

Training matters

The training of psychiatrists for the developing world

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How relevant is the training which postgraduate psychiatrists from the developing world receive in the West? Are the investigations, treatment, and clinical practices taught in the UK transferrable across widely disparate cultures? Should trainees be taught basic psychiatry or only sub-specialities? Should they come at all?*

At a time when the Royal College of Psychiatrists and the NHS as a whole is encouraging graduates from overseas to study and work in Britain, these questions are central to the future requirements of Western training for other cultures. This article attempts to identify key areas for such training courses.

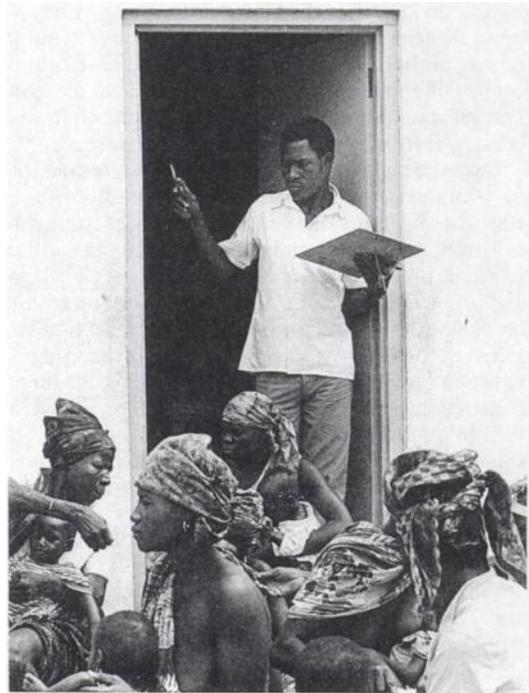
Training patterns and priorities

What factors influence whether trainees in the developing world go abroad and where they go? What are their educational priorities?

Several factors influence the place chosen for post-graduate study, including previous political or colonial links, availability of local and regional training, but economic factors appear to be the most powerful and are particularly able to affect Government-sponsored training. It is through economic factors that wars, oil booms and famine have been able to determine in part the composition of the post-graduate population in the West. Similarly, low fees to European Community doctors and rising medical unemployment have led to a shift in the pattern of students, as at the Institute of Psychiatry where

*These questions and the discussion of them are taken from the content of a course held in the Department of Psychiatry at Withington Hospital, Manchester, from 15–19 April 1991, entitled 'Psychiatric Practice in the Developing World', attended by 22 trainees from Africa, the Middle East and the Indian Sub-continent.

Teachers on the course were Dr L. Appleby, Dr J. Bavington, Dr F. Creed, Dr R. Gater, Prof D. Goldberg, Dr D. Hollander, Prof J. Leff, Prof D. Tantam, and Dr G. Wilkinson.



A health centre in North Ghana.
(Maggie Murray)

many fee-paying postgraduates in the UK train, so that European, and in particular Spanish, students now constitute the largest regional group (Appleby & Araya 1990).

Most of the training they receive is concerned with clinical skills, including investigations and treatments which may not be available in some parts of the world, while relatively little time is devoted to service planning, evaluation and administration. Many trainees believe that there is a potential conflict between what the individual wants to achieve (e.g. clinical expertise, success in the MRCPsych),

what the sponsor is able to offer (e.g. short periods of training only), and the mental health needs of the population in the trainee's country (e.g. basic care delivered through non-medical health workers, sub-specialty training such as child psychiatry or in the addictions).

Training courses and methods

What are the duties of the psychiatrist in training paramedical staff?

Because a developing country may have only a handful of psychiatrists serving an entire population and few mental health-trained paramedical staff among its health workers, the psychiatrist must ensure that general paramedical staff, who provide most of the direct psychiatric care, particularly in rural areas, have suitable training. Psychiatrists should be able to organise training courses covering assessment, treatment, and after-care of the most prevalent conditions.

Various teaching methods may be used, including lectures, group discussions, role play, audio-visual aids, and video recording with feedback. Modern teaching methods and sophisticated teaching technology are spreading rapidly and experience of these should be acquired while studying in the West, as part of training in practical aspects of organising courses.

Administration

How does a psychiatrist learn to be an administrator? In the developing world a psychiatrist will spend much of his or her time on administration, committee work and in consultation with government ministries, addressing subjects ranging from clinical care to the security of property. The attributes needed for administration are said to be caution and sensitivity (!), not always included in clinical training schemes but a necessary part of good communication with other professionals, officials and colleagues.

Although rarely part of a UK training, it would be possible for tuition to expose trainees to administrative duties, at least through observation of senior colleagues. Skills which they picked up through attending committees in UK hospitals could be modified on return home, to make them appropriate to their own culture.

Health economics and evaluation

Should the practising psychiatrist have a knowledge of economics that can be used in the evaluation of services?

Evaluation has become a vital part of health care, both to show that the process of health care provision operates in the way that is intended, and to demonstrate that a type of care has a beneficial effect (or otherwise). One purpose of understanding health economics was to be able to evaluate clinical benefit (or other outcome measures) by converting it into monetary terms and relating these to the cost of service provision. Such cost-benefit analysis can be complex in psychiatry where the burdens of illness and the benefits of care affect the individual, the family and the social environment. Alternatively, it is possible to compare the cost of each service option which will produce a desired clinical result, or to compare the clinical results possible from a fixed budget.

A knowledge of health economics requires teaching of a kind not available in most training programmes. Although economic calculations could at times seem too theoretical – for example, when the family consequences of a treatment are given a financial value – familiarity with the premises and methods of health economists is of great value in the planning of services.

The psychiatrist and the family

What can the West teach the developing world about the therapeutic role of the family when the supportive, extended family is a feature of the developing world already? Studies carried out in Chandigarh on the “expressed emotion” (EE) of the relatives of schizophrenic patients have found a difference between rural and urban areas (Wig *et al*, 1987). Urban families show higher expressed emotion, but not as high as in the West (Wig *et al*, 1987), important because the lower EE in Chandigarh relatives appears to explain the better outcome for first-episode schizophrenia there (Leff *et al*, 1987) and because urbanisation is gathering pace in the developing world.

The low expressed emotion in rural areas may be related to the extended family structure and to the fact that schizophrenic patients are still considered as part of the work force in areas where the work requires no special skill. In addition, contact with any individual family member is often brief, reducing both the risk of critical comments and their impact.

Psychotherapy

Is psychotherapy necessary in the developing world? If it is, what form should it take and where should its skills be taught? In developing countries neurotic disorders are at least as common as in the developed world, as German (1987) has described in his review

of African studies, but the cost of treating these with appropriate psychotherapeutic interventions could be prohibitively high. The most efficient role for the psychiatrist may therefore be the training of primary care physicians in basic psychotherapeutic techniques, such as recognition of distress, sensitivity to patients' feelings, and problem-solving. For those who need drug treatment, compliance can be improved if the treating physician has shown understanding of the patient's problems. Trainees are often keen to learn psychotherapeutic skills as part of their clinical training in the West, and to learn also how to teach these to their professional colleagues.

Research

Is research a priority in the developing world? Where should such research be published? Who should teach research?

Because it cannot be assumed that developed world findings are applicable to the developing world, studies are needed on the prevalence, characteristics, and epidemiological pattern of morbidity in many developing countries, as well as on the use and effectiveness of services. Even when the demands of direct clinical practice are great, some research on these areas is important. When research papers are written, consideration should be given to how the findings will most easily reach others with similar interests. This will influence how concisely a paper is written, and where it is published (in an international or local journal).

Research training can begin early, in that the supervised collection of data can be undertaken *before* coming to the UK. On arrival, the trainee could receive training in data analysis and interpretation, presentation and publication. Research collaboration should continue after return home.

Conclusions

Most UK training posts emphasise clinical practice and those attached to university departments offer research experience also, but none covers all the activities that occupy the practitioner in a developing country. Trainees are often seeking experience at all levels of mental health care, from central planning to hands-on treatment suited to rural clinics. The demand for training in sub-specialities, particularly child psychiatry, is growing with the result that general training is likely increasingly to be provided in trainees' own regions, perhaps in their own countries, while sub-specialities will be taught to selected postgraduates spending short periods in centres in the West. Such a devolved system for the international training of psychiatrists would provide a logical structure to training in the West for the developing world, but would mean a further shift in the current pattern of overseas tuition.

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