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SPECIAL PAPER

Teaching psychiatry in Ethiopia

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There is a pressing need to train psychiatrists in low- and middle-income countries. Psychiatrists from high-income countries have an opportunity to share expertise in teaching and assessing trainees, while learning much in the process. Three trainees from a London psychiatric hospital were invited to help organise a revision course for the Department of Psychiatry, Addis Ababa University, and this paper reports their experiences.

Background

Ethiopia, with a population of nearly 70 million (Central Statistical Authority, 2000), has less than one psychiatrist per 6 million people (Alem, 2004). The vast majority of people with a mental illness have no access to psychiatric treatments and instead rely on traditional methods (Alem, 2000). A major stumbling block to an increase in the numbers of psychiatrists in Ethiopia has been the need for doctors to obtain specialist psychiatric training abroad. This has inevitably led to a draining of psychiatrists away from Ethiopia to countries with greater rewards and career prospects. In additional, psychiatric training in high-income countries may not be wholly relevant to the Ethiopian setting.

In January 2003, the Department of Psychiatry at Addis Ababa University began postgraduate psychiatric training. The objective is to provide 'highly qualified clinical psychiatrists who would also teach other health professionals and conduct basic research in mental health in the country'. Since then, 23 trainees have received two half days of teaching

per week and clinical supervision provided by psychiatrists from Amanuel Hospital and Addis Ababa University, together with intensive periods of teaching from visiting psychiatrists. Ultimately the teaching programme will be self-sufficient.

Through existing links between the Institute of Psychiatry, London, and the Department of Psychiatry, Addis Ababa University, psychiatrists from the Institute of Psychiatry were invited to assist with training Ethiopian psychiatrists. The teaching objectives were:

- to provide Ethiopian psychiatry trainees with experience of teaching and assessment methods commonly used in high-income countries
- to teach general examination skills relevant to the forthcoming end-of-year examination
- to introduce skills essential for continuing professional development.

Methods

The teachers

The visiting teachers, C.H., D.F. and D.S., were trained at a London psychiatric hospital and have extensive experience of teaching. The local teachers are Drs Abdulreshid Abdullahi (Associate Professor), Mesfin Araya (Assistant Professor and Head of Department) and Atalay Alem (Associate Professor). All are consultant psychiatrists who were trained overseas.

The teaching programme

This was developed in conjunction with the Department of Psychiatry, Addis Ababa University. Specific

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Methods for teaching and assessment now commonly used in high-income countries and increasingly favoured for formal trainee assessment seemed to be well received by Ethiopian psychiatry trainees.

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areas of focus were needs led, as indicated by the Ethiopian trainers, and included: multiple-choice questions (MCQs), essays, critical appraisal (in the form of a journal club), objective structured clinical examinations (OSCEs) and case presentations. We also asked the trainees to prepare a clinical presentation as a group in the form of a grand round. An important component was a mock examination that tested both written and clinical skills. Further details of the teaching programme are available from the authors.

Feedback

Trainees were asked to complete feedback forms at the end of each day. These were reviewed daily by the visiting trainers to allow modification of the revision course as it proceeded. For analysis, numerical codes were given to the categories as follows: excellent = 3, good = 2, fair = 1, poor = 0.

Outcomes

The trainees' feedback is summarised in Table 1.

Formal assessment

The majority of trainees found the MCQ examination the most difficult and performed least well in this part of the assessment, owing to difficulty interpreting the language of MCQs and unfamiliar topics. Performance in the essay examination was better, although the format was still unfamiliar to some. Essays were of good quality, with thoughtful, well constructed answers. Candidates seemed most comfortable in the clinical examination and rated this teaching module highly.

Non-assessed modules

The OSCEs were not used as a means of formal assessment but generated most reactions from the trainees. Initially this session was approached with some trepidation: 'It is a new and very difficult experience'. Later in the week trainees reported that this new mode of learning was beneficial: 'I was afraid ... to participate in role-playing but later on I found it [a] very good approach for me to [acquire] good skill'. Interestingly, the trainees gave the most positive feedback to the sessions in which they had had the greatest involvement: the grand round, journal club and OSCEs. They reported that critical appraisal skills

were daunting to acquire and that some of the papers critiqued in the journal club appeared less relevant to local needs.

Discussion

Which training methods?

Methods for teaching and assessment now commonly used in high-income countries and increasingly favoured for formal trainee assessment seemed to be well received by Ethiopian psychiatry trainees. Our teaching programme emphasised non-directive learning, in the form of OSCEs, a grand round and critical appraisal. These teaching modules scored most highly in the trainee feedback. The skills required for critical appraisal may seem technical, difficult to acquire without easy access to scientific journals and of a lower priority for hard-pressed clinicians; however, the benefits are likely to become increasingly apparent as access to free electronic journals becomes a reality.

How to assess?

The Ethiopian trainees performed well across assessments but struggled with the MCQs. In the UK, entrants to the psychiatry membership examination who had trained in a non-UK medical school were less likely to pass (Tyrer *et al*, 2002). The effect was, however, more marked with the clinical examination. The UK Royal College of Psychiatrists has expressed the hope that the introduction of OSCEs, with their more standardised assessment, will overcome the so-called 'linguistic bias' experienced by overseas students (Tyrer *et al*, 2002). By conducting our clinical assessment with local clinicians, any bias may have been circumvented.

What to teach, and to whom

Teaching priorities for Ethiopian psychiatrists will naturally differ from those of UK trainees, for example because of a different frequency of particular conditions, their presentation and the resources available for management. Different emphases within the curriculum are required to ensure Ethiopian trainees become psychiatrists well prepared for the challenges they will face in their own country.

A more contentious issue is whether valuable curriculum time should be spent learning about conditions, investigative techniques and therapies

Table 1 Trainees' feedback¹

	MCQ pre-test	MCQs	OSCEs	Journal club	Essay skills	Case presentations	Grand round	Teaching objectives met
Monday	16/21	17/21	19/21	18/21		16/18		17/18
Tuesday		16/21	18/21	19/21	18/21	18/21		16/21
Wednesday		19/21	21/21	21/21		20/21	20/21	20/21
Total (%)	16/21 (76%)	52/63 (83%)	58/63 (92%)	58/63 (92%)	18/21 (86%)	54/60 (90%)	20/21 (95%)	53/60 (88%)

1. Grading of the components of the course by all trainees. Excellent = 3, good = 2, fair = 1, poor = 0.

which have little immediate relevance in the Ethiopian setting. We argued that this was likely to facilitate greater inclusion in the worldwide community of psychiatrists, in terms of training recognition as well as ability to participate in research. A disadvantage raised by Jablensky (1999) is that Western conceptualisations of psychiatric illness and treatment may come to dominate, precluding the emergence of alternative understandings of mental ill-health.

Jacob (2001) has discussed the problems inherent in transferring models of psychiatric care provision from high-income to low-income countries. He raised questions about the appropriateness of focusing on psychiatrists as the longer-term providers of services to people who are mentally ill, although he sees a role for them more immediately in the training of non-specialist primary care personnel. Mental health nurses have been trained in Ethiopia since 1987 and provide most mental healthcare outside the capital city, albeit with psychiatric supervision. Future teaching collaborations may usefully provide consultancy for nursing education, as well as expertise from clinical psychologists.

Where might training occur?

As the number of Ethiopian psychiatrists working in Ethiopia has increased, together with government support, it has become possible to train psychiatrists in Ethiopia. Not having to send doctors abroad for their training may help to decrease the loss of psychiatrists to high-income countries. High-income countries have been accused of exploiting low-income countries to solve their own shortages of psychiatrists (Patel, 2003; and as discussed in previous issues of *International Psychiatry*). Psychiatrists trained within low- and middle-income countries are, however, still likely to be subject to models of psychiatric service and biomedical paradigms inherited from high-income regions. There is also concern that curricula in low-income countries may be constrained to the acquisition of clinical skills, neglecting the role of the psychiatrist in research, service development and primary care (Farooq, 2001).

For psychiatrists from high-income countries, experience of different systems, priorities and understandings of mental illness may enrich development, and usefully inform evolving psychiatric practice in the home country. Psychiatry trainees from high-income countries can learn skills useful to psychiatric practice in multicultural societies (Subramaniam, 2002).

Developing a transferable collaborative teaching model

We believe that psychiatrists from high-income countries have a role to play in assisting the training of mental health personnel in low-income countries. What can be most usefully offered will depend on the priorities of the country and existing educational resources. Transferable skills such as educational methods, modes of assessment and even the provision

of well-worked curriculum materials could be areas where psychiatrists from the developed world can most usefully contribute. Where curricula are more established, expertise in psychiatric specialties may complement existing practice. Broadening the teachers and audience to include non-medical mental health workers recognises the crucial part they play in mental health provision.

We propose the following model for collaborative training:

- training goals developed in close liaison with the host institution, addressing its priorities and needs
- trainee feedback to allow the training programme to be modified and more appropriately tailored as teaching proceeds
- sharing expertise in sub-specialisms of psychiatry, particularly substance misuse, forensic psychiatry, liaison psychiatry and child psychiatry
- visiting trainers having the opportunity to be able to learn about local services, common clinical presentations and conditions of work where they are teaching
- a commitment to regular and sustained input from outside trainers to allow better planning and integration within the existing curriculum.

Structural support

The Royal College of Psychiatrists has been called upon to develop partnerships with low- and middle-income countries; this should involve directly providing training appropriate to the needs of those countries and in return benefiting from the cultural exchange. The responsibility is to 'actively advocate equality of mental health worldwide' (Ghodse, 2001). The recent College initiative to support voluntary service overseas for specialist registrars could assist the provision of teaching expertise over an extended period. However, the College could play a more active part in promoting training activities, in the following ways:

- allowing overseas centres to register their interest with the College, stating their training needs and priorities
- suggesting standard clauses to be inserted into UK clinical contracts that would encourage the granting of study leave for these purposes
- lobbying the Department of Health for financial support, allowing the government to demonstrate its commitment to mutual development in the face of the International Fellowship Scheme.

Conclusion

One response to the critical shortage of mental health workers in the developing world is for high-income countries to make a commitment to mental health training worldwide. Our experience of teaching trainee psychiatrists in Ethiopia is that this can be a highly enjoyable and mutually enlightening process.

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POINTS OF VIEW

What is important for quality of life of psychiatrists?

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This paper was presented at the annual meeting of the Royal College of Psychiatrists, Edinburgh, 22 June 2005, at the session 'The recruitment and migration of psychiatrists from developing countries'.

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