Unmet Needs During Residency Training Programmes in Psychiatry

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10.1 Introduction

Training is essential to equip aspiring psychiatric specialists with the skills that they need to provide excellent care [1]. In many countries these skills are primarily acquired during dedicated postgraduate training programmes, which doctors enter following the completion of their undergraduate medical degrees [2]. These

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programmes build on the knowledge and skills that doctors have already begun to accumulate during their undergraduate training [3]. Terms for defining participants of postgraduate training programmes vary around the world, with 'resident' common in North America, while other terms, such as 'trainee', 'house officer' and 'registrar' are favoured elsewhere. For consistency, we will use the term resident throughout this chapter.

In this chapter we consider some of the challenges that residents in psychiatry face in their training programmes and outline the most important unmet needs. This will be achieved by examining the current literature and also through perspectives from different countries around the world. These vignettes aim to highlight the similarities and differences of the training experience in a range of settings. In addition to evidence from the literature, the chapter will also include the narrative experiences and personal reflections of the authors. It will explore the common themes that emerge and advance potential solutions, which may offer a chance to challenge some of these unmet needs. Although wider evidence and perspectives will be considered, we will focus on residents and early career psychiatrists' views on their challenges and how they believe these could be addressed.

10.2 Education for Early Career Psychiatrists Across the World

There is a general consensus that a minimum of three years of postgraduate psychiatric training is required for a psychiatrist to be able to provide competent and effective care to patients with mental disorder [4]. This is in addition to a good quality psychiatric education during medical school, including both theoretical and practical exposure [5]. The World Psychiatric Association (WPA) has recently released a position statement on the basic qualities required in order to become a psychiatrist [6]. Nevertheless, psychiatric training varies significantly across the world and even within countries [7]. A joint survey by the World Health Organization (WHO) and WPA has found that 30% of the national partners of the WHO had no psychiatric training programme, all of which were low- and middle-income countries (LMIC) [2]. A more recent survey conducted by the WPA has found that 10% of the WPA's member societies reported having only one year of psychiatric training and another 30% of societies reported having less than three years of training [8]. A worldwide survey of medical students organised by the International Federation of Medical Students' Associations (IFMSA) found that psychiatry is a mandatory part of the student curriculum in 81 countries, except Ethiopia and Nigeria [5]. The lack of expertise in psychiatric training, the limited resources dedicated to the training of mental health professionals and the lack of mental health policy in these countries have contributed to the shortage, or even absence, of trained mental health professionals [9]. Additionally, the brain drain caused by the emigration of qualified mental health professionals from LMIC to high-income countries (HIC) only serves to exacerbate the problem [10, 11]. In this chapter we will focus on the unmet needs of residents in existing training programmes, however, we recognise that there is a

broader question from a global perspective about overall training capacity and the failure of the system to adequately train enough psychiatrists.

At a time of economic challenge, residents are concerned about wider resourcing issues for mental health, including the funding of training, the number of working hours and the pressure of the whole mental health workforce, creating a dysfunctional environment affecting the quality of training [12]. To address these differences and challenges, some residents decide to migrate to another country in order to access better academic and employment opportunities, especially single women [10, 11, 13–16].

Notwithstanding these challenges, across the world there are several innovative opportunities that residents can benefit from. Many of these initiatives are led by residents themselves. One opportunity is represented by the Exchange Programme promoted by the European Federation of Psychiatric Trainees (EFPT), in which residents can do an exchange in other European country, experiencing a different training programme and mental health care system [17]. Another opportunity is the EFPT Porto Research Award, which recognises the best research conducted by a psychiatric resident, based on a donation of the Local Organizing Committee of the 23th EFPT Porto Forum of 10,000€ to encourage psychiatric residents to conduct research in the upcoming years [18].

Despite the changes that have taken place in psychiatric practice in recent decades, much specialist training and continuous professional development (CPD) in Europe continues to be based on old-fashioned paradigms that do not fully equip the newly qualified specialist for contemporary practice as a competent clinician [19]. Several efforts have been made by national and international bodies to describe the gap between the training and practice of early career psychiatrists. In particular, the Early Career Psychiatrists' Committees of the European Psychiatric Association (EPA) and of the WPA have carried out several surveys in different countries to identify the areas with the most significant educational needs, with recommendations about how to address such gaps. The areas identified include psychopathology, psychotherapy, prevention and early intervention, drug management and the treatment of physical diseases in patients with mental disorders [8, 20, 21].

Early career psychiatrists have reported other difficulties in their training, including the lack of practical knowledge to manage the transition phase from residency to independent practice, managing the risk of burnout, skills for dealing with the media, opportunities to be involved with professional and scientific societies and skills for handling difficult patients and colleagues [20, 22–24].

Recent debates about the future of psychiatry have questioned the role of psychiatrists and the training that should be provided [25]. Undoubtedly the future will witness the increased usage of technology in clinical practice, including new formats of care delivery, not yet envisioned [1, 26]. One suggestion is to have more joint collaborations with other specialties and professionals which can benefit the discipline, its professionals and the care provided to patients [27].

The size of the WPA's Early Career Psychiatrists Section has noticeably increased in recent years, having members in all the continents of the world. It offers several opportunities for early career psychiatrists across the world to meet, supported by

the WPA. There are travel fellowships to attend the WPA Congress, a dedicated conference track for ECPs, and innovative sessions using technology (such as the WPA 3 min Competition and, more recently, the Digital Interactive Theater).

10.3 Europe

This first vignette will explore training across a whole continental region. While there are significant variations between individual countries within the region, there are also several political, professional and scientific organisations concerned with training operating at a European level.

10.3.1 Landscape

There are a number of definitions of what Europe pertains to. Various political and health organisations categorise Europe differently in terms of the areas and nations included. The WHO provides a definition that stretches to the Caucasus, across Siberia and includes Israel [28]. The European Union (EU) is an evolving political and trading bloc, which includes within it and incorporates nearby countries, a range of economic and political entities, such as the Eurozone and the Schengen Area [29].

A number of supranational organisations exist within this complex framework that have particular relevance for training in psychiatry. The EFPT is an umbrella association for national resident associations from more than 30 European countries [30]. The Union Européenne des Médecins Spécialistes (UEMS) Section of Psychiatry aims to 'promote the highest standard of care for people who are affected by mental health problems in Europe through postgraduate training and continuing medical education of psychiatrists' [31]. The European Psychiatric Association (EPA) is the major scientific society for psychiatrists and its 'activities address the interest of psychiatrists in academic research and practice throughout all stages of career development' [32]. These organisations work together to address problems in training programmes by advocating for improvements, including the harmonisation of training throughout Europe [33]. Recently an initiative has been established to examine this issue in more detail, called the Task Force for Education in European Psychiatry [34].

10.3.2 Challenges

The EFPT conducts an annual survey, which collects information about the situation of training in psychiatry in its member countries. This has now been running for a number of years, providing a rich longitudinal picture of training and its evolution across the continent. The results have demonstrated that the basic parameters of training programmes vary considerably between countries and sometimes even

within countries. The length of residency varies from just two years to a maximum of six years for a single specialty, although in countries where dual training is possible, this can be even longer [35]. In the European Union, the length of training varies from four years, up to seven years [36]. This is in line with the minimum duration of training required for professional certification to be recognised within the EU [37]. In several countries training is not standardised nationally, which can make it difficult to get a unified picture of residents' experiences [13]. Other concerns identified by residents include problems in certain countries in gaining access to training programmes and financial problems resulting from salary limitations.

The EPA issued a guidance paper in 2014 on postgraduate psychiatric training in Europe, reviewing the available literature. The limited information published at that time reflected a broad variation in training programme structures, quality assurance mechanisms and levels of satisfaction with the experience of training. It goes on to review the curricula in six northern and western European countries, comparing the length of training, compulsory elements of training and assessment structure. The authors recommend that information about curricula in European countries should be more freely available to aid comparison between them. The authors advocate that training should be harmonised across Europe and suggest that a European level examination in psychiatry might help to drive improvement [38].

The UEMS Section of Psychiatry has produced guidelines on training requirements for the speciality of psychiatry, based on the charter on training of medical specialists in the EU [39]. These set out minimum expectations for training, for example, that residents should receive at least one hour of personal supervision each week. They recommend that training should be a minimum of five years full time equivalent and should be possible to complete by working less than full time.

In collaboration with EFPT, the UEMS Section of Psychiatry developed a practical tool to establish the level of compliance with these standards on the ground, called Test Your Own Training (TYOT). This is a freely available web platform that residents can complete on the EFPT or UEMS Section of Psychiatry website [40]. Participants complete 27 questions related to different aspects of the guidelines. The programme generates a total final score and the participants receive instant feedback on whether their answers meet the guidelines.

An analysis of the preliminary data showed that compliance with the guidelines is poor. The mean overall score was just 42% for 77 respondents from 27 countries. Just less than half of residents received a copy of the relevant national guidelines at the start of training, while another large proportion reported knowing that such guidelines existed. This reduced significantly for the European guidelines, with the majority having no idea of the existence of such a document. Almost half of respondents stated that they did not have the option to complete training less than full time. Over half reported problems accessing psychotherapy training during working hours as part of the curriculum. One in four described paying for mandatory parts of training themselves. The particularly problematic issues identified by the respondents were that training needs were subordinated to service demands (71%), feeling unsafe in the working environment (30%), staying in unacceptable hospital accommodation (21%) and feeling punished for seeking help when unwell (16%) [41].

Research conducted with residents has showed that the main concerns in Europe are related to the discrepancies between the stated national programme and the lived experience of residents, especially around delivery of specific training opportunities, access to psychotherapy training and research experience [42, 43]. Levels of recruitment into psychiatry, inadequate working conditions, access to information, access to research opportunities and training are amongst the key areas where residents identify that their needs remain unmet [1, 44–46].

10.3.3 Potential Solutions

EFPT and the UEMS Section of Psychiatry both advocate that any effective improvement in the residency programmes in Europe should involve the residents themselves. EFPT publishes a series of statements, which are reviewed and updated annually. These statements provide a consensus view about issues that are important to residents. Many pertain to the quality of training itself and the experience of residents [47].

One solution that has been repeatedly advanced is harmonisation of training across Europe, to ensure that all training programmes meet similar minimum standards [33]. An examination has been postulated as one way that this could be implemented. This has been effectively utilised in over 30 other specialties and is being considered by the UEMS Section of Psychiatry [48]. An exam may help to push up standards and promote free movement of psychiatrists, although if implemented badly, it may risk creating an additional burden for residents [49].

From the residents' perspective, harmonisation of curricula is perhaps less important than ensuring more consistent and effective quality assurance of training [50]. The results from TYOT suggest that there is often a significant gap between theory and reality. Aspirational guidelines are therefore not enough and robust inspection of compliance with regulations, with requirements for rapid rectification of any deficits, are essential. One component of this is ensuring a high quality of supervision [51, 52]. As well as ensuring that supervision takes place as expected, it is also important that supervisors are adequately trained and supported in their roles [53, 54].

Working conditions, including salaries and working hours, are one obvious target for improvement [55]. These aspects can remain closely linked with the overall economic prosperity and labour regulations of the respective country; however, improvements can frequently be achieved with small changes developed in collaboration with residents [44]. Aspects that are particularly amenable to improvement are around the health and safety of residents [56]. Flexible training for residents with family or other caring responsibilities would also support a better quality of life [57].

Equitable access to training opportunities is another important target for improvement. EFPT recommends that residents should have access to a full range of clinical placements, including in community settings and in a variety of psychiatric specialties, such as child and adolescent psychiatry and old age psychiatry. The UEMS Section of Psychiatry guidelines recommend a minimum of 120 hours

of theoretical teaching in psychotherapy and 100 hours of supervision [39]. There should also be adequate opportunities to gain training and experience in research, with EFPT stating that all residents should have a 'basic knowledge of research methodologies' [47].

10.4 United Kingdom

This second vignette considers the situation within one constituent country within the European region, looking at how the issues discussed above play out in a national context. It also considers specific issues affecting training and practice for residents in the country itself.

10.4.1 Landscape

There are 33 medical schools, with licences to award UK medical degrees from the General Medical Council (GMC) in the UK [58]. Recent studies have highlighted that 80% of UK medical students come from only 20% of UK schools and that these were more likely to be from selected schools [59]. There have therefore been widening participation schemes set up within the UK to encourage more students from disadvantaged backgrounds to enter medical school.

The basic process for becoming a consultant psychiatrist in the UK is detailed in the below Fig. 10.1:

10.4.2 Challenges

Psychiatry has struggled for a long time to recruit enough residents [60]. This has led some to characterise psychiatry as a 'recruiting, not a selecting, specialty' [61]. Medical students cite concerns around prognosis of patients, worries about a lack of scientific basis and a lack of evidence around diagnosis [62].

Paralleled with recruitment struggles are retention difficulties [63]. Doctors have also cited the poor public image of psychiatry, a lack of respect from other specialities, a lack of resources and work-related stress.

Some doctors feel that training is threatened by credentialing, a process whereby additional training in discrete areas of practice can be obtained outside of standard training programmes. The British Medical Association (BMA) sees this process as a risk to high-quality structured speciality training [64], whereas the GMC sees this as complementary to existing training curricula [65].

Furthermore, some doctors see the recruitment of physician associates as another threat to training and doctor numbers; with the BMA raising concerns about who will supervise these new healthcare professionals and the clinical governance of their practice [66].

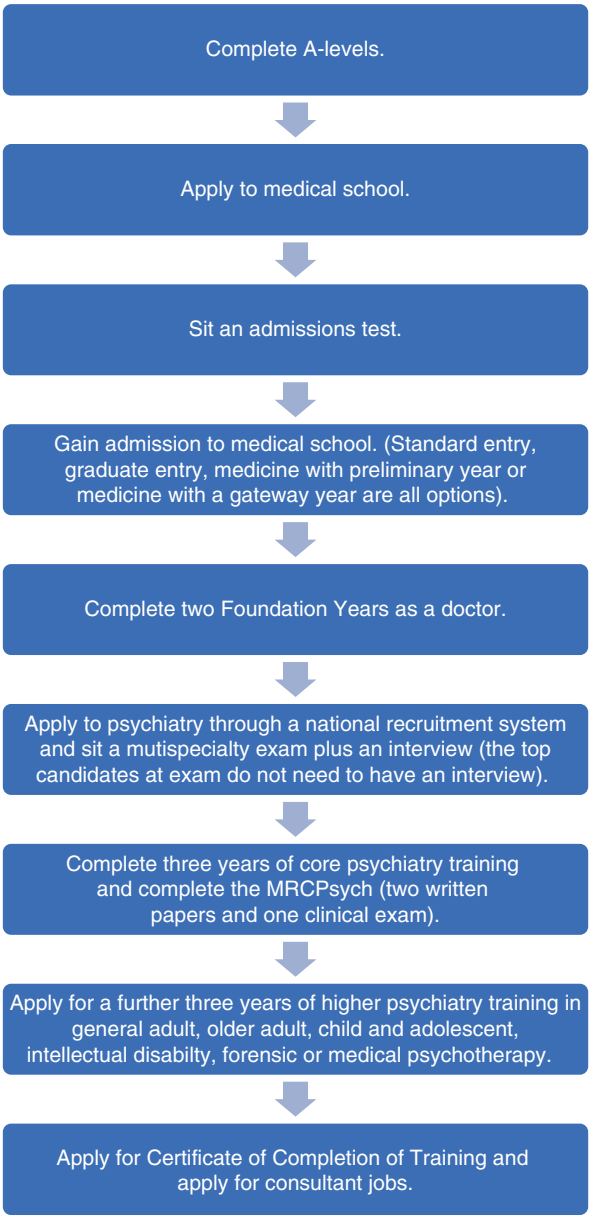

Fig. 10.1 UK journey to become a psychiatrist

Finally, although a problem for all junior doctors, tuition fees for UK Universities rose to £9000 a year in 2012. This means that UK medical students can expect on average to have debts from fees and accommodation on graduation of £64,000, according to the government's own figures [67], which would take them years to pay from their junior doctors' salary.

10.4.3 Possible Solutions

The Royal College of Psychiatrists launched its 'Choose Psychiatry' campaign in 2017 which aims to increase recruitment into psychiatry by targeting medical students. This varied programme has connected to medical student psychiatry groups across the UK, attended careers fairs and launched publicity campaigns, including short films illustrating the role of the psychiatrist. In 2018 recruitment to core psychiatry training was up by a third [68].

In 2017, psychiatry residents themselves strove to improve the quality of training with the report 'Supported and Valued?' which brought together data collected from 11 regional focus groups of residents, and was followed by a national survey [69]. This document provided core recommendations, such as regular supervision and protected teaching time, as well as desired recommendations such as greater career autonomy and enhanced junior doctor forums. This document was published and has been promoted widely.

Run-through child and adolescent psychiatry training, which is a 6-year programme, was first piloted for posts beginning in 2018 and continues in 2019 [70]. Competition for the first year was fierce, with 94 applicants for 11 posts. This follows the recommendations for run through training made by the Centre for Workforce Intelligence, which was commissioned by the UK Government in 2014 to analyse how to meet the demand for psychiatrists in the UK [71].

Furthermore, since 2018, applicants to Core Training can bypass the interview process if they achieve a certain score in the Specialty Recruitment Assessment, which involves questions on professional dilemmas and clinical problems [70].

In more general measures, the government announced in 2018 that there would be 1500 additional medical student places at five new medical schools, as well as adding to numbers at existing establishments [72]. These new student places will prioritise recruitment into areas where there are doctor shortages or in certain specialities. Increasing numbers of medical students may well benefit psychiatry in the long run.

The GMC is endeavouring to make the UK doctor workforce more flexible and, as part of this, enable more doctors to switch between specialities [73]. To achieve this the GMC introduced the Generic Professional Capabilities framework which delineates the skills of the doctor through nine domains, seven of which would apply to any doctor, with specialist skills in the remaining two areas [74]. Doctors in other specialities may more easily retrain as psychiatrists in the future.

10.5 Training in Brazil

The third vignette focuses on training within the largest country in South America, the Federal Republic of Brazil.

10.5.1 Landscape

In Brazil there is a lack of electronic information about psychiatric training programmes. In fact, most services do not have a website providing information about the curriculum [75].

In Brazil, the residency programme in psychiatry lasts for three years [76]. In the first year the resident is placed in a psychiatric hospital, where they will care for the most seriously unwell patients in inpatient wards. Some services are provided in psychiatric beds located within general hospitals and others are in stand-alone psychiatric hospitals. Residents complete theoretical classes and present clinical cases, alongside their practical duties. The medical residency programme is considered the best form of training and expertise in the country. The Council of Medical Residency of the Brazilian Psychiatric Association (ABP) recommends a training distribution of 10–20% for theoretical assignment and 80–90% for supervised clinical practice [77].

Adult psychiatry residents treat a range of patients and conditions during the first year, including both female and male patients, adults, children and adolescents, as well as patients with substance use disorders. Also in the first year, residents do internships in neurology and emergency psychiatry. In the second and third year, residents will have supervised exposure to patients in an outpatient setting. Here, a wide range of patients will be seen, including those with diagnoses of mood disorders, schizophrenia, eating disorders and substance use disorders. Additionally, residents will provide liaison services for other specialties in the general hospital. In the third year residents also offer individual psychotherapy and group therapy and work on psychogeriatric and forensic units [78].

An optional fourth year allows residents to further specialise in areas such as child and adolescent psychiatry, forensic psychiatry, psychogeriatrics, addictions, sleep medicine or psychotherapy.

10.5.2 Challenges

In Brazil, not all residency programmes provide comprehensive training in psychotherapy. In the southern part of Brazil, the focus of most psychiatric services is on psychodynamic psychotherapy, due to the influence of psychoanalysis from neighbouring Argentina. Many residency programmes lack a more comprehensive overview of psychotherapeutic modalities, resulting in many residents taking additional courses in order to improve their psychotherapeutic skills.

The use of simulation as a method to learn about managing complex cases is often neglected during residency training. Role-plays can help to internalise learning of both clinical and psychotherapeutic management [79].

Possibly the greatest challenge in Brazil is the disparity between what is learnt from the academic literature and the precarious nature of the Brazilian mental health infrastructure [80]. For example, it may be that the best medication for a particular patient is too expensive, so the professional is obliged to adapt the management plan accordingly.

10.5.3 Possible Solutions

One solution is to identify how gaps in training might be filled through other institutions. For example, attending scientific activities such as lectures, conferences and participating in an association in the local region are ways to improve academic knowledge. An example of an association in Brazil is the Núcleo de Psiquiatras em Formação da Associação de Psiquiatria do Rio Grande do Sul, located in the southernmost state of Brazil [23]. Created in 1988, it is an association that facilitates collaboration between residents from different services; it develops scientific activities as a way to complement and fill the gaps in residents' places of education. One of the activities involves the presentation of clinical cases by one medical resident and comments from psychiatrists from other services, as a way of gaining an understanding of different approaches. Another activity is the discussion of a film. Such 'cinemeducation' helps the learning process by increasing empathy in the doctor-patient relationship [81].

It is important for those completing the programme to leave psychiatric residency with competency not only in cognitive-behavioral therapy (CBT) and psychodynamic psychotherapy, but also of specialist therapies, such as dialectic behavioural therapy, interpersonal therapy, systemic and family therapy. Therefore, efforts should be made to provide access to such training opportunities. The search for other possible solutions to make up for the deficits in formal education are essential to keep residents updated so that they can help their patients more effectively.

10.6 Africa

The fourth and fifth vignettes are from opposite ends of the African continent, comparing and contrasting the experiences of training in South Africa in the south and Egypt in the north.

10.7 South Africa

10.7.1 Landscape

South Africa has the highest number of psychiatrists in the Southern Africa region, with over 700 psychiatrists registered with the Health Professionals Council of South Africa (HPCSA) in 2012 [82]. South Africa also has one of the highest number of psychiatrist graduates per year in the region, with 27 psychiatrists graduating per year for the decade up to 2015 [83]. This makes the country's training programmes important not only for psychiatric care in the country, but also in the region as a whole.

South Africa currently has eight medical schools that offer specialist training in psychiatry [84]. Psychiatric residents register with one of these medical schools but are employed and work at Department of Health (DOH) hospitals during their

training. At these hospitals, they will be supervised by specialists, also employed by the DOH, with respect to academic, clinical and research needs. These specialist psychiatrists, together with residents, are joint appointees between a university and a hospital where they are employed. This means that although they are employed by a government hospital, they also provide academic input to a university. This academic input includes attending to all the academic needs of the residents, including research supervision, teaching and clinical supervision.

Although universities provide the training of psychiatrists, the College of Psychiatrists examines and provides the required qualification for psychiatrists [84]. The College of Psychiatrists sets the curriculum, decides on training requirements and administers examinations [85]. In order to become registered as a psychiatrist, candidates must pass a College of Psychiatrists' entry examination, complete four years of training as a psychiatric registrar, pass the College of Psychiatrists' final examinations and complete a master's research project. During the four years of training, they must complete the forensic and child psychiatry rotations, in addition to general psychiatry. Psychotherapy training is also mandatory during training.

South Africa's College of Psychiatrists offers four subspecialty qualifications, namely child, forensic, geriatric and neuropsychiatry. Training in a subspecialty requires further two years of training time in a relevant department and successfully completing an exit examination.

10.7.2 Challenges

One of the main challenges that psychiatry residents face in South Africa is the quality of the available resources, both human and non-human. Medical schools are distributed throughout various parts of South Africa. As a result, there is a significant discrepancy in distribution of psychiatrists across the country, with urban areas having a much higher density of psychiatrists than the rural areas [82]. There were seven psychiatrists in rural facilities across South Africa in 2014; this translates to 2% of all psychiatrists in the public sector. Rural provinces, like Eastern Cape and Limpopo (each with one medical school) have very few psychiatrists compared to provinces with big cities like Western Cape and Gauteng. There are certain training hospitals, affiliated to some of the training universities, that may have one or no psychiatrist. Residents then depend on psychiatrists that are based at geographically distant hospitals to assist with tuition and supervision. Most of the time residents continue to work with little or no supervision. The centres with fewer specialist psychiatrists also have limited capacity to supervise residents with research work. They are also poorly resourced with respect to equipment and, sometimes, medication availability. This leads to residents often conducting research with little or no guidance. As a result, the specialist requirements may not be fulfilled within the allocated 4 years of training. Some residents may complete the time allotted for the training programme, but have to leave the training post and try to complete the examinations at a later stage. Many leave to pursue other careers, without ever becoming psychiatrists.

Another challenge that psychiatric residents face is a large and increasing clinical burden. Over and above the academic requirements upon them, residents are expected to offer and prioritise service delivery in the public sector in government hospitals where they are employed and receive their salaries. Psychiatric residents make up more than half of doctors employed by the government in psychiatry, serving the majority of the country's population. Often, they find themselves, doing only clinical work during official working hours, while academic work is done after hours, on weekends and during leave. This results in many residents not meeting the necessary academic requirements, burning out and dropping out of the programme. In other cases, residents complete the programme and become specialists, but feel ill-prepared for the task of being a psychiatrist.

A further challenge that residents face is the discrepancy between training and expected practice as a psychiatrist. Although psychiatric training is geared towards preparation to manage psychiatric disorders adequately, it does not train residents for psychiatric practice overall. Besides managing psychiatric disorders, psychiatric practice requires patients' advocacy, community education and mobilisation, health system management and leadership skills.

Importantly, currently there is very little, if any, training in the use of technology or social media during the psychiatric training programme. Thus, recently-qualified early career psychiatrists are ill-equipped to face the challenges that the digital age brings. As patients become more familiar with social media and technology, the onus falls upon the psychiatric residents to equip themselves for the changing landscape of technology. In fact, the College of Psychiatrists in South Africa does not require any training in electronics or leadership as part of training to become a psychiatrist [85].

Lastly, South Africa is a large and diverse country. Not only is there an uneven spread of resources, there is also an uneven presentation of pathology. People who train in one centre may therefore be more exposed to managing substance use disorders, while others trained in a different location may have far less experience in psychiatric presentations related to substance use.

10.7.3 Possible Solutions

Given the several challenges, some of which were highlighted above, possible solutions are necessarily varied. One major solution is a deliberate, concerted introduction of digitalisation of psychiatric training and practice. The possible benefits for psychiatry are multiple. Academic teaching, research and clinical supervision can all be done through tele-psychiatry. Thus, skills and personnel that are not physically available in the vicinity of training centres can easily reach residents, thus improving the quality of their training, despite resource limitation. In addition, psychiatric residents will become early career psychiatrists that are more familiar with the digital world that they practice psychiatry in.

Another aspect of psychiatric practice that needs attention is the joint appointment between universities and DOH. Residents need uniform, adequate and protected academic time within their regular employment. For residents to achieve the

expected academic outputs, the necessary academic resources need to be provided. Not only will the protection of academic time lead to better academic outputs, but will also help in preventing burnout and reducing drop-out rates [86]. It is important to clarify the relationship between the Departments of Higher Education and Health in overseeing the employment and training of residents who are joint appointees. This should aim to prevent such residents being subject to the changing demands of such an environment and provide greater consistency.

10.8 Egypt

10.8.1 Landscape

Postgraduate training in medicine in Egypt, including psychiatry, takes place under two systems: the academic system, offered by universities, and the Fellowship of the Egyptian Board programme, through the Ministry of Health. The academic system leads to a scientific degree at master's, and subsequently at the higher doctoral level, through both clinical and research training activities. The procedures of the academic system are regulated by the higher education Unified Law No. 49 (1972) and each university has also additional regulations. In general, postgraduate students must attend a certain percentage of the practical activities and lectures, undergoing continuous assessment, usually comprising written, practical and clinical parts leading to summative final exams. Students registered for masters' or doctoral degrees must also write and defend a research thesis. This is obligatory for residents in university hospitals, especially if they expect to continue as academics in their universities. Doctors who do not work in universities also choose to pursue this training pathway due to its high quality and in order to gain a scientific degree. On the other hand, the fellowship system is mainly clinically focused, and assessment is primarily of participants' clinical skills and knowledge [87].

There is no unified training across different universities. Each university has its own programme and regulations. When it comes to psychiatry training, the most prominent difference is that some universities have comprehensive psychiatry and neurology training during residency, integrated within a single department (e.g., Ain Shams University Neurology and Psychiatry Department). This means that residents have to spend half their training in the neurology unit, gaining further knowledge of neurological history and clinical examination, the biological aspects of disorders, managing medical problems and reviewing critical cases. This cross-training is considered an advantage in light of recent calls to acknowledge the overlap between neurology, psychiatry and neuroscience. Advocates have suggested revising the length of neuropsychiatry training for psychiatry residents [88, 89]. In other universities, the psychiatry department is now separate from neurology and acts as an individual silo. Thus, neurology training is less extensive, with more time and focus given to social aspects and psychotherapy. These are adequately covered in the merged system as well, but over a shorter period.

For years, university training was the gold standard and was pursued by doctors from both the Ministry of Health and private practice. However, this system is not suitable for those who do not want to work in research or prepare a thesis as part of their scientific degrees. Those who wish to be recognised as psychiatric specialists, but prefer to undertake training that is more clinically orientated are able to pursue the fellowship pathway. There are two fellowship pathways that can be pursued in Egypt. The first is the fellowship of the Egyptian Board of Psychiatry. The Psychiatry Board requires four years of supervised training that must be conducted in accredited hospitals before sitting the final examination. Psychiatry residents have to spend their training period in general psychiatry, child psychiatry, old age psychiatry and emergency psychiatry. Addictions and other psychiatric specialty placements can also be completed according to the availability of services. Rotations between services are flexible and candidates may start in general adult psychiatry and then rotate to the other specialties, according to service needs and availability [90]. The second is the fellowship of the Arab Board of Psychiatry. Training systems, even the language of training, varies across Middle Eastern and Arabic countries. The Arab Board qualifies psychiatrists to be recognised in several countries in the region. The duration of clinical training is four years. During the first year, the resident must possess enough experience and qualifications to take the first part of the examination. The resident must be given priority to train in general psychiatry (18 months at least) and to develop experience in diagnosing and treating acute and chronic cases. The resident should attend educational meetings and related seminars every week. In the following years, the resident must gain more skills in general psychiatry and other specialist areas of psychiatry (such as child and adolescent psychiatry, old age psychiatry, alcohol and substance abuse, etc.) [91].

It is also noteworthy that some postgraduate students would prefer to pursue an international qualification like the Membership of the Royal College of Psychiatrists (MRCPsych) or the Fellowship of the Royal Australian and New Zealand College of Psychiatrists (FRANZCP) [92, 93]. However, those students mostly plan to work and train abroad or even to migrate permanently.

10.8.2 Challenges

Psychiatric training in Egypt shares many challenges with other countries. The main issue seems to be the lack of unified training amongst universities in the academic pathway. Thus, despite being overall of a similar quality, the training of residents varies across the country. This is more evident when comparing training in psychiatry departments that are incorporated with neurology to the stand-alone ones. While all medical schools adapt the biopsychosocial model, some schools are more biologically oriented and others are more focused on social and psychological aspects.

Another major challenge is that trainers are busy with service provision due to the low number of mental health professionals. They have to cover the gap between service and demand, which leaves little time to provide training. However, this also

has a positive side, as it allows for more 'hands-on' training in real life situations through shadowing senior colleagues.

Residents themselves have a similar situation, often being preoccupied with service provision. Most of the lectures and structured training sessions take place during working hours, while residents are already involved in other activities. With such a workload, burnout is a risk for both trainers and residents, which aggravates the problem.

As a LMIC, the cost of training is another point that many residents worry about. With many residents having to cover the costs of training out of their own pockets, this is not an easy task. One of the major challenges noted in Egypt is stigma. Many residents avoid choosing psychiatry as a career due to the negative attitudes expressed by their families, colleagues and even patients.

Residents have reported feeling unsatisfied with their psychotherapy training and highlight that it needs more standardisation and supervision. This differs between different training centres, but overall psychotherapy training needs to be revised. A similar issue is noted with forensic psychiatry training, which is limited only to certain hospitals.

Finally, research skills training is limited mainly to the academic pathway. Indeed, while research skills and critical appraisals appear in all training curricula, it is only in the academic pathway that residents are required to defend a thesis, where practical research training is mandatory.

10.8.3 Possible Solutions

One possible approach is to revise different curricula and address the real needs of residents, while trying to reach a unified training programme. Flexible training hours and schedules should be considered, while protected hours for scientific activities and research should be implemented and enforced in all workplaces. This also applies for trainers, who should have protected hours devoted to meeting residents, responding to their queries and providing support and advice. On the other hand, resilience training and peer support might help decrease burn out symptoms and help residents stay motivated.

In order to overcome the low number of mental health professionals and increase the number of medical students choosing psychiatry, combating stigma by ongoing campaigns that start amongst undergraduates are needed. Also, campaigns should target the negative attitude amongst other medical specialities and families of doctors [94].

Another solution for the low number of mental health professionals is the training of primary health care physicians to help bridge the service gap and allow more time for better training and service delivery.

Addressing the concerns of residents, those responsible for overseeing training programmes might want to consider standardisation of psychotherapy training across the country, make arrangement to ensure that all residents receive at least a basic training in forensic psychiatry and incorporate research skills in to all training

programmes. This will help them develop critical appraisal skills and the ability to differentiate good research when engaging with continuing professional development.

10.9 Discussion

The five vignettes presented in this chapter aim to give an overview of some of the unmet needs for psychiatric residents in diverse parts of the world. It does not provide a comprehensive insight in to all global regions, but hopefully provides a reasonable barometer of the challenges faced. The literature was highly variable, with some areas rich in published data, while others have very limited record of formal enquiry in this subject.

10.9.1 Common Themes

Across the world psychiatric residents face many similar challenges. Despite the wide variation in the resources available, residents from many different settings identify pressure on the clinical service as an issue. High demand, sometimes coupled with unsupportive administrative structures, create a tension between service provision and training. This can mean that protected time for learning is either non-existent or subordinated to the needs of the service. In some countries this can lead to residents struggling to acquire the necessary competencies in the allocated timeframe. Linked to these pressures, working conditions are often sub-optimal for residents, with low pay, inadequate supervision and poor work/life balance frequent concerns. Consequently, residents are at risk of experiencing burnout before they have even graduated as specialists [95].

Another significant area for concern is the availability and quality of training in particular domains. Commonly cited areas are neurology and psychotherapy, as well as a variety of sub-specialties of psychiatry, such as forensics and addiction medicine. Others pinpoint non-clinical skills, such as research and leadership as being inadequately catered for within certain training programmes [25].

Stigma against the profession remains a serious issue in many countries. This can act as a deterrent to students choosing to pursue psychiatry. Recruitment problems can then exacerbate the workforce crisis, putting even greater pressure on residents to prioritise service provision over training [94].

10.9.2 Contrasts

Despite the many similarities in residents' experiences globally, a number of differences persist. One key issue is the degree of standardisation in training within and between countries. In several countries, residents may have completely different opportunities depending on where they train or which pathway they choose to undertake. While such variability may have advantages for some, by providing

options to tailor training to the individual resident, it risks creating psychiatric specialists with uneven and incomparable qualifications [38].

The vignettes above draw on the experiences of countries and regions with highly variable resources. The experience of training is highly dependent on these resources, which can determine burden of clinical work, availability of formal training and have significant ramifications for the quality of life of residents.

Another discrepancy is the varying attitudes to the role of other professional groups. In some settings other professional groups are perceived to be vital allies, who offer the potential to reduce the clinical burden on residents, freeing them up to focus on their training needs. At the other end of the spectrum, new roles for allied professionals are seen as encroaching on the territory of residents, threatening to reduce the opportunities they have for training. This tension highlights differing perspectives on the fundamental role of the psychiatrist [96].

10.10 Conclusions

Given the many challenges and unmet needs identified by residents, solutions are urgently needed to improve the experience of training. This is particularly important in light of the workforce recruitment problems that pose considerable threats to the quality of patient care [97].

The obvious solution requires the provision of more resources for the training and support of residents. These could be directed to ensuring that residents have protected time to train and to safeguard the working conditions of trainees. Additional support for trainers is also essential, so that they have the necessary time and training themselves to provide adequate supervision [98].

The use of enhanced pedagogical and technological approaches can also support better training in psychiatry. Newer techniques, such as simulation and the use of the humanities in teaching, can be used to give residents a richer and more rounded experience of training. Telepsychiatry can be used to bridge the gap that geography imposes on residents training further away from established academic centres [25].

Greater harmonisation of training across regions offers the opportunity to drive up standards and reduce variability in the training experience. Careful thought must be given to how a comprehensive education can be provided that covers the full range of skills that a fully qualified specialist needs to practice effectively. Robust quality assurance mechanisms need to be in place to ensure that such standards are actually implemented on the ground in a sustainable way [39].

Finally, for solutions to stand a chance of success, they must involve residents themselves. There has been a burgeoning number of organised associations of residents at all levels, from local areas, up to the global scale [23]. Those responsible for designing and delivering training schemes are recommended to work with such organisations, as well as eliciting input from residents locally.

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