

EDITORIAL

Continuing professional development for psychiatrists in developing countries

Saeed Farooq

'It was in early 1984 when after receiving my basic postgraduate training in the UK, I returned to my home country... As I began to settle down in my professional work, I soon realised that I was facing problems on more than one front... Faced with patients from my own cultural background I found myself rather ill equipped... I have to face one of my biggest dilemmas when after teaching my post-graduate students the importance of the 1-hour psychiatric interview, I expect them to see these 40 patients in less than 4 hours. The situation becomes increasingly worse in the heat of summer months when, drenching in sweat from head to toe, one has to interview patients in a hot overcrowded room and still display the "accurate empathy, non-possessive warmth and the genuineness" of a good therapist... The sub-specialities are almost non-existent and so all varieties of patients [are] to be catered for' (Malik, 1998).

One could add innumerable issues to Malik's list of dilemmas facing a psychiatrist working in a developing country. Heavy workloads are one of the most common reasons given for lack of time for continuing professional development (CPD), even in the developed world (Boulay, 2000), where they are perhaps not a fraction of those in developing countries. However, enormous workloads should never be an excuse for the lack of CPD. With less than one psychiatrist per 100 000 population and total health spending equivalent to £7 per person in most developing countries (Garner *et al.*, 1998), CPD for psychiatrists must be considered an important strategy to cope with the colossal burden of mental illness, rather than just an individual need.

The importance of CPD

Continuing professional development implies a long-term approach of lifelong learning and possession of the attitudes and capacities to be

flexible, adaptable, creative and amenable to change. It has benefits for both individuals and organisations and is therefore needed for every professional whether in the developing or developed world.

As long ago as 1947, the Dean of Harvard Medical School explained the need for CPD as follows: 'The rate and magnitude of change is such that the contents of textbooks are out-of-date at the time of publication. Indeed, probably half of what you know is no longer true but what troubles me more is that I don't know which half it is' (Charlton, 2001). An additional problem for practitioners in the developing world is knowing what is relevant to practice in their own countries. It is necessary not only to update knowledge but also to develop a critical approach to the knowledge base.

One of the most important reasons given for CPD is that it allows doctors time to discover and fulfil learning needs, increase job satisfaction and improve self-esteem. This is perhaps more important for a practitioner in a developing country, who is constantly faced with the ruinous effects of bureaucratic problems and the insurmountable hurdles of scarce resources. Planned CPD activities in these settings should help to prevent professional isolation and burnout while boosting the individual's morale.

What is the way forward?

Developing a CPD plan for a developing country, where training and development inevitably take a back seat to meeting the basic needs of the population, is an uphill task. The regulatory and legislative measures resulting in formal requirements for CPD in the developed world are non-existent in almost all the developing countries. CPD in these settings therefore depends heavily on the responsibilities and resources of individuals. Personal development plans (Holloway, 2000) based on clear objectives can

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be useful in this context. Small groups of practitioners can help to support and maintain each other in CPD. An appraiser or mentor who inspires and challenges critical thinking can help an individual to avoid the common trap of ignoring areas of greatest need by denying their existence.

Innovative strategies will be needed in view of the lack of educational resources and widely different working conditions. Work-based learning, perhaps the least recognised method of CPD, should take precedence over other methods. This should also help to allay the common misconception that CPD is a passive learning activity. CPD should be built into busy routines. Its activities might include observation and reflection on difficult cases, seeking the opinions of specialists from other disciplines and the teaching and training of primary health care workers.

Over 25 years ago, a World Health Organization task force on the structure of psychiatric services in developing countries recommended that the psychiatrists in these countries should devote 'only part of their working hours' to the clinical care of patients. Most of their time should be devoted to training primary health care workers and working with other disciplines (World Health Organization, 1975). The mental health services in many developing countries have successfully implemented community mental health programmes based on this model (Goldberg *et al*, 2000). This requires the development of skills in training the trainers, working effectively with other disciplines, particularly primary care, and developing partnerships with the traditional healers who cater for large populations. A CPD programme in these countries must focus on developing these skills, as they are rarely catered for in postgraduate training programmes (Farooq, 2001). This may at times take precedence over the individuals' needs of, for example, being updated in recent advances in psychopharmacology, which may not be applicable or even available for large populations.

The most suitable option is for psychiatrists in developing countries to establish a 'group' CPD programme for their region. The continuing medical education activities organised by the various professional bodies in these countries can be a starting point for the CPD programme. These activities, however, need to be guided by a planned educational policy suitable for a particular country or region.

Does information technology provide a solution?

A few years ago, only 12 countries in Africa had internet access; now it is available in all African

capital cities (World Health Organization, 2001). This provides a unique opportunity for CPD. Three initiatives illustrate this:

- the BMJ publishing group's online, case-based learning modules for continuing medical education of family practitioners worldwide (Harris *et al*, 2001);
- newly established communication links between physicians and health workers in developing countries for major public health problems such as HIV and cardiovascular diseases (Lown *et al*, 1998);
- free online access for a number of developing countries to the Royal College of Psychiatrists' journals (Oyebode, 2002).

The usefulness of these avenues will be limited by a lack of universal access to the internet and, perhaps more importantly, because of their restricted relevance to developing nations. However, a practitioner who has identified his or her training needs can make a suitable selection.

Conclusions

A recent World Health Report (World Health Organization, 2001) recommended that,

'Most developing countries need to increase and improve training of mental health professionals, who will provide specialized care as well as support the primary health care programmes... Once trained, these professionals should be encouraged to remain in their country in positions that make the best use of their skills.'

Regional and international collaboration, supported by the use of information technology, is urgently needed. The challenge of providing mental health for all in these countries can be met only through a well-planned CPD programme, both at the individual and the institutional level.

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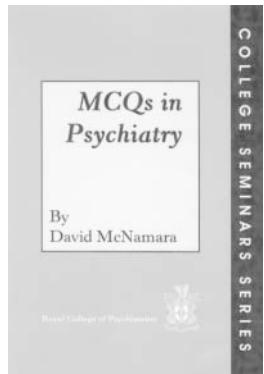
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