editorial

Psychiatric Bulletin (2006), **30**, 41–42

HELEN HAYES

The consultant sabbatical

The new contract for consultants in England and Wales includes a right to apply for sabbatical leave. It is intended that this sabbatical should benefit the patients under the consultant's care and there are provisions within the contract to negotiate additional financial support as well as assuming that locum cover will be provided by the employer. This new contract gives consultants the right to apply for sabbatical leave within their employer's current arrangements. This paper is a personal account of a month's sabbatical to Uganda and aims to show the diversity of benefits in taking up this option.

Preparation

At my 2003 appraisal, after nearly 12 years of consultant practice in a rural community child and adolescent mental health service, my medical director suggested that I should consider taking a month's paid sabbatical leave within the next year. I explored various possibilities that might accommodate my less than adventurous personality, the need to widen my horizons after many years in the same job and my many personal commitments. This led me, in consultation with my consultant colleague, to set the dates for my absence with a vague idea of spending time in tertiary clinics in the UK updating my knowledge base and skills. The idea of going abroad was dismissed owing to considerations of language, lack of contacts and a feeling that I should be going to a centre of excellence in order to benefit my patients on my return.

This situation changed when two members of my extended family announced that they were to return to a mission hospital at Kisiizi in rural south-west Uganda to assist with the financial management. Personal research revealed that this hospital did offer psychiatric services, but that there was no psychiatrist within several hundred miles. Expatriate doctors who had previously worked at Kisiizi thought that an interested self-financing English-speaking doctor with psychiatric skills would be welcome and useful. Hence, I contacted the hospital's medical superintendent, secured an invitation and made the decision to go.

Kisiizi Hospital was established almost 50 years ago near the borders of Rwanda and the Democratic Republic of Congo and is run privately by the Church of Uganda. It has 199 beds and provides medical, surgical, paediatric, maternity and mental health services to a population of over 120 000. There are over 6000 admissions a year, with malaria being the most common reason. The hospital is 90 min from the nearest tarmac road; however, a bus travels the 7 h to and from Kampala daily. Communications are via mobile telephone (with reception available only at two places on the hospital site) and e-mail, the latter being extremely slow. Post is collected from the nearest town weekly. The hospital has its own somewhat erratic electricity supply from a hydroelectric scheme and clean water from hot springs.

The hospital's Ugandan staff are supported by seven expatriate missionaries and are joined by short-term visitors – mainly medical students – on a regular basis. The hospital is funded by a combination of charitable donations from the West, fees charged to patients and central government funding. It is non-profit making.

Ugandan mental health services have been described recently (Kigozi, 2005). In Uganda, I was able to meet senior consultant psychiatrists in Kampala and visit the national referral mental hospital. I also met Uganda's sole child psychiatrist, who was addressing the lack of children's psychiatric skills in the country as a whole, by supporting and training junior psychiatrists, medical students and psychiatric clinical officers.

Mental health services were established at Kisiizi in 1997 by mission hospital doctors, following the recognition that local people had no access to such services. In general, families lacking such access are prepared to care for their relatives with mental illness; however, if they cannot cope (e.g. owing to the patient's aggression) they resort to using shackles or locking their relative in a shed. Local traditional healers are also frequently consulted.

Mental health services at Kisiizi are currently provided by a psychiatric clinical officer and a staff of eight nurses and nursing assistants. The service includes 22 in-patient beds, liaison within the hospital, out-patient and outreach services, and an epilepsy out-patient service. Treatment is by means of a very limited range of older psychotropic drugs: no psychotherapies or electroconvulsive therapy are available. There are limited occupational therapy services and one occupational therapist has a special interest in children's mental health. The most common disorders seen by the service in 2003–2004 were depression (29%), epilepsy (26%), mania (24%) and schizophrenia (13%).

Most of my time was spent training Ugandan staff in children's mental health problems, but I also observed ward rounds, out-patient clinics and an outreach session. I spent 1 day home-visiting with an organisation serving

https://doi.org/10.1192/pb.30.2.41 Published online by Cambridge University Press

editorial

AIDS orphans, another with a community project for disabled children, and was consulted about children's mental health problems. At the conclusion of my visit I brought back a schedule of work to complete in the UK, including the preparation of a development plan for Kisiizi's mental health services, researching the evidence for various interventions, and sending out to Kisiizi psychiatric journals from the last 5 years.

Prior to my sabbatical I spent 2 months preparing myself, my family, my patients and my work colleagues for my absence. This meant a large increase in workload in the 4 weeks before I went and at times I wondered whether it was worth going. I broke the habit of a lifetime by giving my patients some personal information about what I was doing. I found patients overwhelmingly supportive and ready to accept the arrangements that I put in place for their care during my absence. Many simply accepted a longer interval than usual between appointments. Although locum cover was sought by my employers, in the event it was not provided. This resulted in a lengthening in the waiting list and a feeling that I should work harder on my return to make up for having a 'nice' time away. This pressure came mainly from myself and I had experienced similar smaller pressures in the past before and after annual leave. In the absence of locum cover, my consultant colleague based 50 miles away agreed to provide basic cover, comprising telephone support to the team and three clinical interviews during my 4 weeks' absence.

I financed the entire trip myself, not realising before I went that I could request funding. However, I do not think I would have applied for it, as it was important to me that the contribution that I made to the Kisiizi service was my own.

Disadvantages

Deciding, arranging and defining what I would be doing consumed a good deal of time and energy before the event. Further time went into the making of arrangements for cover and patient care, and the stress was compounded by the uncertainties over locum provision.

Undoubtedly, there was some effect on continuity of care for my patients, and the lack of locum cover put extra stress on my consultant colleague. Cost and 'wasted' travel time were significant, although not critical, negative factors.

What I will do differently next time

My experience was positive: so much so that I am keen to repeat it. This is not to say that there are not areas where I would do things differently next time.

I have no doubt that 'second time around' I would be less anxious about knowing exactly what I was to do before I went. Once at Kisiizi I had to adapt to a different pace of work. It would have been less frustrating to have made that adjustment prior to my preparatory contacts.

I would certainly be less anxious about everything that I left behind. The patients, the family and all my other commitments managed well without me.

It would be helpful to go for a longer period. Travelling to remote places takes a long time – nearly half of the total time I had to spend. It would have been nice to have planned time to see more of the country.

Benefits

The main benefits stemmed from the complete change of scene, and the absence of the usual pressure of responsibility. In terms of work, although I acted as a consultant, I did not have the burden of running a service with all the conflicting demands on my time. Equally, there were no housekeeping worries: I paid for my accommodation before I went and my needs were met. The different pace of work produced health benefits, including fewer headaches and a general sense of well-being.

I became much more aware of the vastness of the resources that we have in the UK. This led me to a determination not to undervalue the National Health Service, social or education services in the future.

There were significant benefits from the weather – mainly dry, pleasantly warm in the day and cool at night, a perfect escape from a Welsh December – and from being able to experience different aspects of a lovely country, ranging from the bustle of Kampala, through a lovely valley devoted to a well-run healthcare facility, to the poverty in the remote villages; not forgetting the opportunity to visit a game park.

The main benefit to my patients in Wales is probably that I returned more conscious of the value of each patient and with renewed enthusiasm about the help I can offer. In addition, the sabbatical aided a change in mindset from 'someone else should do something about this' to 'let's think around this issue to see what we can do'. The different pace of work in Uganda helped refocus my efforts on doing my best for the person in front of me rather than trying to meet all needs by spreading myself too thinly. The updating of my skills in adult psychiatry will also benefit my work with parents.

To my employer, the benefits of my sabbatical include: renewed enthusiasm for the service, which in turn is likely to lead to an increased quality of the service provided; recognition of the limitation of resources, meaning that although continuing to flag service deficits I complain less; enhanced cultural awareness, especially important in my current working environment; and the significant benefit of having contributed to improving Third World healthcare at minimal cost. Finally, my colleagues benefit from better team working, as they and I have discovered that I am not indispensable.

Declaration of interest

None.

Reference

KIGOZI, F. (2005) Mental health services in Uganda. *International Psychiatry*, **7**, 15–18.

Helen Hayes Child and Adolescent Mental Health Service, Powys Local Health Board, Ynys-Y-Plant, Plantation Lane, Newton SY16 1JH, e-mail: helen.hayes@powyslhb.wales.nhs.uk

https://doi.org/10.1192/pb.30.2.41 Published online by Cambridge University Press