medical schools, the universities and the Indian Academy of Medical Sciences, and so on.

What could be developed?

To overcome the shortage of teachers in psychiatry in India, a system of visiting teachers could be initiated. A large number of eminent College Members and Fellows are of Indian origin. They could be asked to provide some teaching and training in India. The logistics of operating such a system – by whom, for how long and how much – needs to be worked out through the good offices of the institutions mentioned above, as would the financial support required. Material support to the visiting faculty (costs of travel within India, board and lodging) could be provided with relative ease at institutional level. A pool of visiting professors and teachers from the membership of the College could be established and a group from this pool could visit India for variable lengths of time to provide the requisite teaching and training. With the help of the visiting faculty from the College, special programmes in continuing medical education could be developed for both psychiatrists and GPs. Links could be fostered by developing 'memoranda of understanding', initially between the Indian Psychiatric Society and the College, and later with the medical schools.

Is this feasible or is this a figment of our imagination? We believe that, given the will, this can be achieved.

Further reading

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Training in Europe in perspective

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In psychiatric medicine, as in other fields, Europe offers a diversity of history and academic tradition that belies its limited geographical area. There are numerous centres of excellence – in psychiatric research, service innovation and practice – and many countries have internationally recognised and excellent training schemes in psychiatry. But uniformity of practice is seldom in evidence.

An increasing number of states now belong to the European Union (EU) and, as with other groupings, the profession of medicine has found itself drawn into a need for greater unity by the Treaty of Rome (1957). This is reflected in European law. For example, in Council of Europe Directive 93/16/EEC some important principles are outlined:

- The legal expectations of member states are clarified in respect of such matters as the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications.
- Psychiatry is recorded as a medical specialty with a training duration of a minimum of 4 years following basic medical training.
- The recognised titles of European training qualifications in medical specialties are listed. For the UK, for example, it is the Certificate of Completion of Training; for Germany, it is the Fachärztliche Anerkennung.
- These qualifications must be mutually recognised across national boundaries. Member states are not entitled to require medical practitioners who have such certification to complete any additional training in order to practise within its social security scheme, even when such training is required of holders of diplomas of medicine obtained in its own territory.

The Directive also recognises the need for some coordination over the requirements of training in specialised areas of medicine but leaves it to representatives of the specialties themselves to provide the details – the minimum training period, the method by which such training is given, the place where it is carried out, as well as the supervision required. These, therefore, are the focus of committees referenced for each of the European medical specialties. In psychiatry, this is the Union Européenne des Médecins Spécialistes (UEMS) Section and Board of Psychiatry, on which each EU national medical association is entitled to have two delegates.

Training in practice

With the requirement of mutual recognition of training already in place, one would expect there to be not only unity of content in training but also unity of conduct and audit. This is not the case. Surveys of UEMS national organisations of specialist training in psychiatry in Europe reveal continued variation in all aspects of training. The UEMS has sought

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broadly to outline training requirements, advocating a multi-dimensional approach. But the differences in the content of training reported in surveys of specialist training are striking and significant. A miscellaneous range of issues appear to lie outside the orbit of unity or receive limited attention within it. Among these are the psychiatry of old age, community psychiatry, research methodology, epidemiology, forensic psychiatry, learning disability, transcultural issues, management and medical informatics. The settings in which psychiatry is taught within the EU are split between university psychiatry hospitals, general hospitals and general psychiatric hospitals. Although the majority of these have out-patient functions, the community aspects of care generally receive less attention and do not feature at all in many training programmes, despite a recognition that this is the likely future direction of the specialty in general.

Audit of training schemes

The recognition of training centres falls to the national authorities. The UEMS has neither the staff nor the legal authority to certificate or accredit training institutions. None the less, there are relatively few countries which engage in independent audit of training. That is, most engage in internal systems of review, and external visits are rare (Strachan & Schudel, 2004). This seems a serious omission, as those national associations which do engage external audit processes regularly identify discrepancies between what is described as happening in respect of training and what occurs in actual practice. In particular, the perceptions of those providing training and of trainees is often at variance. Recently, however, European psychiatric associations have become increasingly interested in audit as a means of enhancing training quality assurance (Prinz, 2005).

Procedures for the assessment of trainees are likewise widely varied in form; many centres rely solely on the internal assessment completed by local university staff. Competency-based examination programmes have mainly still to be developed. Few countries have an independent national system of examinations that assess both knowledge and clinical skills.

Psychotherapy

A significant area of discrepancy concerns the place of psychotherapy in psychiatric training. Some countries require trainees to undertake personal experience of psychotherapy, often at their own cost, while others provide training in psychotherapy which is partially funded.

There is as yet no consensus as to what forms of psychotherapy should be taught. Despite the current support for evidence-based intervention, psychoanalytic psychotherapy still dominates, although cognitive–behavioural and other systematic psychotherapies are gaining increasing recognition. Most centres provide both a theoretical and a practical training experience, although the time allocation for these varies widely. There is likewise variation in the training experience expected of those working with individual patients, families and groups.

Teaching in psychotherapy is seen as an area of particular interest to psychiatrists in Europe. Such treatments can be, and often are, delivered by professions other than medical in several countries and in many there is a challenge to the view that psychotherapy is of necessity a medical act. Particular challenge comes from those insurance and other agencies expected to meet the financial costs. Improvement in training in psychotherapies for psychiatrists is therefore a particular focus for many training schemes.

Clinical and educational supervision

There is similar variation in the experience trainees get in their supervision. A distinction between clinical and educational supervision has been highlighted by the UEMS. In brief, the former relates to the process of routine clinical practice, the latter to a dedicated period which each trainee has with a senior trainer in order to explore academic, theoretical and career aspects of training on a regular (usually weekly) basis. The demands of the service determine the agenda in clinical supervision; the needs of the individual trainee determine it in educational supervision. The available evidence from international surveys and from the outcome of audit processes suggests that educational supervision is not consistently provided. This has inevitable adverse consequences for a training which incorporates apprenticeship as well as theoretical elements.

Conclusion

It comes as a surprise, therefore, that both trainers and trainees report general satisfaction with their national training programmes. One suspects this reflects in part a persistent insular perspective in respect of expectations of both the content and the process of training. But it presents a real challenge for pan-European agencies trying to implement a more unified approach.

Psychiatry is not alone in its complex perspective on training in Europe – many other specialties report similar variation. Some, most notably in the surgical field, have been more successful in establishing European standards in their approach to training, the assessment of trainees and the audit of schemes.

In psychiatry at present there is a process of exploration of mutual strengths and challenges. This reveals very different political and social arrangements and attitudes in different member states. It will require change not only from psychiatric professionals but also from allied social and medical services if unification of psychiatry training in Europe is to proceed. But now that the differences and similarities are becoming clearer, further progress seems much more attainable.

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