

The challenges faced by national psychiatric associations and societies

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Currently, national associations and societies in psychiatry are facing major problems and dilemmas concerning most of their core values and objectives. Example include (Griffith & Ruiz, 1977; Matorin & Ruiz, 1999):

- addressing ethical issues pertaining to their relationship with pharmaceutical industries
- upgrading of the educational and training models used with medical students, graduate residents in psychiatry and postgraduate trainees in the psychiatric sub-specialties (child and adolescent psychiatry, forensic psychiatry, geriatric psychiatry, etc.)
- finding a good balance with respect to research and investigation in the areas of biological psychiatry, neurosciences, psychosocial and cultural psychiatry.

Among these challenges, though, there is one that transcends the others. This is the problem related to psychiatric/mental health staff numbers (Ruiz, 1987). This challenge has existed since the end of the Second World War, but it has been accentuated during the past decade or so by globalisation. Following the war, a strong migratory process developed; this included the migration of physicians from low- and middle-income nations to richer ones. This trend was most readily observed in the immigration patterns of the United States, Canada, England and, to a certain extent, Australia. However, since the globalisation process began, migration has affected all regions of the world. In the European Union it is accentuated by the free movement of labour among member states.

As in other medical specialties, in psychiatry this migratory process has led to substantial 'brain drainage' in certain areas of the world. This phenomenon creates major problems in the educational, investigational and service aspects of all specialties, but particularly psychiatry (Garza-Trevino *et al*, 1997; Guynn & Ruiz, 1998). Take, for instance, the United States. In the United States there were approximately 646 000 physicians in the year 2000 (according to the US Bureau of the Census). Of this number, about 153 800, or 23.8%, were 'international medical graduates' (IMGs). In psychiatry, something similar is also happening. For instance, about 40% of the general psychiatric residents training in the United States (just under 2300) are IMGs. The situation is accentuated with respect to the psychiatric specialties. For example, in child and adolescent psychiatry training, 43% of the trainees are IMGs, in geriatric psychiatry the proportion is 69%, in addiction psychiatry 58% and in consultation and liaison psychiatry 48%. In the American Psychiatric Association, from a total of 26 756 fee-paying members in 2001,

25.2% were IMGs, or 6743. Of this number, 1398 were from India, 512 from the Philippines, 341 from Pakistan and 220 from Argentina. Of interest is the fact that 32% of the IMG psychiatrists are working in the public sector while only 22% of the US graduate psychiatrists do so. In other words, psychiatric care in the public sector in the United States depends to a great extent on IMGs. This situation is similar in Australia and other industrialised nations.

Another factor that needs to be taken into consideration in this regard is the fact that more than half of the total world population (about 3 billion persons) live in Asia. The Asian continent is one of the areas of the world which is most seriously affected by the migration of physicians, especially psychiatrists, to industrialised regions. Such migration has serious negative effects on the delivery of health and mental health services in the socio-economically deprived regions of the world.

The rate of serious mental illnesses, such as schizophrenia and bipolar disorders, is essentially the same all over the world. Of course, if many physicians, particularly psychiatrists, leave Asia, the number of people with serious mental disorders does not decrease in this region of the world; in fact, it remains constant or increases in accordance with the rate of increase of the population. This means that fewer of those with schizophrenia and bipolar disorders in Asia have access to specialised psychiatric care. This unfortunate situation is similarly observed in sub-Saharan Africa, where the numbers of available psychiatrists are minimal in comparison with the total population. In addition, the increase in the life span of individuals across the world makes the shortage of psychiatrists and mental health professionals yet more critical and challenging (Ruiz, 2003, 2006).

The worldwide crisis over the numbers of mental health professionals is especially striking in relation to psychiatrists in Asia, where there are today approximately 35 000 psychiatrists for a population of about 3 billion, while in the United States there are an estimated 50 000 psychiatrists for a total population of about 285 million. There are too few psychiatrists in all Asian countries. China has approximately 14 000 psychiatrists for a population of about 1.3 billion; Pakistan has about 350 psychiatrists for approximately 152 million; India about 3500 psychiatrists for a population of approximately 1 billion; and Laos has only two psychiatrists for some 5 million people. Obviously, the crisis in Asia is both acute and endemic.

In this editorial, I have described a brain drainage and a shortage of psychiatric personnel that have reached crisis proportions in many areas of the world, owing in part to

the process of globalisation seen in particular over the past decade. In addressing this situation we have to accept the fact that governments and societies in the industrialised world do not have the social interest to address and resolve this problem (Sox, 2002), while governments and societies in many other regions of the world do not have as yet the financial strength to address and resolve this situation either. Thus, it is imperative that national associations and societies in psychiatry from both high-income nations and low- and middle-income countries prioritise this issue. These associations and societies need to work together to develop a strategic plan of action to address this mental health problem. The World Psychiatric Association (WPA) has never addressed this situation in a worldwide effort. The World Health Organization (WHO) has made reference to it but has not yet made it a priority. Therefore, we need psychiatry's leaders to bring this situation to the forefront of the profession. This issue is currently the greatest challenge to the mental health system worldwide. To continue to look the other way is both inhumane and unacceptable.

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THEMATIC PAPERS – INTRODUCTION

Teaching and training in psychiatry

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One of the chief remits of the Board of International Affairs of the Royal College of Psychiatrists is to highlight, review, encourage and determine the development of psychiatric training, and to support trainees through collaboration in the development of curricula, as well as in relation to the conduct of examinations and continuing professional development. Here we present three more or less polemical articles that report on difficulties pertaining to the training of psychiatrists in Bangladesh, India and Europe. In each case, the authors turn to the College for advice, guidance and, potentially, intervention, with the aim of standardising the training of psychiatrists around the world.

Mohammad Mullick works in Bangabandhu Sheikh Mujib Medical University, in Dhaka, Bangladesh. Dhaka is situated on the banks of the Buriganga River and has a population of some 11 million. It is the largest city in Bangladesh and one of the fastest-growing cities in the world. In a country of over 120 million there are only 77 trained psychiatrists, and just two child psychiatrists for 47 million children under 15 years of age. While it would seem the quality of training is good, he asks how, given the limited resources available for aspirant psychiatrists, it is going to be possible to provide the numbers of mental health specialists required to deal with a vast and largely hidden need. He makes a number of suggestions about how the College could help, principally with a variety of schemes aimed at training the second generation

of potential Bangladeshi psychiatrists. He does not discuss the substantial 'brain drain' of mental health workers from that country, a topic that has recently been reviewed by Adkoli (2006).

Professors Kulhara and Avasthi from Chandigarh, India, discuss the similar problems facing that country in its attempts to train a new generation of psychiatrists. One point they forcefully make concerns the extraordinary discrepancies between different regions of India in their provision of medical schools. The range is from just one small school in, for example, Chandigarh (with a population of 90 million) to 32 schools in Karnataka (population 56 million). Persuading medical students to consider a career in psychiatry is not easy at the best of times, and the relative lack of exposure to the specialty in curricula laid down by the Medical Council of India, together with lack of examinations in the subject, does not encourage many to select it. They review a range of problems, before turning to the College with a number of specific suggestions about how it might be able to help.

No doubt both the South Asian and European International Divisions of the College could have a role in responding to these pleas from the Indian subcontinent and to the third of our contributions, which concerns the state of psychiatric training in Europe. James Strachan draws our attention to an anomaly whereby the European Union requires mutual recognition of postgraduate specialist training schemes, but