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Training psychiatrists in Britain to work in developing countries

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The economically developing countries face a perpetual challenge to provide essential health care. The available health care delivery systems are primitive and lack organisation and resources. Mental health care suffers even more acutely for want of attention, widespread ignorance and prejudice. The services in this field are inadequate and often inappropriate. The urge for a qualitative change has led to a focus on higher training of specialist doctors.

Indigenous schemes are supplemented and strengthened through training of psychiatrists abroad. Each year doctors from developing countries join training programmes under different schemes in the UK with the avowed purpose of returning as better-trained psychiatrists.

In practice, the vast majority of trained psychiatrists get absorbed into the British health system. Others who return are disillusioned and frustrated with standards of mental health care prevalent in their communities. They find working in this environment incompatible with their recently acquired knowledge and practice of psychiatry. This conflict forces many of them to return to Britain or countries with a more enlightened regime of psychiatry. As a result, the benefit of specialised training in the UK does not permeate down to developing communities. An attempt is being made to examine the current training programmes in the UK in order to make them more beneficial for mental health care in developing countries that are dismally lagging behind.

Background of trainees

In a social environment where stigma is attached to mental illness, psychiatry is not a prestigious avenue for medical professionals. Low priority for the teaching of psychiatry and behavioural sciences, and limited numbers of qualified teachers for undergraduate programmes, tend to deter fresh graduates from a career in psychiatry. Many graduates are practically forced into psychiatry when more popular specialities are not available. The postgraduate training programmes are scarce and concentrated in few developed areas. Well-established psychiatrists in these centres pass on conservative clinical practice to their trainees. There is no compulsion for them to upgrade the methods or adopt a more progressive clinical practice. In this situation, the training of psychiatrists in the UK assumes great importance. Senior psychiatrists sponsor the most promising of their pupils for these schemes. From the available doctors with modest talent, a very small percentage have the opportunity to be considered for such programmes. Many better-motivated doctors with an aptitude for service to the community are deprived of selection.

The stage at which a trainee proceeds for training is critical. Fresh graduates can learn the theory and practice of psychiatry with an open mind and benefit from it without the inherent contradictions with the prevailing practice in their own country. They will, however, find the conflict more pronounced on their return. On the other hand, experienced psychiatrists may have to 'unlearn' some of their practice before acquiring modern concepts and skills. Developing countries can contribute significantly in improving the quality of their trainees by broadening teaching modules and curricula at the undergraduate level, providing better local training at postgraduate level and adopting a broad-based, transparent and uniform selection system for further training abroad.

Examination of a model of health services in these countries would show that primary health care is

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dedicated to general medicine with staff having very little knowledge of psychiatric illness. There may be marginal variations in some countries. Lack of knowledge of psychiatry among primary care physicians, along with social taboos and deeply ingrained tendencies to resort to pseudo-folk remedies, make the task of psychiatrists even more challenging. The entire burden of treatment then shifts to trained psychiatrists who are seriously handicapped without the support of allied professionals. Psychiatrists work in poorly structured environments which demand their expertise in dealing with inadequacies and lack of support in the health care system. Therefore, an ideal programme of training should take into account the health services environment in which the psychiatrist has to work, contribute to and strengthen.

Training in the UK

Postgraduate training is meant to equip doctors with an ability to provide specialised service to patients. Training programmes are designed to work in an environment modelled on the health services in the UK. In the field of psychiatry, patients have access to primary health care, social support, specialised consultation and hospital treatment through a well-structured and institutionalised arrangement. The general practitioner (GP), physician, psychiatrist and hospital unit are part of an integrated system for providing mental health care. Highly motivated social workers, experienced psychologists, fully trained nurses and occupational therapy staff complement the system. In this environment, the role of psychiatrists is well-defined. They concern themselves with the specifics of their assignments working in harmony with their colleagues. Their earliest contact with a patient may be at a time when there is an optimum need for their attention and their therapeutic interventions are ensured by a network of team members. Postgraduate training in the UK prepares the doctor for this duty.

Currently, overseas training posts are organised through the Royal College of Psychiatrists or through regional schemes based on direct liaison with the sponsoring psychiatrists. All overseas candidates, irrespective of previous experience, work through routine (and sometimes, unpopular) rotation posts for the ultimate goal of passing the MRCPsych examinations, without any emphasis on individual objectives of training. Most of them are well-versed in the theoretical aspects of the subject right through their training. There is a general deficiency of skill for keeping up to date with and critically appraising research. Trainees are disproportionately engaged in adjusting to and understanding an alien social environment. They spend considerable time in improving communication skills, especially proficiency in English. Some very experienced doctors with many years of practical experience in own their countries struggle with postgraduate examinations because of technical difficulties rather than a deficiency in their academic knowledge.

Trainees are put through a clinical experience that is non-existent in their country or are over-exposed to areas of low priority in treatment because of social or cultural differences between the UK and their home country. Working in a well-provided and efficiently organised infrastructure amounts to training in Utopian conditions. This, along with security and abundant opportunities, encourages trainees to consider settling in the UK. This outcome is in direct conflict with the aims of the overseas training programme as well as the needs of the communities from which these doctors have come.

Evaluation of training needs for economically developing countries

German (1975) gives an optimistic view of the vast scope for successful and effective development of services in developing countries:

> "The major advantage for a psychiatrist in a developing country is the very paucity of previous provision for the mentally sick. Thus he does not have to expend his energies in frustrating attempts to dismantle an inert and cumbersome administrative infra-structure; nor does he have to concern himself with finding a method of absorbing large numbers of solidly built, prison-like mental hospitals into a more efficient and humane psychiatric programme. There is little need for him to struggle with large armies of personnel in various categories, each... unwilling to change from the security of well-defined roles to meet the challenge of the present and future. [He has] at least a fairly clean canvas on which to develop [his] themes".

Psychiatrists newly returned to their home country following UK training are overwhelmed by the various clinical presentations totally alien to those trained in a different social context. The gap is narrower since the arrival of ICD–10 (World Health Organization, 1992), which is far more comprehensive than ICD–9 (World Health Organization, 1978), but which still far from encompasses all the variants commonly encountered. The vague memory of chronic fatigue syndrome lies in the remote corner of their minds while they try to comprehend the

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perplexities of hysteria, bizarre presentations of depression, frequency of catatonia and the wonders of culture-bound syndromes. The choice of a drug is primarily governed by its cost-effectiveness rather than its side-effect or safety profile. Psychopharmacological responses are also different. Patients presenting with severe mental illness are often desirous of aggressive physical treatments, as the family who has travelled miles away from home is mostly concerned with a quick response rather than the recommendations of the leading research. Psychotherapeutic interventions appear more time-consuming and expensive than ever before and often become a novel and special treatment option for privileged patients only. Compliance and follow-up of treatment is at the mercy of fate, circumstances and available resources rather than the GP, community psychiatric nurse and social worker.

The social dilemmas of single-parent families, homelessness, elderly people struggling to live their days in isolated bungalows, and delinquent children involved in arson are replaced by the social evils of poverty, ignorance, complexities of intermarriages, exorcism and lawlessness. The process of adjustment seems endless in the initial years and then slowly one learns the cultural taboos, the language of the patient's distress, dysphorias and delusions, the intricate and quizzical family dynamics and becomes cognisant of various existing resources. Quite obviously, the psychiatrist has to rely more on his clinical acumen and neurological assessment than on scarcely available technological aids.

The psychiatrist must also be able to assess and cope in an environment of resistant administrators, indifferent policy-makers, medical colleagues who are insensitive towards progress and a frustrated community. Some of this might also be true of the work environment in developed countries, but the organised system in these takes over the clinician's responsibility of making decisions and finding solutions. There is a greater need to develop intersectoral collaboration to find pragmatic solutions.

The duties of psychiatrists often involve planned and focused changes in undergraduate medical courses, motivation and education of doctors and staff engaged in primary health care, orientation courses for practising physicians and surgeons and training of nursing staff. Trainers have a far greater responsibility at a much earlier stage of their career compared to their counterparts in the UK. Therefore, teaching skills must be an integral part of training for overseas doctors. They must be encouraged to attend training courses and workshops throughout their training periods. They should have some exposure to training of medical students from the outset.

Even when they have a good understanding of research methodology, psychiatrists have to modify their approach for undertaking research in a daunting environment where the funds are non-existent and the tools are limited. Far from the glamour of getting their work published in the 'yellow journal', they must be highly motivated to persist in their efforts.

The need for leadership development outweighs the many other aspects discussed earlier. Psychiatrists must develop the ability to initiate, oversee and ensure accomplishment of any task in hand designed for the patients' well-being. The effects of their performance are governed by their decision-making ability, initiative and resourcefulness.

Recommendations

The stark difference in mental health environment evident from the availability of quality trainees cannot be remedied in the UK alone. The economically developing countries have to make efforts to close the gap in basic education and approach to prepare future psychiatrists. Improvement of curricula and training modules for undergraduate courses, provision of more qualified teachers and higher motivation may help in drawing better medical graduates to a career in psychiatry. Broad-based selection of candidates for overseas training, after evaluation and testing and a preparatory phase of training, can assist in designating the best available psychiatrists for training in the UK. Doctors with a few years of experience may be more amenable to adjustment and adoption of progressive clinical practice. Wide dissemination of professional literature can act as a catalyst in stirring interest in psychiatry. Exchange programmes for teachers, seminars and workshops would be valuable in raising the standards of medical education as well as motivation for a career in psychiatry.

Replication of the health care environment of a developing country for the purpose of imparting meaningful training may be impracticable. A well-tried scheme of rotation of posts helps candidates to qualify in MRCPsych examinations. For trainees from developing countries, assessment of their level of professional prowess and identification of areas meriting special emphasis (e.g. child psychiatry, forensic medicine, learning disability) may be useful in devising an objective-oriented rotation plan. Working in a transcultural environment in the UK would be an added advantage. This would cater for the experience needs of the trainee without compromising the standards of the MRCPsych examinations.

Economically developing countries, plagued with scarcity of resources and poor management, place

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an enormous burden on their psychiatrists. Training in the UK should include in its curricula administration as well as management of psychiatric hospital and units. Resorting to viable and conservative medical treatments should not be ruled out when faced with resource constraints. Trained psychiatrists will return to their communities with knowledge of cost-effective treatments.

In the absence of well-established training facilities in developing countries, training schemes for overseas trainees should provide the training necessary for candidates to be able teach undergraduates and postgraduate doctors and train nurses and paramedics back in their home country. Whereas neither psychosocial nor economic conditions can be changed, there is good scope for reform and improvement of clinical practice, organisation and optimum utilisation of resources. National institutions of psychiatry and postgraduate training should be closely associated for the development of a joint strategy aimed at the qualitative improvement in training of psychiatrists.

It is reiterated that doctors who do not return to their countries defeat the very purpose of their overseas training. It is therefore essential that the stay of trained doctors should be regulated by law. There should be no dearth of competent and qualified doctors to keep the British health system fully augmented through a regular inflow of trainees.

One is seriously handicapped in presenting accurate data about some of the premises of this paper. All training must be mission-oriented. From the time the overseas training schemes started, how many of these produced better and successful psychiatrists? How many trained psychiatrists returned home, remained in the UK or settled elsewhere? There may be many more relevant questions that will help the planners to make the entire scheme purposeful and rewarding. Monitoring of results of training and post-training employment at various stages will also enable modification of programmes.

Conclusions

Training schemes for overseas doctors are well-intentioned and should continue in one form or another. The concept of a global village implies greater responsibility on the part of countries blessed with the advantage of higher standards of mental health care. Overseas training in the UK should help to produce psychiatrists who are unafraid, cherish challenge, are obsessed with a desire to help their patients, have current knowledge of psychiatric advancements and are well-versed in the psychiatric practice. Such psychiatrists should be able to work in an unfriendly environment of malpractice and prejudice. They should have the ingenuity to overcome resource constraints and a flair for reform. The programme for training of psychiatrists in the UK has the potential to fulfil its legitimate role.

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