

Training matters

Training psychiatrists for work in the East of Africa

DIGBY TANTAM, Senior Lecturer, Department of Psychiatry, Withington Hospital, West Didsbury, Manchester M20 8LR

There is growing interest in this country in developing training programmes suitable for overseas psychiatrists. The motive is partly one of self-interest. The implementation of current Government policy means that many departments will look to overseas visitors to fill their registrar positions in excess of their career registrar allocation.

This paper is the result of my observations during three weeks in Zambia, three in Tanzania and 11 days in Ethiopia. It is therefore inevitably impressionistic. It would be invidious to single out particular departments in a paper such as this. Impressions from all three countries have therefore been combined except where specified in the text. In general there was sufficient similarity between them for this not to introduce too great a distortion.

General comments

Cost-inflation has hit all three countries hard and professional salaries have not risen accordingly. In Zambia a specialist is likely to earn considerably less than £1,000 per year, and in Tanzania, where there has just been a sizeable pay rise, less than £2,000 per year; in Ethiopia salaries are higher but still too low for many psychiatrists to be able to buy a house or a car. One Tanzanian psychiatrist estimated that he could live on half his salary when he qualified, but just before the pay rise, his salary was meeting a quarter of his food bill. Low or zero cost Government housing is an important benefit, but many psychiatrists have to develop other sources of income. Ethiopian psychiatrists are slightly better paid and there is some private practice, but in Tanzania and Zambia it is almost non-existent. Despite these difficulties most of the psychiatrists I met lived comfortably – a tribute to their entrepreneurial skills.

Telephone communication may be difficult in Tanzania and Zambia and proportionately more time has to be spent in visiting colleagues, often at home. Transport is everywhere a problem. Roads are bad, traffic is hazardous, cars may be many more times more expensive in real terms than in the UK, buses are overcrowded, infrequent and transport pick-pockets along with their other passengers.

The possession of a car is crucial for effective psychiatry but beyond the means of a psychiatrist unless he or she has extraordinary earnings which can be saved. Many psychiatrists in training in Europe use this as an opportunity for acquiring this sort of stake. Nor do hospitals have adequate transport. Vehicles often acquired through aid monies break down and have to be got going by cannibalising other vehicles. As the pool of vehicles shrinks, so does the opportunity for keeping in touch with outlying health units or for community psychiatric nursing.

Poor and expensive transport, combined with large catchment areas, means that non-compliance with out-patient attendance is common and that, when patients do return, it may often be in a crisis, usually an acute psychosis, which requires immediate attention. The budget for psychiatry is small in all three countries and this is reflected in the facilities. Few beds were available in one large hospital where food and blankets were also scarce. Overcrowding was common because of lack of nurses as well as lack of space. Occupational therapy was almost extinct in all but one hospital that I visited, although it must also be said that Tanzania's rehabilitation villages are, or were intended to be, occupational therapy in its present form.

Another frustration was the intermittent availability of drugs. Lithium was rarely used because of a lack of laboratory facilities, carbamazepine was often unavailable, as were depot neuroleptics. Sometimes psychiatrists had only one neuroleptic, one anticonvulsant, and one antidepressant available to them, and even these could run out. The actual drug available was rarely the single best agent. Parenteral diazepam was, perversely, often available and used for the sedation of acute psychotics.

The doses of drugs were generally smaller than those used in the United Kingdom. Reasons given for this were: (1) cost; (2) difficulty in monitoring adverse effects; (3) poor nutritional status; and (4) greater sensitivity to the drug. The lower likelihood of previous exposure to neuroleptics may have contributed to (4): in two cases of patients transferred from developed countries that I heard of, large



Residents and staff of a Tanzanian rehabilitation village.

doses of medication were needed to control their symptoms. Perhaps because of the low doses used, destructive behaviour seemed more of a problem and patients had occasionally to be tied to their beds, or confined in nets, or shackled. ECT was falling out of favour in all the countries I visited. In Tanzania it was given unmodified because of lack of drugs.

The problems with drugs and transport were major sources of frustration. Other frustrations for psychiatrists whom I met were the unavailability of books and journals, electricity cuts, interruptions of water, food shortages, and the control over their conditions of service exercised by Ministries of Health.

Advantages of African psychiatry

Psychiatrists in Africa deal mainly with the psychoses and epilepsy and these include a higher proportion of deliria and good-prognosis functional psychoses. Suicide is rarer, and attempted suicide rarer still except among the very urbanised. Cannabis use and abuse is common, but other drug misuse is just beginning. Personality disorder, even when related to crime, is rarely seen as a psychiatric problem. This

emphasis on the psychoses and epilepsy ensures that psychiatry has a more traditional medical orientation than in the United Kingdom and psychiatrists do not suffer the same assaults as to their legitimacy from other professional groups. Ethiopian psychiatrists thought that physical assaults on staff were also rarer than in the West.

All the psychiatrists whom I met attributed the small numbers of institutionalised patients to family support. More epidemiological evidence is needed to determine whether the chronically mentally ill and the mentally handicapped are, in fact, better off than in the developed countries. The number imprisoned were reported to me as small. Courts are very loth to give custodial sentences to the mentally ill in all three countries. A survey of vagrants in Dar es Salaam conducted by Dr Kilonzo, the head of the department of psychiatry at Muhimbili Medical Centre (personal communication), found that many were psychiatrically ill but that their total number was only about 200. The number of vagrants was, however, said to be growing in all three countries, and to be especially large in Addis Ababa.

Other consequences of family and mental pathology in the United Kingdom such as chronic

anxiety and depression, self-mutilation in 'borderline' patients, and child abuse do not come to psychiatrists' attention and are of unknown prevalence. Most psychiatrists I met were of the opinion that these were evils of urbanisation. If this is so, then Africa faces an epidemic of psychiatric disorder since urbanisation is occurring rapidly.

The last asset of the psychiatrist in Africa is a pool of non-medical staff, variously trained as assistant medical or clinical officers or psychiatric nurses, who are often highly skilled, may have amassed considerable experience, and expect to exercise considerable responsibility, often assessing and treating patients with medication and by other means with belated or minimal medical supervision.

Similarities with the United Kingdom

The assessment and treatment of patients is closely modelled on traditional English and American practice, even when this is apparently extravagant of limited resources, as in the use of psychologists for diagnostic assessment or in the duplication of assessments by both doctor and assistant medical officer. The case load of psychiatrists also seems comparable to that of a UK psychiatrist. Although less time may be spent with new patients, and follow-up visits are proportionately less common in the three countries, the number of patients per week seen personally by the doctor did not appear greater.

Many of the everyday problems of psychiatrists are the same in Africa and Europe. Most patients in Africa have consulted a traditional healer before referral, or wish to consult one during the course of treatment. Substitute acupuncturist, hypnotherapist, herbalist, or spiritualist for traditional healer and it becomes apparent that a similar situation may arise in the United Kingdom.

Compliance in both continents seems to depend on the ability of the doctor to provide a convincing explanation of the patient's problem, and effective treatment. Ward conditions appeared to me less of a factor than families' acceptance that psychiatry could be the most beneficial approach. Family counselling was also the most important part of the management of mental handicap and was also a factor in reducing relapse in families with chronic difficulties.

Repeat admissions are much commoner than first admissions in the United Kingdom and, as far as I could tell and in the opinion of the psychiatrists whom I met, also in Tanzania and Zambia, although possibly not in Ethiopia. Many psychiatrists would consider that most repeat admissions are preventable, either by better diagnosis, different treatment or, most often, by ensuring compliance. Dealing with non-compliance more effectively is thus a priority everywhere.

Contrary to my expectation, psychiatrists had access to photocopiers, telexes, adequate computing facilities, and secretarial services although none were as liberally available as in the typical UK department. Heads of department had access to foreign funds which enabled them to travel fairly frequently. As in this country, psychiatrists may often be asked to lecture or broadcast and many were involved in university and ministerial committees in a range of fields sometimes only remotely related to psychiatry.

Implications for training

Clinical training

The core of training for the psychiatrist anywhere in the world has to be general psychiatry. The presentations and problems of schizophrenia and mania are the same in both the UK and Africa. Melancholia may be rarer and somatised depression commoner than in the UK but the assessment of depression seemed to me little different. Although general psychiatry in the UK will not provide much experience of pellagra, malarial psychosis, epileptic psychosis, and AIDS encephalopathy – all common conditions in one or other of the three countries – most overseas trainees will already have had plentiful experience of these before they come to the UK.

Psychiatrists in the countries that I visited need to know little, as yet, about psychiatry of old age and have little to gain from a psychogeriatric attachment. Forensic psychiatry is, on the other hand, of considerable importance. Many psychiatrists have patients on hospital orders, many patients are brought to hospital by the police, and psychiatrists are often called upon to appear in court.

The proportion of children in Africa is much higher than in Europe. Children with mild to moderate mental handicap, or emotional and behavioural problems are rarely referred to the psychiatrist, but children with epilepsy, severe developmental disorders and severe mental handicap are dealt with by all psychiatrists. Child psychiatrists with special interests in these areas or with a neuropsychiatric orientation are therefore particularly valuable trainers.

Child psychiatrists can also teach family counselling skills. These are of great importance, as are counselling skills generally. There is, however, no place for the long-term treatment of personality disorder, and little call for the use of behavioural methods in the treatment of neurosis except possibly in university departments of psychiatry who offer a student counselling service. Short-term, focal psychotherapy would also be a useful skill in this setting. Psychotherapy attachments that concentrate on long-term treatment of highly selected patients

may not therefore be suitable for a trainee intending to work in Africa, although psychotherapists and counsellors involved in general psychiatry or primary care have a lot to teach.

Community psychiatry will have most to offer if the service is not biased towards neurosis. Rehabilitation psychiatry has a surprisingly limited place in the current climate of shortage of staff and facilities. Occupational therapy, work therapy, and retraining may be almost non-existent and training in these areas be inappropriate for some trainees.

Alcohol dependency is a major problem in some countries, both directly and through its effect on psychosis. An attachment to an alcohol service is likely to provide a trainee with many relevant skills.

Teaching

Most of the basic teaching given on Membership courses is likely to be of relevance to a trainee returning to one of the three countries considered, but they will also need special skills relevant to service development. We have concentrated on the organisation, implementation and evaluation of services on our courses in Manchester but have possibly paid inadequate attention to funding. Money, especially recurrent funds under departmental control, is so often the limiter of developments that special attention needs to be given to this. Committee skills, preparation of administrative papers, lobbying and budgeting skills are all very relevant to psychiatry in Africa.

Psychiatrists in Africa are very active in teaching and are often involved in courses. Teaching techniques are therefore also relevant.

Orientation

Newly arrived trainees will have had little experience of assessing overdoses, dealing with neurosis and personality disorder, working in collaboration with a general practitioner, having a wide-range of drugs

to choose from, having unstinted access to investigations, and legal safeguards to the rights of patients. All these should be explained as soon as possible to prevent later dissatisfaction on either side.

The emotional experience of a long visit to another country is a useful reminder of the pressures on a trainee from abroad simply by virtue of their being in a strange country and away from family and friends. My own experience is that there are some useful antidotes to the bewilderment and unease. Immersion in familiar work is one, and a clearly defined programme of duties is therefore particularly helpful in the early stages. Filling the evenings and weekends is also important for morale. There is no short-cut to this but living in the hospital, having contact with another trainee from one's country (who may or may not speak your first language), and organised social events may all be valuable.

Most trainees are happy to tolerate the inconvenience of travel for the sake of training, and there is a tendency for many to want all the training that is going. In Manchester, for example, most enrol for the MSc course as well as their other training. New opportunities breed new ambitions. It is another of the responsibilities of the clinical tutor to ensure that these do not also lead to new and unexpected disappointments.

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East-Anglian trainees' day

NEIL HUNT, Senior Registrar, St Bartholomew's Hospital, London EC1; NIGEL PRIOR, Registrar, Friern Hospital, London N11 3BP; and CHRISTINE VIZE, Registrar, Fulbourn Hospital, Cambridge CB1 5EF

The East-Anglian CTC Trainees' Day was held at Friern Hospital, London, on 14 December 1989. The

programme comprised a morning session with two speakers and lunch sponsored by Duphar, followed