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A year in Auckland

A personal view

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Preparation

I had acquainted myself with the psychiatric services in New Zealand some years ago during my student elective. I wanted to return to experience further a system which was both similar and different to the NHS. The New Zealand hospital system was funded in a similar way to the NHS. One organisational difference was the managerial layer, which was still filled by medical superintendents. Another difference was the extensive no-fault accident compensation scheme through which settlements were made without resort to lawsuits. Thus doctors paid low medical defence fees and were rarely sued, but the Government had regularly to meet a large bill. The psychiatric services were in the process of moving from hospital-based to community-based, in line with prevailing clinical and public attitudes. This was fuelled by some headline-making scandals over patient care in the asylums. One cause for general alarm was the poor health of ethnic minorities, especially the indigenous Maori. This issue resonated with racial and political overtones.

Just when to go was a dilemma. I spoke with a number of consultants and received varying replies. It was up to me. Between sitting the Preliminary Test and Membership exam seemed an appropriate time. Applying for a registrar post in Auckland involved the usual host of letters and references and then waiting. By the time the Selection Committee met I had spent 15 months in psychiatry in Bristol and passed the Preliminary Test. There was no interview, merely a blunt message of acceptance by telegram. The appointment would be for a year (renewable), to start in December 1986, then some months away. Nobody was surprised when I began to run out of steam as the time passed. I came to doubt whether the venture would really be such a marvellous idea. Immigration proceedings diverted me to some extent. The quest for a Work Permit took on significant proportions. Eventually I left, quietly.

First six months

My first post was on the Professorial Unit, in Acute General Psychiatry. The unit was situated on the 10th (top) floor of a general hospital, somewhere above Cardiology and well above General Surgery. I was struck by this anthropomorphic representation with the 'Mind Specialists' given pride of place at the top of the tower. One advantage was a most pleasing view of the harbour. I had arrived in sports jacket, shirt and tie (almost standard attire for male trainees in the UK) but seemed out of place. There was a notable lack of formality, most easily seen in dress, but also reflected in attitudes. No one was hesitant about expressing an opinion. And why so many staff? Not only did two general psychiatry teams work here, but also an adult neurosis team and an eating disorders team. The single ward bulged.

My early remit was to look after a mixture of in and out-patients, although the numbers were small (perhaps 10 and 20 respectively). The team was developing as a specialist resource for the acutely psychotic in-patient, using an intensive care wing with a high staff-patient ratio. Patients were subjected to a battery of research tests that reflected the team's interest in biological psychiatry. Those needing the intensive care facility seemed more acutely disturbed than I had seen in the UK. Did this reflect a delay in presentation (GPs charged directly for consultations and domiciliaries, and for some the cost could be prohibitive)? Or maybe the rather claustrophobic 'goldfish bowl' atmosphere of the intensive care wing contributed to raised arousal levels and further energised the psychotic patients? Or was it the sight of steel-reinforced, unbreakable windows (ten floors up, remember)? Whichever, I vividly recall being bundled to the floor by a well-placed blow to my trachea from a young, acutely psychotic man who took fright.

Those patients not requiring intensive care facilities were seen in another part of the ward after admission by the whole team, usually the next working day. A one-way mirror was used so that everyone could appreciate the interview from an adjoining room, leaving the interview room uncluttered but for patient and interviewer. The interview was not used for collective information (I had already done this) but to highlight aspects of the case. The interviewer was, in turn, any member of the multidisciplinary team. My initial feeling was one of vulnerability, being unused to such close scrutiny. I wondered what

the patients felt? Actually most were unconcerned once the interview was underway. I am sure my own interview skills improved, and seeing how colleagues coped in the same situation was useful and reassuring.

I enrolled for the Postgraduate Psychiatric Education Course, which would have led to preparation for the local qualification – MRANZCP. The course was arranged by the University Department of Psychiatry to meet the Royal Australian and New Zealand College requirements. Two afternoons per week during term-time were set aside for this tuition, usually in seminar form. By preparing work beforehand the seminar was then used for wide-ranging free discussion. Numbers were kept low and this facilitated frank exchange. Trainees were streamed according to experience into four year-groups, and each year had a recognised tutor who organised the programme. This format seemed to work well, feeding off the small group principle which offered camaraderie and support. The New Zealand trainees seemed greatly concerned about the MRANZCP examination and tackled it with more trepidation than I had previously seen with postgraduate exams. I soon found out why. Unlike the MRCPsych, it is an 'exit' qualification, and is a high hurdle, demanding a number of typed case histories (including a long psychotherapy case) even before the two written exams, followed by two days of clinical and viva voce tests. Those still interested at this stage would see both a psychiatric hospital and a general hospital case, followed by a medical case, and capped with a 'consultancy viva'. I attended the course for a year and covered the usual topics, albeit with DSM-III overtones. Someone remarked that they had widened the goalposts at the American end of the pitch when DSM-III-R arrived.

I slowly gained a perspective of broader psychiatric issues in the city. The Auckland population is roughly one million, covering a north–south distance of almost 100 miles, but most live in the city. Auckland is multi-racial, the indigenous Maori now having to share with those of European stock and the more recently arrived Polynesians. Most Maori and Polynesians lived to the poorer south of the city, and not in our catchment area. The range of psychiatric services available was similar to the UK, although the psychogeriatric and forensic services were in their infancy, and the multi-purpose community mental health centres seemed an American import. The psychiatrists were mostly New Zealanders, many who had spent some time training in the UK, although the younger ones had preferred Australia or the USA. There were a few British and South African psychiatrists, creating something of an international flavour.

The ward was in a state of flux. At an immediate level we were grappling with the role of a psychiatric unit in a general hospital. Is it adjunctive or pivotal (Richman & Harris, 1985)? How could we improve services into the community if constrained by the traditional delivery system? Many were aware of community care initiatives elsewhere that had worked poorly, and advised caution. For perhaps the first time the psychiatrists were actually planning with the Department of Health to ensure a comprehensive community service for Auckland, eventually to close the asylums (which served the other catchment areas) and to concentrate most resources for the severely mentally ill in the community. Projects in Australia (Hoult, 1986) and the USA (Stein & Test, 1980) had been visited and scrutinised. Management skills were being learnt quickly. Senior psychiatrists 'went public', using television appearances to keep up the momentum for change. With a relatively compact population, along with Government goodwill and money, a favourable outcome was feasible.

Maori mental health was a grim issue. Probably for historical reasons there seemed little but polarised views. Maoris were over-represented in prisons, among those detained in psychiatric hospitals, in the illicit drug-abusing population and in the unemployed. I didn't feel comfortable assessing the few Maori patients I saw, and tried to investigate further. There was a Maori Mental Health Unit but it had not settled well into the asylum where it was housed. The unit had been set up by Government initiative and was staffed by Maori mental health workers. No consultant had been charged with the task of running the unit. This led to disagreements about clinical responsibility, underpinned by a deepseated mutual mistrust. Through my colleagues-in-training we met some Maori elders. Hearing them speak, and hearing others speak of them, highlighted their holistic appreciation of health. They pointed to our own preoccupation with independence and individuation and our mechanistic approach to behaviour – concepts alien to Maori thinking. Traditional Maori concepts of health rested upon particular methods of child care, land (and its legislation), language and the special significance of bereavement. These cultural differences required greater understanding by mental health workers. Perhaps these differences ran deeper than just health issues, into the application of justice and education, throughout the fabric of society? If so, then this was an institutionalised form of racism. With this in mind I was more aware of my own limitations and relied upon a peripatetic 'cultural team' to provide help in clinical situations. There was a need for a greater number of Maori professionals in the mental health field, along with some recognition of the volunteers already working amongst the Maoris. Parallels could be drawn over the provision of mental health services for ethnic minorities in the UK.

Second six months

From June 1987 and for the next six months I trained in liaison psychiatry. Some of the American methods of practice had arrived in New Zealand, and liaison psychiatry had a high profile. Each major general hospital in Auckland had a psychiatric registrar attached solely for liaison work. Formal experience in liaison psychiatry was mandatory under the local college rules. The department of psychiatry had actively fostered close links with medicine, and saw this as another 'heartland' of psychiatric interest.

Most of the referrals for psychiatric consultation from a particular general hospital came my way – usually of better quality than "please see and advise". Orthopaedic and neurological units made the most referrals. Patients who had taken overdoses were seen separately by a trained nurse. My initial attempts to apply the framework of general psychiatry to liaison work met with limited success. Good communication with medical colleagues was a prerequisite. Also an appreciation of current medical practice was necessary. Even though the decision to refer was up to my medical colleagues, psychiatric disorder seemed to be found easily in this general hospital setting. In addition I was often involved where there was no formal psychiatric disorder but where the constraints of the hospital regime or treatment programme had led to a breakdown in normal doctor-patient communication, resulting in non-compliance or even regressive acting-out behaviour. The least I could do was to be an advocate for the patient.

Otherwise I encountered delirium, adjustment disorder and major depression most often, being asked for help with diagnosis and management. I saw relatively few patients with functional psychosis. To my mind, the most interesting group were the somatisers, who may have comprised 15% of referrals, and seem to be a group little appreciated or widely seen outside the general hospital. I delved into the relationship between seizures and pseudoseizures, angina and pseudoangina. Few of the somatisers seemed to have any underlying affective disorder, just a rather limited repertoire of coping mechanisms. Why some people psychologise (producing symptoms of anxiety and depression) and others somatise seems a complex issue.

Severe suicide attempts were plenty, far more in number and somewhat more gruesome than I had seen in the UK. One man tried to insoufflate his stomach with a high pressure air hose introduced by mouth. Another lobotomised himself with a length of coathanger introduced through the eye. Both suffered from schizophrenia. Some were from the large psychiatric hospital in the next catchment area. Possibly they had perceived the anxieties and uncertainties generated by the move to community care and this had tipped their balance. At times the staff on the medical wards needed extra support to care for these damaged people.

Along with the consultation work were also opportunities to act in a true liaison mode. My first attachment was to the concussion clinic. I attended weekly, and although I did see some referrals the bulk of the work was providing psychological awareness to the clinic staff when they discussed problems managing their patients. Most of the patients were fairly normal young men, now somewhat changed, with low energy levels and poor concentration, fluctuating affective symptoms and impotence. Most could not work full time as yet. They were frustrated by lack of any visible evidence of injury, (indeed the initial trauma need not have been severe), the persistence of their symptoms, and by subtle changes in frontal lobe functioning. (I did not see any particular improvements after the State paid out compensation through the no-fault scheme). The interplay of biological, psychological and social factors was fascinating to observe, and interventions required a keen appreciation of all three. Clearly liaison psychiatry had to sow seeds of psychological awareness in the ward doctors and nurses themselves, otherwise there was the real risk of artificially splitting the patient's problem into physical and psychological components. Psychiatry could then be accused of perpetuating a dualistic attitude.

My own interest in mind-body interaction is leading me towards a career in general hospital psychiatry, and a stimulating attachment in liaison psychiatry reinforced this process. For that opportunity I am grateful. In Auckland, psychiatry is on the move, in ferment, aiming at community care, trying to be sensitive to the needs of all races. I experienced the ups and downs in the process for a time. The 1987 Royal Australian & New Zealand College annual meeting, held in Auckland, was aptly called 'Running with the Wind'. Often there is a fair breeze from the harbour.

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