

the hospital, as it helps to maintain standards of care and benchmarks training against UK standards and practice.

A recent community survey commissioned by the hospital board highlighted the need to improve the awareness of mental health issues in Bermuda; a campaign to reduce stigma and provide education is under way.

The relative stability and small size of the population of Bermuda facilitate genetic and epidemiological studies into mental illness. In particular, there appears to be a strong line of schizophrenia and bipolar affective disorder among the St Davids islanders. Collaborative research projects are currently being explored. One study is currently

looking at the effect of cannabis on the presentation of psychosis.

Mental Health Act

The Mental Health Act is largely based on the English Act. There is an assessment order and a longer treatment order that lasts for up to 1 year. Two consultant psychiatrists make a recommendation to either a nearest relative or a mental welfare officer. Appeals are allowed and there is a tribunal which hears cases, presided over by a lawyer.

COUNTRY PROFILE

Canadian psychiatry: a status report

Nady el-Guebaly

Professor, Department of Psychiatry, University of Calgary, Canada,
email nady.el-guebaly@calgaryhealthregion.ca;

Past President, Canadian Psychiatric Association; President, International Society of Addiction Medicine

The delivery of health care in Canada is shaped by a number of variables – geography, legislation, federal structure, location and culture.

A vast geography

At 10 million km², Canada is the second largest country in the world but it is sparsely populated – it has only 32 million inhabitants. Canada would cover the whole of Europe and part of Asia but two-thirds of the population live within 300 km of the US border.

A federally monitored Health Act

Since 1967, the country has embarked on the ambitious provision of 'medically necessary' health care to all its citizens based on five tenets – universality, comprehensiveness, accessibility, portability of coverage and non-profit public administration. These equally apply to mental and addiction disorders. Currently, the main problem is long waiting lists interfering with accessibility.

The dynamics of provincial jurisdiction

Each of the governments of the ten provinces and three territories has the responsibility and control of health care within its own boundaries. The national congruence of service delivery remains remarkable.

Location

Canada's contiguity with the USA shapes the public debate concerning health care. On the one hand, national pride is readily expressed at the high standards of North

American care delivery, while training and publishing in the USA are highly valued; on the other hand, there is widespread public concern about the excesses of US-based managed care and the significant portion of that population without insurance. This results in a determined effort to learn from both US and European influences to create a uniquely Canadian blend (Rae-Grant, 2001).

A cultural mosaic

Canada is a welcoming land of opportunity to a steady stream of immigrants and with a birth rate of 1.5 children per couple the country will continue to depend on migration for its sustenance. With two official languages, English and French, and many unofficial cultures, multiculturalism rather than a 'melting pot' policy is one of the prized social characteristics. The health care workforce reflects society's mosaic. The first inhabitants of this country, the First Nations, have not fared well so far and this is reflected in higher morbidity and mortality risks.

Canadians in general highly value their health care system, known as medicare (which is publicly financed but privately run) and public polls suggest that medicare is considered an essential ingredient of Canadian identity. There are concerns, however, about the capacity to sustain it (Romanow, 2002).

Mental health policies and statistics

The Canadian Community Health Survey (CCHS) in 2002 reported that some 20% of Canadians personally experience some form of mental illness during their lifetime (Health Canada, 2002). Eighty-six per cent of hospital admissions for mental illness are to general

The Canadian Community Health Survey (CCHS) in 2002 reported that some 20% of Canadians personally experience some form of mental illness during their lifetime.

hospital. Seven major mental illnesses (excluding addiction) account for 3.8% of all general hospital admissions. Between 1950 and 1975, 35 000 beds for patients with mental illness were eliminated from psychiatric hospitals but only 5000 were added to general wards. In 2001–2002, while psychiatric hospitals accounted for only 13% of all admissions for mental illness, the average length of stay in psychiatric hospitals was 162 days, compared with 25 days for general hospitals. These average lengths of stay were down 35% from 1994–1995. The widespread policy of deinstitutionalisation did not, however, induce an appropriate increase in community-based services. Provincial Mental Health Acts have increasingly upheld patients' rights, and involuntary hospitalisation is currently limited to the presence of 'immediate danger to self or others'.

Canada's suicide rate is relatively high. Suicide accounts for 24% of all deaths among 15- to 24-year-olds and 16% among 25- to 44-year-olds. Suicide rates among the First Nations population are three to six times the national average. In 1998, the direct and indirect costs related to mental health problems were estimated to be arguably the highest of all conditions, representing some 14% of the national corporate net operating profits.

Human resource planning for psychiatry

Physician resource planning is a puzzling task. Canadian psychiatry has been involved in human resource planning for some 40 years and in the process doubled the number of psychiatrists per population between 1972 and 1997 (el-Guebaly, 1999). Severe shortages remain in all geographical areas and all sub-specialties. Since the 1990s, a target psychiatrist : population ratio of 1 : 8400 has been achieved and surpassed in many urban areas. Some 4000 psychiatrists, 10% of whom are child psychiatrists, address the needs of the population of 32 million, with an average working week of 46 hours. Only the USA and The Netherlands have comparable ratios. The patients seen display a DSM-IV Axis I diagnosis (American Psychiatric Association, 1994) in 86% of cases and half will have more than one diagnosis.

There are on average 600 residents in training programmes and of the graduates of medical school 6–7% choose psychiatry. While statistics about the supply of physicians abound, less is known about the drivers of demand for their services – demographics, prevalence of illness, standard of living or accessibility or cost. Family physicians are the most commonly consulted professionals for mental health problems, followed by psychiatrists and psychologists. Of late, a shared-care model of delivery with family physicians and, on a more limited basis, with paediatricians has been implemented (Kates *et al*, 1997). Interdisciplinary teams staff most publicly funded mental health services, but national figures about other professions specialising in mental health are not readily available.

International medical graduates have accounted for about a quarter of the supply of physicians in Canada, this

portion doubling in the provinces of Newfoundland and Saskatchewan. The current shortage of physicians and the fact that their average age is 49 years have spurred a renewed effort to streamline the entry of prospective immigrants through the Medical Council of Canada, provincial licensing colleges and medical schools.

Educating physicians in psychiatry: a lifelong process

Undergraduate courses

The 16 medical schools generally have a 4-year medical curriculum, although a few offer a 3-year course. The Canadian Psychiatric Association, founded in 1951, supports the organisation of Coordinators of Undergraduate Psychiatric Education (CUPE) to provide a forum for identifying the core knowledge, attitudes and skills required for graduation. Graduating students are evaluated by the Medical Council of Canada Licensing Examination, where about 20% of the questions are on psychiatry. A multiple-choice format as well as observed structured patient interviews are used to test the students. Broad topics taught in the pre-clinical years include interviewing skills, the doctor–patient relationship, detection of psychopathology and diagnosis, as well as specific subjects such as violence and mental health legislation.

Currently most schools have autonomous courses in psychiatry somewhat complementary to the neurosciences. The clinical clerkship rotation in the final years varies between 6 and 8 weeks. Medical students, particularly female students, have of late regarded psychiatry as a much more attractive specialty than in the past (Leverette *et al*, 1996).

Evolving postgraduate education

The accreditation of postgraduate training is the purview of the Royal College of Physicians and Surgeons of Canada (RCPSC), which has the task of certifying specialists from all disciplines. With the incorporation of the internship year under the direction of the chosen specialty, training in psychiatry is, in fact, a 5-year process, not uncommonly complemented by a 6th year of academic fellowship.

Training requirements and objectives reflect a balance between biological and psychotherapeutic approaches, as well as the promotion of evidence-based clinical practice guidelines (Cameron *et al*, 1999; Paris, 2000). The 'social contract' required of medical specialties is also a concern of the Royal College. The 'Can MEDS 2000' project identified a cluster of seven competencies to be achieved in training: medical decision maker, communicator, collaborator, manager, health advocate, scholar and professional (Societal Needs Working Group, 1996). It remains uncertain as to how well these requirements are being met.

Other training challenges have included the provincial budget reductions to the hospital sector, which have resulted in a shift to 'community-based care' training and increased involvement in multi-disciplinary teams. This shift has also resulted in the increased involvement of family

Between 1950 and 1975, 35 000 beds for patients with mental illness were eliminated from psychiatric hospitals but only 5000 were added to general wards. In 2001–2002, while psychiatric hospitals accounted for only 13% of all admissions for mental illness, the average length of stay in psychiatric hospitals was 162 days, compared with 25 days for general hospitals.

Canada's suicide rate is relatively high. Suicide accounts for 24% of all deaths among 15- to 24-year-olds and 16% among 25- to 44-year-olds.

physicians in the care of people with a mental illness and 'shared care' programmes, where psychiatrists and trainees provide consultations in family physicians' offices.

A perennial organisational issue has been the accommodation of sub-specialty training. Canadian psychiatry, compared with US psychiatry, has been very conservative in recognising sub-specialties and currently identifies only three – child, geriatric and forensic psychiatry. The Royal College recommends a 2-year sub-specialty programme, one within the 5-year complement and one additional to it, but the debate continues. Members of other sub-specialty practices such as addiction or administration have sought credentialing from US organisations to remedy the lack, so far, of such an avenue in Canada.

Pressure to incorporate new knowledge and skills in the training programme has somewhat eased with the concept of lifelong education.

Continuing professional development and maintenance of certification

Education does not end with graduation from a training programme. Indeed, graduation certifies the acquisition of necessary skills to embark upon a journey of lifelong learning. It is of interest that several of the less popular topics among training residents are in high demand in continuing education activities.

'Top down' lectures are of limited value and have been partly replaced by needs-based activities, including reading, meeting with colleagues, quality assurance and brief traineeships. The Royal College Maintenance of Competence programme rates continuing medical education programmes, including their funding source, particularly from industry; there is also a random audit of learning diaries. An annual report of these activities for a total of 400 credits over a 5-year period is required to maintain specialty certification (Royal College of Physicians and Surgeons of Canada, 1999).

The challenges of psychiatric research

Following the Second World War, Canada made a far-reaching decision not to create national research institutes like those in the USA but to create instead a Medical Research Council and develop research capacity within the 16 medical schools. This initiative has had mixed results and over the past 5 years the Canadian Institutes of Health Research have channelled research funds from governments while fostering the creation of multi-disciplinary, inter-provincial research teams to implement a consensual research agenda.

Compared with the burden on society placed by mental illness and addiction disorders, research into these has been persistently underfunded, at about 4% of the total government expenditure on health research. Indeed, this funding shortage would have been worse were it not for the ability of Canadian researchers to access US funds. This has also led to the pharmaceutical industry assuming a prime role in funding pharmacological clinical trials, which range from the truly innovative to post-marketing surveys.

In the 1950s, the McGill University group, headed by Dr Lehman, was credited for introducing several neuroleptics and tricyclics to North America. Currently the Canadian College of Neuropsychopharmacology monitors a thriving network of trials in schizophrenia, mood and anxiety disorders and more recently pharmacological trials on the early manifestations of mental illness.

In the field of epidemiology, Dr Leighton's Stirling County Study of Psychiatric Disorders has now developed into a multi-sited group of collaborators, which has resulted in achievements such as Dr Bland's Edmonton city-wide surveys, Dr Offord's Ontario Child Health Study, and Dr Arboleda-Florez's forensic work.

Several diagnosis-specific clinical investigations have had a significant effect on practice. These studies have looked at: linkage and association in schizophrenia (Drs Bassett and Maziade), sex differences (Dr Seaman), eating disorders (Dr Garfinkel), personality disorders (Drs Paris and Livesley), affective disorders (Dr Kennedy), anxiety disorders (Dr Stein), addiction (Drs Negrete and el-Guebaly) and psychotherapy (Drs Azim, McKenzie and Leszcz).

Conclusion

Psychiatry in Canada is a vibrant specialty within an evolving universal health care system. A recently formed coalition of 12 non-governmental organisations, including the Canadian Psychiatric Association, has urged government to identify specific mental health goals, a policy framework embracing both mental illness and mental health promotion, adequate resources to sustain the plan and an annual public reporting mechanism (Canadian Alliance on Mental Illness and Mental Health, 2000).

At the same time, the practice of psychiatry is increasing in complexity, with such cumulative demands on practitioners as lifelong learning, as well as the expectations of increasingly informed consumers. Hospitals downsizing and the pressure to discharge patients early without a significant increase in community resources have increased workload stress. Programmes addressing physicians' stress and impairment are increasingly popular. Expanding telehealth programmes appear to provide some relief to poorly resourced communities. While fee-for-service was the main form of remuneration for physicians, alternative forms of sessional payments are becoming popular. The motto 'the only constant is change' describes well Canada's current health care and psychiatric practice.

References

- American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders* (4th edn) (DSM-IV). Washington, DC: APA.
- Cameron, P., Leszcz, M., Bebhuck, W., et al (1999) The practice and roles of the psychotherapies: a discussion paper. *Canadian Journal of Psychiatry*, **44** (suppl. 1), 18S–31S.
- Canadian Alliance on Mental Illness and Mental Health (2000) *A Call for Action: Building Consensus for a National Action Plan on Mental Illness and Mental Health*. Ottawa: CAMIMH.
- el-Guebaly, N. (1999) Thirty-five years of psychiatrist workforce planning: what do we have to show for it? *Bulletin of the Canadian Psychiatric Association*, **31**, 101–104.

The practice of psychiatry is increasing in complexity, with such cumulative demands on practitioners as lifelong learning, as well as the expectations of increasingly informed consumers.

Compared with the burden on society placed by mental illness and addiction disorders, research into these has been persistently underfunded, at about 4% of the total government expenditure on health research.

- Health Canada (2002) *A Report on Mental Illness in Canada*. Ottawa: Health Canada.
- Kates, N., Craven, M., Bishop, J., et al (1997) Shared mental health care in Canada. *Canadian Journal of Psychiatry*, **42**(8) (insert).
- Leverette, J., Massabki, A. & Peterson, H. (1996) Factors affecting medical students' selection of Canadian psychiatric residency programs: Part II – some contemporary issues. *Canadian Journal of Psychiatry*, **41**, 582–586.
- Paris, J. (2000) Canadian psychiatry across 5 decades: from clinical inference to evidence-based practice. *Canadian Journal of Psychiatry*, **45**, 34–39.
- Rae-Grant, Q. (2001) *Psychiatry in Canada: 50 Years 1951–2001*. Ottawa: Canadian Psychiatric Association.
- Romanow, R. (2002) *Building on Values: The Future of Health Care in Canada – Final Report*. Ottawa: Commission on the Future of Health Care in Canada.
- Royal College of Physicians and Surgeons of Canada (1999) *Maintenance of Certification: Information Guide for Fellows*. Ottawa: RCPSC.
- Societal Needs Working Group (1996) Can MEDS 2000 project. Skills for the new millennium. *Annals of the Royal College of Physicians and Surgeons of Canada*, **29**, 207–216.

SPECIAL PAPER

Recruitment of consultant psychiatrists from low- and middle-income countries

David Ndetei¹, Salman Karim² and Malik Mubbashar³

¹Professor, Department of Psychiatry, University of Nairobi, Kenya, email dmndetei@uonbi.ac.ke

²Lecturer, Department of Psychiatry, University of Manchester, UK

³Vice Chancellor, University of Health Sciences, Lahore, Pakistan

The UK's 2-year International Fellowship Programme for consultant doctors has inadvertently highlighted the long-standing issues of the costs and benefits of such recruitment for the countries of origin, and of whether it is ethical for rich countries to recruit health personnel not only from other rich countries but also from low- and middle-income countries. The 'brain drain' from poor to rich countries has been recognised for decades; it occurs in the health sector as well as other sectors, such as education, science and engineering. It has had serious ramifications for the health service infrastructure in low-income countries, where poverty, morbidity, disability and mortality are increasing rather than decreasing, and it is a matter of serious concern for both the World Health Organization and the International Monetary Fund (Carrington & Detragiache, 1998; Lee, 2003).

This article seeks to explore some of the ethical issues surrounding the recruitment of psychiatrists from low- and middle-income countries, and to stimulate debate. The UK is not alone in its recruitment from low- and middle-income countries as well as from rich countries, and a number of other articles have drawn attention to the attendant problems (e.g. Ehman & Sullivan, 2001; Pang *et al*, 2002; Patel, 2003; Scott *et al*, 2004).

The ethical issues of international recruitment of psychiatrists as well as other health personnel concern:

- the rights of those who are recruited
- the rights of the population to which they are recruited
- the rights of the population from which they have come.

On the first, the UK Department of Health has gone to considerable lengths to establish a supportive framework for recruitment, and provides an enhanced package, relocation expenses on arrival and return, and refund of pension contributions upon return. Recruits are entitled to participate in a programme of continuing professional development in the same way that all consultants are encouraged to do.

On the second, the UK has long experience of recruiting from low- and middle-income countries, and the clinical and cultural competence of psychiatrists from regions such as Africa and Asia is not in question.

This article is focused on the third aspect – the ethical issues for the population from which the psychiatrist was recruited. What are the rights of people living in poor countries to have accessible health care, which is not doubly disadvantaged by the Western-driven brain drain, as well as by the economic structural adjustment programmes which are imposed by Western aid donors?

Variation in the distribution of psychiatrists worldwide

The World Health Organization (2001) has recently compiled data from governments on the distribution of human resources in mental health, and the International Consortium for Mental Health Policy and Services has produced detailed country profiles of context, needs, service inputs, processes and outcomes (Gulbinat *et al*, 2004; Jenkins *et al*, 2004; website www.mental-neurological-health.net). While the UK has 1 psychiatrist per 25 000 population, the US has 1 per 10 000,

This article is focused on ... the ethical issues for the population from which the psychiatrist was recruited.