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Foreign reports

Impressions of South African psychiatry

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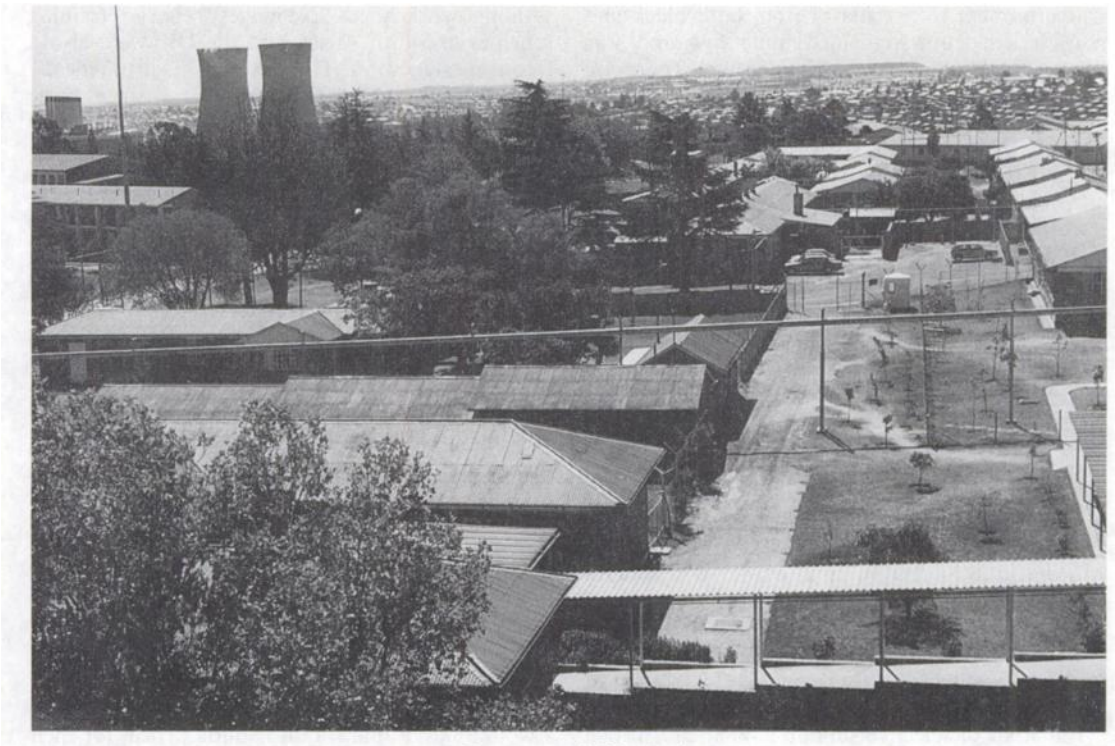
Why go to South Africa? Curiosity ... its natural beauty ... the lure of the recently forbidden ... the chance to witness the crumbling of apartheid – and to see the response of the psychiatric services ... For me it was all of these, and because I was invited. I spent a week in South Africa in October 1991 on a lecture tour; as one of the first psychiatrists from the United Kingdom to visit since the publication of the College's 'Selective Support' Guidelines I took advice from the Dean of the College and adhered closely to them.

Within my five day visit I took part in a workshop on Depression in Old Age and gave lectures in the Medical Schools of Witwatersrand University, Johannesburg; the University of Pretoria, Cape Town University and the University of Stellenbosch. I also chaired a case conference at Stellenbosch, and gave talks to audiences of predominantly private psychiatrists in Johannesburg, Cape Town and Durban. I visited the Academic Unit of Old Age Psychiatry at the University of Cape Town and Baragwanath Hospital in Soweto. I was thus able to meet more than half of the approximately 200 psychiatrists currently working in South Africa and serving a population of about 35 million people.

As far as clinical service delivery was concerned, my overwhelming impression was of the enormity of the task facing so small a number of practising psychiatrists. There were no formal barriers to service delivery irrespective of race but geographical and administrative vestiges of apartheid remained and the achievement of equal service provision appears dependent on considerable further overall growth in psychiatric provision. At least half the psychiatric care currently provided is from individual practitioners within the private sector. Most of the white population and about half the employed black population (i.e. only about 10% of the total) are covered by private health insurance paid largely by employers which gives free access to private care. Several of the psychiatrists I spoke to assured me that, contrary to the impression reported by the College Working Party, it was impossible to practise as a psychiatric specialist in South Africa without a minimum of six years post graduate experience (two years outside psychiatry and four years of psychiatric training) and successful completion of a specialist exam. Despite this, everyone I spoke to admitted that the quality of private psychiatric care was very uneven. Patients ineligible for such care are treated mainly in the University Hospitals. Professor George Hart, Head of Psychiatry at Witwatersrand, told me that academic psychiatry in South Africa was faced with the painful choice of either spearheading the service growth necessary to provide an equal and adequate service to the population (and neglecting academic work) or retreating to the ivory tower of research.

For the present, expansion of psychiatric services outside the big cities was largely non-existent. However, within Soweto, the largest black township in Johannesburg, a psychiatric service had grown through the 1980s despite major government opposition. This is centred at Baragwanath Hospital (Bara to all who work there); an enormous general hospital with a catchment population of about four million. In the last few years active links have been made between the psychiatric service at Bara and the rapidly growing primary health care system in Soweto. Bara was crowded, dirty and run-down. Psychiatric wards were segregated by sex, and most of the psychiatric patients were kept in night clothes by day. The majority were floridly psychotic and many were heavily sedated. Despite this, my overwhelming impression was of excitement and commitment, with doctors, nurses, OTs psychologists – and patients – working together for good quality care, the development of community links and teaching. There was still so far to go – but the pessimism and despondency I frequently saw elsewhere was notable by its absence.

My visit to Bara coincided with that of Dr Mary O'Keeffe, an Irish psychiatrist and member of the College, who has been the only consultant psychiatrist in Zambia (apart from the Professor at the Medical School and two specialist psychiatrists) for the past 25 years. Sadly, she said, this was now more than enough as psychiatry, and indeed medicine as a whole, could no longer meaningfully be practised in Zambia since all hospital and outreach services were overwhelmed with AIDS. Members of her clinical



Baragwanath Hospital

team were developing AIDS at the rate of about one a month. The Zambian blood transfusion service still operated but, even in donors recruited for their seeming health, the blood had to be rejected half the time because it was HIV positive. In South Africa, HIV has as yet had relatively little impact, largely because its borders have until recently been closed. In recent months however, HIV positive rates have been rising in the mining community, which traditionally has employed a high proportion of migrant labour. Many of the doctors I spoke to were resigned to escalating HIV as the price to be paid for a South Africa no longer isolated from the rest of the world.

Old age psychiatry has only just begun to emerge as a subspecialty in South Africa. There is only one full time old age psychiatrist and three part-time specialists. The Unit I visited in Cape Town was uncannily like its British counterparts. The Senior Lecturer and Honorary Consultant, Felix Potocnik, and one registrar had 25 acute in-patient beds and 75 chronic beds. Their referral rate, including liaison work, was 300 per year. The population they served, though, was 2.5 million. Dr Potocnik thought the difference was due in part to the smaller proportion of elderly in South Africa; partly to the higher degree of family tolerance of confused elderly people, and partly to a policy of only admitting demented patients for control of intolerable behaviour disturbance. He saw education of GPs in domiciliary assessment and management of dementia as one of his main responsibilities.

Undergraduate training in psychiatry varied considerably between medical schools. The greatest exposure was at the University of Pretoria where all students had a psychiatric attachment lasting 8-10 weeks followed by a clinical and written exam which was a constituent of the MB Final examination. Considerable recent effort had been made to increase the intake of black students. Several of the academics I spoke to felt that it would be several years before deficiencies in black secondary education would be worked out of the system. Meanwhile the approach at Witwatersrand and Pretoria was to have entrance requirements emphasising potential rather than secondary school level achievement and providing extra support in the early university years. Several approaches to such support were being tried including the opportunity to take an extra year, to drop optional subjects and to use a "buddy" system in which other students (either contemporary or in more senior years) provide monitoring of progress and support where necessary. The benefits of these programmes were beginning to be seen, I was told, in final examination results.

Recruitment to psychiatry from both black and non-black doctors remained quite low and was aggravated by a low rate of retention. There are apparently more South African psychiatrists practising in Canada than in South Africa and the exodus continues. Low rates of pay within the academic sector were particularly blamed for driving psychiatrists into the private sector or out of the country. There seemed little optimism that current political changes would either improve retention or encourage expatriate psychiatrists to return.

I was able to gain only a very limited impression of psychiatric research activity. Many of the academics to whom I spoke said they felt isolated from research activity in the UK and the United States. They looked forward keenly to increased research contact and collaboration. There seemed no doubt, however, that good quality research was taking place despite the difficulties. In particular, the rapidly growing psychiatric service at Baragwanath Hospital was providing major opportunity for research. Dr Allwood, the Senior Psychiatrist at Baragwanath was, for example, able to examine phenomenology and outcome in post-partum psychosis in collaboration with an obstetric unit whose 26,000 deliveries per year resulted in approximately 50 cases of post-partum psychosis.

But what of selective support? What can British psychiatrists do to help out South African colleagues to develop their service and their training? Increased research links were seen as a high priority by those I spoke to. Particular value would be placed on more frequent visits by psychiatrists active in research and in particular by their participation in research training workshops. Exchanges between training schemes in South Africa and the UK were also a frequent suggestion. These would most practically be provided at SHO/registrar level since basic qualifications are mutually recognised whereas post-graduate qualifications in psychiatry are not. The setting up of such exchanges would require considerable preparation both at College level and at the level of the individual British training scheme but I have no doubt that the resulting training opportunity would be invaluable for British as well as the South African participants.

My visit was an exciting and humbling experience. As far as I could see, the dedication and tenacity of those psychiatrists who had worked towards developing a fair service in the face of a repressive regime are finally beginning to reap some reward and deserve our selective support. I am very much aware, though, of how superficial my impressions must be after so brief a visit to a small number of selected hospitals. Now that the gates are open, British psychiatrists can, and should, make longer visits and more representative evaluations.

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Community Supervision Orders

At it's meeting on 13 January, Council approved a report on Community Supervision Orders. There has been extensive media coverage on the report, copies of which are available from the Publications Department of the College, at a cost of £2.00.