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POINTS OF VIEW

What is important for quality of life of psychiatrists?

Santosh K. Chaturvedi, MD MRCPsych

Professor of Psychiatry, National Institute of Mental Health and Neurosciences, Bangalore, India, email chatur@nimhans.kar.nic.in

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The concern for the mental health of people living in low-resource and industrially developing countries has been blown out of proportion. Economic well-being, as a psychological factor, has a complex association with mental health and may prove to be good or bad for it; after all, mental health in low- and middle-income countries (even with few psychiatrists!) is generally better than it is in high-income countries. Government funding may be low but there are innumerable socio-cultural resources, many more than in most high-income countries. The number of psychiatrists per population may be low but numerous (informal and alternative) mental health services exist, many more popular and even more effective than psychiatry. The healthcare systems are so different that, whereas the average waiting period for a psychiatric patient in the UK may be about 90 days, it is about 90 minutes in India (and all patients are seen the same day). In fact, less than 10% of mental health problems are seen by psychiatrists!

It is sad to see that there is a publication bias, as only reports questioning the migration of health professionals are being published. The current tirade against migration smacks of prejudice against new National Health Service (NHS) fellows. Should psychiatrists from poor nations serve only patients in their home nation? Should they not venture (or earn) elsewhere, even if they are jobless and struggling in their own country? Is it right to leave high-income countries to their own mercy, even if they are short of staff? Is it ethical to let the jobless remain jobless, to let poor doctors remain poor, to destroy a professional's dreams and aspirations, to infringe on an individual's rights and freedom of choice, and to insist that a doctor born in a poor country remains there?

The drift hypothesis

The factors that persuade clinicians to emigrate are poor remuneration, bad working conditions, academic politics, job insecurity and the threat of violence, low standards of living, a wish to provide a good education for their children, and discrimination. Factors that force medical researchers to emigrate are lack of funding, poor facilities, limited career structures, poor intellectual stimulation and dissatisfaction. Health professionals are driven away from their home nations by lack of jobs (for example in India there are 250 training posts in psychiatry every year for less than 10 jobs), low wages, bureaucratic frustrations, indignity and stagnation. The saving grace has been provided by well paid jobs in the UK NHS and multiple opportunities offered by other high-income countries.

The NHS International Fellowship Programme has provided an avenue for those in permanent jobs to take a much-needed break from their routine, and thereby acts to postpone (or even prevent) eventual burnout. Consultant psychiatrists in India have no

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options – no changes are allowed, there is no locum system, no job hopping, no movement to better opportunities – they are stuck until they retire or resign. There are no fellowships for senior psychiatrists.

There is also a gradual reverse drift, with people who migrated in the 1980s returning to India, for family or socio-cultural reasons (or even because of the English weather!). More than 10% of fellows have returned prematurely. Quite a few consultants have returned to their countries of origin, and this refutes the claims of critics that most professionals will stay in the UK.

Social impact on the host country

There are speculations and unfounded fears about the adverse social impact of migration. There is no evidence of a worsening of mental health conditions or situations, or of people going without care, or of any appreciable effect on national training and policies. On the contrary, there are many advantages, like making way for younger professionals to advance, learning a different system of practice, fighting job stress and burnout, and realising one's own worth.

The Fellowship gave me multiple opportunities to broaden my knowledge and experience the practice of psychiatry in a different setting. In return, it was common to share my own experiences from home with colleagues in the UK. Other contributions from professionals who have left their home countries are financial, academic, clinical, research, social and developmental.

Who lures health professionals?

A large number of specialists who emigrate from low- and middle-income countries are attracted by international organisations. The World Health Organization (WHO) attracts the best health specialists to fulfil its mandate from 191 countries, many of which are poor countries.

The WHO recruitment process is by nomination, unlike the NHS fellowships, for which there is global advertisement. In NHS recruitment, equal opportunities are ensured and the process is transparent; there is also adequate time for induction and so on. Sadly, in India posts are advertised but not filled, selection procedures are opaque and there is *ad hoc* cancellation of selections.

Stopping recruitment

If recruitment is stopped from those countries that have jobless doctors, will it help? No amount of coercion and regulation will prevent people from seeking a livelihood. Such coercion would be considered dictatorial, immoral and unethical. The idea of compensating home nations is baseless and lacks logic. Would reimbursing the cost of training improve health? What would such reimbursement cover – medical training, further education, schooling, childhood, antenatal care? There is no evidence in any case that reimbursement would be a solution. Those who choose to migrate will have been tax payers and have invariably repaid their 'dues'. Coercion is harassment, abuse and bullying. The services of harassed, abused, frustrated health professionals, provided against their will, are no good for anyone. In contrast, fellowships lead to professional growth.

If we stop migration, the countries seeking doctors will have longer waiting lists and a poorer state of health for their populace. The countries sending doctors will have more unemployed, frustrated, poor doctors, and a similarly poorer state of health for their populace. It would be bad for the medical profession and it would persuade some to change profession.

The situation in rich countries will only get worse. The more you have the more you need, it is said; the less you have, the less you learn to live with. Rich countries need to look at ways to improve their healthcare systems. They should examine the strengths of healthcare delivery in low- and middle-income nations, and adopt or adapt some ideas.

We need better evidence on the extent of the problem of professional migration, its effect on both countries, and the effectiveness of measures to deal with it. The future of sensible migration lies in conducting campus interviews and selection. Health trusts in the UK could liaise or collaborate with centres in low- and middle-income nations. Such exchange of professionals could strengthen health systems mutually and globally.

My own fellowship experience was a pleasant break from routine, with learning opportunities. The most memorable moments were the farewell meetings with the carers group, the trainees, and a farewell from my patients. My British patients said they were sad that I was leaving them, but that I was not leaving psychiatry and that I would still make differences in the lives of people in a different part of the world. How I wish the critics of the Fellowship Programme would heed these comments.

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