editorial

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Consultant recruitment from India: the best-fit model?

The shortage of consultant psychiatrists has been recognised for some time and in recent years the National Health Service (NHS) has recruited consultants from developing countries. A survey of vacancies by the Department of Health in March 2004 reported that 9.6% of consultant psychiatry posts needed to be filled in England and Wales.

The NHS Plan envisaged reform of mental healthcare services by investment in facilities, patient empowerment, reduction of waiting times and determining clinical priorities (Department of Health, 2000) and accepted that the Department of Health could achieve this through its strategy of international recruitment (Department of Health, 2002). Two recruitment campaigns were initiated: Global Recruitment in September 2001 and the International Fellowship Programme in January 2002.

A robust process of selection and appointment was set up to ensure that the recruited consultants:

- possessed the necessary skills and competency levels to provide the highest quality of clinical care
- were able to provide adequate training and supervision to the members of the multidisciplinary team
- were able to communicate effectively with patients and other healthcare professionals
- possessed all the attributes outlined in the General Medical Council's good medical practice guidelines.

The recruitment process strives to achieve these parameters by setting extremely high standards – the same as those in the UK. The applicant's medical qualifications must be approved by the Specialist Training Authority and the General Medical Council (GMC). Specialist Training Authority approval is granted following advice from the Royal College of Psychiatrists based on a stringent scrutiny of full details of the applicant's training (Holsgrove, 2005). A clearance of the International English Language Testing System is also mandatory before the GMC grants specialist registration. An appointments advisory committee then selects the doctors by a procedure similar to that faced by other consultants who train in the UK (Goldberg, 2004).

There have been extensive discussions about the ethics of such recruitment. However, such discussions have given little thought to the difficulties and needs of these consultants (Patel, 2003; Goldberg, 2004; Jenkins, 2004; Khan, 2004; Ndete *et al*, 2004; Holsgrove, 2005).

To support this recruitment process, in line with the requirements of clinical governance, the Department of Health (2002) proposed an infrastructure comprising:

- a comprehensive and thorough induction programme focusing on the needs of those practising psychiatry, including adaptation to a new culture
- support ensuring the development of adequate linguistic and communication skills for clinical duties
- mentorship by a senior medical colleague and if necessary by a clinical director
- regular appraisal to ensure clinical and continuing professional development
- pastoral support, usually by a welfare officer from Human Resources Development
- encouraging doctor and families to join social and clinical networks being developed by the Department of Health international recruitment team.

Goldberg reported in 2004 that 84 psychiatrists from India have been appointed as consultants in the NHS. This article discusses the difficulties faced by consultants who have been recruited via the Department of Health's initiative and the mechanisms in place to help them settle into their new role.

Training and clinical practice in India and the UK

Psychiatric training in India and the UK are similar in terms of both clinical and theoretical background and available time-frame (Das *et al*, 2003). However, in the UK there is a wide exposure to various specialties but in India the main focus of training is on adult psychiatry.

Basic specialist training in psychiatry in the UK takes place in rotational training schemes approved by the Royal College of Psychiatrists and lasts 3 years. Trainees spend about 6 months in each of the specialties offered by the training scheme as well as fulfilling the basic requirement to train (initially for 1 year) in general adult or old age psychiatry and a minimum of 6 months in either child and adolescent psychiatry or learning disabilities psychiatry prior to being awarded Membership of the College. The training may also be offered in other subspecialties, e.g. forensic psychiatry, psychotherapy and eating disorders.

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Training in the UK is comprehensive in that it encompasses many sub-specialties that do not exist as discrete sub-specialties in developing countries. These include old age psychiatry, child and adolescent psychiatry, forensic psychiatry, addictions, rehabilitation psychiatry, etc. Exposure to these specialties provides a far broader basic training than is available in India. If specialties such as eating disorders, perinatal psychiatry and neuropsychiatry are included, then the differences become even greater.

Basic specialist training in India is based at training centres approved by universities and the Medical Council of India. This training is on a rotation basis over 2–3 years and results in the achievement of a diploma or master's degree in psychological medicine. The trainees spend most of their time in adult psychiatry with additional work in substance misuse, liaison psychiatry and child psychiatry. Some of these centres offer additional training in rehabilitation psychiatry, family therapy and various other forms of psychological therapies. The trainees at some centres have an option of training up to a maximum of 6 months in general medicine or neurology. Psychiatry training in India results in the award of general postgraduate psychiatric qualifications. The diploma or master's degree is achieved at the end of the training by passing a set of clinical and theory exams.

There is also an important difference in the assessment of trainees in India and the UK. In the UK there is a national examination, which for all its flaws is at least standardised. In India, the MD programmes are university based and it could be argued that these programmes are only as good as the awarding institutions.

The clinical assessment and management of patients in India is based on the Western model but there is a significant difference in the training and practice of community psychiatry. In India the existence of the extended family is responsible for the low perceived need for and the relative lack of development of a community care model in healthcare, including psychiatry. Training in community psychiatry in India is non-existent; although there have been some recent steps towards development of such services at some centres (Srinivasamurthy, 2000). The tendency for families to care for their relatives with psychiatric illness means that Indian psychiatrists have limited experience of mental health legislation.

There is a shortage of all trained mental health professionals in India. In 2000 there were about 3000 psychiatrists, 600 psychiatric social workers, 600 trained psychiatric nurses (Srinivasamurthy, 2000) and 600 trained clinical psychologists (Verma, 2000) for a total population of 1028 million (census results released in 2003). This forces psychiatrists in India to develop a 'compensatory' but considerable clinical expertise in discharging the functions of other mental health professionals but limits their experience of managing patients in a multidisciplinary team setting, especially in terms of dividing responsibility among team members. They also have limited experience of being line managers for other professionals or being responsible for budgeting and the commissioning of services.

Research and continuing professional development depend upon personal initiative rather than being guided by job-related protected time. The long working hours and heavy patient load provide a huge amount of clinical experience and expertise, but the use of these advantages in research depends on the personal initiative of the individual. A few centres do expect trainees and the consultants to take part in active research after working hours.

Hence, the most important differences are those that result from the sociocultural context of practice and include a limited experience of community care, the use of mental health legislation and multidisciplinary working.

Professional and personal challenges

The international recruitment team has given doctors appointed from India little opportunity to discuss their needs or difficulties following their appointment as consultants in the NHS: merely a half-day welcome reception jointly organised by the Department of Health and the Royal College of Psychiatrists. Our brief description of training and clinical practice in India, as well as the limited resources available there, may explain some of the potential difficulties faced by these experienced and competent clinicians. The fact that psychiatry in itself is well-recognised as a stressful specialty is a further complication (Rathod *et al*, 2000; Brockington & Mumford, 2002).

Community care

In India, the role of social services in the provision of community services is very limited. This role is usually taken by members of the patient's family, who take responsibility for supervision of treatment, follow-up visits and the use of resources within the community. Psychiatrists have little opportunity to experience working with community teams. Thus sharing responsibility with other agencies and voluntary organisations, as well as responding to requests for assessments and prioritising them in an appropriate way, can be problematic for psychiatrists who have been recently recruited from India.

There is also the associated issue of risk assessment and the management of patients in the community in the absence of family support. A recent analysis (Kapur *et al*, 2005) showed low sensitivity values for the prediction of repetitive self-harm by mental health staff in the UK. Consultants appointed from India through the international recruitment scheme would have little or no practical knowledge of the system for assessment and management of such risk.

In India, there is no care model for the delivery of services on lines similar to the UK primary care trusts, and hospital-based doctors are not expected to liaise with general practitioners. These differences lead to differing levels of communication with other services and colleagues.

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Cultural differences

These issues are further complicated by cultural differences, which are reflected in the expectations from patient–doctor interactions, the power differential in relationships between doctors and other healthcare workers and communication with other healthcare professionals. The consultant recruited from overseas may find it difficult to address these issues without adequate supervision, as they have already practised in a different cultural and professional environment over variable lengths of time.

Lack of pastoral support

Relocation is a stressful process for any individual, especially if it also involves the family. Coming to the UK at different stages of one's professional and personal career is difficult, a fact acknowledged by the Department of Health (2002). Linked with relocation are issues of accommodation, insurance, tax, pension, transport, education of children, work opportunities for a spouse, etc. These issues assume greater importance because many of the doctors recruited from overseas have been working in psychiatry for a reasonable period and had a settled family life in India. Joining as an NHS consultant is an onerous task in itself; if this is coupled with the relocation issues discussed above, the overall process can become daunting for any individual.

Although Department of Health and local NHS trust guidelines recommend the provision of pastoral support, relocation support and induction programmes have not been universally available. This has led to a lack of understanding (and little explanation) of the administrative systems that exist in the NHS, which has not proved helpful for doctors who are expected to adhere to and maintain high standards of service delivery.

We know of some doctors who have had clinical responsibilities thrust upon them from day one without even being given the basic trust induction programme; many have not been provided with mentorship. Even when mentorship has been provided, the duration, content, and scope of the mentorship or induction have not been clear. It seems that certain trusts have been more than eager for doctors to take up responsibilities without giving them a chance to understand the systems in place.

Appropriate interpretation and implementation of the Mental Health Act 1983, confidentiality issues, risk assessment and management are aspects of practice in general adult psychiatry that are probably not easy even for consultants trained in the UK. However, there has generally been no structured and/or sustained effort by the trusts or the Department of Health to support doctors recruited from overseas in learning about these complex issues. Issues such as continuous professional development, appraisal, and involvement in the teaching and supervision of senior house officers are not addressed specifically.

In some instances, there have been glaring deficiencies in the pastoral support provided by the relocation agency. Relocation is a dynamic, ongoing process, which requires the individual to face challenges and handle system-related issues at various stages of the tenure (but especially in the first year). However, it appears that relocation has somehow been considered by the relocation agency and/or Human Resources Development as a simple physical displacement from India to the UK and has excluded the prolonged process of settling down.

There is a recommendation (Department of Health, 2002) that clinical and social networks be developed by the international recruitment team, but this has not been put into practice. Without any observable active input from the Department of Health for some time now, Indian doctors have been trying to develop their own networks – one of these being the Internationally Recruited Indian Doctors Association (IRIDA–UK), an informal e-group to provide pastoral support.

However, it needs to be emphasised that numerous doctors, including the co-author (N.G.), have also had positive experiences, with considerable support from their respective trusts and mental health colleagues.

Conclusion

Doctors trained in India have a wide experience in clinical psychiatry but little training and experience in management or intra-/inter-agency working. This does not limit their ability to function as efficient clinicians but does put them under considerable pressure in relation to communicating with other colleagues and professionals. It also restricts their ability to manage patients in community settings while relying on other agencies or professionals to do the same.

The NHS trusts, Department of Health and Royal College of Psychiatrists need to provide a comprehensively linked package of services and guidelines for induction and training. The aim should be to make these doctors feel comfortable in the new environment not only on a personal but also a professional level. It would also be useful to have a single, consistent access point for the guidelines, services and support networks.

Declaration of interest

N.G. was recruited as a consultant psychiatrist in December 2003 through the Global Recruitment Scheme of the Department of Health.

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References

BROCKINGTON, I. & MUMFORD, D. B. (2002) Recruitment into psychiatry. *British Journal of Psychiatry*, **180**, 307–312.

DAS, M., GUPTA, N. & DUTTA, K. (2003) Psychiatric training in India. *Psychiatric Bulletin*, **26**, 70–72.

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DEPARTMENT OF HEALTH (2000) *The NHS Plan: A Plan for Investment, a Plan for Reform.* London: Stationery Office. http://www.dh.gov.uk/assetRoot/04/05/57/83/04055783.pdf

DEPARTMENT OF HEALTH (2002) *International Recruitment of Consultants and General Practitioners for the NHS in England: Current Initiatives and Guidance to NHS Employers on an Infrastructure to Support International Recruitment.* London: Department of Health. http://www.dh.gov.uk/assetRoot/04/06/71/45/04067145.pdf

GOLDBERG, D. (2004) The NHS International Fellowship Scheme in Psychiatry. *Psychiatric Bulletin*, **28**, 433–434.

HOLSGROVE, D. (2005) The International Fellowship Programme: some personal thoughts. *International Psychiatry*, **2**, 7–9.

JENKINS, C. (2004) Ethical international recruitment. *International Psychiatry*, **1**, 18–19.

KAPUR, N., COOPER, J., RODWAY, C., *et al* (2005) Predicting the risk of repetition after self-harm: cohort study. *BMJ*, **330**, 394–395.

KHAN, M. M. (2004) The NHS International Fellowship Scheme in Psychiatry: robbing the poor to pay the rich? *Psychiatric Bulletin*, **28**, 435–437.

NDETEI, D., KARIM, S. & MUBBASHAR, M. (2004) Recruitment of consultant psychiatrists from low- and middle-income countries. *International Psychiatry*, **1**, 15–18.

PATEL, V. (2003) Recruiting doctors from poor countries; the great brain robbery? *BMJ*, **327**, 928.

RATHOD, S., ROY, L., RAMSAY, M., *et al* (2000) A survey of stress in psychiatrists working in the Wessex Region. *Psychiatric Bulletin*, **24**, 133–136.

SRINIVASMURTHY, R. (2000) Community mental health in India. In *Mental Health in India 1950–2000; Essays in Honour of Professor N. N. Wig* (ed. R. S. Murthy), pp. 150–156. Bangalore: People's Action for Mental Health.

VERMA, S. K. (2000) Clinical psychology in India from 1950–2000. In *Mental Health in India 1950–2000; Essays in Honour of Professor N. N. Wig* (ed. R. S. Murthy), pp. 200–208. Bangalore: People's Action for Mental Health.

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