An Alternative 'Been to America'

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Travel has always been a part of medical education. Many of the great figures of British psychiatry seemed to have derived some of their inspiration from periods spent in European clinics, and more recently no c.v. seemed truly complete without the all important 'Been to America'. Unfortunately, as the Atlantic has become cheaper to cross, the professional welcome at the other end has become increasingly lukewarm and the VQE and FLEX have proved substantial deterrents. There are, however, several alternatives which are worth considering. From 1980 to 1983 I worked as a psychiatrist in Africa, in the Republic of Botswana, and I thought a description of some of the practical aspects involved in making such a step might be of interest.

Going there

My wife was absolutely an equal partner in all the relevant decisions. Primarily, we went to Africa for an adventure. I had started psychiatry fairly soon after qualifying, so that by the time I was 30 years old I was already a third-year senior registrar. I had completed most of the work for a research degree and our then only child was too young for us to have to worry about her schooling. It seemed that we had a 'window of opportunity' in which to do something different. Having made the decision to go to a developing country for a period, actually getting the job in Botswana took a further 18 months to arrange.

Positions in developing countries are very rarely advertised and for those who wish to go for more than an extended holiday there are basically two ways of doing so. One can either be a volunteer or an expert. Of course, some volunteers are more voluntary than others; we met German and French doctors whose voluntary service counted against their military call-up, but people working for the British volunteer agencies (IVS and VSO) made very real personal and financial sacrifices to work in Botswana. Although volunteer organizations are placing more and more emphasis on recruiting people with identified skills to accompany their enthusiasm, few such bodies have the expertise to be able to assess the need for a highly specialized health worker such as a psychiatrist.

Experts, as the term implies, are those people with specific skills and experience who work in a country until it can generate its own relevant expertise. They are recruited by national or international aid and development bodies and are usually part of some wider aid programme.

I had been prepared to volunteer, but eventually I went as an expert, though by a rather tortuous route. At the suggestion of a senior British psychiatrist, I wrote to the Mental Health Division of the World Health Organisation. I later discovered that they act as an informal clearing house for a number of developing countries and they identified two positions for which I seemed appropriate. Over the next year I became acquainted with the multiple agencies involved in funding a post overseas. The first job I was interested in fell through, but as a result I was much better prepared when Botswana surfaced. As a first step I wrote a long letter to the Permanent Secretary of their Ministry of Health, outlining my experience and qualifications and including a copy of my c.v. Within that letter I specified a deadline for a response and stated that after that time I would not be available. In retrospect that was an arrogant but vital step.

Bureaucracy in developing countries can be even more byzantine than that of the NHS, but it usually can be cut through by a senior official. Sure enough, I got a cable within my deadline indicating the Botswana Government's willingness to employ me. The WHO again proved helpful in arranging visits to meet staff and familiarize myself with Botswana's specific psychiatric programme, but I was never formally a WHO employee, and my travails were by no means over.

I had discovered that the support of the British Government would be very important to ensure adequate health and other cover should any disaster befall us whilst we were away. The British Government sends Technical Experts to developing countries under the Overseas Service Aid Scheme. To get my position funded involved the right bits of paper flowing from the Ministry of Health in Botswana through the British High Commission there, back to England, through the geographical (Botswana) desk and the medical advisers in the Overseas Development Administration (the relevant Government Department) and out to the Crown agents, who would check my qualifications and formally recruit me. With pushing and prompting I got my contract two days before I was due to leave. All this time my own department in London and the relevant District Division of Psychiatry proved extremely supportive. They offered me a prolonged leave of absence with continued superannuation payments and an assurance that I could slot back into my SR rotation at the next available vacancy after my return. With that backing we were able to go.

Being there

Our actual stay in Botswana was fascinating. Technical aspects of the work are described elsewhere,[1,2] but there are a number of points that seem worth mentioning here. The pattern of work was extremely demanding. It took a long time to get used to clinics of 40 or 50 patients, half of whom would be new referrals. Few people had watches, so no appointment system was possible. People waited more or less patiently to be seen, but fearful of losing their place, one patient would slide in through the door of the consulting room as the last patient left: this gave little respite to the doctor.

The Government provided a driver, which was necessary as we would often travel very long distances (50–300 miles) to

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perform clinics. Commonly we arrived late in the day and as the patients may already have been waiting for several hours, it was usual to get started straight away and work until everyone had been seen. Botswana's long summers are very hot, with temperatures over 40°C being common; the four-wheel drive trucks that we used did not have air-conditioning.

This style of work was sustainable only by the relatively young and fit. During our stay two distinguished general physicians came to work in Botswana at or near their retiring age, and both had myocardial infarcts soon after their arrival. Good physical health is an obvious prerequisite for anyone contemplating a period in a developing country.

For a time I was the only psychiatrist in the country. My predecessor left 24 hours after I arrived, and the Government was insistent that I take up my duties straight away. A period of adjustment, adaption and language training would have been very helpful. Such a time is worth pushing for.

We stayed in Botswana for just over two and a half years. Aid contracts are usually for two or two and a half years minimum period. It is not really worth spending the large sums of money involved in sending relatively senior professionals abroad for periods of less than two years. Cynically, most people say it takes six months to settle in, you work for a year, and then spend six months thinking about what to do next. We had initially intended to go away for just a year, but in the end we felt guilty that we left Botswana as soon as we did. Certainly 12 months would have been too short a time to do anything useful.

Coming back

It was clear to me from the start that I had to look on working in Botswana as an experience in itself and that there was no point thinking about it in career terms. Of course, that did not stop me intermittenty becoming pre-occupied with what I would do when I left.

As part of a cost-cutting exercise the British Government scrapped its advisory service for aid personnel returning from overseas. They sent round a rather depressing booklet by way of compensation which made the point that experience overseas is neutral, if not actually disadvantageous, in career terms. The experience of working in a developing country seems so far removed from every day working life in Britain, that it is hard for colleagues to make any connection with it. When investigating consultant posts on my return I found people were concerned only with what I had done up to the time I had left and that I seemed professionally to be at the same point that I had been before I went away. As a general guideline the more experience one has, the easier the work is abroad, and the easier the return. It is unlikely that experience in a developing country would routinely count towards higher professional training.

In the event the cultural shock of return was considerably softened by the Wellcome Trust. I had been able to do some research whilst in Botswana, and I had applied to the Wellcome for support to get it organized. They were wonderful. One of the senior staff said over the phone to me, 'English doctors are so stuffy and boring, they hate people going away and doing anything different. How can we help you?' They then gave me an eight-month grant, which enabled me to work on my data and 're-enter' gradually.

Conclusions

The real danger of spending a prolonged period working in a developing country is that the experience may be so intense that it changes one in unpredictable ways. Plans made before leaving become less relevant on return.

There are few opportunities for psychiatrists in the developed world to work on the large canvas afforded by single-handed practice in a country of one million people. Anybody contemplating such a move should be aware that the professional demands made on him or her will be extremely varied and the broader one's training, the better.[3] I found my experience by turn exhilarating, fascinating and frustrating and sometimes all three at once. I certainly valued it enormously, and suspect that many others who enjoy a challenge would do so as well. In Botswana, emotions are experienced in the heart and I fear that I may have left a part of mine in Africa.

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Interdisciplinary Association of Mental Health Workers

This new association has been set up to promote active schemes, policies and research which will help professionals engaged in health and social service practice to reach a better understanding of each other's contributions to the care of the psychologically distressed. Further information is available from Chris Born (Publicity Convener) or Peter Huxley (Secretary), Interdisciplinary Association of Mental Health Workers, 126 Albert Street, London NW1.

Computer Program on the MHA 1983

Dr T. F. Packer (17 Lily Crescent, Jesmond, Newcastle upon Tyne) writes: I have compiled a computer program which contains 100 questions on the Mental Health Act 1983. The program is called 'Testcards' and runs on a BBC Model B microcomputer. It uses coloured text and optional sound to pose a randomly selected set of questions. The score of correct answers is given at the end. Copies of this program on a compact cassette are available at a cost of £1 to cover tape, post and packing.

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