Correspondence

Psychiatry back home

DEAR SIRS

After staying in Britain for almost five years, during which time I received my training in psychiatry, I returned home to Pakistan in early 1984. I became the latest addition to the 90 psychiatrists already working in this country which has a population of nearly 100 million. Finding suitable employment was not easy. I was told to "pull the right strings" and for quite some time this was just about all that I was doing. I finally succeeded in securing a consultant's job on a temporary basis and became attached to the psychiatry department of a large teaching hospital in Lahore.

My first day was full of surprises. With no facilities for a day room, the patients were lying in their beds all day. The patients assumed that, since this was the practice on the medical and surgical wards, they were required to adopt similar roles here as well. 'Occupational therapy' was almost unheard of by the staff members. Ward rounds were conducted every morning and a group of junior doctors headed by a senior colleague went from one bed to another enquiring about patients' health. They asked questions which, because of the close proximity of beds, could be heard across the small ward in which they were all crowded. As the doctors approached a patient in bed, the patient made efforts to appear as 'sick' and miserable as possible to ensure better attention from the doctors.

Patients were frequently prescribed far more drugs than they required. It was almost routine to prescribe two or more neuroleptics simultaneously from the start where in fact one would have been adequate. It was similarly the case with antidepressants.

The state of ECT administration was bad enough to give anybody a shock. To begin with, ECT was administered without anaesthetic and muscle relaxant. The machine used was obsolete and unpredictable in its performance. Yet patients often seemed to do well and on repeated admissions to hospital some insisted on receiving it straightaway, having recovered promptly in the past.

There was little concept of a multidisciplinary team approach. A clinical psychologist was available but junior doctors had little idea of when to seek her assistance. There was a part-time social worker but he played little role in the management of patients.

My Professor was my greatest support; as Head of Department most of his time was spent arguing and bargaining with the civil servants in the Health Departments to secure better facilities for his unit. This left him with little time to attend to the Department which was run mainly by his registrar and staff.

It is now over two years since I joined the Department and the gradual changes that have come about are most gratifying. With the help of the Professor the routine has completely changed. We now hold twice weekly review meetings where patients are assessed using a multidisciplinary team approach. An occupational therapy department, though still in a primitive state, has been established. Instead of lying on beds throughout the day, most patients now attend for OT. We have sharply cut down on polypharmacy. Medication is prescribed only when necessary and the optimal amounts used. Junior doctors are surprised that neuroleptics or antidepressants given singly also 'work' with good results. The administration of ECT has improved tremendously. One of the latest machines is now being used and ECT administered using anaesthetic and muscle relaxant drugs. A qualified anaesthetist assists in the procedure.

We have also started group therapy and community meetings for in-patients which has been a totally new experience both for patients and staff. We were apprehensive at first but the response has been very encouraging. On the teaching side, we now have regular journal clubs, case conferences, lectures by guest speakers and occasionally Multiple Choice Questions (MCQ) sessions for the trainee doctors.

Recently the trainee psychiatrists formed an association of Psychiatrists in Training (APIT Pakistan) to press demands for better training facilities in hospitals. During a recent Regional Meeting of the Royal College of Psychiatrists in Rawalpindi they were able to communicate their feelings to the visitors from the College.

One question which worried me during my psychiatric training in the UK concerned the relevance and applicability of that knowledge back home. There is little doubt that the psychiatric problems I came across in the UK were, in many ways different from those in Pakistan. We see, for example, more of conversion hysteria, catatonic schizophrenia and obsessional neurosis here and less of 'overdose' personality disorders and 'social problems'. The pathoplastic effect of culture is also apparent. Depressives almost invariably have somatic complaints bringing them to the doctor whilst manics often show increased religiosity by visiting shrines and overindulgence in prayers.

Despite these differences, I have come to believe firmly that the basic training I received in Britain has been of enormous help in the assessment and management of these patients. Admittedly the techniques may have to be modified at times to suit the educational and cultural background of the patient but the basic approach remains largely unaltered.

Many of the overseas trainee psychiatrists in the UK may be sharing my initial apprehension of whether the training they receive there would necessarily be useful when they return to their home country, which is generally in the third world. My own experience has shown me that provided one is prepared to follow an eclectic approach in psychiatry one successfully adapts to the new class of patients and circumstances. By bringing back home new ideas and trends these young psychiatrists can be of tremendous help in improving the status and practice of psychiatry in the developing world where in many countries, regrettably, psychiatry is still practised as it was decades ago in the West.

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