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Going back home?

R. ARAYA, Ladislao Errazuriz 2149, Dpto B11, Santiago, Chile, South America

The socioeconomic situation in many developing countries has deteriorated markedly over the last decade. When governments face hardships, social and health programmes suffer the most. Health initiatives have been chronically under-funded in most developing countries, and health personnel's wages and working conditions are invariably poor (Appleby & Araya, 1991). It comes as no surprise that many doctors from poor countries are searching for something better in the more developed world. The forces of supply and demand which rule the international manpower market leave some countries in an unwinnable position. In the UK over 30% of junior doctors are from abroad and this percentage is even higher in psychiatry. Legislation has been passed in several countries, for instance the USA and the UK, to impede overseas doctors staying permanently. Little has been done, however, to help overseas doctors to return home. This short essay is about the painful process of doctors returning to their own countries.

Returning home: a happy dream?

It is widely accepted that there is a huge shortage of trained doctors in the less developed world. For instance, in some regions of Africa there is less than one psychiatrist per million and only a small proportion of these doctors work for state health services which offer meagre salaries and very tough working conditions. This situation is better in Chile, where there is approximately one psychiatrist per 100 000 people working for state health services (Araya & Araya, 1991). There are, however, many African or Chilean doctors working abroad, and the question is, are these doctors wanted back home? Can these countries afford to bring them back and offer them a reasonable professional prospect?

The answer is undoubtedly complex. My own experience, coming from Chile, a country of intermediate development without the serious financial problems of Africa, should serve to illustrate the subtleties involved in this process.

Before departing for postgraduate training abroad, most Chilean trainees are requested to sign a formal commitment, supported by a guarantor's signature, that they will return to work in university or government posts after their training. This commitment is generally accepted as fair. I was a very fortunate overseas doctor who came to the Maudsley Hospital for training many years ago. Everything went well; I passed my Membership exam at my first attempt exactly three years after arrival and I was appointed senior registrar at the Maudsley, a position which I occupied for a few years. During that period I published scientific papers and worked on epidemiological research as part of my PhD thesis. After seven years of intense work in the UK I went back to Chile.

One year after my arrival in London, the university post which I was supposed to occupy on my return to Chile was closed, so while in London I had to look for employment in other Chilean university departments. Initially I was given time to find a suitable job. However, as too often happens in our countries, this situation changed suddenly. I was notified that charges would be pressed against my guarantor and myself unless I returned to Chile within four weeks: no reason to stay in the UK was good enough, and I had to return to face, among other things, certain unemployment. Nevertheless, I went, eager to share some of the skills, knowledge and experience I had acquired. I even entertained the idea that perhaps all this hurry was due to a genuine need to use my skills with urgency. I was wrong. Despite my prompt return, The Council of State Defense decided to press on with the court case against us, arguing that I did not return on time and, more importantly, that I did not have a university post.

I began another unsuccessful pilgrimage through several universities offering my services. Despite the shortage of young trained scientists, professional jealousy, bureaucracy, and other more idiosyncratic reasons were more important in the end. All my efforts to explain to members of the Council that getting a job did not depend entirely upon me were unheeded. To prove my commitment I worked for free in ministries and universities, but this was not sufficient because I still had no formal contract with a university. Pressure to earn money for our daily living was increasing rapidly. I was advised I should waste no more time and establish a private practice. With some reluctance I made an effort in this direction, but soon realised that this would also take time. At present, more than one year after my return, the court case goes on and with it a great deal of unnecessary suffering and waste of time and money.

Sadly, there is evidence that my case is not an isolated example. Following an article about overseas doctors unable to return home (Patel & Araya, 1992), I received several letters from other doctors who have had experiences similar to mine.

Some lessons from my experience

We no longer live in small, isolated countries – we live in a global village and we must all look for shared solutions to the many issues affecting health. Improving shortages in medical manpower in less developed countries does not depend entirely on outside agencies – a great deal can be achieved locally. It is an unforgivable waste of money to train people abroad at a high cost without giving these trained professionals an opportunity to spread their knowledge and use their expertise at home.

Punitive measures may force overseas doctors to return home, but legislation should be accompanied by a clear plan to improve the career and work prospects of those doctors. Support and practical help for these foreign doctors must be readily available. A resettlement fund could be created to provide competitive job opportunities. This help could be linked to a particular project or task to be carried out on return. Some agencies, and European countries such as Germany, have implemented successful programmes of this nature. The establishment of regional centres could also become an intermediate step in the process of resettlement, providing a stimulating working environment. International networks could also provide some support and help. The International Clinical Epidemiology Network – INCLEN, supported by the Rockefeller Foundation (Halstead *et al*, 1991), seems to be a good example of a postgraduate training programme which maintains contact and provides ongoing support to its members.

Sadly, there are too many fine and well trained overseas doctors from all over the world who have gone back to their countries to find themselves unable to practise. An effort should be made to help less developed countries recover some of their "drained" talent. Legislative measures taken by host countries to secure that overseas doctors will return to their countries of origin are important. But it is also fundamental to find ways of making the prospect of returning home for an overseas doctor more attractive than it is at present.

Dr Patel and I would like to hear from overseas doctors who have some experience to share in this subject.

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