



Brain Exchange: Bidirectional Flux of Medical Personnel to Ensure Equitable Distribution of Resources between Developed and Developing Countries

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Abstract

This article is intended to address the plummeting numbers of trained medical personnel in developing countries due to exodus to developed lands often termed as 'brain drain' and to put forth ideas and suggestions that turn this brain drain into 'brain exchange' thereby benefiting both the donor and the recipient countries. A few suggestions presented here may help in creating an equilibrium of such efflux and influx of such medical personnel, thus completing the so-called 'brain circulation.

INTRODUCTION

This article aims to bring to light the often heard yet poorly understood, and to some extent, an archaic concept of 'brain drain' and how it snatches away health resources from low-to-middle-income countries (LMICs). The article further goes on to throw light on the phenomena of brain exchange, a positive flip to the term 'brain drain', the latter having negative connotations attached to it. Brain drain is the migration of skilled human resources from a relatively developed country to a relatively developing country in areas like science, health, business, engineering and other professional fields. Drain of the precious brain occurs due to better standards of living and quality of life, higher salaries, access to advanced technology et cetera. Developing countries invest huge capital in the education and training of young professionals; migration of such professionals after completing their education and serving some foreign land becomes a growing concern for such developing countries. This results in the loss of considerable resources when such professionals migrate, resulting

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in direct benefit to the recipient country who has not borne any cost of educating them. Such professionals who choose to migrate are some of the most expensive resources because of their training in terms of material, cost and time.

Due to their limited resources and less attractive job opportunities, developing countries cannot keep their sharpest brains away from such migration. Such an exodus leads to deterioration of the economic growth of developing countries. To overcome this problem the phenomena of 'brain exchange' must be brought to the foreground. Brain exchange is the mutual exchange of professionals across countries that helps benefit both nations.

In order to harness the medical workforce better, it becomes imperative to pay attention to some key points that may be helpful in promoting 'brain exchange' and thereby completing the loop of 'brain circulation' within the donor and recipient countries. The COVID-19 pandemic saw a surge in the use of online technologies for delivering education to trainees as well as for diagnostic and treatment purposes in the form of telepsychiatry. Such technology can be furthered in organizing large-scale symposia and conferences for medical professionals and clinicians which can act as platforms for discussion and a bidirectional flow of knowledge and experiences. Such conferences can incorporate guest lectures delivered by renowned faculty, case presentations and brief online training organized for trainees and clinicians alike. In this digital world, any exchange is possible across the globe. If policymakers can regulate the transfer of data safely then it can open several avenues of brain exchange. Virtual brain exchange can also occur without the physical migration of professionals. It can be utilized for both learning as well as for earning purposes. For example, a doctor from a country can give online consultation to a country with poor medical resources and in turn save many lives which would also be a cost-effective method for people who can not afford expensive medical facilities.¹

For both sides to benefit, it must be considered the differences in the medical curriculum and training programs in the two countries. Hence, rather than the graph being lopsided to one country with early career psychiatrists and clinicians from LMICs

migrating to HICs, exchange programs in the form of externships and observerships with a bidirectional flux of clinicians for short durations could be put into place. This would help the respective clinicians familiarize with the health care delivery system of the other country, thereby ensuring equity in health care.

While there are standard diagnostic guidelines in Psychiatry, diagnostic approaches may vary from country to country and among different cultures. Cultural factors also affect presentation of psychiatric illness. This is where exchange programs may help. Such programs may familiarize the clinicians with the foreign country's culture and how it affects presentation and diagnostic approach. This would help them evolve as better clinicians putting a comprehensive world view into the picture while treating a patient.

A young psychiatrist, Dr Anurag Senger from India, shared his own experience of being invited to Bhutan during his post-graduation in psychiatry for a month's duration so that he could share his experiences with Psychiatry postgraduates in Bhutan. In return, they would also have sent their candidates to his institution for a mutual learning process. This would have improved the relationship between the two countries and created an environment for mutual learning. Termed the 'Postgraduate exchange programme', it could have been a great opportunity for individuals of both countries. Unfortunately, due to the Covid-19 pandemic, this could not be implemented.

Many HICs do not recognize/partly recognize the degrees earned by migrating clinicians from their parent countries. This puts the clinician in a fix, who has to undergo a training program in the recipient country for a certain number of years, leading to wastage of resources and a loss at both ends, since the already trained clinician could have well contributed to the existing workforce in delivering health-care. In lieu of this, brief fellowship programs can be initiated in the recipient country. This will not only help the clinician hone their existing skills but also help boost their confidence during the distressing phase of acculturation.

I would like to draw your attention to one such travel fellowship initiated by the Indian Psychiatric

Society. Two fellows are chosen yearly to undergo a brief training lasting for 2-4 weeks at the institution and subspecialty of their choice.² This fellowship helped the fellow gain useful insights into perinatal mental health and effective management of psychological conditions in the perinatal period. Psychiatry is considered a 'terminal' branch and the need for super (? sub) specialization is not so much in the current times. Super specialization courses are time-consuming and robs the healthcare system of general psychiatrists, the numbers of which are already quite low in many developing countries.³ Ergo, such short-term fellowships, like the one mentioned above, might be a solution to cater to the population's growing needs, serving a dual purpose of creating specialists whilst maintaining a sufficient pool of qualified psychiatrists in the country.

Major governing bodies in the mental health field in various countries should encourage interested Psychiatrists of Indian Origin (PIO) to start an online platform for delivering regular, high-quality lectures to trainees and clinicians in their parent countries. This would ease the burden on the LMICs who are already reeling under the pressure of low human resources and help aspiring trainees gain useful insights into the other side of the world, one of the reasons for relocation.

The donor countries should recognize the contribution made by the expatriates in their respective fields. They may be felicitated if they decide to return to their parent country. This would put an impetus on other migrant clinicians in returning to their country of origin and help fill the void in health care delivery services.

Research plays an important role in generating good quality evidence for effective treatment and management. The two countries can participate in such research together to be more comprehensive and holistic. This will increase the population pool of the study as well as such studies could be undertaken on a larger scale, thus generating high-quality evidence.⁴ Some authors have also noted that expatriate scientists and clinicians publish more papers than those in the host countries, thus contributing more to the pool of scientific literature.⁵ The host countries can harness such skills of research and participation in clinical trials gained over years of working in foreign lands by expatriate clinicians.

Last but not least, one of the major reasons for the exodus of doctors from developing countries to developed ones is a desire for political stability, escape from political upheaval, better funding for research programs and good governance. Recipient countries can help their case by financial funding and provision of appropriate infrastructure for researchers whilst the host country can pitch in with highly skilled manpower of clinicians, thus both working as 'commensal'.

To conclude, exodus among medical personnel has become quite common of late and the reasons are manifold. While this benefits the recipient country, the native country suffers from a lack of trained medical manpower. This article furthers the case of the original article by pondering on underlying issues and delivering suggestions as to how this process of 'brain drain' can be converted into 'brain exchange'. In a nutshell, proper planning regarding brain exchange and meticulous implementation by the policymakers of different nations can really change the global perspective. In this era, talented brains with immense capabilities are underutilized by their own nation and in this brain, the exchange can be a real game changer

Conflict of Interest None

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