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TRAINING OF PSYCHIATRISTS

by

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During the last two decades so much has been written and debated on the subject of training of psychiatrists in different countries that it seems a little pretentious to assume that one can add any new points to already well known controversies. The World Health Organization addressed to this problem quite early and the deliberations of Expert Committee on Mental Health are well summed up in their 12th Report TRS. No.252, 1963). The Royal Medico Psychological Association (now Royal College of Psychiatrists) in 1969 had a 3-day conference with over 150 participants which devoted itself exclusively to this subject which has come out as a special publication of British Journal of Psychiatry 1970. I am sure in many other countries also such debates must have taken place. Unfortunately the problems of mental health services are so different in different parts of the world that model of one region cannot be completely

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applied to the other. In this paper an attempt has been made to discuss this problem as seen in developing countries particularly India. I have divided this paper into 3 broad areas in an effort to answer three general questions.

1. How many trained psychiatrists do we need?

2. Who should train them?

3. How they should be trained

In the end I have also tried to consider some special problems and difficulties being faced by training centres in developing countries.

I HOW MANY TRAINED PSYCHIATRISTS DO WE NEED?

The first question which arises whenever we consider the larger issue of the training of the psychiatrists is how many psychiatrists do we need to man our mental health services? Somehow the debate about the ideal numbers seems a bit irrelevant in the context of developing countries where it is obvious that whatever we may do for increasing the number of psychiatrists, the number will never be adequate by western standards in the foreseeable future. For example in India where we have about 300 trained psychiatrists, even if we double this number in the next ten years, we will reach only the dismal figures of one psychiatrist for a million of population. Obviously it cannot be enough to depend on trained psychiatrists alone to man the mental health services in developing countries. We shall have to think in terms of training of G.Ps and other para-medical staff for psychiatric care of the vast part of our population. However, it would be beyond the scope of this paper to discuss that problem at length. Along with such difficult task of doubling the number of psychiatrists in a decade we have another paradox. On one side we do not have enough psychiatrists and

on the other side, for the new psychiatrists in developing countries there are not enough of job opportunities. Burdened with the uphill task of raising the living standard of teeming millions, along with the urgent-health problems like malnutrition, provision of safe water and control of infection, most of the governments are unable to give high priority to development of mental health services. On top of all this is the lure of affluent West which is constantly draining away our best brains. It is sad to see a poor country tightening its belt to provide its best facilities of training to its best scientists - only to loose them to rich countries. Thus in the field of Medicine and Psychiatry the rich countries are getting richer and poor are getting poorer. It is difficult to imagine how this gap would ever be filled. This complex question of "Brain Drain" has been debated many a times in different forums. Recently the whole problem in reference to psychiatry in USA was excellently put by Torrey and Taylor in a debate at the American Psychiatric Association and published in the Journal of A.P.A. 1973. There are unfortunately no easy solutions but I do hope our workshop would be able to devote sometime to this vexed problem which is so intimately connected with training of specialists.

II WHO SHOULD TRAIN THEM?

We have to next address ourselves to this question that who should train these new psychiatrists? Should they be trained in their home countries where there are often inadequate facilities or should they be trained in the well established psychiatric centres of the affluent nations. Most of us would agree that the best place to learn psychiatry would be in one's home country, learning from patients whom one is ultimately going to serve. Each country has evolved its own pattern of health care best suited to its own

local needs and in keeping with the prevailing political philosophy. Training in another country is often not suited for local needs. For example a young psychiatrist trained in an American teaching centre with all the stress on psychodynamics, individual psychotherapy, and crisis intervention, may find his training quite inadequate when posted at a district centre in India where he may be called upon to see 40-50 patients every morning single handed and run a 12 beded observation ward without the help of a trained psychiatric nurse or a social worker and where the nearest mental hospital is 200 miles away. The problem is further complicated by different legal and public health systems. However, the biggest inadequacy which a foreign trained psychiatrist feels is his unfamiliarity with the local clinical material. The classical cases he saw of depression schizophrenia drug addiction and sexual deviations in Europe and America are hard to find in India but in contrast there is a confusing mass of multiple somatic symptoms, gross hysterical reactions and culture bound phenomenons hiding the basic psychiatric syndromes. It is only by working with the indigenous population that one can hope to learn the pattern of psychopathology and norms of mental health in the given population. The training in the foreign countries has additional disadvantages that the local centres do not develop and of course there is more possibility of "Brain Drain" to which we have earlier referred to.

Having said that the best training can be given by the psychiatric centres in the home country we still have to find a solution for the time being in the countries who do not have such training facilities. They obviously cannot wait that long to have their own centres and their doctors must be given training in other countries. However, in this connection I have the following 3 suggestions to make:

1. Instead of sending every candidate to Europe and America, it might be more useful to train psychiatrists in well established centres in the neighbouring countries where the cultural background and psychiatric problems are relatively similar. The Wrold Health Assembly can possibly play a very important role in developing and strengthening such centres in various regions of the developing world.

2. Those training centres in Europe and USA which are prominently concerned with the training of psychiatrists from developing countries. should specially design their curriculi and training programme to meet the needs of developing countries. The improved curriculum should include courses on transcultural psychiatry, and clinical training geared toward single handed management of cases with minimal help from other para-medical staff. For example in a developing country a psychatirst should have enough training to give simple psychological tests himself without the help of a clinical psychologist, to give anaesthesia for E.C.T. himself without the help of an anaesthetist, to manage a disturbed and suicidal patient in a general ward without the help of a qualified nurse and to do the social case work with the family without the help of a qualified social worker. Another useful idea might be for these centres to invite teachers from developing countries for short assignments so that they can provide the necessary stimulation and orientation of psychiatric problems back home.

3. I also fully support the recommendation of the WHO Group Meeting on Mental Health in Alexandria in September 1972 that those doctors who go out for psychiatric training abroad should have some exposure, at least for a year or so, of psychiatry in the home country before proceeding on for further training. Unfortunately a large number of overseas students who are currently in training in psychiatry in UK or USA have not originally

gone there for training in this speciality but have drifted into psychiatry due to easy job opportunity or more pay. Very often they land up in hospitals where there is hardly any facility for proper training. It is doubtful whether such jobs and period spent in those hospitals can be really called a training period.

Next we might consider the minimum requirements for a centre eligible for training of psychiatrists in a developing country. In India we have evolved 2 different models, one is the training centres located in mental hospital based institutes like the one situated at Bangalore and Ranchi, entirely devoted to the teaching of psychiatry and possibly other related disciplines like clinical psychology, psychiatric nursing and social work. The other model is that of training at the department of psychiatry at a medical college or a post-graduate institute attached to a general hospital, like the centres at Chandigarh, Delhi, Lucknow, Bombay etc.

Both models have their own advantages and limitations. However, I must confess that I have my bias in favour of the general hospital based department. Firstly it must be clarified that in Indian context these general hospitals psychiatric centres like our centre in Chandigarh or Prof. Neki's Centre in Delhi are very different than the average general hospital psychiatric unit in Europe or America in being much more comprehensive in terms of patient care. This is because mental hospitals are so few and inadequate that the general hospital psychiatry departments are forced to evolve an extensive programme for the care of the psychosis, as well as for the neurosis, personality disorders and psychosomatic illnesses. This assumes still greater importance when we realize that in view of the Government's policy of not opening more mental hospitals but first concentrating on psychiatric departments at all teaching hospital and district

hospital centres, the psychiatrist trained in general hospitals has a more wholesome training for his needs. For example in our clinic the spectrum of mental illness would contain about 45% psychosis, 40% neurosis and 15% personality disorders and psychosomatic illness, in contrast to mental hospital based institutes where neurosis, psychosomatic illness or personality disorders patients are a rarity (Khanna, 1972). There is the additional advantage of close proximity of other specialities like general medicine and surgery and also the possibility of attracting young students from undergraduate career to psychiatry. However, one must grant that administrative psychiatry, forensic psychiatry and care of the chronic cannot be learnt in general hospitals. Possibly the best solution under the circumstances would be if the students can be sent to a different centre for 3-6 months for the additional training which is not available at one centre. For example during 3 years of training we send our students to a mental hospital for 2-3 months for additional training.

We might also consider briefly the questions of newly started post-graduate training centres without adequate facilities. Recently in India we are seeing such a phenomenon which is worrying many of us. In my opinion certain basic requirements must be met with before a centre is recognized for post-graduate qualifications. It would be unwise if every consultant at a teaching hospital is permitted to start a training course in psychiatry. In my opinion a minimum requirement programme at a teaching general hospital must have:

1. A daily out-patient psychiatric service
2. A 20-30 beded independent in-patient psychiatry ward
3. A separate child psychiatry service

4. An adequate emergency and referral service for psychiatry
5. At least 3 consultant psychiatrists (a Professor, Asst. Professor and Lecturer)
6. 1 to 2 clinical psychologists, trained nurses, social workers and occupational therapists
7. Adequate teaching facilities for basic neural sciences psychology, sociology etc.
8. Training facilities for clinical neurology
9. Link with a mental hospital for additional training in forensic psychiatry

III HOW THEY SHOULD BE TRAINED

Now we come to the crucial question how the psychiatrists should be trained. Here the opinions are widely divergent in different countries, and enough has been written and discussed in different seminars. One question which has been debated very much in our country is the duration of post-graduate courses in psychiatry. There are a number of models available. Our own institute at Chandigarh awards a degree of M.D. Psychiatry after 3 years training following one year's house job and a year's rotating internship after 4 1/2 years of medical degree. This is probably the longest course and same is the pattern at A.I.I.M.S. in New Delhi. Some universities like Lucknow and Bombay are giving M.D. after 2 years training. Some universities are not insisting on one year of compulsary house job before training. The institutes at Bangalore and Ranchi have 3 years M.D. programme but have in addition a 2-year training course for diploma in psychological medicine. In general the Indian Medical Council has recommended 3 years training for M.D. and 2 years for a diploma in psychiatry. Till

recently most of trained psychiatrists in India had their qualifications as D.P.M. However, the position is rapidly changing in the last 5 years when 5-6 centres for M.D. have become available and most of the selection committees are insisting on M.D. for teaching hospital jobs. This is historically similar to the situation in UK after the start of M.R.C. Psych. examination. I personally feel that gradually D.P.M. should be abolished and M.D. Psych. should be the qualifications for all consultant posts in psychiatry. A limited problem will remain for the training of doctors who are already working in mental hospitals but do not have any qualifications in psychiatry. For some of them it may be difficult to undergo 3 years training and obtaining the degree. Possibly for them a short certificate course in psychiatry for one year may be introduced which may chiefly concentrate on clinical training.

About the pattern of training a common debate in other countries has been whether psychiatry should stick to the medical model or should psychiatry evolve the new model based on social sciences. Much can be said on both sides. However, in the context of developing countries the general model would largely remain medical for a long time to come. This is because immediately, medical model has more to offer particularly in the management of psychosis and acute emergencies. Secondly the medical model is more easily comprehensible to the general population.

Controversy about the subjects to be taught in training programme continues. There are no universal answers as the needs vary from region to region. Our views based on our training programme at Chandigarh are briefly summed up below.

1) Clinical training should be central to the training programme.

2) Psychotherapy including individual and group therapy should be an essential part of the training not only for their value in treatment, but also for their important role in understanding psychodynamics and psychopathology.

3) Research orientation should be an integral part of post-graduate training. Students should be encouraged to take up independent research projects under supervision.

4) Neurology teaching is important for a psychiatrist but relationship of psychiatry to other branches of general medicine and surgery is equally important.

5) Adequate number of lecturers covering basic sciences and social sciences should be provided. We have been regularly using services of neighbouring university departments of psychology, sociology, anthropology for lectures to students.

6) Though there should be exposure to subspecialities like child psychiatry, forensic psychiatry, geriatric psychiatry, the main aim of the training should be to turn out competent general psychiatrists.

There are many other questions related to training programmes which have been left uncovered in the present paper partly due to shortage of time and partly due to varying problems in different regions. Thus there is the whole question of differential training in psychiatric specialities. What specialities should receive priority in our training programmes? Then there is the question of selection of candidates for training. How to attract better doctors to psychiatry? What should be the aptitude of those who are selected? How much weightage should be given to this aptitude to

psychiatry in selection procedures? Should the training programmes also try to inculcate in the trainees special attitudes towards psychiatry and psychiatric patients? When discussing the question of training, we will also have to consider the issue of assessment and examination, as well as the need for continuing training after initial qualifications. Similarly there are many other areas of interest and controversy but before closing this section of "How to train psychiatrists" I would like to address myself to one problem which I think is crucial to the whole training programme. This is related to the central aim of the training programme. What are we trying to make of the future psychiatrist? What is the role of the future psychiatrist in the organization of mental health service in developing countries? I find there is a lot of confusion in this area and as a result there is no clear sense of direction in the training programme. Most of the training programmes are oriented toward providing the trainee necessary knowledge and skill to recognize and to treat psychiatric illness in an individual case when that individual presents himself in the clinic or hospital. But is that enough of a role for a psychiatrist in developing countries? At the beginning of this paper we conceded the point that the total number of psychiatrists is so small in developing countries that they can never look after all the patients. So even if we provide excellent knowledge and skill to our trainee to diagnose and treat an individual and even if this future psychiatrist goes on seeing patients 24 hours a day, how much of the national problems shall we solve? On the other hand there is a positive danger that such specialized knowledge and skill of the psychiatrist would be exploited by the rich and urban sections of the society alone. Should the new developing countries invest so much for this limited goal?

If we envisage the role of the psychiatrist as the leader of the mental health team, as a teacher, guide and supervisor of non-specialized workers, as a planner and organizer of mental health activity in the community, are we giving the future psychiatrists enough training or background knowledge for such new roles? My impression is that in most of the centres this aspect is largely neglected. This hardly finds a place in any curriculum and certainly does not form part of any examination system. Why is it so? There can be many reasons for this state of affairs.

Firstly we have borrowed a pattern of training from Western countries which was largely a curative model of medical care which we are blindly following without seriously examining its usefulness and limitations in our context. It is always easy to copy an existing design than to plan a new one. Secondly the medical men have a vested interest in this curative model which is more paying and assures a more comfortable income and status in the society. Here there is also an element of trade unionism. In many countries doctors neither are willing to go to the villages, nor are they prepared to let the lesser qualified people take over health services in the rural areas. My own personal view in the matter is that technical knowledge and skill should not remain the monopoly of a small class. The medical technology should be simplified and made available to lesser qualified workers. After all transistor radio or automobile was once the domain of a very small, highly skilled engineering group but today it is within the scope of an ordinary mechanic in every town. Similarly medical and psychiatric skills should be simplified and should not be the private reserve of psychiatrists alone. Rather psychiatrists

should be the disseminators of this new knowledge and the training programmes for psychiatry should equip the future psychiatrist with this new knowledge, skill and aptitude to lead the mental health team. He should be able to work not as an individual but able to work in a group; should be able to use to the maximum the skills of general practioners and lesser trained workers and should also be able to successively enhance the skill of these workers so that they can share more and more load of mental health care, for the larger interest of the community. I am aware that all this is not possible immediately till there is some degree of national consensus on the future roles of psychiatrists and other mental health workers. However, I do feel that ability to teach non-specialist workers, ability to work in a group for the delivery of better mental health care, ability to plan and organize future services, should be among the essential goals of any training programme psychiatry in developing countries.

IV SPECIAL PROBLEMS RELATED TO TRAINING CENTRES IN THE DEVELOPING COUNTRIES

Before I end this paper I would like to devote some time to the special problems faced by new training centres and the role of WHO to relieve these difficulties.

Our first problem is shortage of personnel. Probably there is no easy solution till we train enough of our own young doctors and other para-medical staff. However, for the time being, some help can be given to these centres if suitable specialists from other countries can spend time at these training centres. Apart from specialists in general psychiatry we possibly need more help in subspecialities like child psychiatry, psychotherapy, social psychiatry and peripheral areas like statistics, record keeping and research methodologies. However, a word of caution should be given about such visits. Firstly to be effective, these visits should be for a sufficient

time of 6 months to a year at one centre. Fleeting visits covering 8 centres in one month may have some general stimulating effect for the centre but cannot meet the need of extra hands. Secondly the visitor to be accepted in a centre should be of certain merit and professional standing. Sending out relatively junior people with designations of professors only create more rivalries and problems as has been the experience in many centres. Similarly persons with their own personality problems and maladjustments would hardly be the best of teachers for such ambassadorial jobs. However, one can understand the difficulty on the other side too. After all why should persons with outstanding abilities and busy teaching and research schedules leave their own countries to take up such philanthropic assignments?

The second major problem of these newly emerging centres is the need for advanced training for their own staff. In this area WHO is already helping considerably. Possibly other fund giving organizations can further help in this area. Unfortunately most of the difficulties in this matter are raised by the local institutions and governments. By and large most of the governments accept aid from WHO more readily than when it comes from individual countries. Hence it would be better if fund giving agencies route their aid through WHO.

There are a number of other problems related to resources where WHO and other agencies can help. For example it is sad, how our trainees have to suffer due to lack ofup-to-date books, journals, reprints, etc. These things appear so ordinary in American or European contexts but in India even in the well developed centres it takes months and years before we can obtain the desired books and journals. There are endless delays and frustrations over lack of finance , red tape and poor communications. Help in the form of

regular supply of books, journals, reprints by various agencies would be most welcome. It would be equally helpful, if data retrieval systems could supply the desired bibliographies as well as the necessary reprints. Probably WHO regional offices can be very helpful in this regard. The use of audiovisual aids, like video tapes, slide projectors, tape recorders, medical films, etc. are many new devices which have rich potentials in our training programmes where we are so short of teachers, but unfortunately very few centres are able to procure and use them. For the last 5 years I have been trying very hard to import medical films for teaching. There are now hundreds of such films on mental health in English language and some of them are very good too. In India there is a peculiar fascination for films and I am sure it can prove as a very important teaching device particularly for para-medical groups, but alas! so far I have not been able to convince any national or international agency to provide funds for the venture.

SUMMARY

The problem of training of psychiatrists in developing countries is considered in the light of experience gained in India during the last two decades. It is suggested that best training in psychiatry can only be given in one's own social milieu, and training centres should be developed at local and regional levels in different parts of the world. The training programme should provide training not only in clinical psychiatry but should also aim to equip the future psychiatrist with the knowledge, skill and attitude to fulfil his new role as a leader of mental health team in developing countries. The minimal requirements for the fresh training centres and some special problems of such centres in the developing countries have been discussed.

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