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Finding a voice in UK academic psychiatry: perceived barriers and facilitators to engagement among Indian international medical graduates

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Received: 26 April 2026 / Accepted: 31 August 2026
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Abstract

Background Academic psychiatry in the UK is in a precarious situation with diminished academic to clinical posts. There has been a growing reduction in psychiatrists engaged in academia in the last 25 years. This has coincided with increased growth of International Medical Graduates (IMG) working in UK psychiatry. IMGs may face unique barriers to involvement in research, which may contribute to the academic gap. IMGs from India form the largest minoritised ethnic group among UK psychiatrists. This study explores interest in and perceived barriers and facilitators to academic engagement among IMGs of Indian origin working in psychiatry in the UK.

Methods A questionnaire with 14 questions was developed with the British Indian Psychiatric Association (BIPA) members. It was disseminated online among IMG psychiatrists of Indian origin. A non-discriminatory exponential snowballing technique leading to non-probability sampling was used to distribute the survey in electronic form. The survey was disseminated via a convenience sampling approach, including through local professional networks. The questionnaire covered professional characteristics, past non-UK academic involvement, and perceived interest in and barriers and facilitators to engagement in academic psychiatry in the UK. Quantitative analysis explored: non-UK academic activities including by gender; self-reported interest in academia at the time of arrival in the UK and at present; differences in self-reported interest according to gender, region of work, prior research involvement, and years of psychiatric experience/grade. Thematic analysis of free-text responses using Braun and Clarke's methodology was undertaken.

Results Of 89 respondents 61% reported prior, non-UK academic involvement. Male gender and having prior academic experience were significantly associated with greater academic interest at UK entry. Perceived barriers were cultural and discriminatory, structural and navigational, and capacity and resource related. Facilitators included motivation to contribute to evidence-based practice, improved balance between clinical work and research, increased opportunities, and a supportive research culture.

Conclusions IMG psychiatrists of Indian origin are motivated to engage in research but face challenges and perceived barriers of cultural, discriminatory, and job planning factors. Similar surveys are needed to capture

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the unique experiences of other diaspora groups working in psychiatry to address the glass ceiling of clinical academic engagement.

Keywords Immigrant doctors · Immigrant psychiatrists · Indian psychiatrists · Academic psychiatry

Introduction

The importance of academic psychiatry and its current situation

Academic psychiatry generates new knowledge and evidence, which can be translated into practice to improve patient outcomes [1, 2]. Research capabilities are important among medical professionals [1, 2]. Not only does a more research-active psychiatry workforce contribute to improved evidence-based practice, it also cultivates an organisational culture of enquiry and improvement, resulting in better patient care [1, 2]. A research-engaged psychiatry workforce could help address important mental health challenges and is key to the specialty's future [2]. However, despite the numerous scientific advances over the last decade, there has been a concerning reduction in the clinical academic workforce [3].

From 2004 to 2023, the number of academic psychiatrists fell from 330 to 206, representing a 37% reduction [4]. This happened despite the number of UK medical schools increasing from 30 to 46 and the number of medical students increasing in this time [2]. This may be in part due to the number of Senior Lecturer, Reader, and Professor posts decreasing by 35% since 2006 [5]. It is unclear whether this is mainly due to reductions in university or NHS spending, or both [5]. However, there are also concerns about whether interest among medical students and clinicians in pursuing psychiatry or academic psychiatry could play a role. Factors that may contribute to this include limited Integrated Academic Training posts, inadequate doctoral funding, and concerns about combining clinical and academic work [5].

The role of international medical graduates and the problems faced by them

Within this landscape, the role of international medical graduates (IMGs) becomes particularly salient. IMGs form a substantial proportion of the workforce in the National Health Service (NHS), with over two-thirds of all doctors joining the UK workforce between 2022 and 2023 being non-UK graduates [6]. This is especially true in psychiatry, where 39% of Royal College of Psychiatrists members are Black (6%), Asian (27%) or other IMGs of minoritised ethnic background [7]. Nearly half (44%) of trainees in psychiatry at the start of this decade were IMGs [8].

IMGs bring valuable, global experience and diversity [8]. However, IMGs often face unique structural, cultural, and organisational barriers, which may prevent full participation in UK academic psychiatry [8, 9]. The literature points to several challenges of IMGs in the NHS, including career progression, adaptation to new teaching and learning styles, examination hurdles, and psychosocial stressors [10]. Furthermore, in an analysis of data from General Medical Council databases and the 2019 National Training Survey, there was reported to be a 'very low' number of academic trainees who were IMGs [11]. At more senior levels, academic trainees are significantly more likely to be of white ethnicity, although among UK graduates, no ethnicity differences were seen, suggesting that graduating outside of the UK was an important factor [11].

Speciality, Associate Specialist, and Specialist Doctors (SAS) doctors also face unique barriers to research, given that the focus of their role is on delivering clinical care [12]. Most SAS doctors in the UK are IMGs and of minoritised ethnicity, meaning the challenges faced by these groups are likely to be further exacerbated in academic psychiatry [12]. In addition, IMGs may struggle with the cultural nuances and formal syntax required for high-level academic writing and peer-to-peer communication [13].

Psychiatrists of Indian origin

Indian psychiatry is recognised to have provided extensive and pioneering research that has made significant contributions to global mental health despite major economic and resource challenges [14, 15]. Indian psychiatry has had a considerable influence on World Psychiatry and the World Health Organization's (WHO) mental health agenda by contributing to the development of the cultural bases of psychiatry through the work of many eminent researchers [16]. It is recognised that psychiatrists who come from India to the UK have been well exposed to academic psychiatry because, in India, training is provided by universities [15]. Thus, the experiences of Indian psychiatric IMGs are uniquely placed to highlight the structural and institutional challenges of UK academic psychiatry in being inclusive and equitable particularly for non-UK medical graduates.

Objectives

This study aimed to:

- 1) Explore perceived facilitators of and barriers to involvement in academic psychiatry by IMGs of Indian origin.
- 2) Characterise self-reported interest in academic psychiatry at the time of arrival in the UK and at present among UK-based IMGs of Indian origin.
- 3) Explore whether self-reported academic interest (at arrival, at present, and change over time) may differ according to gender, region of work, prior research involvement, and years of psychiatric experience/grade.

Methods

The Strengthening and Reporting of Observational Studies in Epidemiology (STROBE) checklist for cross sectional studies was used to design and execute this study (*related file: STROBE*).

Design and distribution

The questionnaire used was developed for this study (Supplementary information 1). The questionnaire was developed collaboratively by the authors and by a group of relevant stakeholders who were members of British Indian Psychiatric Association (BIPA). Questions were selected based on their relevance to the study objectives and assessed for face validity by the stakeholder group to ensure that they were understandable and appeared appropriate for capturing the outcomes of interest. No formal validation against an established instrument was undertaken prior to use.

BIPA is a diaspora organisation in the UK, which was established over 25 years ago to provide support to and represent psychiatrists of Indian origin, and to promote mental health awareness in the community. BIPA is recognised as one of the largest psychiatric diaspora organisations in the UK, second only in size to the Royal College of Psychiatrists. It is continually growing, with a current membership of professionals most of whom are first generation IMGs. More information about BIPA's aims, activities, and events can be found on its official website: <http://www.bipa.org.uk/>.

The survey was developed on the Google Forms platform. The average completion time was approximately ten minutes. The survey was online from 18th of March 2025 to 21st of August 2025. The survey questionnaire consisted of 14 questions related to the demographic characteristics of the respondents (e.g. job role, region in which they work), their past non-UK academic involvement, their interest in academic work, and their perceived barriers and facilitators to academic engagement.

Members were contacted via the official membership database and asked to promote it to other suitable and eligible participants. This encompasses Consultants, SAS Doctors, and resident doctors, all of whom are IMGs

and who have previously provided institutional consent to receive communications regarding BIPA-led projects and research. Two reminders were sent. To ensure ethical rigor, all participants were required to provide explicit informed consent at the start of the survey for the anonymised responses to be used in subsequent publications. This dual-channel approach leveraged both formal and informal networks to maximise reach while maintaining strict adherence to participant confidentiality and data protection standards.

Sample

Inclusion criteria were: [1] medical doctors currently practising psychiatry in the UK of first-generation Indian origin, and [2] those possessing a primary medical qualification obtained outside the UK.

Ethics and consent

Institutional ethics was obtained from University of Kent, School of Psychology ethics committee (ref: 2026177635357210551). The project proposal was also reviewed and approved by the BIPA executive committee. A non-discriminatory exponential snowballing technique leading to non-probability sampling was used to disseminate the survey in electronic form. The survey was disseminated via a convenience sampling approach, including through local professional networks such as BIPA. No participant identifier data was collected. Further, the participant group was made up of medical professionals where consent was implicit by participation. All participants were advised at the start of the study that participation was voluntary, and informed consent would be presumed if the survey was submitted. If they chose to participate, data would be pooled, anonymised, and analysed. Explicit consent to participate, and to use data anonymously for research and publication was obtained. This was obtained in a written format, with participants ticking a box if they consented for their responses to be used for these means.

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2013.

Data analysis

Quantitative

All quantitative analyses were conducted in R version 4.4.0. The characteristics of respondents were summarised using descriptive statistics. Responses on a 5-point Likert scale of self-reported interest in academia (with higher scores reflecting greater interest) were summarised by median and interquartile range (IQR) as measures of central tendency and variability.

Change in self-reported interest in academia upon arrival to the UK and at present was compared using the Wilcoxon signed-rank test for paired data. Items 11 and 12 of the questionnaire were used for this (*Supplementary information 1*). Effect size was calculated using the matched-pairs rank biserial correlation (r_b), which quantifies the magnitude of within-participant change. A Chi-squared test was used to assess the distribution of prior engagement in academic activities outside of the UK (Y/N) by gender.

Wilcoxon rank sum tests were used to compare self-reported academic interest at UK entry, at present, and the change between these time points across gender, region (London vs. non-London), and prior research involvement. Boxplots were generated to visualise these differences using the ggplot2 package in R. Wilcoxon rank sum tests were also used to compare self-reported academic interest at present according to psychiatrist seniority (consultants/SAS doctors vs. residents) and years of experience in psychiatry (<15 years vs. ≥15 years).

Qualitative

The study qualitatively explored participants' free-text responses to two questionnaire items: “*Can you identify (up to) three things that might encourage you get involved in psychiatry academia?*” and “*Can you identify (up to 3) issues that might have been barriers to you getting involved in psychiatry academia?*”. Participant responses were thematically analysed for each question separately, following Braun and Clarke's (2006) six-step framework [17]. This method enabled flexible pattern identification despite participants' short answers. An inductive approach was used, with codes generated directly from the data.

Initially, two authors (*MD* and *MM*) independently read responses to familiarise themselves with the data before generating codes from patterns that emerged from the data. Related codes were then iteratively grouped into categories and subsequently refined into themes and subthemes through discussion and comparison of interpretations. *MD* used *Taguette* (open-source qualitative analysis software), whereas *MM* used *NVivo* 1.7.2 software to manually induct codes from the data and to organise these into themes and subthemes. Coding decisions and theme definitions were discussed, and disagreements were resolved in consultation with a third researcher (*PT*).

Results

A total of 91 participants completed the survey. Two respondents' data were removed because they did not meet the inclusion criteria. One had retired from clinical practice, and one reported their undergraduate degree to have been in the UK.

Among the 89 remaining participants, 71% (63/89, 71%) were male and 83% (74/89, 83%) held consultant positions. 82% (73/89, 82%) had 15 or more years' experience in psychiatry. The most represented regions were London and the West Midlands (Table 1).

Of the 89 participants, 75 provided information on the country in which they completed their primary medical qualification. Among these, 71 (71/75, 95%) had trained in India, while the remaining four participants trained in China, Egypt, Nepal, and Turkey. These participants were of Indian origin and therefore met the study's inclusion criteria (first generation Indian origin and possessing a primary medical qualification obtained outside of the UK).

Interest in academia

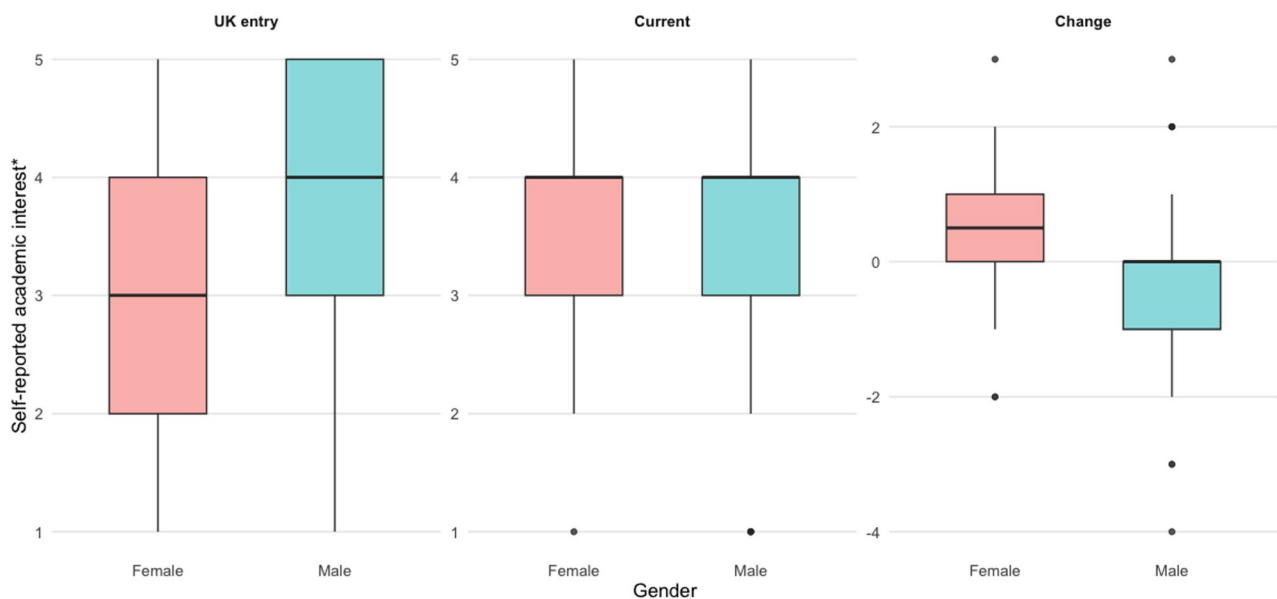
There was no significant difference between self-reported academic interest from UK arrival (median=4, IQR=3–5) and at present ((median=4, IQR=3–4), $V=682$, $p=.952$, $r_b=0.037$). 61% (54/89) of respondents reported prior engagement in academic activities outside the UK (Table 1). There was no significant association between gender and prior engagement in academic activities outside of the UK ($\chi^2(1, n=89)=1.75$, $p=.185$, $\phi=0.09$).

Gender

Males (median=4, IQR=3–5) had a significantly higher self-reported academic interest on UK arrival than females ((median=3, IQR=2–4), $W=590$, $p=.034$, $r_b=0.28$). However, there was no significant gender-based difference for self-reported academic interest at present ((males: median=4, IQR=3–4; females: median=4, IQR=3–4), $W=801$, $p=.870$, $r_b=0.02$). Females (median=0.5, IQR 0–1) had a greater increase in self-reported interest in research from UK entry to present than males ((median=0, IQR=1–0), $W=1035$, $p=.043$, $r_b=0.26$) (Fig. 1: *self-reported academic interest by gender*).

Table 1 Characteristics of respondents (n=89)

Characteristic	% (n)
Gender	
Male	71 (63)
Female	29 (26)
Level	
Core training (CT1 to CT3)	4 (4)
Higher training (ST4 and above)	3 (3)
SAS doctors	9 (8)
Consultant	83 (74)
Years worked in Psychiatry	
Less than 5 years	18 (16)
15 or more years	82 (73)
Start of work in the UK	
Before 2000	30 (27)
2000-2010	48 (43)
2011-2020	9 (8)
2021 onwards	12 (11)
Region in UK	
London	20 (18)
West Midlands	20 (18)
East of England	10 (9)
North West	10 (9)
Yorkshire and the Humber	10 (9)
East Midlands	9 (8)
North East	6 (5)
South West	6 (5)
Wales	6 (5)
South East	3 (3)
East Anglia	0 (0)
Prior involvement in academic activities outside of the UK	
Yes	61 (54)
No	39 (35)

**Fig. 1** self-reported academic interest by gender

Region

There was no significant region-based difference for self-reported academic interest at present ((London: median=4, IQR=3–5; non-London: median=4, IQR=3–4), $W=752$, $p = .236$, $r_{\beta} = 0.18$). There was also no region-based difference in change in self-reported academic interest from UK entry to present ((London: median=0, IQR = -0.75–0; non-London: median=0, IQR = -1–1), $W=556$, $p = .377$, $r_{\beta} = 0.13$) (Fig. 2: *Self-reported academic interest by UK region*).

Prior research experience

Psychiatrists with prior research involvement (median=4, IQR=3–5) reported significantly higher academic interest on UK arrival than those without prior involvement ((median=3, IQR=2–4), $W=489$, $p < .01$, $r_{\beta} = 0.48$). Those without prior research involvement reported a greater increase in interest in research from UK entry to present (median=0, IQR = -1–0) than those with prior research experience ((median=0, IQR = -1–0), $W=1230$, $p = .013$, $r_{\beta} = 0.30$) (Fig. 3).

Experience

Self-reported current academic interest did not differ significantly according to years worked in Psychiatry ((<15 years: median=4, IQR=3–4; ≥ 15 years: median=4, IQR=3–4), $W=642$, $p = .524$, $r_{\beta} = 0.10$). There was no significant difference between consultants/SAS doctors compared to resident doctors with respect to academic interest at present ((consultants/SAS doctors: median=4, IQR=3–4; resident doctors: median=4, IQR=4–4.5) $W=164$, $p = .052$, $r_{\beta} = 0.43$).

Facilitators and barriers to engaging in academia

Multiple themes emerged from qualitative analysis of the open-text responses to questionnaire items 13 and 14 (Supplementary information 1; Fig. 4). Barriers generated three main themes, each including two subthemes:

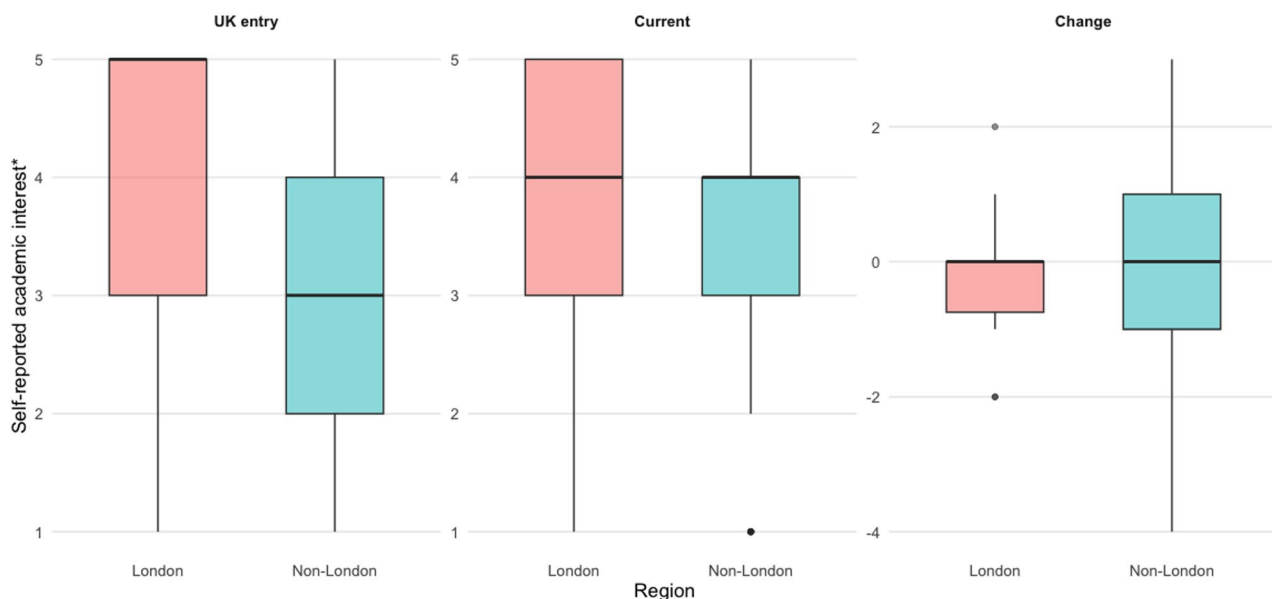


Fig. 2 Self-reported academic interest by UK region

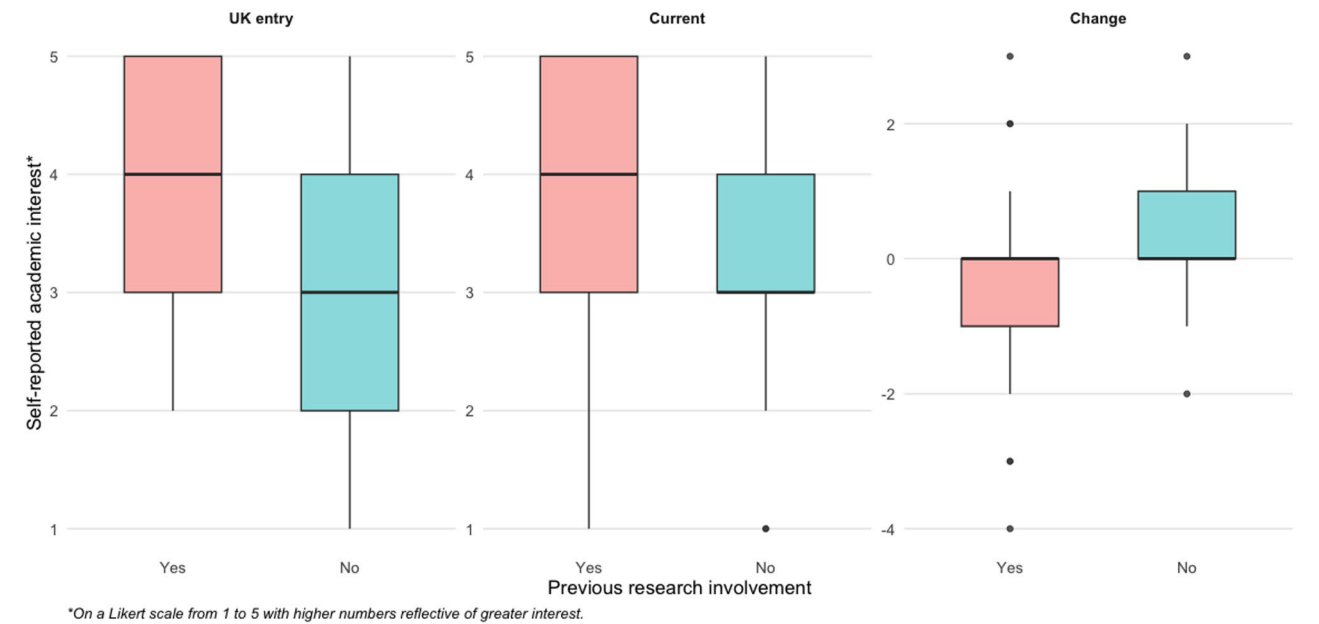


Fig. 3 Self-reported academic interest by previous research involvement

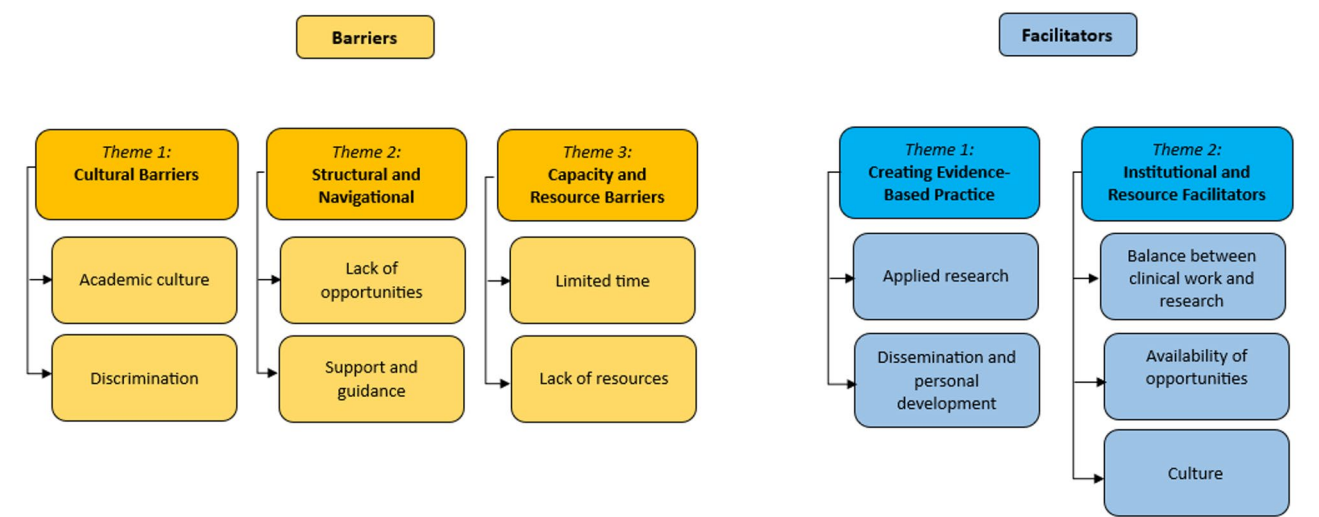


Fig. 4 ...

(a) Cultural barriers, (b) Structural and navigational barriers, and (c) Capacity and resource barriers. Facilitators generated two themes: (a) Creating evidence-based practice and (b) Institutional and resource facilitators. Indicative quotes are available in Table 2.

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Table 2 Indicative quotes and their associated themes, subthemes, and codes

Theme	Subtheme	Codes	Indicative Quotes
Cultural barriers	Academic culture	• Academia is unwelcoming • Unimpactful	<i>"Academic is a very competitive field", "We also need a welcoming attitude from those in academics"</i> <i>"Academia's limited impact on clinical psychiatry- specialty LGBT community in the UK"</i>
	Discrimination	• Racism • Colour • Stereotyping • Favouritism	<i>"Delays in recognition of expertise as a non-Caucasian academic"</i> <i>"Cultural factors like migration"</i> <i>"Racism at workplace"</i> <i>"MGs carry the burden of services while local candidates are prioritised for research opportunities"</i>
Structural and navigational barriers	Lack of opportunities	• Research network • Funding	<i>"Distance of main academia hubs", "access to resources and like-minded peers"</i> <i>"Lack of funding",</i>
	Support and guidance	• Mentoring • Employer support • Knowledge of entry routes • Applying for grants • Publishing	<i>"Lack of any guidance, mentoring", "Unhelpful, non-encouraging professors and researchers"</i> <i>"No clear pathway for getting involved in research research would mean undertaking additional degree (MD or PhD)", "Lack of access and knowledge of who and how"</i> <i>"Getting research funds"</i> <i>"Lack of support from employers"</i> <i>"Getting papers published"</i>
Capacity and resource barriers	Limited time	• Clinical workload • Job plan • Protected time • Work-life balance • Bureaucracy	<i>"Clinical demands and nature of work, busy",</i> <i>"Clinical constraints, Job planning"</i> <i>"personal/work life balance" "children"</i> <i>"Lengthy protocols to get started"</i>
	Lack of resources	• Personal resources: • Confidence • Financial • Knowledge • Training • Language	<i>"Not knowing how to be Smart, focussed and prioritise" "lack of confidence"</i> <i>"cost of living", "Financial commitments"</i> <i>"Lack of education", "no help with research methodology training"</i> <i>"English is not first language"</i>
Creating evidence-based practice	Applied research	• Relevant research topic • Innovation • Patient outcomes • Service development	<i>"Topic of interest"</i> <i>"Research about novel therapies, "AI based personalized clinical care"</i> <i>"Make it related to patient care",</i> <i>"Contributing in research conducting surveys Nd evaluation for service development"</i>
	Dissemination and personal development	• Publication • Sharing (talks and teaching) • Leading own project • Updating knowledge • Expanding horizons	<i>"Easy to do publications"</i> <i>"Sharing of knowledge", "Teaching, giving talks", "practising Specialist skills I achieved over years would be helpful for next generation"</i> <i>"Participation in research studies as investigator"</i> <i>"Updating knowledge"</i> <i>"Expanding horizons of professional career"</i>
Institutional and resource facilitators	Balance between clinical work and research	• Time • Clinical workload • Job plan • Protected time • Financial stability	<i>"Dedicated time", "Time commitment"</i> <i>"Manageable clinical caseloads"</i> <i>"Allocating dedicated SPAs in job planning", "Flexibility and support through job planning",</i> <i>"Make it part of objectives and give time on the job"</i> <i>"Protected time and money outside of clinical duties"</i>
	Availability of opportunities	• Partnerships • Research and teaching opportunities • Recognition • Flexibility • Funding	<i>,"Affiliation to an academic institution", "Affiliation to an academic institution"</i> <i>"Research opportunities", "Better teaching opportunities", "Clinical or Practical teaching"</i> <i>"More opportunities"</i> <i>"Recognition by the employer", "Honorary roles"</i> <i>"Ability to do it remotely"</i> <i>"Funding opportunities"</i>
	Culture	• Support • Mentoring • Knowledge of resources • Pathway • Training	<i>"Encouragement during job planning and appraisal", "The department's openness to research and development"</i> <i>"Good mentoring and guidance on how to enter psychiatry academia", "Hand holding by native graduates"</i> <i>"Mentoring to do projects jointly"</i> <i>"More information on the options along with clinical work", "Easy access"</i> <i>"Training on how to write academic writing", "Help with research methodology"</i>

Barriers

Theme 1: Cultural barriers Participants commented on cultural barriers in academia and their own cultural backgrounds, including two subthemes: (a) Academic culture and (b) Discrimination.

Subtheme: Academic culture Participants described the academic culture as unwelcoming and difficult to access. A participant noted that “*Opportunities (are) only for the research colleagues*”, highlighting an implicit favouritism towards psychiatrists already involved in research. Similarly, another participant expressed the need for a more welcoming academic environment: “*We also need a welcoming attitude from those in academics*”. Moreover, two psychiatrists characterised academia as competitive but also unimpactful, suggesting a perceived irrelevance of clinical practice.

Subtheme: Discrimination A greater number of participants identified their cultural background and education as factors that hindered their academic involvement, stating “*Cultural factors like migration*” and “*Feeling skills from other countries would not be recognised in the UK*”. Participants reported “*racism at workplace*”, “*colour*”, and “*stereotyping*”, while “*IMGs carry the burden of services while local candidates are prioritised for research opportunities*” and “*IMG trainees are implicitly discouraged to take up academic training*”.

Theme 2: Structural and navigational barriers Participants highlighted the structure of academia and its accessibility. Two subthemes emerged: (a) Lack of opportunities, and (b) Support and guidance.

Subtheme: Lack of opportunities Participants reported lacking a research network that would allow them to engage in research activities. They mentioned feeling disconnected from where research is occurring and attributed this to physical distance and a lack of networking opportunities: “*no contact with universities; no effective research network*”; “*working in rural community settings, lack of local networks*”. Furthermore, some participants reported limited funding opportunities, with one participant mentioning “*Research funding issues*” as a barrier to their involvement in research.

Subtheme: Support and guidance Navigational barriers were highlighted. Specifically, many participants reported that accessing the academic environment is challenging without adequate encouragement and guidance: “*lack of support from the employer or research department*” and “*less guidance on teaching and research in (the) UK*”.

Furthermore, some participants expressed feeling uninformed about the process of getting involved with research. A participant stated: “*Right information, current lack of ease of access to right programmes, better awareness of how one could take an academic career and still progress to complete training*”. Participants found that there is a general lack of knowledge on how to get started, “*Lack of understanding/knowledge of what is available or possible*”, which creates a vague picture of whether clear procedural entry routes exist. Additionally, some participants mentioned difficulties in publishing and applying for grants.

Theme 3: Capacity and Resource Barriers This theme centred on resource availability, namely, time and personal resources. Participants identified a range of resources and capacity limitations that hindered academic participation. The emerged subthemes were: (a) Limited time and (b) Lack of resources.

Subtheme: Limited time Most participants reported feeling unable to pursue research activities due to time constraints. They stated they that their job arrangement was dominated by clinical practice, leaving little room for other pursuits, and that they felt they had been working at full capacity. One participant described it as “*Full-time & arduous clinical work*”, while another mentioned “*lack of allocated time*”. Another participant referred to “*personal/work life balance*”, further emphasising the demands of clinical work. Additionally, two participants

commented on bureaucracy and administrative procedures as time-consuming, preventing them from engaging in research: *“Too much administration, bureaucracy”*.

Subtheme: Lack of resources In this subtheme, participants primarily referred to personal resources. Specifically, they identified a lack of training as a barrier to their involvement. A participant noted: *“insufficient knowledge”*. Another cited a language barrier: *“English is not (the) first language”*. Three participants also felt less confident in undertaking research: *“anxiety about outcome and imposter syndrome”*. In contrast, others showed no motivation at all: *“Not relevant as I don’t want to get involved in the first place”*. Finally, three individuals highlighted financial barriers, such as *“needing to concentrate on bills”*.

Facilitators

Two themes emerged from questionnaire item 13: (a) Creating evidence-based practice and (b) Institutional and resource facilitators.

Theme 1: Creating evidence-based practice This theme included participants’ aspirations to develop practice supported by an evidence base. Two subthemes emerged: (a) Applied research and (b) Dissemination and personal development.

Subtheme: Applied research Several participants expressed their desire to innovate as a reason for pursuing academic involvement. Quotes included *“Innovation, new treatment”*, *“improving clinical care”*, *“patient outcomes”* and *“Contributing in research conducting surveys Nd evaluation for service development”*. They would also pursue a research project that would be personally relevant and applied: *“Real research which is applied”*.

Subtheme: Dissemination and personal development This subtheme reflects participants’ desire to share their knowledge and expertise. Participants mentioned *“sharing of knowledge”* and *“creating small groups to scaffold others to write papers”*. Many participants emphasised the importance of teaching: *“Practising specialist skills I achieved over years would be helpful for next generation”*. This may suggest a view of teaching as an active form of participation that promotes personal growth and the dissemination of evidence-based knowledge. Additionally, two participants referred to publishing papers, with one specifically alluding to the difficulty of the process: *“Easy to do publications”*.

Theme 2: Institutional and resource facilitators This subtheme includes three subordinate themes: (a) Balance between clinical work and research, (b) Availability of opportunities, and (c) Culture. It reflects themes two and three of the barriers, but it differs structurally due to the size of the subthemes.

Subtheme: Balance between clinical work and research Participants identified facilitators in this subtheme that share similarities with the subtheme from the barriers analysis: ‘Limited time’ (from the overarching barrier theme ‘Capacity and Resources’). Unlike the ‘Limited time’ subtheme, the ‘Balance between clinical work and research’ subtheme explicitly refers to a more balanced job arrangement that allows for both clinical and academic responsibilities: *“Job plan changes to allow more academic involvement”*. Clinicians mentioned that undertaking research is impossible without allocated time within the job plan and argued that it should not be expected of them to do it in their own time: *“Paid release days - clinical duties during that time need to be covered rather than left for me to deal with on my return”*. Apart from designated time, some clinicians expressed that a reduced clinical workload would enable academic involvement: *“Time in job plan with corresponding reduction in clinical workload as well”*. However, it was noted that this should not endanger their financial stability: *“financially well remunerated for taking up academic role”*.

Subtheme: Availability of opportunities The identified facilitators in this subtheme centred around the availability of opportunities. Participants noted that forming partnerships would enable academic engagement. This might include a *“Peer group support”* or a broader research network wherein opportunities for collaboration are more likely to arise: *“better relationship with academic departments, developing relationships with researchers”* and

“Link with academic/ professorial units”. Moreover, clinicians stated they would consider involvement if more teaching opportunities were available, demonstrating a comprehensive view of the profession that encompasses practice, research, and teaching. Participants responded: *“Honorary roles”* and *“clinical or practical teaching”*. Finally, one participant stated that there is a need for *“more funding opportunities”*, while another quoted *“recognition by the employer”*.

Subtheme: Culture This subtheme encompassed facilitators related to the broader work culture. Some participants referred to institutional culture and expressed a need for a more inclusive and open academic environment: *“Inclusive culture is needed in academic circles, which are currently closed up and non-inclusive”*. They also highlighted the need for equality of opportunity and fair access to academia: *“access to opportunities for all consultants not just clinical academics”*. Psychiatrists also expressed the need for more support. They shared comments such as: *“Friendly supportive environment”*, *“organisational support”*, and *“support from Trust”*. Additionally, participants underscored the value of mentoring and guidance to enter, *“Good mentoring and guidance on how to enter psychiatry academia”*, and to navigate the academic realm, *“Happy with following the advice from established academics”*. Participants also identified the need for research methodology training and academic writing: *“Guided research methodology workshops, daily clinical and academic discussions”*. Lastly, two participants mentioned the need for a clear pathway and knowledge of available resources.

Discussion

This cross-sectional observational study explored interest in and perceived barriers and facilitators to academic engagement among UK-based psychiatry IMGs of Indian origin. Perceived barriers to academic involvement were cultural (including perceived discrimination), structural and navigational (limited opportunities, support, and guidance), and capacity and resource constraints (both time and personal resources). Perceived facilitators included motivation to support evidence-based practice, balanced clinical and research roles, accessible opportunities, and supportive academic cultures on both an individual and institutional level. Interest in academia was high on UK arrival and broadly unchanged over time, though patterns differed by gender and prior research experience: men and those with research experience reported higher initial interest, while women and those without experience showed greater increases over time.

Interest in academic psychiatry

Despite the considerable barriers identified in this study, Indian IMGs in psychiatry reported high levels of academic interest upon entering the UK to work, and this interest generally persisted over time. This indicates that lack of interest itself is not a pervasive barrier among the group surveyed, consistent with some previous findings from the broader UK medical workforce [18]. Given these consistently strong levels of interest, addressing cultural, structural, and institutional barriers could facilitate greater participation in academic psychiatry among IMGs.

Participants without prior research experience showed greater increases in academic interest from UK arrival to the time of survey ($p = .013$). This reflects previous research indicating that newly arrived IMGs often focus on ‘surviving’ before they can begin to ‘thrive’ in their new work environment [19]. Additionally, one study using pre- and post-research fellowship questionnaires found that medical students undertaking a National Institutes of Health research fellowship reported increased interest in academic careers, and that the majority of students went on to conduct additional research after the fellowship. This supports the idea that research exposure itself can develop academic interest rather than it simply attracting clinicians who are already interested [20]. Further research would help to explore whether this finding is particularly pertinent among IMG psychiatrists and, if so, why, or whether it reflects a broader pattern among clinicians generally.

On commencement of clinical work in the UK, female IMG psychiatrists self-reported lower levels of interest in academia compared to males ($p = .034$; Fig. 2). This aligns with research highlighting that women in medical

training express lower interest in academic careers than men, particularly at senior levels [21]. Structural inequities may contribute to this pattern: even after adjusting for factors such as time in practice, specialty, and the number of publications, men are significantly more likely to be professors [22]. As of 2022, only 35% of UK clinical professors were women, revealing a persistent gender imbalance at the highest levels of medical academia [23]. These disparities could reduce early academic aspirations among women due to a lack of visible role models and mentors.

However, our findings also indicate that female IMG psychiatrists experienced a greater increase in academic interest than males from the start of their UK clinical practice to the point of survey ($p = .043$; *Fig. 1*). This contrasts with findings from a 2014 longitudinal questionnaire study, which found that, among doctors surveyed in their first year of medical work and again approximately nine years later, men showed a substantially greater interest in their intention to pursue clinical academic training than women [24]. This contrast may reflect differences in study populations and methodology, as most of our participants were experienced psychiatrists and were asked to retrospectively recall their academic interest at UK entry, rather than being surveyed prospectively at that time. Nevertheless, the proportion of women in UK academic psychiatry posts almost doubled from 2001 to 2019, meaning our findings may be consistent with the broader expansion of women's participation in academic psychiatry in the UK [25]. This finding warrants further investigation, particularly through comparison with non-IMG psychiatrists, to determine whether the greater increase in academic interest among female psychiatrists is specific to the IMG experience or whether it reflects broader changes associated with clinical experience in the UK.

Culture and discrimination

Survey respondents described the academic environment as unwelcoming, exclusionary, and difficult to navigate. There is a sparsity of literature focusing on discrimination of IMGs in academic psychiatry. However, in clinical roles, existing research demonstrates that IMGs feel discrimination from colleagues and institutions [26]. Furthermore, almost a third of locally employed doctors, the majority of whom are IMGs, reported having been bullied, undermined, or harassed in the workplace in the General Medical Council's (GMC) 2019 workplace experiences survey [27]. One study of IMGs in academic plastic surgery in the US found that, despite IMGs having comparable Hirsh indices, number of publications, and number of citations, they received almost seven times lower research funding from the National Institutes of Health compared to domestic graduates [28]. Although outside of the UK, it reflects institutional discrimination against IMGs in academia that was similarly highlighted by the participants in our study.

Navigating research and structures

Many of those surveyed reported limited awareness of academic career routes within the UK, challenges in accessing opportunities, and limited contact with universities and research networks. Structured pathways such as the Academic Clinical Fellowship (ACF), which provides joint clinical and academic training over three years, along with support for doctoral funding, appear to be accessed disproportionately by White, British doctors. In 2022, fewer than five General Practice ACF posts were accepted by doctors of Asian or Asian British Indian ethnicity [29]. For IMGs, who often begin NHS work outside formal training pathways, these disparities may be compounded by a lack of tailored guidance and limited institutional support. Mentorship is recognised as highly important in developing academic clinicians. However, minoritised groups often receive less mentoring than their non-minoritised peers [30, 31]. This underrepresentation and lack of parity in mentoring suggests systemic inequities in access to academic medicine at early career stages. Our study did not find any regional differences suggesting that those with more academic interest gravitated closer to established academic centres.

Capacity and resources

Time constraints and job arrangements being dominated by clinical practice emerged as key barriers. In contrast, having dedicated research time formally included in job plans and paid release days were identified as important enablers of academic involvement. This reflects findings from the Royal College of Physicians' (RCP) '*Research for All*' report, which highlighted lack of time as the predominant barrier to research participation among doctors working in the UK [18].

Participants also raised concerns about the impact of research on work-life balance, suggesting that academic activity would likely have to occur outside of working hours. This also aligns with a report by the Royal College of Physicians, where respondents described research as overwhelming home life, often being conducted during evenings and weekends [18]. This pattern is also true among psychiatry registrars specifically [32].

Further personal barriers were identified, including insufficient research knowledge, imposter syndrome, and English not being a first language. Some IMGs may find it difficult to conduct research due to language difficulties. Although Indian graduates are trained in English, varying dialects may create difficulties. These issues are consistent with existing literature showing that IMGs are more likely to experience self-doubt and feelings of intellectual inadequacy [33]. Language challenges, especially during the initial stages of clinical work, are also described in the literature, further connecting with our observed increase in academic interest over time for some groups surveyed [19].

Implications for policy and practice

Research experience is becoming a necessity for career progression in psychiatry in the UK [34]. For entry into higher specialty training, candidates are awarded points for completion of research degrees, publication of academic manuscripts, and presentations delivered at national and international conferences [35]. However, not all clinicians have equitable access to research opportunities [36, 37]. Mentorship, cultural, and discriminatory barriers are particularly important among IMGs. To prevent inequality in academic psychiatry, national training bodies and trusts could ensure protected research time is embedded within job plans, even at the core training level. Particular effort could be made to support those IMGs who arrive "pre-loaded" with academic qualifications or experience [3]. Clearer guidance, improved opportunities for mentoring, and enhanced institutional support could help to cultivate a research-active psychiatric workforce that reflects the diversity of the UK medical profession. The Royal College of Psychiatrists Academic Strategy recognises these issues but requires systematic implementation [36].

Strengths and limitations

To our knowledge, this is the first study to explore interest in, and perceived barriers and facilitators to, academic engagement among UK-based psychiatry IMGs. The design, combining quantitative survey data with thematic analysis of free-text survey responses, provides both breadth and depth. We recruited IMG psychiatrists across multiple UK regions, grades and years of experience, and included clinicians with and without prior research involvement. The credibility of our qualitative analysis was improved through independent double-coding of qualitative data, discussion of conflicts, and adjudication by a third researcher. Partiality was reduced as the qualitative analytic team had diverse professional backgrounds, including a medical doctor, a PhD candidate in education research, and a senior lecturer in intellectual disabilities. The detailed reporting of participant characteristics also allows for greater assessment of the transferability of our findings.

However, a relatively small number of psychiatry residents responded, and academic interest was self-reported at a single time point; retrospective ratings of past interest are vulnerable to recall bias. Although multiple comparisons were performed, we did not apply a formal correction for multiplicity. This was because these analyses were exploratory and intended to generate hypotheses. Additionally, strict family-wise error control (e.g. Bonferroni)

can be overly conservative, particularly in studies with modest sample sizes and correlated outcomes, increasing the risk of Type II error. We therefore report exact p-values and place greater emphasis on effect sizes. These findings should be interpreted cautiously and warrant confirmation in larger studies.

The questionnaire used did not undergo formal validation. It was developed by a group of stakeholders and the questions were selected based on their relevance to the study objectives and face validity. Although this approach provided pragmatic and contextually relevant measures, the absence of formal validation means that the reliability and construct validity of the questionnaire have not been established.

Additionally, IMG psychiatrists responding to this survey may not be representative of the wider pool of all UK-based Indian IMG psychiatrists. This may limit the generalisability of our findings to IMGs from other regions, although the majority of UK-based IMGs trained in India [6]. Finally, this study focused exclusively on psychiatrists of Indian heritage and did not include comparison groups, such as IMGs from other backgrounds or psychiatrists whose primary medical qualification was in the UK. This limits our ability to determine whether our findings are specific to our study population, or whether they reflect broader experiences across IMGs from other backgrounds or of UK-trained psychiatrists. This would be valuable to determine in future studies.

Conclusion

Despite significant structural and personal barriers, IMG psychiatrists of Indian heritage working in the UK expressed strong interest in pursuing academic work. Importantly, this interest was sustained or increased over time, particularly among those with less prior research exposure and female IMGs, suggesting that early barriers may ease with adaptation.

Our findings suggest that the level of academic engagement is not driven by disinterest, but by access to research infrastructure, mentorship, and institutional guidance, as well as other cultural and discriminatory factors. Targeted strategies, such as integrating research time into clinical job plans, expanding mentorship schemes, and offering structured academic induction for all doctors, including new IMGs, could enhance inclusion and progression in academic psychiatry. Addressing these barriers is not only important for supporting IMG clinicians, but also for building a representative and innovative academic workforce in UK psychiatry.

Further research is needed to determine whether these findings are specific to psychiatrists of Indian heritage or are shared by IMGs from other backgrounds and psychiatrists whose primary medical qualification was obtained in the UK. Comparative studies using larger, nationally representative samples, alongside qualitative approaches such as focus groups or in-depth interviews, would provide a more comprehensive understanding of the barriers and facilitators to academic career progression and help inform interventions that are effective across diverse groups.

Supplementary Information The online version contains supplementary material available at <https://doi.org/10.1186/s12888-026-08598-6>.

Acknowledgements none.

Author contributions MD - Data curation, Formal analysis, Investigation, Methodology, Visualisation, Writing (original draft); MM - Formal analysis, Methodology, Visualisation, Writing (original draft); SSM - Conceptualization, Investigation, Project administration, Supervision, Validation, Visualization, Writing – review & editing; SM - Investigation, Project administration, Writing – review & editing, DS - Investigation, Project administration, Writing – review & editing; VZ - Investigation, Project administration, Writing – review & editing; PT - Formal analysis, Validation, Visualization, Writing – review & editing; SJT - Formal analysis, Validation, Visualization, Writing – review & editing; DM - Conceptualization, Validation, Visualization, Writing – review & editing; RS - Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Resources, Supervision, Validation, Visualization, Writing – review & editing.

Funding This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Data availability All data supporting the findings of this study are available within the paper and its Supplementary Information.

Declarations

Ethics Statement We confirm that we have read the journal's position on issues involved in ethical publication and affirm that this report is consistent with those guidelines. Institutional ethics was obtained from University of Kent, School of Psychology ethics committee (ref: 2026177635357210551). Informed consent from participants for participation and publishing data was obtained.

Consent for publication Not applicable.

Competing interests SSM and SM serve as trustees for the British Indian Psychiatric Association (BIPA). SJT is on the editorial board of the BMC psychiatry but was not involved in the editorial or review process. He holds grants from the NIHR and Baily Thomas Charitable Fund outside of this work. RS has received institutional and research support from LivaNova, UCB, Eisai, Veriton Pharma, Neuraxpharm, Bial, Angelini, UnEEG and Jazz/GW pharma outside the submitted work. He holds grants from various national funding bodies all outside this work. No other author has any declared conflict of interest related to this paper

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Publisher's note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

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