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Psychiatry in the 'New South Africa'

SEAN KALISKI, Consultant Psychiatrist, Valkenberg Hospital, Private Bag XI, Observatory 7935, South Africa

Academic medicine in South Africa was created largely by talented graduates who, having travelled overseas (especially to Britain) for postgraduate training, returned to teach in the newly established medical schools and teaching hospitals. However, over the past three decades fewer have decided to return. Consequently academic medicine generally is in decline. Hospital specialists are demoralised, and about 80% of those recently surveyed indicated that they intended leaving the public health service if the present imbalance between service commitments, research opportunities, and poor pay persists (Curtin, 1991). About 40% of graduating medical students emigrate, usually to avoid conscription. The continuing violence and political uncertainty within the country probably ensure that few will ever return.

There are only some 200 registered psychiatrists in South Africa, of whom about half work lucratively in private practice. That leaves about 100 public service psychiatrists tending to a population of almost 35 million. Apartheid has ensured that almost all are white, and either speak English or Afrikaans. Not surprisingly service commitments virtually overwhelm research opportunities and teaching duties.

Psychiatry and the 'Old South Africa'

Psychiatry in this country has always been a Cinderella specialty. Most psychiatric institutions not associated with a medical school employ mostly medical officers, not psychiatrists.

Valkenberg Mental Hospital in Cape Town, which last year celebrated its centenary, has only been part of the University of Cape Town over the last two decades. Those with academic ambitions and talent were often so frustrated at the poor infrastructure for psychiatric research, that political considerations aside, it was logical to migrate overseas. The other medical specialties in South Africa have succeeded in garnering international recognition for themselves because they managed to attract funding for better facilities, and were able to divorce themselves more easily from the psychosocial realities of their patients. Ironically, the World Medical Association has always maintained warm relations with the medical fraternity here, despite having authored the Declaration of Tokyo. The recent report from the American Association for the Advancement of Science on health care in South Africa (1990) noted

The main buildings of Valkenberg Hospital in which the original hospital was housed. These were commissioned in 1891, and last year (the Hospital's centenary) were declared a national monument. At present they serve as an administrative block.

that all sectors of medicine practised apartheid, and that psychiatry enjoyed a particularly low status. Yet psychiatry bore the brunt of the international academic boycott. Some battled against the system, but many psychiatrists, themselves products of apartheid institutions, were just as adamant in their defence of the status quo. The Society of Psychiatrists of SA (SPSA) seemed always to be in a state of suspended intentions.

The threat and use of intimidation by the authorities always inhibited concerted protest. In 1987, 100 junior and senior doctors at Baragwanath hospital signed a letter condemning the conditions at that hospital. All were ordered by the Transvaal Provincial Administration to submit apologies, even though the Director of Hospital Services officially admitted in a letter to a medical journal that there was substance to their concerns (van Wyk, 1987). Those who refused had their contracts cancelled and were barred from working in any hospital in the province thereafter. Many left for indefinite 'holidays' abroad.

The appalling failure of the Medical Association of South Africa (MASA) to censure the doctors involved in the Biko case underlined the split within the medical profession, and together with the fact that the institutions of medicine and health care have always been under the control of the state (directly and indirectly), and policed accordingly, has meant that the abolition of apartheid in medicine would only follow general socio-political change.

Sanctions: Academic boycotts and selective support

There has not been a change in heart among the ruling elite, but rather a sober realisation that the status quo cannot be sustained. The academic boycott provoked much internal debate, as this did contribute to the decline of academic standards, which will be difficult to reverse.

The corollary of the academic boycott is that South African doctors should have been denied employment in other countries. Sanctions were intended to seal the country hermetically from the rest of the world to force social change, and professionals should have been encouraged to remain to facilitate this. There is an anecdote that during job interviews for psychiatry posts in the UK, South Africans are sometimes asked to list ex-countrymen now prominent in British psychiatry. Apparently the list is still growing.

The report of the delegation to the president of the College on its preliminary visit to South Africa is generally accurate (although the statement that practitioners without specialist training are allowed to practise as psychiatrists is not true), and recommends that a policy of 'Selective Support' be applied, which "would mean eschewing official contact with any organisations or individuals in South Africa that continue to support apartheid, while maintaining active professional relationships with those who advocate ending apartheid and the development of an integrated, unitary health service, and who can be seen to be working towards those ends" (1990, p 34). This strategy, which would have been most powerful if applied at the height of the international campaign against apartheid, is to be welcomed. Overseas support for anti-apartheid organisations within the country always distressed the government and its supporters. Now in the throes of socio-political transition, it has become fashionable for all official bodies to proclaim an abhorrence of apartheid and racism. Their efforts in abolishing racist practices and structures have not necessarily followed apace of these utterances. How, then, will such a policy of "selective support" be monitored? Either a mission representing the College will have to be established within the country, or regular visits by delegations will be necessary. A new, internationally acceptable political dispensation may be realised in South Africa before the Society of Psychiatrists of SA (SPSA) manages to satisfy the above requirements. Under such circumstances would the College be obliged to continue the campaign of isolation, even though general sanctions surely will disappear? This is not a theoretical question as the inequalities in this country, which have been painstakingly maintained over the last 300 years, will surely persist for decades still.

After apartheid

South African psychiatry faces three challenges: to provide equitable non-racial care to all within the country, to develop within the general African context, and to explore the 'new' transcultural psychiatry.

A future health system will have to be national, comprehensive, available to all without financial or geographic barriers, subject to constant evaluation, and have the support of local communities (Susser, 1990). Although it is generally accepted that many existing institutions will survive, the immediate goal is to unify all psychiatric services into a more efficient and non-racial department, instead of the present tripartite system (in which it is possible for psychiatrist, nursing staff and patient each to be administered by different departments simultaneously).

Devising an egalitarian psychiatric service will not in itself assure a favourable outcome on the mental health of the populace. Redress of social, political and economic injustices is essential, together with a realignment of priorities and allocation of resources toward serving the needs of the mentally ill.

The College of Medicine of South Africa has introduced a Diploma in Mental Health for GPs to integrate psychiatry into the primary health care service. Community nurses, and perhaps even lay people, could also be trained to deal with common psychiatric problems, and to recognise those that require referral to psychiatrists, who for some time will continue to practise predominantly in those urban areas served by teaching hospitals. In addition to training and evaluating the above, psychiatrists must be involved in dismantling, and researching the effects of racism.

In Africa the manifold problems of poverty, disease and war are overwhelming, and it is not surprising that psychiatric services are in a parlous state. There is scant research on the natural histories, phenomenologies, and management of disorders in the African context. Despite current problems and grievous lack of resources, South African psychiatry has the advantage of being indigenous, and in possessing an academic infrastructure that could participate in research and care on the entire continent.

The application of first world psychiatric principles could ultimately lead to reappraisals of contemporary concepts. Transcultural psychiatrists are often overconcerned with the search for evidence of universal core psychiatric syndromes that may manifest and progress differently in various cultures. Daily contact with patients often involves an appreciation of personal meanings beyond the exercise of clinical acumen. Xhosa patients sometimes, for example, display distress, "acting out behaviour", or relapse of a known chronic disorder for the need to fulfill particular rituals, such as circumcision, death rites, or to overcome witchcraft etc. The psychiatrist-patient relationship may be further complicated by current political events, and of course a suspicion by patients that the white doctor, even with good intentions, is patronising them. Exploring the differing personal meanings between care giver and patient may provide valuable insights for psychiatry generally.

Psychiatric ethics and political action

All tyrannical regimes disrupt family life and impact on the mental health of their citizens. Even in democratic societies psychiatrists have a responsibility, with accountability, to promote equality of care, and to act positively on behalf of the disadvantaged. Even though each psychiatrist may be ethical in his daily contact with patients, there now appears to be the added obligation that he be actively involved in changing the socio-political structure of his society. This should be distinguished from those instances where psychiatry is abused as an instrument of oppression, such as the involuntary hospitalisation of political dissidents. But psychiatrists could also be guilty collectively for acts of omission, that is, failure to oppose injustice, especially when it impacts on mental health. There is, however, the danger that this may lead to a politicisation of psychiatry in which ideology displaces ethics.

Accountability is a difficult issue as the oppressed and disadvantaged are seldom able to apply sanctions to the professionals within their own societies. As countries monitor each other's treatment of their citizens it is logical that, likewise, psychiatrists should monitor their colleagues working in oppressive societies. But it has been argued, with respect to South Africa, that where mental health problems are beyond the realm of psychiatry (that is, they are primarily political) then the application of sanctions by colleagues in other countries is not only unfair, but also unethical because this would further impair the delivery of adequate care to the oppressed. Selective support for those who combat injustice combined with a boycott of those who do not, is an effective strategy that partly overcomes those objections. Perhaps a universal code of ethics on psychiatrists' obligations over socio-political issues (with prescribed sanctions) should be drawn up and ratified by members of international psychiatric organisations.

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