The Place of Exchange Programs

19

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Contents

Introduction 392
The Place of Exchange Programs in Medicine and Psychiatry 393
When to Undertake an Exchange 395
Educational and Professional Exchanges in Medical Education 395
Professional Exchanges in Postgraduate Medical Training 397
Practical Aspects of Undertaking an Exchange 402
Shortcomings of Exchange Programs 405
Implications and Recommendations 406
References 408

Abstract

Over the last decades, interest in international educational experiences has increased among students at all levels and in every field of education. Many educational institutes and organizations around the world have acknowledged the need to prepare students for a globalized work environment and actively promote international exchanges. In this chapter, we explore the historical and political contexts which allowed for the development of these exchange programs in different regions of the world, and how these have changed over time. We review several existing exchange programs within the field of mental health which range

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across the different educational and professional levels. Some of these programs are well-known and large-scaled operations, such as the Erasmus programs, whereas others are successful examples of smaller-scales initiatives independently ran by (associations of) healthcare professionals. We go on to evaluate the impact which the duration of the exchange, language barriers and psychological cultural adaptation phenomena may have on the outcomes of an international experience. Finally, we critically evaluate the limitations and the merits of exchange programs on an individual and societal level, in a contemporary context where local and global mental health are increasingly connected.

Keywords
Global health · Medical mobility · Psychiatry education · Exchange programs

Introduction

"The world is a book, and those who do not travel read only a page." – Saint Augustine

It is often said that life's real education happens outside the classroom. Similarly, travel – as a powerful agent for change – has always been an essential part of young people's education, helping them to broaden horizons and find purpose. Student exchanges in their current, well-organized, form became popular after World War II, and were intended to encourage participants' understanding and tolerance of other cultures, while also improving their language skills and broadening their social horizons. Exchange programs were also used as a tool of Government Foreign Policy. This is most evident in the Unites States of America (US), where the introduction of relevant legislation in the postwar period led to increased US Government support and formalization of cultural exchange programs such as the 1946 Fulbright Program. To date, more than 200,000 students have participated in this program across over 150 countries worldwide. The notion that exchange programs could play a role in establishing and maintaining good international relations between countries was explicitly mentioned by US President Eisenhower, who stated that after his 1955 meeting with Soviet Premier Nikita Khrushchev in Geneva, "*The subject that took most of my attention was the possibility of increased visits overseas by the citizens of one country into the territory of the other nation. In this subject, there was the fullest possible agreement between the West and the Soviet Union*" (People to People International Website). In 1961, the U.S. Congress passed the Mutual Educational and Cultural Exchange Act, mandating an increase in governmental programs to enhance mutual understanding between the people of the United States and other countries (United States Congress 1961). This increased government focus and spending on Exchange programs, particularly exchanges between the US and Soviet Union, dropped significantly after the Cold War came to an end. Yet following 9/11, there has been a new increase in US support for exchange programs, this time targeting Arab and Muslim countries. An example is the creation of the Partnership for Learning (P4L), which provides scholarships for

secondary school students from countries with significant Muslim populations to spend up to one academic year in the United States (Djerejian 2007).

In Europe, the establishment of Exchange programs paralleled the progressive development of the European Union, which sought political and economic collaboration as an antidote to extreme nationalism in order to secure lasting peace on the continent. This process began in 1957 with the Treaty of Rome which created the European Economic Community (EEC), a customs union between six countries. Following the Maastricht Treaty of 1993, the European Union was founded and has since then steadily grown to incorporate 28 member states today. An important milestone in this process has been the 1985 Schengen agreement, which paved the way for the creation of open borders without passport controls and facilitated international exchanges (European Union Website). Two years later, in 1987, the European Union initiated its international university mobility programs.

Over the last decades, interest in international educational experiences has increased among students at all levels and in every field of education. Many educational institutes and organizations around the world have acknowledged this need and are now promoting exchanges and the internationalization of school curricula. Their aim is to prepare students for a globalized world and work environment.

Exchange programs have traditionally been designed as programs in which students from a secondary school or higher education institute are given the opportunity to study at one of their institution's partner institutions for a certain period of time. The term "exchange" here means an agreement between partner institutions to accept each other's students. However, it does not necessarily mean that a student has to find a counterpart from the other institution with whom to exchange. Although such exchanges do not necessarily need to take place abroad, in this chapter we will focus on international exchange programs, which provide participants with an opportunity to study or work in a different country and environment. We will cover the place of exchange programs in terms of why to implement them in medical training, when and under which format they can take place. We will also cover how to take part and follow that with a broader discussion on the value of professional exchanges and expected outcomes. The focus will be on exchanges in medical training, but the topics covered can be applicable to other healthcare professions.

The Place of Exchange Programs in Medicine and Psychiatry

Exchange programs can be found in various shapes and sizes throughout the medical curriculum, undergraduate and postgraduate. In a globalized world, both patients and healthcare professionals demonstrate greater mobility than ever before due to improved transportation and changes in the economic and political landscape. Understanding of different healthcare structures and how culture influences service provision and care becomes of great value. A number of advantages can be identified

in support of exchanges in the field of medicine, as it has become clear that both society itself as well as the sending and receiving institutions and the individual undertaking the exchange can benefit from them. On a professional community level, such exchanges stimulate exchange of best practices and facilitate the sharing of knowledge (Monroe-Wise et al. 2014), They provide opportunities to create networks of professionals to help facilitate additional learning opportunities. When long-term relationships are formed, these can in turn result in valuable research collaborations. The person leaving on an exchange can do it for their professional development, achieved for instance through increased cross-cultural competence and better communication skills (Mutchnick et al. 2003; Jeffrey et al. 2011). On a personal level, the person leaving on an exchange may also do it to improve their foreign language skills, or for general personal growth through an increased sense of independence and confidence.

In psychiatry in particular, there is an increasing understanding of the fundamental role that the social environment plays in the etiology, access to care, and outcomes of mental illnesses. Rising immigration, mass movements of refugees, and international travel have led to the recognition that in a globalized world, the psychiatrist of the future will need to be equipped to understand and assess mental health problems across different cultural groups. Culture shapes the clinical presentation of mental disorders, as well as interactions between doctor and patient within mental health services (Kirmayer 2012). Exchange programs can therefore provide an excellent added value to the future psychiatrists' training. Exchange programs allow them to obtain better skills to treat patients of a certain background or with a certain type of intervention unavailable in their own country.

Furthermore, global mental health has been recognized as a key domain of study and research for several years now (Patel and Prince 2010). Some advocate that in view of the recommendation to obtain and demonstrate global health competencies, psychiatrists should be encouraged to travel and work abroad, but that can be controversial. In this context, "abroad" usually refers to psychiatrists from richer, more developed countries traveling to and working in countries where the mental healthcare is less well developed. Critics condemn the approach of developed countries "teaching" developing countries what to do. The reality is that in a true exchange, there is not a "teacher and learner." Both parts, the exchange participant and the host, learn and share knowledge. The exchange continues when the participant returns home and shares what they have learnt.

Local and global health are intricately connected, and to understand health and illness of populations as the world rapidly changes, doctors need to be equipped (Drain et al. 2009; Casanova Dias et al. 2017). Global health training involves learning about health issues that transcend geographic borders and commonly present a greater burden to disadvantaged populations.

Hence, exchange programs take up a unique place within the psychiatry curriculum, providing an enriched learning experience that promotes a deeper understanding of professional practice issues through comparative experience of another mental health system, offering a broader perspective at both professional and personal levels and encouraging mobility among future mental health professionals.

When to Undertake an Exchange

Exchanges can take place at different periods in a student's curriculum, starting from before they enter higher education, until after participants have already taken their first steps into the workplace. Exchanges serve different needs at the various life stages, entailing different levels of theoretical versus practical experience at each stage.

Educational and Professional Exchanges in Medical Education

The European Union describes learning mobility (transnational mobility for the purpose of acquiring new knowledge, skills, and competences) as "*one of the fundamental ways in which young people can strengthen their future employability, as well as their intercultural awareness, personal development, creativity and active citizenship*" (Council of the European Union 2011b).

Since 1987, the EU developed several programs for transnational exchanges of university Masters and Doctoral students, which have over time gone by the names of the most important European philosophers and humanists (Socrates, Erasmus, Leonardo da Vinci). Celebrating its 30th anniversary in 2017, the Erasmus Program (***E****uropean* ***R****egion* ***A****ction* ***S****cheme for the* ***M****obility of* ***U****niversity* ***S****tudents*) is probably the most well-known and largest student exchange program, through which over 3 million students have been able to study abroad at one of the more than 4000 higher institutions across 37 participating countries. As a parallel program, the Erasmus Mundus cooperation and exchange program of the Education, Audiovisual and Culture Executive Agency (EACEA) of the European Union ran between 2004 and 2013. Erasmus Mundus was oriented toward globalizing European education through joint programs and partnerships between higher education institutions from the EU and elsewhere, as well as projects to enhance the visibility and attractiveness of European higher education in foreign countries. Whereas the regular Erasmus Program is open to citizens of the European Union, Erasmus Mundus was open to students from both EU and non-EU countries, having awarded almost 14,000 Masters students of largely non-European nationality and from over 150 different countries with a scholarship to undertake an exchange. (EACEA statistics 2004–2005 to 2013–2014).

As of 2014, the Erasmus+ Program is the umbrella framework program for education, training, youth, and sport, combining all the EU's current schemes for these target domains. It includes the Lifelong Learning Program which hosts the Erasmus exchanges, and several international cooperation programs, including Erasmus Mundus. Erasmus+ falls under the broader Europe 2020 Strategy and aims to tackle specific issues such as reducing unemployment among young people, promoting adult learning for new skills required by the labor market, encouraging young people to take part in European democracy, reducing early school leaving and supporting innovation, cooperation and reform. The Erasmus+ Program is projected to run until 2020 on a total budget of 14.7 billion euro, and aspires to create mobility opportunities for more than 4 million people (EC ERASMUS+ Statistics). The new

program targets a larger audience, offering mobility opportunities in higher education institutes not only for undergraduate students (e.g., medical students) but also for teaching staff. It also provides traineeships abroad for higher education students and recent graduates, and international volunteering opportunities for young people. In Erasmus+, participants from "Program Countries" (Member States of the European Union plus former Yugoslav Republic of Macedonia, Iceland, Liechtenstein, Norway and Turkey) are differentiated from those from all other countries, called "Partner Countries." Some of the program's modalities are only open to Program country participants, while others (including the option to study abroad) are open to all. A study period abroad can last from a minimum of 3 months (or 1 academic term or trimester) to a maximum of 12 months (or 2 years in the form of a Joint Master Degree), with grants available to help with travel and subsistence costs. Data from the most recent Erasmus+ Annual Report highlight the scale at which this program is run: in 2014, around 500,000 young people studied, were trained, volunteered, or participated in youth exchanges abroad (EC 2015). For the Erasmus+, students who went abroad in 2013–2014, the top five of destinations consisted of Spain (39,227 students), Germany (30,964), France (29,621), the United Kingdom (27,401), and Italy (20,204). Countries outside of the top five received less than half of these numbers. Countries where Erasmus students make up the largest proportion of the total graduate population are Finland (10.4%), Estonia (10.6%), Latvia (9.9%), and Slovenia (9.7%) (EC Erasmus+ Statistics).

Whereas educational exchanges allowing students to take courses at a foreign educational institute broaden horizons and offer many advantages to participants, clinical internships abroad go one step further. They expose students to another way of practicing medicine, and at the same time give them a better understanding of international healthcare. Participating in an international clinical rotation has been reported to "*provide educational benefits in knowledge (e.g., tropical diseases, cross-cultural issues, public health, alternative concepts of health and disease, and health care delivery), enhanced skills (e.g., problem solving, clinical examination, laboratory expertise and language), and fostering attitudes and values (e.g., idealism, community service, humanism, and interest in serving underserved populations*" (Thompson et al. 2003).

Founded in a post-World War II setting, the International Federation of Medical Students' Associations (IFMSA) was created to foster cooperation and collaboration among medical students by breaking down social barriers through promoting opportunities for dialogue and creating clinical exchanges (IFMSA Website). Its Professional Exchange program (Standing Committee on Professional Exchange, SCOPE) for undergraduate students offers clerkships to medical students who wish to explore health care delivery and health systems in different cultural and social settings and for whatever reason cannot or do not want to do so through their own university. SCOPE is endorsed by the World Federation of Medical Education (WFME), the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA), the Federation of European Neuroscience Societies (FENS), and the European Society for Emergency Medicine (EUSEM).

As early as 1952, a total of 463 students spent a period of practice abroad in eight participating European countries. Since then, SCOPE has grown into the largest student-run exchange program in the world, with more than 11,000 medical students participating every year from 98 National Member Organizations. This is achieved by providing a network of locally and internationally active students that globally facilitate access to research and clinical exchange projects, which usually last 4 weeks. Although the IFMSA exchanges consist of clinical internships in all fields of medicine, according to the IFMSA Exchanges Profile Book for the students enrolled in the academic year 2014–2015, 49 engaged in an internship in mental health care (46 in Psychiatry rotation, 2 in Addiction, and 1 in Psychotherapy), representing less than 0.5% of annual exchanges (IFMSA 2015). The reasons for this seemingly low interest for international rotations in mental health services remain yet to be defined. In view of the "recruitment crisis" of the psychiatric specialty observed in many countries, it would be of interest to take this phenomenon into consideration when studying potential reasons and solutions to improve recruitment (Katschnig 2010). In the UK, a recent recruitment campaign to encourage medical students to choose psychiatry ("Choose Psychiatry") has increased the exposure to psychiatry at undergraduate and postgraduate training (Royal College of Psychiatrists Website). It would also be relevant to study whether the availability of solid exchange programs increases recruitment figures.

Professional Exchanges in Postgraduate Medical Training

The European Parliament and the European Council adopted the Directive 2005/36/EC on the automatic recognition of professional qualifications, enabling freedom of movement for hundreds of professionals, including doctors and nurses (European Parliament and Council of the European Union 2005; Costigliola 2011). The increased mobility of patients and doctors that ensued raises the need for cross-cultural and public health training. For medical doctors who undertake several years of specialized postgraduate training, periods of training abroad have been vigorously advocated by both the trainees (i.e., those who are medically qualified and are pursuing postgraduate education, specializing in a specific medical specialty; also called residents or interns) themselves and organizations involved in the quality improvement and assurance of postgraduate medical education. However, not all medical specialties have considered periods of training abroad in the postgraduate curriculum, or made provisions for them (Drain et al. 2009; Lee et al. 2011; Casanova Dias et al. 2013).

To address this issue, and based on the successful experience of the above-mentioned undergraduate exchange programs, in 2011 the European Federation of Psychiatric Trainees (EFPT) initiated its own exchange program specifically targeting psychiatric trainees in Europe (Casanova Dias et al. 2012). The EFPT is an independent, nonprofit umbrella organization representing European national psychiatric trainees' associations. The organization currently represents psychiatric trainees from 39 European countries. The primary objective of EFPT is to enhance,

harmonize, and standardize the quality of psychiatric education and training across Europe by working in partnership with relevant international and/or national bodies. As a permanent member of the Section of Psychiatry of the Union Européenne de Médecins Spécialistes (UEMS), more commonly known as the European Union of Medical Specialists, the EFPT actively contributes to the development of the Section's position papers. In addition to this, the EFPT harbored for a long time the wish to create an opportunity for psychiatric trainees to take part in exchange programs. This leads to the establishment of the EFPT Exchange Program project (EFPT Exchange program Website). In this chapter, we provide some more extensive background information on this particular program as it is a prime example of how learners can set up and run their own collaborative Exchange program.

The EFPT Exchange program started with a pilot phase in 2012, including 14 trainees and seven host countries. Since then it has grown steadily both regarding the number of applicants and the number of offered places. In the first 5 years over 180 European trainees in psychiatry have taken part in the program, some several times. In 2016, the program received 108 applications from 17 countries, of which 84 were accepted. The highest number of applicants came from Turkey, Portugal, France, Romania, and Slovenia. Overall, the countries that have hosted the most trainees are UK, Croatia, Ireland, Portugal, and France (EFPT 2017). Testimonies of participants can be found in the EFPT seasonal Newsletter and detail how they discovered new ways of organizing mental health care (http://efpt.eu/efpt-ecxhange-testimonial-from-bristol-uk/) or how they were inspired to eventually take "the big leap" to move abroad for a career in a different country (http://efpt.eu/how-efpt-changed-my-view-on-training/). In 2017, the EFPT Exchange program included a total of 66 different programs in 16 countries covering all major fields of clinical psychiatry, including addiction psychiatry, child and adolescent psychiatry, eating disorders psychiatry, forensic psychiatry, general adult psychiatry, liaison psychiatry, old age psychiatry, perinatal psychiatry, psychiatry of learning disability, psychotherapy, rehabilitation and social psychiatry, as well as other specified fields of psychiatry like simulation training in psychiatry and sleeping disorders. The duration of the stay can be modified between a minimum of a 2-week and a maximum of a 6-week stay, in which the hosting department provides possibilities to get involved in clinical, research, and teaching activities, to learn about the mental health care system and the training program. The program may contain visits to different institutions, as well as the possibility to engage in a variety of social and cultural activities in the host country. To ensure the educational value of the exchanges, all trainees hand in an agreement to fulfill the requirements of the program prior to acceptance. The trainees are given an opportunity to present in the host clinic about their clinical experiences in their home country, areas of best practice, and their training program. After leaving the host clinic, participants fill in an online feedback form and write a report. The trainees are further encouraged to also make a presentation in their home clinic after the exchange and to engage in the exchange program locally, hosting participants. After the required steps are completed, trainees are issued an EFPT Exchange certificate for their CV. The program is coordinated by the EFPT Exchange Working Group (WG) consisting of the EFPT General Manager – Exchange Coordinator and

WG Chair, Co-Chair, IT manager, and new programs coordinator together with national and local coordinators from participating host countries. Altogether, 64 European trainees are involved in coordinating the exchange process. The national coordinators are chosen by or cooperating with the national trainee associations. National coordinators recruit and are responsible for the work of the local coordinators. New host countries are added on the initiative of locally engaged trainees within the EFPT network. Supported by the WG Chair and the new programs coordinator, programs are set up by national and local coordinators in collaboration with specialist colleagues and the head of the department. Information about available programs is collected and presented on the EFPT Exchange webpage. The program is open to applicants training in EFPT Member Countries, and they may apply to the program two times yearly for a period of 1 month with eventual unfilled placements made available for late application after selections have been completed. To take part in the program, trainees need to provide a reference letter from their head of department including current level of training, a motivation letter, and a CV detailing relevant experience for the program. Documents supporting the language proficiency are optional. Information about the applicants is sent to the respective national and local coordinators and the selection process is performed locally in agreement with the host departments. A standardized scoring scheme is used in the selection process. Some local coordinators make use of Skype interviews to assess the language level. Hence, the EFPT Exchange WG acts as a facilitator and the exchange agreement is established locally between the trainee, the trainee's home institution, and the host institution. As every coordinator is at the same time a fellow psychiatric trainee, who has excellent and extensive knowledge of the possibilities of the exchange program, this allows for maximal tailoring of an Exchange experience to an individual applicant's wishes and availability. The visiting trainee shadows another trainee of similar or higher experience and takes part in seminars and other learning activities.

Thanks to highly engaged and motivated trainees within the EFPT network and their voluntary work, the program has been able to be set up without structural financial resources. The ambition of the EFPT Exchange WG remains to make good quality international clinical experiences readily available to as many psychiatric trainees as possible. Effort is made to set the threshold in every step to what is minimally required to arrange an exchange experience that maximizes the outcome for all parties involved. As a consequence, the overall presentation and organization may look quite different between countries and cities involved. Some programs offer placements in specialized units with a well-described outline already available at the time of application, while other programs are more flexible, allowing tailoring according to individual wishes and availability with a wide range of possibilities. Hosting clinics may define local requirements and time periods available. The programs are searchable by country or by psychiatric field that can be covered. Once the trainee has been selected and set in contact with their local coordinator, agreements on the details are decided in dialogue.

A few years after the start of the EFPT Exchange Program, the Early Career Psychiatrists Committee of the European Psychiatric Association (EPA) launched a

similar program, called "Gaining Experience." It offers Early Career Psychiatrists (ECPs; psychiatrists under 40 years of age and/or 5 years after passing the specialist exam) who reside in a country included in the World Health Organization Europe region short observership placements (2 to 8 weeks) in various psychiatric institutions across Europe, supported by a travel grant. The first four exchanges took place in the year 2014–2015. Since then, the program has remained a solid part of EPA's activities supporting Early Career Psychiatrists.

Another example of this successful model of exchanges organized by healthcare professionals themselves is the Hippokrates exchange program for medical doctors specializing in General Practice/Family Medicine (GP/FM) and junior GP/FM Practitioners (within 5 years of completing specialty training). The program is supported by the WONCA Europe and by the European Academy of Teachers in General Practice (EURACT). Now thriving and well structured, the program was first presented at the 6th European Conference on GP/FM (WONCA Europe) in Vienna in 2000, under the auspices of the EURACT, which has always had an important role in shaping and enhancing medical education in Family Medicine throughout Europe. In 2008, the program was entrusted to the then established Vasco da Gama Movement (VdGM) which reviewed the scheme 2 years later and established a database along with a standardized framework to guarantee a beneficial and verifiable educational outcome for every exchange. The visitor is given a template where he/she is required to fill in his/her learning objectives for the exchange. These learning objectives are assessed by the host who then draws an educational program accordingly. At the end of the exchange, the visitor is expected to reflect on the learning outcomes and submit a report on his/her activities (Barara and Rigon 2015; Rigon et al. 2015). Over the years, the program has grown extensively, from an initial pilot phase of five participating countries; the Hippokrates Program today counts an extended network of hundreds of host practices in 28 European countries. The total number of participants and completed exchanges has also increased from 13 in 2010 to 105 in 2014 (WONCA Europe 2015).

As a global spin-off to this program, the seven WONCA regional Young Doctors' Movements (YDMs), namely, the AfriWon Renaissance (Africa), Al Razi (the Middle East region), Polaris (North America), Rajakumar Movement (the Asia-Pacific region), Spice Route Movement (the South Asia region), VdGM (Europe), and Waynakay (Central and South America), have been working together to create a global exchange scheme for young GPs/FM practitioners, leading to the establishment of the FM360° program in 2013. Its aim is to promote worldwide intercultural exchanges and allow young doctors learn from each other in different cultural and socioeconomic contexts. While it is built on a similar structural framework as the Hippokrates program, FM360° is organized as a 4-week program. During this period, the visitor shadows the host in their clinical practice or other community-oriented activities. In its first 2 year, the program has received 163 inquiries and organized close to 50 exchanges. Most of these inquiries have come from the European region (64%), followed by the Central and South American regions

(27%). Globally, the top three most popular destinations are Spain (15%), USA (14%), and Brazil (11%) (Barata et al. 2015).

Also in the US, the benefit and possibilities of exchange programs in higher education have remained of interest. Over 25% of graduating US medical students have international health experience before starting residency and the availability of international electives has been ranked as among the most important factors in their choice of residency program (Duncan et al. 2017). Although an increasing number of residency programs offer international rotations, (overall 59% of the training institutions do), it remains challenging and as few as 10% of residents actually participate. The most common challenges have been reported to be lack of funding, lack of international partnerships, lack of supervision, and scheduling. According to a 2015 literature review, survey-based studies found that the specialties with the highest percentage of residency programs offering global health training were preventive medicine (83%), emergency medicine (74%), and surgery (71%) (Duncan et al. 2017). A web-based study of the 183 accredited US psychiatry residency programs showed that global health training was offered in 17 of them (9.3%). International elective-based rotations were offered in 10 of the 183 psychiatry residency programs. Most global health training opportunities were not departmental initiatives for psychiatry residents but rather externally administrated, institution-wide initiatives available to residents from different clinical specialties (Tsai et al. 2014).

One example of a US exchange program in psychiatry that has been very well received, both by the trainees and their institutions, is the DC – Valparaiso Connection. The University of Valparaiso in Chile (UV) opened their first training program in child psychiatry in 2008. Four years later, exchange programs were formed with two child and adolescent training programs in Washington, DC, USA, Children's National Medical Center (CNMC) and Georgetown University (GU) School of Medicine. During the first 4 years, seven trainees and three faculty members from UV traveled to Washington, DC for an average period of 6 weeks. The trainees rotated through inpatient units, consult-liaison programs, outpatient services, and specific programs targeting immigrant populations, autism, ADHD, and gender variance at several institutions. Traveling in the opposite direction, five trainees and four faculty members went from Washington DC to Valparaiso for an average of 2 weeks. Faculty from Washington DC and Valparaiso visited their counterparts and presented in conferences. The participating training programs in Washington, DC support the learning objectives to help develop global perspective, improve Spanish skills, and observe mental health interventions applicable to immigrants and Hispanic populations in Washington, DC (Table 1). By building up a program with a formal agreement and including both residents and faculty, strong relationships have been built between the participating institutions. The program has allowed trainees from Valparaiso to meet leading researchers and experience care models in centers with greater resources and technologies. For the participants, the exchanges broaden their view toward an integral understanding of the patients and their environment (Parada 2017; Cohen and Ortega 2017).

Table 1 Exchange programs, scope and participants

Program	Scope	Region	Participants annually
Erasmus+	Masters and PhD students	Worldwide	Over 50,000[a]
IFMSA	Medical students	Worldwide	Over 10.000
EFPT	Psychiatry trainees	Europe to Europe	84[b]
EPA gaining experience	Recently specialized psychiatrists	Europe to Europe	5[b]
Hippokrates/ FM360°	Trainees/ recently specialized GP/FM	Europe to Europe/ global	Not available
DC-Valparaiso connection	Psychiatry trainees and faculty	US to Chile Chile to US	2–3[c]

[a]Data from 2014
[b]Data from 2016
[c]Approximation

Practical Aspects of Undertaking an Exchange

Exchange experiences can vary widely in terms of their duration, with short-term programs of 1 week up to 3 months, and long-term stays for 6 months up to 1 year. The wide range of flexibility allows applicants to organize their stay abroad in the way best suited to their living and working conditions. Typically, short periods of training abroad are preferable during postgraduate training in order to overcome difficulties with funding, and obtaining time off, both from family and professional responsibilities. There is currently no evidence available if these longer duration stays result in higher benefits than the shorter "sniffing periods." One may imagine that a longer stay will possibly lead to better mastery of the foreign language or specific skills. Besides the duration, the nature of the exchange experience may also have a significant influence. In some cases, the time abroad consists of pure theoretical courses. For other participants, it may concern clinical work, either as an active observing companion to a local clinician without directly interacting with a patient or even actual residency/internship. Most of the larger existing exchange programs focus on the more readily mobile undergraduate students. Exchange programs less frequently appoint postgraduates, already involved in clinical work, though potentially more beneficial for their professional development. It allows participants to get a true grasp of the reality of the foreign healthcare system.

A frequently heard comment, limiting taking part in an exchange is the amount of work one has to put in to adequately prepare everything. Indeed, there are big differences in the support offered by different programs. Sometimes the whole exchange organization depends on the participant's own initiative, from establishing contacts to set up practical arrangements. Previously, potential applicants were largely dependent on existing bilateral agreements between theirs and a second institution. Current international communication facilities and access to information make it easier for interested applicants to organize and shape their own exchanges.

Furthermore, within the European Union, visa-free travel and automatic recognition of qualifications have greatly reduced the administrative burden for those wishing to organize their exchange.

At an undergraduate level, elective rotations abroad are very attractive. Accreditation for mobility programs of 6–12 months duration is common and well established. Participants of the Erasmus Program are guaranteed recognition of their time spent abroad by their own university. However, at the postgraduate level, there is no international accreditation system yet. The WFME states within its global standards for postgraduate medical education that as a basic standard, training program providers must "*formulate and implement a policy on accessibility of individual trainees to education opportunities at alternative training settings within or outside the country.*" Training program providers should also "*facilitate regional and international exchange of trainers and trainees by providing appropriate resources*" and "*establish relations with corresponding national or international bodies with the purpose of facilitating exchange and mutual recognition of education elements*" (WFME 2015). Furthermore, the UEMS Section for Psychiatry wrote in its Charter on training of Medical Specialists in the EU: "*Trainees should have the opportunity to be trained in recognised training institutions in other EU member states during the training with the approval of their training program by the national authorities of their country of origin. National authorities can recognize training in non-EU countries*" (UEMS 2003).

Notwithstanding these standards and guidelines, to spend time abroad at a postgraduate level currently still mainly depends on bilateral agreements. Hence, there is a large variation in the way exchanges can be organized. Overall, training abroad in psychiatry seems optional at best and largely reliant on the own initiative of the trainee. In some countries, the time spent abroad can be integrated as a full part of an existing training program upon agreement with individual institutions and training program directors. However, because postgraduate curricula in most countries worldwide neither make provision for nor accredit training taken abroad, creativity, and goodwill among trainees and seniors are required to make an exchange experience a success (Casanova Dias et al. 2013). Organizing the exchange will have to fit in training requirements and clinical work responsibilities. This will ultimately limit the flexibility to arrange the exchange experience in the best possible way. Not surprisingly, many trainees end up using their annual leave allowance, ranging from 2 to 6+ weeks per year for the wished-for exchange.

Other major barriers may be some practical limitations such as having to obtain a visa, lack of transportation, finding affordable accommodation, and health issues that can occur during the stay in a foreign country. Many of the above-mentioned programs indeed are financially self-supported by participants who are expected to cover their travel and accommodation expenses. However, hosts are often very willing to assist participants in providing budget-friendly options for accommodation. Language requirements may vary depending on the program and country one wishes to visit. Most programs require the applicant to be fluent in English. Some knowledge of the local language is helpful but may not be compulsory. A certification of language skills upfront either through internationally validated and certified

language proficiency tests or through a skype assessment interview with the local hosts may be required.

Data gathered from 76 participants of the EFPT Exchange Program between 2013 and 2016 indicate that for 55.3% of participants, the language of the host country was one of the main reasons for participants to choose a specific destination country. Nevertheless, over one-third of respondents stated that they did not speak the language of the host country at all prior to the exchange experience. Questioned on the impact level of a possible language barrier on their exchange experience, only 5.3% of participants felt that this barrier was a relevant issue when relating to staff at the host site. However, 31.6% perceived language as problematic in the communication with patients, regardless of their level of fluency in the host language. Participants without prior knowledge of the language were significantly more likely to perceive the language barrier as a "big issue" during their exchange (see Table 2; EFPT Exchange unpublished data).

For many participants, the exchange program may be the first time they have to face living and studying in another country. Even with preparation and knowledge about the new environment, participants may still experience a significant *culture shock*, a term first used in the 1960s by Oberg to define an "*occupational disease suffered by those suddenly immersed in a culture very different to their own [. . .]*" (Oberg 1954) and could cause "feelings of helplessness, irritability, and fears of being cheated, contaminated, injured or disregarded" (Adler 1975). It was seen as an illness with "its own etiology, symptoms, and cure" (Oberg 1954). Several models were designed to describe the adaptation process, such as Oberg's four phase-model (identifying "Honeymoon," "Hostility," "Adjustment," and "Recovery" phases) (Oberg 1960); a "U-curve model"(Lysgaard 1955) and a "W-curve model" (Gullahorn and Gullahorn 1963) – a W-shaped seven-stage model which describes a traveler's rollercoaster of emotions when entering a new culture, as well as the re-entry shock experienced when returning home.

Since then, the term "culture shock" has become widely used in the popular vocabulary but may encompass a wide range of emotions. In some cases, "fatigue,"

Table 2 Pre-exchange fluency in language of host country and perceived language barrier in communication with staff and patients at the host site ($n = 76$)

Level of fluency in the language of the host country prior to exchange (self-indicated)?		Problematic language barrier perceived with host country staff	Problematic language barrier perceived with host country patients
Advanced (%)	40.8	0	6.5
Basic / intermediate (%)	27.6	9.5	28.6
Did not speak the language (%)	31.6	6.5	51.6

"stress," "homesickness," or frustration due to not being able to function effectively in a foreign language seem to be more appropriate terms. Such negative emotions can affect the learning curve abroad negatively. Attributing feelings of discomfort to cultural differences, appealing as it may be, may also prevent travelers from reflecting on the true causes of their discomfort. It may lead them to pay more attention to differences than similarities, to experience more hostility than openness, etc. Some studies conducted in the context of the Erasmus program have found that participants' discomfort varies strongly and cannot be automatically attributed to culture shock as expressed in the following conclusion: "*the individual journeys of the sojourners can be extremely varied, and are affected by a large number of internal and external factors, such as motivations, expectations, personality, coping strategies, skills, specific characteristics of the environment, and chance, among others*" (Beaven 2012).

Shortcomings of Exchange Programs

Some have argued that exchange programs solely benefit a small niche or elite of healthcare professionals who can afford to travel often. Even a seemingly highly democratic program such as the Erasmus Program, which waives participants' tuition fees at the university they visit and provides grants to help cover the expenses of living abroad or extraordinary expenses for students with disabilities, cannot escape this criticism (Ballatore and Ferede 2013). Despite its apparent numerical success – as of 2012, Erasmus students represented 5% of all European graduates – several studies have raised questions regarding the representativeness of the Erasmus participants and their selection process. Studies researching the socioeconomic background, level of study, and academic performance of Erasmus participants have found that although access to the program has progressively widened, financial issues and family background still count as important barriers to participation in the program (Otero 2008). Certainly, exchange programs should be aware of these potential selection biases, and efforts should be made to encourage students from diverse socioeconomic backgrounds to apply. Yet many initiatives aim at reducing expenses and increasing mobility and help to overcome financial barriers. Free websites offer students and young people opportunities to rent, sublet, offer, and swap accommodation. The successes of several independently run small exchange programs that currently cannot offer scholarships on a regular basis indicate that exchanges are possible even on a very low budget.

However, an aspect to consider is that the beneficiaries of an exchange are not limited to those who have the possibility of traveling. The exchange of skills and experiences takes place at a local level between the host team, their institution, and the exchange participant. Since many programs require the exchange participant to share learnt experiences upon return, reporting adds an international layer of beneficiaries belonging to the sending institution but unable to travel.

Another frequently heard criticism is that observerships abroad are not much more than tourism dressed up as work, or simply a means for participants to "add yet

another line to their CV." Countering this argument is the explicit importance given by every exchange program mentioned above to formal procedures enveloping the exchange experience, aimed at optimizing the learning outcomes. This can be in the form of formal evaluations, such as in the Erasmus programs, or in the case of clinical observerships, through requirements such as work place based assessment for the portfolio, or to prepare a presentation to be performed upon arrival at the host institution, containing information on the participant's country, the education and institution and areas of best practice, as well as to write a report and/or present about their experience to their colleagues at home upon return.

Finally, questions have been raised related to the societal costs of these programs, both in terms of the burden they place on the hosting and sending organizations, as well as the risks related to the promotion of mobility in a profession where skilled staff are a scarcely available resource – potentially adding to the negative consequences of brain drain in certain countries (Pinto da Costa et al. 2017). There are indications that short term mobility experiences such as those acquired through exchange programs can influence psychiatry trainees' attitudes in favor of migration later in life (Pinto da Costa et al. 2016). However, mobility of medical doctors can be demonstrated to have both positive and negative effects on healthcare systems. When staying abroad is temporary and with the purpose of achieving new experiences and additional training, followed by a return to the home country, the effects are usually beneficial for the country of origin. On the other hand, in the case of a long-term exchange, when the participant's home country is struggling with shortages of medical staff, the healthcare system will be affected in a negative way. And if the exchange leads to subsequent migration, next to losing a trained professional, this country will face the financial loss having paid for their education. Consequently, a lack of or misdistribution of medical staff will impact patients' access to care (Costigliola 2011). Still, although there are indications that short-term mobility experiences such as those acquired through exchange programs are positively correlated with future mobility and migratory experiences, it has never been proven that the availability of exchange programs adds to brain drain. On the contrary, healthcare professionals participating in an exchange early in their career have been reported to be more likely to opt for a career in public service, and to demonstrate increased awareness of resource use and of the impact a healthcare system has both on patients and staff (Mutchnick et al. 2003; Jeffrey et al. 2011). These features set them out as key players who can help to improve healthcare organization in their own country, thereby potentially reducing brain drain in the long term.

Implications and Recommendations

The UK's General Medical Council has acknowledged the need for medical professionals to be equipped to work in a globalized world by recognizing global health competencies as crucial to doctors' capabilities in health promotion and illness

prevention (GMC-uk.org). A recent consultation (Walpole et al. 2016) highlighted five core global health competencies for doctors.

They include being informed about different health systems, such as key differences between a private and a public healthcare system, how these differences impact on the life and task of a health professional. Core competencies also include the need for professionals to be aware of diversity, environmental, social, and economic determinants of health, to appraise disease epidemiology, and matters of health governance at a global scale. Participating in a hospital internship abroad is currently perceived as one of the best ways for a professional to effectively learn how a country's healthcare system impacts on a healthcare professional's practice.

Exchange participants will grow as professionals, having had the opportunity to further improve their professional skills in specialized fields of psychiatry, less developed or unavailable in their home country, and on occasions, apply reverse innovation. Participants have mentioned their intercultural awareness was enhanced by the exchange experience and value their increased knowledge in transcultural psychiatry specifically. They will learn to explore and reflect on differences in attitudes, in treatment recommendations, and in mental health care organization. The acquired competencies both in specific skills and knowledge of transcultural aspects, as well as the increased sense of initiative and level of self-empowerment, and improved foreign language competences governed through the exchange experience, will improve a participants' position on the labor market and career prospects both in their own country and abroad.

Furthermore, as acknowledged by the Council of the European Union in its recommendations on learning mobility, "*those who are mobile as young learners*" are more likely to be mobile as workers later in life, and demonstrate increased sharing of best practices and knowledge with colleagues both at home and abroad, for instance, in international networks. (Council of the European Union 2011b) As such, trainees that have the opportunity to work abroad at an early stage may benefit from this experience throughout their further careers, as from our own anecdotal experience we have witnessed these trainees as the ones who will continue to demonstrate a transnational perspective, taking on active engagement in international networks and organizations.

Remarkably, 35.5% of EFPT Exchange participants surveyed between 2013 and 2016 indicated they had already taken part in an Exchange or Mobility program before their application to EFPT Exchange. This contrasts with the 5% of the general higher education student population that make up the Erasmus participants, possibly highlighting a bias towards mobility fostering future mobility.

With the majority of exchange programs taking place in Europe, there is potential for development in other areas of the world. This will probably require different exchange formats to address local educational needs and fit in with existing training formats.

In its final conclusions on the matter of learning mobility, the Council of the European Union has convincingly chosen to support exchange programs, stating that "*providing the widest possible access to mobility for all, including disadvantaged groups, and reducing the remaining obstacles to mobility constitute one of the main*

strategic objectives [. . ..] in the field of education and training" (Council of the European Union 2011a). Further research on the impact of exchange programs during mental health professionals' training is needed to determine the actual educational value and outcomes of international rotations. It is our hope that the continuous gathering of data on the contribution of exchange programs might not only contribute to the personal and professional development of individual participants, but also to a greater collective professional identity of specialists in psychiatry and lower the stigma. These data also might deliver strong evidence for the implementation of exchange programs in the curricula of all mental health professionals.

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