competence in clinical care and teaching abilities, as well as documented educational and administrative abilities and experience in their field.
   b) The physician faculty must be certified in the specialty from a recognized board of psychiatry, or possess qualifications judged to be acceptable by the authorized scientific committee.
   c) The physician faculty must be appointed in good standing to the staff of an institution participating in the program.

4. Qualifications of the Non-physician faculty are as follows:

   - Non-physician faculty must be appropriately qualified in their field.
   - Non-physician faculty must possess appropriate institutional appointments.

5. The faculty must participate regularly and systematically in the training program, and must be readily available for consultation whenever a resident is faced with a major therapeutic or diagnostic problem.
6. The faculty psychiatrists should actively participate in the planning, organization, and presentation of conferences as well as in clinical teaching and supervision.
7. A member of the teaching staff of each participating institution must be designated to assume responsibility for the day-to-day activities of the program at that institution, with overall coordination by the program director.
8. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty, and an active research component must be included in each program. Regular participation of the teaching staff in clinical discussions, rounds, journal clubs, and research conferences in a manner that promotes a spirit of inquiry and scholarship (e.g., the offering of guidance and technical support for residents involved in research such as research design and statistical analysis); and the provision of support for residents' participation, as appropriate, in scholarly activities.

There must be evidence of scholarly activity among the faculty psychiatrists. Although not all members of a faculty need to be investigators, scholarly activities should be present on a continuous basis.

There should also be evidence of participation in a spectrum of academic and professional activities within the institution, as well as within local and national associations.

9. The teaching staff must be organized, and have regular documented meetings to review program goals and objectives as well as program effectiveness in achieving them. At least one resident representative should participate in these reviews.
10. The training centre must assure that training faculty has enough time to fulfill their training duties and their administrative responsibilities.

C. Chair of Psychiatry

The chair of psychiatry must be a physician, and must either be certified by the A recognized Board of Psychiatry and Neurology or judged by the OMSB to possess appropriate educational qualifications.

D. Education Policy Committee

The director of the residency program should have an educational policy committee composed of members of the psychiatry program teaching staff that includes representation from the residents as well as a member of the teaching staff from each OMSB approved subspecialty residency that may be affiliated with the psychiatry residency. There should be a written description of the committee, including its responsibility to the sponsoring department or institution and to the program director. This committee should participate actively in:

1. Planning, developing, implementing, and evaluating all significant features of the residency program, including the selection of residents (unless there is a separate residency selection committee);

2. Determining curriculum goals and objectives; and

3. Evaluating both the teaching staff and the residents.

E. Other Program Personnel

Additional necessary professional, technical, and clerical personnel must be provided to support the program.

Residents' Appointment

A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.

1. The program director is responsible for maintaining a process for selecting resident physicians who are personally and professionally suited for training in psychiatry. It is highly desirable that each program have a residency selection committee to advise the program director.

2. The residency program director must accept only those applicants whose qualifications for residency include sufficient command of English and Arabic to facilitate accurate, unimpeded communication with patients and teachers.

3. All programs should state specifically and as clearly as possible the objectives and competencies required for successful completion of the program. These objectives and criteria should be made available to residency applicants.

B. Number of Residents

OMSB will approve the number of residents based upon established written criteria that include the adequacy of resources for resident education (e.g., the quality and volume of patients and related clinical material available for education), faculty-resident ratio, institutional funding, and the quality of faculty teaching. However, in order to promote an educationally-sound, intellectually-stimulating atmosphere of effective and graded responsibility, programs must maintain a critical mass of at least 3 residents at each level of training.

C. Residents' Transfers

To determine the appropriate level of education for residents who are transferring from another residency program, the program director must receive written verification of previous educational experiences and a statement regarding the performance evaluation of the transferring resident prior to their acceptance into the program. A program director is required to provide verification of residency education for residents who may leave the program prior to completion of their education.

1. The program must document the procedures used to select residents. Application records must contain complete information from medical schools and graduate medical education programs. A documented procedure must be in place for evaluating the credentials, clinical training experiences, past performance, and professional integrity of residents transferring from one program to another. This procedure must include solicitation and documentation of relevant information from the training directors of the previous programs participated in by the transferring resident. This documentation must specify all clinical and didactic experiences for which the resident has been given credit. Those residents selected at the second postgraduate-year or above must have satisfied the training objectives cited above for reaching that level of training.

2. A transferring resident's educational program must be sufficiently individualized so that he/she will have met all the educational and clinical experiences of the program, as accredited, prior to graduation.

D. Residents' Policies

1. The program should not allow on-call schedules and activities outside the residency that interfere with education, clinical performance, or clinical patient care responsibilities.

2. Each resident must be given a copy of the *Essentials of Accredited Residencies* at the beginning of training.

3. Readily available procedures for assisting the resident to obtain appropriate help for significant personal or professional problems should be in place.

E. Residents' duty hours and the working environment

1. Providing residents with a sound didactic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being.

2. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfil service obligations.

3. Didactic and clinical education must have priority in the allotment of residents' time and energy. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

F. Supervision of Residents

1. All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.

2. Faculty schedules must be structured to provide residents with continuous supervision and consultation.

3. Faculty and residents must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract its potential negative effects.

G. Duty Hours

1. Duty hours are defined as all clinical and academic activities related to the residency program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.

2. Duty hours regular-40 hours/week+ on call duty hours as specified by the training institution.

3. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. *One day* is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.

4. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

5. The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. *In-house call* is defined as those duty hours beyond the normal work day, when residents are required to be immediately available in the assigned institution.

    a) In-house call must occur no more frequently than every third night, averaged over a 4-week period.

    b) Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.

    c) *At-home call* (or *pager call*) is defined as a call taken from outside the assigned institution. The frequency of at-home call is not subject to the every-third night limitation. At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.

    d) The program director and the faculty must monitor the demands of at-home call in their programs, and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

6. Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Duty hours must be monitored with a frequency sufficient to ensure an appropriate balance between education and service.

7. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.

H. Resident's Competencies

The residency program must require its residents to obtain competence in the six areas listed below to the level expected of a new practitioner.

Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their residents to demonstrate the following:

1. ***Patient care*** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health;

2. ***Medical Knowledge*** about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care;

3. ***Practice-based learning and improvement*** that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care;
4. ***Interpersonal and communication skills*** that result in the effective exchange of information and collaboration with patients, their families, and other health professionals;

5. ***Professionalism*****,** as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds;

6. ***Systems-based practice***, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

7. **Clinical Records** must reflect the residents' ability to:

   a) record an adequate history and perform mental status, physical, and neurological examinations;
   b) organize a comprehensive differential diagnosis and discussion of relevant psychological and socio-cultural issues;
   c) proceed with appropriate laboratory and other diagnostic procedures;
   d) develop and implement an appropriate treatment plan followed by regular and relevant progress notes; and
   e) prepare an adequate discharge summary and plan

I. Residents' Scholarly Activities

Each program must provide an opportunity for residents to participate in research or other scholarly activities, and residents must participate actively in such scholarly activities.

1. Graduate medical education must take place in an environment of inquiry and scholarship in which residents participate in the development of new knowledge, learn to evaluate research findings, and develop habits of inquiry as a continuing professional responsibility.

2. The program must promote an atmosphere of scholarly inquiry, including the provision of access to ongoing research activity in psychiatry.

3. Residents must be taught the design and interpretation of research studies, including the responsible use of informed consent, research methodology, and interpretation of data. The program must teach expertise in the critical assessment of new therapies and developments that are described in the literature. Residents must be advised and supervised by faculty members qualified in the conduct of research. Programs must have a plan to foster the development of skills for residents who are interested in conducting psychiatric research. This plan should include opportunities for conducting research under the supervision of a mentor and training in the principles and methods of research.

J. Record of Clinical Experience

There must be a record maintained of specific cases treated by residents, in a manner that does not identify patients, but which illustrates each resident's clinical experience in the program. This record must demonstrate that each resident has met the educational requirements of the program with regard to variety of patients, diagnoses, and treatment modalities. In the case of transferring residents, the records should include the experiences in the prior as well as the current program. This record must be reviewed periodically with the program director or a designee, and must be made available to the surveyor of the program.

Resources

The program must ensure that adequate resources (e.g., sufficient laboratory space and equipment, computer and statistical consultation services) are available.

1. All programs must have adequate patient populations for each mode of required training and, minimally, must include organized clinical services in inpatient, outpatient, emergency, consultation/liaison, and child and adolescent psychiatry.

2. Training programs must have available to them adequate inpatient and outpatient facilities and other suitable clinical placements where the residents can meet the educational objectives of the program. The program should specify the facilities in which the goals and objectives are to be implemented.

3. All residents must have available to them offices adequate in size and decor to allow them to interview patients and accomplish their duties in a professional manner. The facility must also provide adequate and specifically-designated areas in which residents can perform basic physical examination and other necessary diagnostic procedures and treatment interventions.

4. Other Educational Resources

   a) The administration of the facility where the program is located must provide ample space and equipment for educational activities. There must be adequate space and equipment specifically designated for seminars, lectures, and other teaching exercises.

   b) The program must have available audiovisual equipment and teaching material such as films, audio cassettes, and videotapes, as well as the capability to record and play back educational videotapes.

   c) Residents must have ready-access to a major medical library, either at the institution where the residents are located or through arrangement with convenient nearby institutions. Library services should include the electronic retrieval of information from medical databases.

   d) There must be access to an on-site library and/or to an electronic collection of appropriate texts and journals. On-site libraries and/or collections of texts and journals must be readily available during nights and weekends. This library should provide:

      1. a substantial number of current basic textbooks in psychiatry, neurology and general medicine;
      2. a number of the major journals in psychiatry, neurology, and medicine sufficient for an excellent educational program;
      3. the capability to obtain textbooks and journals on loan from major medical libraries;
      4. the capability to perform MEDLINE or other medical information searches (or ready-access to a library that has this capacity); and
      5. access to the internet.

   e) Each clinical service must have a mechanism that ensures that charts are appropriately maintained and readily accessible for regular review for supervisory and educational purposes. Randomly-selected charts will be reviewed at the time of survey.

Evaluation

A. Evaluation of Resident

The faculty must evaluate in a timely manner the residents whom they supervise. In addition, the residency program must demonstrate that it has an effective mechanism for assessing resident performance throughout the program, and for utilizing the results to improve resident performance.

1. Assessment should include the use of methods that produce an accurate assessment of residents’ competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

2. Assessment should include the regular and timely performance feedback to residents that includes at least semi-annual written evaluations. Such evaluations are to be communicated to each resident in a timely manner, and maintained in a record that is accessible to each resident. These will be made available on review of the program. Regular, systematic, documented evaluation of the knowledge, skills, and professional growth of each resident, using appropriate criteria and procedures, must be maintained, including complete records of evaluations containing explicit statements on the resident's progress toward meeting educational objectives and his or her major strengths and weaknesses. Each evaluation should be communicated to the resident in an ongoing and timely manner.

3. Assessment should include the use of assessment results, including evaluation by faculty, patients, peers, self, and other professional staff, to achieve progressive improvements in residents’ competence and performance.

4. The program must provide documented evidence to demonstrate that the proficiency/competence of each resident is assessed using techniques that may include supervisory reports, videotapes, oral examinations, case reports, patient care observations, or other methods.

5. The program must provide opportunity for and document regularly scheduled meetings between the resident and the program director or designated faculty members. These meetings should be of sufficient frequency, length and depth to ensure that the residents are continually aware of the quality of their progress toward attainment of professional goals and objectives. These evaluation sessions should be held at least semi-annually and preferably more frequently. The program should give residents opportunities to assess the program and the faculty in a manner that ensures resident confidentiality. Provision should be made for remediation in cases of unsatisfactory performance.

6. The program must formally examine the cognitive knowledge of each resident at least annually by conducting an organized examination at the end of study year during the 4 years of training. In a timely manner, the program must develop specific remedial plans for residents who do not perform satisfactorily. Residents must not advance to the next year of training, or graduate from the program, unless the outcome from the remedial plan results in the attainment of educational and clinical goals established for the program.

7. Residents should be advanced to positions of higher responsibility only on the basis of evidence of their satisfactory progressive scholarship and professional, educational, and clinical growth.

8. A written set of due-process procedures must be in place for resolving problems that occur when a resident's performance fails to meet required standards. These procedures must conform to those policies and procedures adopted by the sponsoring institution for the provision of due process to all residents training in sponsored programs, and must include the criteria for any adverse action, such as placing a resident on probation, or for terminating a resident whose performance is unsatisfactory. The procedures should be fair to the residents, to patients under their care, and to the training program. A copy should be provided to the residents at the beginning of training.

9. Upon any resident's departure from a program (including by graduation), the program director must prepare a letter describing the nature and length of the rotations for which the resident has been given credit. If a resident departs the program without receiving full credit for all educational experiences, the reasons for withholding credit must be specified in the letter. The resident must be given the letter, and a copy must be retained in the resident's permanent file.

10. When a resident leaves the program (including by graduation), the program director will affirm in the training record that there is no documented evidence of unethical or unprofessional behavior, nor any serious question regarding clinical competence. Where there is such evidence, it will be comprehensively recorded, along with the responses of the trainee. The evaluation should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. This final evaluation should be part of the resident's permanent record maintained by the institution.

11. The program director must provide **a final evaluation** for each resident who completes the program. This evaluation must include a review of the resident’s performance during the final period of education, and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. The final evaluation must be part of the resident’s permanent record maintained by the institution.

B. Faculty

The performance of the faculty must be evaluated by the program no less frequently than at the midpoint of the accreditation cycle, and again prior to the next site visit. The evaluations should include a review of their teaching abilities, commitment to the educational program, clinical knowledge, and scholarly activities. This evaluation must include annual written confidential evaluations by residents.

C. Program

The educational effectiveness of a program must be evaluated at least annually in a systematic manner.

1. Representative program personnel (i.e., at least the program director, representative faculty, and one resident) must be organized to review program goals and objectives, and the effectiveness with which they are achieved. This group must conduct a formal documented meeting at least annually for this purpose. In the evaluation process, the group must take into consideration written comments from the faculty, the most recent report of the OMSB of the sponsoring institution, and the residents' confidential written evaluations. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes of the meeting.

2. The program should use resident performance and outcome assessment in its evaluation of the educational effectiveness of the residency program. Performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness. The program should maintain a process for using assessment results together with other program evaluation results to improve the residency program.

3. Programs must demonstrate that they have an ongoing mechanism to evaluate the effectiveness of their didactic and clinical teaching.

Accreditation process of the training centres and programs by OMSB accreditation committee

1. The accreditation committee of OMSB will visit the training centres which apply for accreditation for the first time.

2. The committee will pay periodic visits to the training centres and programmes.

3. The committee will study the specific requirement for Psychiatric program and implement the program systematically.

4. The OMSB accreditation committee will evaluate the centre and the program every 3 years and when necessary to continue accrediting them.

Freezing and Revoking the accreditation of the training centres and training programs.

The OMSB has the right to freeze and revoke accreditation from the training centre and the training programme if they do not fulfil the accreditation requirements according to the steps described in article 49,section 6 of OMSB bye-laws.