

From Crisis to Collaboration: Addressing the Neurologist Shortage in the Caribbean and Beyond

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The global shortage of neurologists is no longer a silent crisis—it is a rapidly worsening threat to public health, particularly in low- and middle-income countries (LMICs) and underserved regions of high-income countries (HICs) such as Canada. Nowhere is this more evident than in the Caribbean, where access to specialist neurological care remains chronically inadequate. In Jamaica, a country of nearly three million people, only six full-time neurologists are available, mirroring the stark neurologist-to-population ratios seen across the Global South (1).

This situation is not merely a matter of numbers. It reflects deeper structural blind spots: neurology's persistent under-representation in national health plans, a lack of coordinated training and retention strategies, and an over-reliance on foreign donations, in the form of temporary Cuban personnel, or temporary solutions that ignore local realities. These problems are compounded by 'neurophobia' in undergraduate education (2), digital transitions that sometimes sideline rather than support clinicians (3), and international initiatives that too often exclude the voices of those working on the ground, possibly representing implicit bias (4, 5).

Neurophobia, a term used to describe the fear and misunderstanding of neurology among medical students and general practitioners, remains a critical barrier to neurological workforce expansion (2). It begins early in medical education, driven by poor neurology teaching, limited exposure to patients with neurological disorders, and the perception that neurological conditions are complex and offer little scope for effective intervention. This negative perception continues into post-graduate training, deterring new entrants and contributing to attrition. Curricular reform that includes more clinically accessible teaching, early exposure to role models, and integration of neurology with other medical disciplines is essential. National and institutional efforts to address

neurophobia through continuing medical education and targeted mentorship programmes could help demystify the specialty and potentially attract more students into the field.

Compounding this challenge is the rising tide of burnout among neurologists globally (6, 7). In LMICs, burnout is exacerbated by inadequate staffing, a lack of diagnostic tools, overwhelming patient volumes, and professional isolation. The emotional burden of caring for chronically ill patients with few treatment options adds further strain. Without supportive work environments and access to professional development, neurologists often feel trapped and undervalued. In the Caribbean and other LMICs, this leads not only to early retirement but also to migration. Recognising burnout as a systemic issue rather than a personal failing is crucial. Investments in peer support networks, sabbaticals and flexible career pathways are practical interventions. HICs must also prioritise workforce well-being, especially in rural and remote communities where service demands are high and resources scarce (7).

While Canada has greater absolute numbers of neurologists, it too faces inequities especially in remote, rural and Indigenous communities (8). These challenges, when juxtaposed with those in the Caribbean, highlight an opportunity: greater strategic cooperation between countries with shared histories, similar population health profiles, and, potentially, complementary strengths.

Despite many attempts by the first author over the years, mentees who have left for neurological training only infrequently return, opting to benefit from greater opportunities—academic and financial—in the places they have trained. As an example, a Canada–Caribbean partnership, built around workforce training, shared digital platforms, cross-border mentorship, and twinned centres of excellence, could meaningfully address these chronic shortages. Canadian neurology departments

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could support supervised rotations and remote Continuing Medical Education for Caribbean trainees. Meanwhile, suitably trained and licensed Caribbean-based neurologists could reciprocally help extend care into Canada's underserved diaspora populations, participating in collaborative telemedicine and AI-driven initiatives tailored to ethnically diverse populations (9, 10).

We must also reframe how innovation is introduced in LMICs. Donations of diagnostic equipment without maintenance contracts, or algorithms trained exclusively on high-income population data, while worth evaluating as methods to increase the pace of diagnosis and care in underserved environments, could do more harm than good (11). Caribbean nations, like many LMICs, need investment in infrastructure, not just gadgets. Digital health strategies such as tele-epilepsy platforms, wearable seizure monitors or AI-powered triage systems, must be developed and tested with input from local clinicians, ensuring they reflect our unique epidemiology, cultural norms and even more mundane logistical issues such as broadband internet access (12, 13).

Equally essential is valuing the experience of senior neurologists. In both Canada and the Caribbean, late-career specialists represent a vital but underutilised resource. They are repositories of decades of clinical and institutional knowledge and are often eager to continue in part-time, teaching or advisory roles. Retaining this expertise through phased retirement schemes, academic partnerships and cross-regional mentorship programmes would yield immediate dividends (6).

The World Health Organization has taken a step forward with its Intersectoral Global Action Plan on Epilepsy and Other Neurological Disorders (14). However, without practical, funded implementation in LMICs and genuine representation of LMIC professionals in decision-making, these initiatives risk becoming more symbolic than transformational as envisaged.

A critical component of solving this crisis is aligning neurology policy with broader national development and financing priorities (15–17). Neurology must be positioned as central to ageing policy, chronic disease management and disability services. Integration into public health strategies, such as linking stroke prevention to cardiovascular programmes or embedding epilepsy services in maternal and child health, can improve both cost-efficiency and patient outcomes (18). Furthermore, ministries of finance and planning must be made to understand that underinvestment in neurological care leads to higher long-term costs due to lost productivity, increased dependency and repeated

hospitalisations. Building this economic argument is essential for securing sustainable funding. In brief, brain health is population health. Canada's health-financing models offer instructive lessons, including bundled care, regional integration, and incentives for rural deployment (19).

Neurologists—indeed physicians in general—in the Caribbean and other LMICs must be seen not as passive recipients of aid or training but as co-creators of solutions. Only by engaging these professionals as equal partners through shared research networks, policy advisory roles, and regional leadership will we build sustainable neurological systems as is now so essential around the world (5, 20).

In summary, the shortage of neurologists is a global crisis with local consequences. It impairs not only the national capacity to manage acute neurological emergencies but also undermines long-term public health gains through inadequate stroke rehabilitation, epilepsy management, and dementia care. Multisectoral solutions combining education, infrastructure, digital innovation and sustained financing must be urgently pursued if we are to ensure equitable access to neurological care in the years to come. Its solution demands a new kind of partnership: one that bridges borders, centers equity, and values lived experience as much as technology. Especially in this time of changing opportunities and increasing isolationism, the Caribbean and Canada may be ideally positioned to lead such a model.

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