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Correspondence

Training in Britain for psychiatrists from overseas

Sir: I would like to point out that views expressed by Mubbashar & Humayun (1999) are unrepresentative, contradictory and simplistic. One gets the impression that the authors have a personal axe to grind against their colleagues working in the UK as well as the trainees who wish to come to Britain in future.

The authors suggest that trainers in developing countries use outdated methods and are non-progressive in their clinical practice. In the same breath they denounce psychiatric trainees in developing countries as possessing 'modest talent'. One wonders as to the facts on which these assumptions have been based and what standards have been applied to measure the capability of the trainees. One also wonders whether the ethical and professional repercussions of these statements have been taken into account, especially the fact that this sort of article endangers the morale of both trainers and trainees in developing countries.

It is stated in the article that senior psychiatrists sponsor the "most promising of their trainees" and they join the scheme "with the avowed purpose of returning as better trained psychiatrists". Although infused with much missionary zeal, both these statements are incorrect and misleading. Trainees anywhere in the world who choose to move abroad do so for a number of reasons. These include personal choice and ambition, attainment of higher qualifications, monetary gains, social and sometimes even political reasons. Many equally talented doctors choose to train and work in their own countries, for as many different reasons. Some doctors return after their training abroad, others choose to work in the UK. In fact, more doctors return to their own countries from the UK than from any other country, and this is evident by the fact that, at least in Pakistan, many senior teaching posts (including the authors) are held by members of the Royal College of Psychiatrists. However, this is fast changing, and points towards another major contradiction in this paper.

It seems that the authors, in their haste to denigrate local training schemes, forget that in many developing countries, including Pakistan, the training schemes have considerably developed and grown in stature and importance over the past couple of decades. The local postgraduate degree is on a par with the MRCPsych, for all competitive posts. In fact, there is now a trend towards recruiting more locally trained postgraduates into academic posts as it is felt, rightly or wrongly, that these doctors are better equipped to provide services, than doctors trained abroad. Particularly with reference to Pakistan, the number of trainees aspiring to local postgraduate qualification is at least ten times that of overseas Pakistani trainees in the UK. In talking to senior academics from India and Nigeria, where the bulk of the UK trainees originate, one gets a similar picture. However, it seems that the authors wish to put across the view that the future of psychiatry in developing countries depends entirely on the return of trainees from the UK. Quite to the contrary, with the increasing number of locally trained psychiatrists in the job market, even those UK-trained psychiatrists who choose to return have to compete hard to find jobs that merit their experience and qualifications.

The authors present a rosy picture of psychiatric services in the UK. They say that "working in a well-provided and efficiently organised infrastructure amounts to training in Utopian conditions". Colleagues in the UK will testify to the fact that this is far from true, and misleading for readers who have not recently been to the UK. Psychiatry in the UK, like elsewhere, is in a state of flux. Resources are limited and there are tremendous pressures on junior as well as senior doctors, albeit of a different nature.

The authors go to great lengths to describe the differences in the social, cultural and clinical milieu in the developing countries and the UK. It is asserted that the training of overseas doctors is inappropriate in this setting, but are vague about what should be done. A long list of training ideals is presented with the expectation that the British trainers should somehow understand the cultural, social, clinical and political complexities of each trainee's home country, and then fashion a tailor-made programme. This is a tall order indeed, which in fact is not practical for any training scheme in any country.

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So how can British psychiatry, in these conditions, contribute to training in developing countries? I tend to agree with the authors' suggestion that British psychiatrists can collaborate in many ways with local schemes to enhance their training programmes. This already happens in many instances and can be expanded. Perhaps the most valuable activities could be assistance in developing curricula, training trainers and postgraduate examiners through focused workshops. It might be worthwhile to invite experienced overseas psychiatrists working in the UK who are well versed in both systems to contribute to this process. I am sure many colleagues in the UK will be keen to engage in this type of activity. It is important to realise that many psychiatrists would find it easier to return home and stay, if their points of view and contributions were welcomed and valued. It might be a good idea to develop collaborative training as a two-way process, because, undoubtedly, there are useful lessons to be learnt from the practice of psychiatry in developing countries. The basic premise should be that trainers and trainees in developing countries are intelligent, resourceful and capable of seeking solutions to their problems. They should be encouraged in this by the international (particularly British) community of psychiatrists.

The Overseas Doctors Training Scheme offered by the Royal College of Psychiatrists for trainees from developing countries has been extremely useful not only for the doctors who came to Britain for their training but also for their home countries. This scheme provided trainee doctors with an opportunity to work in a different environment, to learn specialised skills and to contribute usefully to the field of psychiatry once they returned. Freezing of the training scheme, I feel, will have an adverse effect not only on the development of the speciality in the developing world but also on the healthy collaboration and exchange of information, as the trainees constitute a useful link with their country of origin. If we wish to see the speciality of psychiatry flourish in developing countries, it is important that specific slots be kept in various training schemes, even if the time period is reduced because of limited available placement possibilities. It needs to be reiterated that these trainees constitute a small minority. Some will return to their own countries but will continue to maintain links with their training institutions or individual colleagues, through collaborative research, other academic activity or simply exchange of views. It has to be pointed out that these doctors have a right to choose for themselves whether they wish to return to their home country or stay on in a country where they perceive a better future. The history of psychiatry is awash with eminent people who migrated from their countries of origin and were thus able to contribute much more effectively to their chosen field. It must be remembered that people will work best, and be most productive, if they are happy. Laws that restrict freedom of choice or movement are never successful and it would be unwise for institutions of learning inadvertently to collude in this. I feel strongly that if any such restrictions were to be applied, trainees would seek and succeed in finding opportunities elsewhere and it would be a tragedy for many of us who wish to retain lasting links with British psychiatry.

Mubbashar, M. H. & Humayun, A. (1999) Training psychiatrists in Britain to work in developing countries. *Advances in Psychiatric Treatment*, **5**, 443–446.

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