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Training matters

Training in psychiatry in less developed countries*

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The declared aim of the World Health Organization, based on the Alma Ata declaration (1978), is to promote health care for all by the year 2000. It is recognised that this can be achieved only by the channelling of efforts into the development of primary health care, with medical care greatly augmented by the utilisation of non-medical carers, traditional healers and public health measures. As in more developed countries, where psychiatry struggles to maintain its share of national health resources against the ever increasing demand of technical advances in physical health care, so the mental health services of the less developed countries constantly are in danger of losing out to physical health in the battle against illness and natural disasters. To redress this balance and to meet the needs for mental health by the year 2000, the less developed world needs more psychiatrists (who are currently estimated to relate to the population at a rate of approximately only one per million) and these psychiatrists need to be appropriately trained to meet the challenges. How can the more developed nations help in this training of trainees from the less developed world? Can a partnership be formed between nations that ensures that trainees in psychiatry, in whichever country, are equipped as well as possible for the needs of their home country?

The WHO Workshop on 'Collaboration in Psychiatric Training' met to attempt to identify the problems for training in psychiatry in developing countries, and to make recommendations as to the way forward. Before concentrating on the recommendations, it is worth looking at the current problems in training faced by trainees from the less developed countries.

Problems of indigenous training in the developing world

Although it is unfair to generalise, and many less developed countries have made great advances, it is a fact that training in psychiatry in many centres of the less developed world is hampered by poor structure and lack of resources. Psychiatry training is often based in 'Victorian colonial' asylums, inappropriate extensions to general hospitals and prisons. Frequently there is little or no university support. Programme structure to the training rotations is poor or absent and service priorities are paramount. There are often severe problems of lack of bibliographic support, and high technology support is absent or erratic. Often financial difficulties for the trainees lead to their training being part-time while they indulge in private practice or participate in other branches of medicine to supplement their income. The situation is exacerbated by a tendency toward premature subspecialisation by both trainers and trainees, and by the centralisation of psychiatric facilities for predominantly rural communities in urban bases. Crowning this sad situation in some countries is the lack of appropriate national or regional examinations and absence of standards for accreditation.

*A brief report from the WHO workshop on 'Collaboration in Psychiatric Training' held in April 1986.

Problems for training of trainees from the developing world in developed countries

Although traditionally masquerading as the 'ideal solution' and the 'chance of a lifetime' for trainees from the less developed world, the record of this pathway of training is generally poor. Often the choice of centre is arbitrary and directed by international politics and personal contacts. For example, in recent years many trainees from the new Commonwealth, who in previous decades would have travelled to train in centres in Britain, now find sponsorship and training in the Eastern Bloc countries with added language barriers and implications for the individual's political development. Often trainees make contact with developed centres by meeting visiting professors or through the friendships of their senior colleagues. These considerations, however practical, and however much based on goodwill, cannot replace proper planning and appropriate matching of training courses to the needs of the trainees (and their countries).

On arrival in their new countries, many trainees face a bewilderment of language and cultural barriers. Even when theoretically speaking a common language, inevitably they will have to make

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considerable colloquial adjustments in dealing with colleagues and patients. This 'culture shock', which can last up to a year, is exacerbated by financial problems and accommodation difficulties. (Courses in the developed centres are often prohibitively expensive. Current British university fees are in excess of £8,000 per annum and this does not include living expenses and incidental study expenses such as books and stationery). One solution to these problems is to obtain paid employment during training, but national regulations such as PLAB and ECFMG increasingly block this avenue of escape.

Examination success is often limited. This causes misery and misdirection of efforts. Trainees will inevitably concentrate on passing 'western' examinations such as MRCPsych or 'State Boards' (which are inevitably 'culture bound') instead of concentrating on obtaining appropriate training for their future practice. Paradoxically, many successful candidates with these examinations, on return to their own country, become frustrated by lack of immediate employment with appropriate status or financial reward in comparison to the 'Western world' and may return to the more developed countries using their qualifications as a 'passport'. Such pressures to emigrate permanently are enhanced by the secondary 'culture shock' that trainees will face on their return. By the time of their return some trainees will never have treated a mentally ill patient in their own culture.

Problems caused by the different training needs of trainees from the developing world compared with their counterparts from the developed countries

The development of mental health care in the developing world depends on the utilisation of primary health care systems which already exist in these areas or the specific development of such systems. Trainees working in such areas need to have different skills. They need to be able to work with primary health care systems. Rather than 'hands on' clinical experience they need the skills of administration, research, innovation and teaching. Unfortunately, these skills are often not taught well to overseas trainees in developed centres. Experience gained in, for example, the British system, may not stand them in good stead for their return.

Recommendations from the workshop

(1) That psychiatric training should be led by service needs, with a realistic appraisal of what is required in terms of skills for the psychiatrist in the developing world. The true service needs of a developing country must determine the type of psychiatric training offered to their postgraduates by centres in the developed world.

(2) The pattern of collaboration between countries should not be restricted to any one type of arrangement. Encouragement should be given to innovation. A high degree of flexibility in arrangements is necessary in the light of changing requirements.

(3) Basic postgraduate training in psychiatry should, whenever possible, be given in the trainee's own country or neighbouring 'regional centres'. This would allow training in the indigenous settings and contact with indigenous patients.

(4) For the foreseeable future a need will continue for sub-specialty training which can be offered by developed countries to psychiatrists from the developing world. These courses of training could be for 12 months or less and their nature should be flexible to cater for the visiting trainee's requirements.

(5) Research training for psychiatrists from developing countries is required and should be geared to those skills which are applicable for future research in their own countries. (For example, high technology research is not usually appropriate).

(6) Support for developing countries in the organisation and design of teaching material such as textbooks, journals etc. is required. This might be achieved by the creation of links between specific developed and less developed centres.

(7) Visits by psychiatrists from developed countries to teaching centres in the developing world can be of great value and is more cost effective in teaching terms. Such visitors might help in the development of the curriculum, research planning and additionally in the 'management consultant' role.

(8) Centres in the developed countries must be more informed about the service needs of developing countries, better equipped to mount training courses to meet these needs, and strongly committed to a vision of international psychiatry. They must be able to offer a primary care and public health perspective, and teach administration, service development, advocacy, basic research methodology and teaching techniques themselves.

(9) All parties to collaboration should be encouraged to develop and adhere to mutually acceptable guidelines for good practice relating to their shared responsibilities towards trainees. The trainee's sponsoring authority should inform the host country explicitly and in detail as to what type of training experience is required. The host country should be clear about the content

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of the course which it is offering. The country of origin should ensure adequate language training and there should be provision for the trainee's professional employment on his return home.

(10) Examination and certification should, as far as possible, be determined by the authorities in a trainees own country. These examinations could be carried out locally or regionally.

(11) Regional training centres for psychiatry should be strengthened and capable of offering short and long-term courses to trainees.

(12) The WHO has a vital role to play in the co-ordination of efforts:

(a) maximising and integrating financial support from other international agencies, governments and foundations

(b) acting as an international clearing house for information on the kinds of financial support available for individual trainees and the types of courses etc. which are available

(c) providing a continued international forum for discussion, development and monitoring of all relevant aspects of collaboration and psychiatric training.

Post-script

The author would like to acknowledge the recent initiative from the Royal College of Psychiatrists, and the development of more appropriate courses for overseas trainees by the University of South Manchester (Tantam & Goldberg, 1988) and the Institute of Psychiatry, London. Such schemes deserve praise and encouragement, but at the same time cannot lessen the force and relevance of the above recommendations.

Reference

Tantam, D. & Goldberg, D. (1988) The Manchester scheme for training overseas psychiatrists. *Bulletin of the Royal College of Psychiatrists*, **12**, 444–446.

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