of psychiatrists in the region, as well as helped to disseminate research findings. In fact, *JPPS* brought out a special issue devoted to the 2005 earthquake, the very subject of Abbasi's letter. Since restarting its publication, it has played an important role in promoting evidence-based medicine. I would request your readers to contribute to the journal.

Dr Saeed Farooq
Editor, JPPS (Journal of Pakistan Psychiatric Society), email sfarooqlrh@yahoo.com

Ethno-psychopharmacology and the clinical relationship

Sir: Although the three linked articles on ethnopharmacology in the July 2007 issue of *International Psychiatry* were necessarily heavily biologically focused, I must take issue with the fact that culture and clinical relationship attracted such brief comment. It is not possible, let alone desirable, to reduce people to the biological functions of their brains. The development of tools for testing individual genotypes opens up interesting possibilities, but represents a dangerous distraction from the challenge of addressing the realities represented by the global burden of disease. According to the World Health Organization, low- and middle-income countries, which will represent 80% of the world's population by 2020, are expected to bear the brunt of the projected increase in the burden of mental illness. The acquisition of approval by Roche of its Amplichip by the USA and European Union, as David Skuse mentions in his introduction to the series of papers, is a distortion of this reality by the pharmaceutical industry. Addressing the needs of most of the 400 million people disabled by neuropsychiatric conditions globally cannot be done without challenging these priorities. Those interested in international psychiatry need to reach a clear consensus about their agenda.

A thorough understanding of the culture of a patient (or patient group a service is supporting) is of course an essential bedrock on which to build sensitive relationships. The dynamic nature of any relationship is central to its positive development. A clinician should gradually know a patient or community better with time, and service users also gain a greater understanding of the opinions and attitudes of clinicians and services as they access care. An attitude of sensitive response to needs and aspirations is an important way for trust to develop, even when the starting points have been far apart. This can be fostered with good service design and continuous constructive evaluation at the formative, process and outcome stages, so that a service remains responsive to its intended users. It is with this attitude at a personal clinical level and as a component in system design that we can move forward in our complex world and not see cultural diversity as an obstacle to delivering care.

In my experience of working as a British psychiatrist in Nigeria, I have often been impressed by my clients' ability simultaneously to hold some of the messages of orthodox psychiatry and more traditional ideas. Local service staff such as field workers are also very skilled at working through these issues. Sometimes emphases for treatment plans seem to be in conflict, but much more frequently a plan for moving forward that is mutually acceptable is reached through which all parties involved are enriched.

Julian Eaton MRCPsych
Mental Health Advisor, West Africa, CBM International National Coordination Office, PO Box 8451, Wuse, Abuja, Nigeria, email julian_eaton@cbm-westafrica.org

MRCPsych recognition in India

Sir: We read with interest the article by Kulhara & Avasthi on the teaching and training of psychiatry in India in the April issue of *International Psychiatry* (p. 31). We acknowledge the possible options suggested by the authors to overcome some of the difficulties faced in psychiatric training in India.

Mr Ramadoss, Minister of Health, India, in a recent media report highlighted the acute shortage of psychiatrists in India and stated that over 30 000 psychiatrists are required to serve a billion people, while there are only 3300 practising in the country. Currently there are a significant number of doctors of Indian origin who are undergoing basic and higher specialty psychiatric training in the UK.

Owing to changes in immigration policies by the Home Office (i.e. termination of permit-free training for international medical graduates), some trainees are currently experiencing difficulties in progressing and obtaining consultant-grade posts. Some of the doctors who have completed their membership examinations (MRCPsych) and some who have completed their higher specialty training (CCT) are considering a return to establish their psychiatric practice in India. Strong family commitments and a desire to contribute to training and the development of the specialty (as well as economic growth) in India have enhanced their willingness to return home. These highly qualified psychiatrists will be great assets to the country.

Owing to the high standards in training and assessment for the MRCPsych qualification, it has been recognised by the Royal Australian and New Zealand College of Psychiatrists and the Canadian Psychiatric Association. However, the MRCPsych qualification is currently not recognised by the Medical Council of India (MCI). Hence these doctors will be ineligible to work in a teaching hospital or even in the public health services. Given the acute need for qualified psychiatrists in India it is unfortunate that the available resources are not being utilised adequately.

In this context we would like to suggest that there should be collaboration between the Indian Psychiatric Society, the MCI and the Royal College of Psychiatrists to negotiate for the recognition of the MRCPsych qualification by the MCI. If this succeeds, it would be the first step in encouraging psychiatrists trained in the UK to return home.

Dr Sudheer T Lankappa,[1] Dr Ritu Gupta[2] and Dr Abhijeeth R. Shetty[2]
[1]Academic Clinical Psychiatry, The Longley Centre, Sheffield S5 7JT, UK, email s.lankappa@sheffield.ac.uk
[2]Mental Health Unit, Rotherham General Hospital, Rotherham, UK

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