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A view from the road: experiences in four continents

Vikram Patel

Since graduating from medical school eight years ago, I have had the chance of experiencing clinical psychiatry in four countries on four continents; Bombay and Goa, India, my home, where I trained in medicine and began my psychiatric training; Oxford and London, United Kingdom, where I acquired a taste for academic psychiatry and completed my clinical training; Sydney, Australia, where I worked in a liaison unit in a large general hospital and a community mental health centre; and now, Harare, Zimbabwe, where I am conducting a two year study on traditional concepts of mental illness and the role of traditional healers and other care providers in primary mental health care.

Travelling to new cultures as a tourist is in itself an enriching experience; travelling to work is altogether different. The quick explorations of tourist spots take a back seat to the essential tasks of 'living'; overcoming complex immigration and medical licensing bureaucracies, settling in to a new work environment, working with new languages, developing a social structure and so on. Amidst all this are the exhilarating opportunities of learning about the cultures with a level of intimacy that psychiatry allows more than many professions. Most of all, though, is the experience of life in a new setting, at a different pace, with new colours, smells, climates, food, music, social system and more. In this article, I will attempt to share some of the difficulties and joys of my cross-cultural experiences in the hope that some of my colleagues may be inspired to pack their bags in anticipation!

Where does one go and how does one get a job?

The world may be shrinking for most people, but for medical professionals there is a different perspective. In the past two decades, many countries have erected barriers to the free flow of medical personnel across national boundaries (Patel & Araya, 1992). Indian medical degrees were fully acceptable in the UK just ten years ago but we are now expected to 'requalify' by sitting exams. Now, even British degrees are not accepted in India, Australia or the USA. And as the tit-for-tat continues, often instigated by the bodies that represent the needs of doctors themselves, the barriers get higher. There is a need for the medical councils of different nations to establish a dialogue on how to improve the cross-national acceptability of one another's qualifications. After all, the system of medicine as practised in all four countries I have worked in is virtually indistinguishable. There still are a few routes open (other than resitting general medical exams, which after several years in psychiatry can be a demoralising life event); some countries

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welcome expatriate medical staff due to local shortages, such as in sub-Saharan Africa, the West Indies and the Middle East; it is still possible to arrange time-limited schemes such as exchange schemes or locums in Australia; one can forfeit clinical practice and settle for research, as in the USA and Canada; or, one can wait till one becomes a professor and then, virtually all immigration battles end.

The best place to look for opportunities is in the University Appointments or Overseas Section of the advertisement supplement of the *British Medical Journal*. Other opportunities include working with international development agencies such as OXFAM or the Overseas Development Administration of the UK which regularly send medical staff (albeit very rarely any psychiatrists) to work in projects in developing countries. Then there are the infrequent opportunities to apply for research grants to conduct studies in a foreign country.

Although mental health is rarely ever a priority area in the developing world, the recent World Bank report showing that mental illness was an important cause of disability may change that (1993). For those who are already in the developing world, a few Fellowships are provided by the World Health Organization and Commonwealth, and programmes such as INCLEN (Halstead *et al*, 1991) and the Overseas Doctor Training Scheme of the Royal College of Psychiatrists which assists in providing special training.

Hassles

There is no standard formula for obtaining a work permit; my experiences with the UK have been reasonably smooth and quick; with Zimbabwe, long and unnerving as it is often impossible to get any time frame as to when the permit would be issued; and in Australia, there were gargantuan delays and strange rules which required me to have an HIV test and where my wife was not automatically entitled to enter the country with me. Luckily, I have never needed to apply for a work permit to work in India, but I understand from those who have tried that it falls in the Zimbabwe category.

The initial euphoria of a warm climate and new sights and sounds is quickly replaced by the intense activity sorting out the chores of survival. These 'hassles' are in fact fascinating opportunities to begin the discovery of a new culture. Queuers are especially good for this sort of endeavour. Everywhere, there are faces of resignation; in Harare, more often than chance one can spot a white face in a queue with that 'it wasn't like this in the old days' look; in Bombay, there is a lot of jostling and (generally) good-humoured banter and every so often someone you could swear was 20 people behind you is already at the counter; in Sydney, there are plenty of political pundits debating everything from Keating's arm around the Queen to the Japanese takeover; in London, it is quiet, orderly, efficient and like all the other places, one gets a glimpse into a national psyche.

The costs involved in relocating, especially with children, is no small amount, and once again, it would be a perfect venture for our representative bodies to help with funds if only because working overseas is not just beneficial to the overseas medical system, but also a tremendous training opportunity for the doctor.

Rewards

Once the painful changes of moving home are adapted to, the rewards of a cross-cultural experience are tremendous. Take language as an example. Moving around Commonwealth nations may suggest an ease in adapting. In fact, the only time that I was rarely called to use any other language than English was, not surprisingly, in England. In India, it didn't matter which Indian language you spoke since many patients spoke some other Indian language altogether. Still, most patients spoke smatterings of Hindi or English, and one could get by. Sydney, with its vibrant migrant populations, required the use of a diverse group of interpreters; Cambodian, Vietnamese, Russian, Turkish to name just a few. In Harare, while it is true that one can get by with English alone, one needs an interpreter for the vast majority of any clinical work. For the first time, I have felt the need to enrol in a language school. Learning Shona is by no means an easy task, but it can bypass the frustrations of using interpreters whose translation is often suspect such as when a seemingly endless response by a patient is converted to a terse monosyllable.

I have faced new priorities and challenges with every move and, in the process, come into contact with different aspects of being a psychiatrist. In London and Bombay, it was almost entirely a hospital-based clinical service with plenty of academic opportunities; in Sydney, much time was spent in clinical service in an excellent community mental health centre and a busy general hospital liaison unit. In Zimbabwe, with barely ten psychiatrists for nearly 10 million people, clinical duties take a backseat to the essential job of teaching medical and paramedical staff. Clinical settings are widely different, from well-organised multidisciplinary teams in London and Sydney, to understaffed, overcrowded clinics in Bombay and Harare. Changing from two to 20 new patients in a clinic demands a radical change in clinical practice. Psychosocial and

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community treatments change to predominantly pharmacological management of psychotic illness. In some settings, the patient attends with their family, in another, most come alone. The very clinical material is different; the proportion of psychotic disorders can vary from about half the case-load to almost the entire case-load. Even though I can confidently recognise severe psychotic illness in all the cultures I have worked with, it can be difficult to be sure whether it is 'schizophrenia' or 'brief reactive psychoses' especially when previous medical histories are inadequate and follow-ups rare.

Depressive and anxiety disorders are even more complex; from overt presentations of mood problems in one setting, one switches to inferring the existence of an 'underlying' mood disorder often out of ignorance of any more appropriate category. Research priorities are different; whereas one could easily settle into studying the hippocampus in obsessional-compulsive disorder in one setting, evaluating the ideal means of incorporating mental health in the primary health care of 100,000 people with just one psychiatric nurse and hundreds of traditional healers is the priority in another. The ability to communicate with colleagues changes dramatically; there were more psychiatrists in the corridor where I worked in London than in the whole of Zimbabwe. And the few psychiatrists there are in this country are busy with the task of providing essential services leaving little time for academic chit-chat.

Working in such contrasting societies has given me perspective on the sociopolitical and economic factors which bring about striking differences in prosperity between and within these societies. Working in Zimbabwe where the tragic social effects of 'Economic Structural Readjustment Programme', enforced by the World Bank and Western donors, are beginning to actually cause a deterioration in public health (Logie & Woodruff, 1993) leaves little doubt about who is calling the shots with the lives of millions in poor nations. All the societies I have worked in are democracies, yet the inequalities in each have been staggering; the status of Afro-Caribbeans and Asians in the UK, the dispossession of the Aborigines in Australia, the caste and religious divides ripping Indian society, and in Zimbabwe, a society which despite 13 years of independence from an apartheid-like rule still remains racially segregated.

These experiences add up to a process of discovery and learning with no parallel. It is an opportunity which I would encourage my colleagues to pursue. If psychiatry is the medical science of human behaviour, then the amazing cultural diversities in our world surely make it the best 'laboratory' for us to improve our skills, and ourselves.

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