

About the authors

Clare Oakley is Chair of the Psychiatric Trainees' Committee and specialty registrar in forensic psychiatry, and **Amit Malik** is President of the European Federation of Psychiatric Trainees and consultant in old age psychiatry, UK.

References

- 1 Strachan JG. Training in Europe in perspective. *Int Psychiatry* 2007; **4**: 33–4.
- 2 Lotz-Rambaldi W, Schafer I, ten Doesschate R, Hohagen F. Specialist training in psychiatry in Europe – results of the UEMS survey. *Eur Psychiatry* 2008; **23**: 157–68.
- 3 Strachan JG, Schudel WJ. Accreditation of European training schemes in psychiatry. *Psychiatr Bull* 2004; **28**: 19–20.
- 4 Gribbin N. The European Federation of Psychiatric Trainees (EFPT). *Eur Psychiatry* 1999; **14**: 468–9.
- 5 Day E, Grimmer C, Lloyd A. Psychiatry training in Europe: a brief history of the European Federation of Psychiatric Trainees. *Psychiatr Bull* 2002; **26**: 152–4.
- 6 Oakley C, Malik A, Kamphuis F. Introducing competency-based training in Europe: an Anglo-Dutch perspective. *Int Psychiatry* 2008; **5**: 100–2.



Training psychiatrists in Europe: fit for purpose?

Commentary on . . . Psychiatric training in Europe[†]

Matthijs Muijen¹

The Psychiatrist (2010), **34**, 450–451, doi: 10.1192/pb.bp.110.030189

¹World Health Organization (WHO)
Regional Office for Europe

Correspondence to Matthijs Muijen
(mfm@euro.who.int)

Summary Psychiatric training in all European Union (EU) Member States complies with the relevant Council Directive 93/16, permitting free movement of specialists within EU borders. This assumes that the training offers similar experiences, and produces specialists fit for purpose in all EU countries. Surveys demonstrate that, although all countries adhere to the conditions of the Directive, the diversity of training is striking on all but the most fundamental aspects. An added complication is that psychiatric practice has become increasingly diversified, even between neighbouring countries, and psychiatric training will have evolved to meet national service requirements. Questions about how to safeguard competence of psychiatric specialists to practice across the EU are therefore pertinent, and introducing systems to regulate quality control of training should be considered.

Declaration of interest None.

A fundamental right within the European Union (EU) is the free movement and employment of labour. For professionals, this requires the recognition of formal qualifications across the Member States, as set out by Council Directive 93/16/EEC.¹ In its crucial Paragraphs 23 and 24, the Directive specifies the minimum training requirements that national qualifications should guarantee, including knowledge, experience and minimum hours of theoretical and practical instruction. Authorisation of qualifications from outside the EU Member States remains subject to national rules.

Inevitably, the education specifications of the Directive are fairly broadly phrased, relying on mutual trust of standards and quality control in countries. No formal transnational inspection bodies exist, and although the Union Européenne des Médecins Spécialistes (UEMS) has developed requirements on training for specialists in psychiatry, these are advisory only.²

Since there is a large amount of international movement of medical specialists, and since many of these doctors are working in positions of independence and great responsibility, it could be reasonably expected that quality and content of training across Europe will have been subject to some scrutiny, not only to test the assumption that clinical competence travels well, but also to judge whether any adjustments to curricula are necessary. Some specialties seem to have progressed more than others. For example, in surgery, a European Board of Surgery Qualification was established in 1996.³ In psychiatry, no such international qualifications exist.

Oakley & Malik's study of psychiatric training in Europe (including some countries beyond the EU borders),⁴ undertaken by the European Federation of Psychiatric Trainees, is therefore welcome and important. It is based on information provided by trainees during the conference and will therefore reflect personal experience as much as national standards. It is surprisingly rare to find such comparisons of postgraduate psychiatric training. The only

[†]See education & training, pp. 447–450, this issue.

other international training survey, slightly more detailed, was performed by UEMS a few years ago.⁵ The UEMS paper used data from questionnaires that were sent to all national representatives on the UEMS board and to training institutions in the Member States. When these papers are considered together, some patterns emerge.

Unsurprisingly, all countries within the EU adhere to the training conditions specified in the Council Directive, such as a minimum specialist training duration of 4 years, in contrast to some external countries where specialist training can be only 1 year. Nearly all training centres are subject to national recognition. All centres offer training in psychopathology and biological treatments.

The points of agreement are important but limited. The diversity within the scope of the Directive is remarkable, and it is a somewhat bewildering experience trying to find a system within the variation of the data. Training curricula are not uniform in some countries; instead, universities determine their own unique curricula. Across Europe, subspecialties are not standardised: less than 50% of countries recognise subspecialisation and, if they do, training durations and experiences differ. Management and leadership training are offered by 40% of training schemes, and training in community psychiatry is mandatory in 66% of training schemes. Not all countries require examinations, and methods of evaluation differ considerably across the other countries.

Not included in the surveys is the provision of continuing education, which was briefly addressed in a World Health Organization (WHO) survey of policies and practices in Europe.⁶ Very few countries keep a register or set minimum standards – often it is left to personal initiative. Education providers are mostly unaccredited, many coming from the private sector.

Two important aspects of such surveys are too often ignored. One aspect is that terminology is accepted at face value and competence is assumed, whereas major differences of meaning are hidden behind concepts such as community care and psychotherapy. The survey question about community psychiatry may intend to explore and suggest training in community teams, but the responses may relate to out-patient clinics in some instances, or even work on wards in district general hospitals in others.

The second concern is that percentages coverage and comparisons of content offer little information on quality. Experiences of international trainee representatives are not always reassuring in this respect, mentioning poor working conditions, lack of adequate supervision, and varying standards of training across teaching institutes in some countries.

These studies and the lack of additional comparative information suggest a mixed picture. The common denominator, covered by specialist psychiatric training in every country, includes diagnosis, pharmacological treatment, some psychotherapy and practice on a psychiatric ward. Beyond this, the training within the boundaries set by Directive 93/16 reflects increasingly complex and diverse services and practices in countries. Mental health delivery in 1993, the year of the Directive, was relatively uniform and based largely on hospital services. Now some countries are providing highly complex community-based systems of care.

Each country is constantly evolving an education that is fit for purpose at a national level, matching the requirements of structures and functions of its services. For example, the rate of beds per 100 000 of the population varies from 8 to 152 across the EU and the number of psychiatrists from 5 to 22. The populations of only a third of EU countries have access to community-based crisis care. These variations result in different practice and training. Since many European countries have not created multidisciplinary community teams, it would be unrealistic to expect such training as standard. Expertise in specialist practices that can be the norm in some, such as early intervention and cognitive-behavioural therapy, may be exceptional in others.

Even if one accepted the assumption that every country trains psychiatrists fit for the purpose of its own requirements, it remains uncertain how the competence of these psychiatrists to work in every other EU Member State can be ensured. At a time of high levels of public scrutiny and growing demands for quality control and accountability of professional performance,⁷ the question is whether one can continue to rely exclusively on the broad standardisation of training as required by EU Directive 93/16.

Free movement of labour is an essential founding principle of the EU, and few would wish to argue against it anyway. Central standardisation of European training is practically undesirable and politically unrealistic. An important role has been identified by UEMS as its aspiration to 'ensure the unification of training standards and assessment of efficacy of this training . . . through mutual recognition arrangements' such as peer review or audit.² A big step towards international quality assurance would be the establishment of a European training standards agency along those lines. The papers on psychiatric training in Europe offer the evidence that some regulation is in both the professional and the public interest.

About the author

Matthijs Muijen is Regional Advisor for Mental Health at the European Regional Office of the World Health Organization.

References

- 1 European Commission. *Council Directive 93/16/EEC*. European Commission, 1993 (http://ec.europa.eu/internal_market/qualifications/specific-sectors_doctors_en.htm).
- 2 Union Européenne des Médecins Spécialistes. *Report of the UEMS Section for Psychiatry, The Profile of a Psychiatrist*. UEMS, 2005 (<http://www.uemspsiatry.org/section/reports/2005Oct-PsychiatristProfile.pdf>).
- 3 Union Européenne des Médecins Spécialistes. The European Board of Surgery Qualification (EBSQ). UEMS, 2010 (<http://www.uemssurg.org/index.jsp?documentid=ADA68EE82BFA0FA8C12573A2003C8623&form=Documente&parent=DA460EB21AEC296BC125734F005A1FA1&submenu=6F150A17C7816961C125734F005A838>).
- 4 Oakley C, Malik A. Psychiatric training in Europe. *Psychiatrist* 2010; **34**: 447–50.
- 5 Lotz-Rambaldi W, Schafer I, ten Doerschate R, Hohagen F. Specialist training in psychiatry in Europe: results of the UEMS survey. *Eur Psychiatry* 2008; **23**: 157–68.
- 6 World Health Organization Regional Office for Europe. *Policies and Practices for Mental Health in Europe: Meeting the Challenges*. World Health Organization Regional Office for Europe, 2008.
- 7 Samanta A, Samanta J. Regulation of the medical profession: fantasy, reality and legality. *J R Soc Med* 2004; **97**: 211–8.