Psychiatry in South Africa: some reflections

An abridged version of an invited lecture, originally titled ''South African Psychiatry: Challenges and Opportunities'', presented at the Lilly Neuroscience Forum held on the 13th May 2006.

It would probably be safe to say that any psychiatrist in South Africa could deliver a lecture, without too much preparation, presenting their own view of the ''state of our psychiatric nation''. To consider psychiatry in South Africa in terms of the status quo, or more bravely in terms of the future, one has to take an integrated, multi-faceted view.[1] There is no doubt that in this editorial as many issues as will be raised, there will be as many not raised. At a recent Management Advisory Committee meeting at the Johannesburg Hospital (2nd May 2006), the current hospital CEO shared a sobering insight based on his ''out of South Africa'' African sojurn (he left the hospital for some 18 months, during which time this institution with a 1 billion rand per year budget had no permanent CEO). He said that in Africa, those with wealth have two passports and are very clear that their children will leave Africa. He went on to say that at least in South Africa our people stay until the system drives them out (at this point). Hence we need to address the systemic problems we face or else we will ''catch up'' with the rest of Africa. An interesting observation, well suited to the spirit of this editorial.

Let us accept that in order to be a service provider, in this instance a clinician, one needs a knowledge base that encompasses not only formal theory but also practical know how. In order to acquire such knowledge in a credible, consistent manner there is a requirement for a recognized standard of content that is delivered by institutions or individuals who are deemed eligible to perform this task. These are the teachers who also supervise and ideally conduct research in these institutions of higher learning which we call universities. The so called ''academics''. It is my contention, that unless these centres of formal and higher learning retain, or should I be saying recapture, their pre-eminence there is no future for any kind of psychiatry in South Africa. These sentiments are intentionally framed in extreme terms as it most likely provokes greater response, both emotionally and intellectually. A component of the definition of the word ''academic'' is scholarly, and a component of the definition of the word ''scholar'' is ''person who learns''. One could argue that by virtue of attending a lecture or symposium or reading scientific material, one is an academic. Rigid understandings of academia may not be a luxury we can afford in this country. In general, the academics in Health Sciences are those employed by the state and as a consequence granted a joint status of university employee, where the facilities who employ them have such an affiliation. As a consequence, academia in the clinical setting is state funded insofar as the so called ''joint appointees'' are provincial employees. But should this in fact be the status quo ? Is it not potentially preferable for all senior academics, to start with, to be university funded and thus devoted to the pursuit of an academic agenda with any clinical involvement to be within that context ? There is an old expression ''who pays the piper calls the tune''. In this sense within the status quo there is an existing issue of dual loyalties. Maybe loyalty is too strong a word. So if not a loyalty, then more likely a pressure to deliver to two institutions i.e. the state and the university. How to balance such delivery and determine the extent of either remains nothing more, to the best of my knowledge, than an understanding of a 30:70 split (in favour of service delivery) with there being no official policy in this regard.[1] And, maybe there shouldn't be. Having said that, for most ''joint appointees'' academic pursuits are squeezed into gaps between service demands, certainly during regular working hours, or generally undertaken after hours. This being the case only the driven, passionate or obliged will deliver with such delivery varying according to motivation. This being the situation, academic psychiatry is in a perilous position.

And yet there is endeavor. We have seen South African psychiatrists achieve at the highest level academically both whilst practicing in South Africa, and after leaving. And leave they do, with such attrition a major threat to academic psychiatry and the practice of psychiatry in South Africa generally. But in an era of increasing mobility maybe this is a global phenomenon varying probably only in terms of extent. Certainly there is concern that developing countries who can least afford to lose skills are providing well trained professionals to service the developed world's market. Is this not simply the free market model at work: supply and demand ? Well, maybe a little more than that according to the president of the African Union, Alpha Oumar Konare, who attacked the policy of ''selective immigration'' whereby developed countries draw skilled workers away from developing countries.[2] He described these policies as amounting to a ''brain trade''. In fact there are two sides to this argument, one (as espoused by the Algerian foreign minister, Mohammed Bedjaoui) that argues that such a brain drain is a cause rather than consequence of under-development whereas the other regards this sentiment as ''highly questionable''.[2] A Swedish researcher based at the University of Dar es Salaam in Tanzania, Robert Egnell, asserts that whilst there is no doubt that selective immigration laws encourage educated Africans to emigrate, he says the real reasons people leave their homes and families are ''poverty, corruption, political mismanagement and lack of opportunities'' with the flow of educated labour being a sign of how a government is doing politically and economically. He further states ''if people are leaving, the government must shape up.''[2] A recent World Bank commissioned study called for greater investment by international donors in Africa's universities.[3] What about investment from African governments ? At what point will there be internally motivated sober reflection such that potential truths are not verbalized by Swedish academics at African universities ? In response to the ''brain drain'' phenomenon, three strategies have been proposed i.e. retaining talent, luring professionals back or turning to the diaspora.[4] The last of the three conjures up the notion of the ''virtual university'' whereby individuals (those who have left and those remaining in a given country) form partnerships and collaborate beyond defined institutional affiliations. One tends to think of ''diaspora'' in terms of the spread of a people around the globe. What about our own internal ''diaspora'' ? There exists in South Africa a distinction between private and state psychiatry, as if these are two mutually exclusive worlds. Maybe they are, and yet all of our private

psychiatrists trained in the state sector and many are affiliated to local universities if not formally then at the very least in terms of services rendered (generally without payment) e.g. as examiners at an undergraduate level. How does one strengthen local institutions through greater collaboration between individuals in either sector ? According to a recent request, from the South African Society of Psychiatrists (SASOP), to all psychiatrists in private practice to complete a questionnaire related to fee increases for 2007, there are 170 psychiatrists in full time private practice with another 50 in part time practice (an alternative SASOP source has a figure of 173 psychiatrists in ''full private practice'' excluding the Western Cape, with some 600 odd names on their main database, of whom 357 had been contacted during the course of 2006). The latter group in part time private practice probably includes those state employees engaged in so called RWOPS i.e. remunerative work outside the public sector. A figure of 90 state employed psychiatrists has been bandied about and in fact the SASOP database cites 115. The private practice group within SASOP appears to have successfully negotiated fee increases and may yet have further success. In contrast, to quote a South African Medical Association medigram headline: ''Public sector doctors 'holding breaths' for new salary structure''.[5] If state employees provide the core of academia, and remuneration is a critical component of staff retention in this sector it is essential that we form a cohesive body (e.g. through the State Employee Special Interest Group of SASOP) that might strengthen our hand in negotiating a key aspect of our existence. Further dissatisfaction and personnel attrition is something we can ill afford.

Returning to the ''push'' and ''pull'' factors alluded to earlier. The lure of prosperity, opportunity and stability cannot be ignored as prime motivating factors in the skills attrition i.e. the ''pull'' factors. But potentially it is the ''push'' factors that render the ''pull'' factors so attractive. Local, discipline/specialty related, circumstances would appear to be a major threat together with the broader socio-political factors which cannot be ignored. The fact that locally trained professionals are readily employed elsewhere in the world speaks of their competence and thus the status of the local academic capacity to train. This requires ''trainers'' who ideally are replenished from the ranks of former trainees. But are we simply training professionals to leave (for foreign countries or other sectors of the economy) ? At which point do we lock trainees in ? Can we ? Should we ? It would seem more prudent to create circumstances that encourage them to stay: both trainers and trainees. What happens when we dip below a critical mass of suitable trainers who themselves leave and continue to do so ? Will we even realize this when it happens ? That would most likely depend on how one understands ''academic psychiatry''. Teaching is but one component. What about research ? Within this realm, what is the benchmark of adequate output ? How does one even go about determining such a benchmark, specifically in a predominantly service orientated, resource constrained environment ? Should one ? What about higher degrees e.g. MMed's and PhD's ? A major deficit appears to be the paucity of higher degrees amongst specialists, who tend not to have a higher degree. This situation applies at certain institutions even amongst the staff complement of joint appointees. Is this a threat to ''academic psychiatry'' ?

Psychiatry has always been the Cinderella of medical disciplines. Yet in spite of this position psychiatry has achieved a status as one of the ''big 5'' together with medicine, surgery, obstetrics and gynaecology and paediatrics. And then there is the Health Professionals Council of South Africa (HPCSA) who in their wisdom relegated psychiatry to ''mental health exposure'' within the family medicine domain of the new 2 year internship. And what of the notion of psychiatry as one of the neurosciences? All good and well until psychiatry disappears, for example, into a department of neurosciences together with neurology, neurosurgery, opthalomology and ear nose and throat surgery. Downgraded from a department in it's own right to a division within a department, yet potentially bigger as an individual entity than all the others put together. Would psychiatry benefit ? This remains to be seen, which is not to say that interdisciplinary collaboration isn't a critical consideration in moving our discipline forward. The point is that whilst one can justifiably look to socio-political factors to explain the woes of a discipline, one should not be blind to issues within the discipline that are seemingly of our own doing. A recurring theme it seems is one of consultation. Who makes decisions on behalf of psychiatry ?

What of bureaucracy ? It would be hard to imagine that there is a single psychiatrist who is not burdened at some level, whether in the state or private sector. From medical aids or whatever that industry calls itself these days, to the Mental Health Care Act. When are we going to get an administration that administers thus allowing clinicians to focus on patient care and academics time to think ? Does anyone ever conduct exit interviews with people who leave the state sector/university and actually do something with that information (assuming that such information was truthful and articulated the issues in a meaningful way) ? What of those who leave the private sector ? One of the biggest factors cited in the early retirement of psychiatrists in the United Kingdom is bureaucracy, a major contributor to shortages of clinical staff in that country[6] , albeit a developed one. And yet whilst a discouraging environment to their locals, still an employment destination of choice for developing country professionals.

There must clearly be some powerful ''push'' factors at play, but are they all about the broader socio-political environment ranging from crime, about which one could say so much, to employment equity ? Turning one's attention to employment equity, the recent ''Eskom decision'' comes to mind.[7] Here there was a decision taken as to whether a coloured man was less previously disadvantaged than a black man who being less qualified nonetheless got the job ahead of the coloured man on the basis of being deemed more previously disadvantaged. Such a decision raises the thorny issue of racial politics. To quote Rehana Rossouw, ''We are not being racist if we talk about race today, we are remembering our pain, hoping never to experience it again ''.[8] I wonder how the coloured applicant, and the coloured community for that matter, feels ? In relation to employment equity, is it set to become a divisive approach that undermines rather than fosters redress ? Dr Iqbal Surve, a medical doctor and one of the founders of the Sekunjalo Investment Group, a group rated as the country's most empowered company had this to say about empowerment: ''We need to stop thinking in terms of race in SA.'' ''Let's dump the empowerment bandwagon and terms and let's get onto a pro-development agenda, where we take the skills of people, black and white, old and young, rich and poor and build another country again. We need to start accepting people for their skills base, but at the same time the value systems or drivers must be pro-development and pro-poor. We need to do that for the next 20 years.''[9]

So what is this dabbling in politics ? Purists would argue that one has no business doing that in an editorial for a psychiatry journal, that one should confine oneself to psychiatry. The same could no doubt have been argued of the guest editorial in the May 2006 edition of the Journal that dealt with same sex marriages.[10] In response one might say that the bio-psycho-social approach, which confers upon

our specialty a truly holistic ethos and as much as anything else defines psychiatry as unique in medicine, contains the word ''social''. We need to be acutely sensitive to the social aspects of not just our patient's existence but also our own, both as individuals and as a specialty. Political developments whether they represent threats or challenges always afford opportunity to engage both on behalf of psychiatry and ultimately our patients. The point to be made is that whilst such political factors are relatively easy targets, they are in fact to some extent obvious and accordingly ''soft targets''. What of how we as South African psychiatrists co-exist ? The private-state divide has been mentioned, but what of the regionalism ? Aside from industry initiated and sponsored clinical trials, which one might argue do not truly represent collaborative work, how much collaboration is there ? Certainly we get together in various forums. Meetings mainly, but opportunities to interface nonetheless. In addition, one should not ignore the publication of numerous texts that have brought colleagues together as well as the local journals that currently exist which have national representation both at an editorial board level and in terms of published material. Yet how much do we otherwise know about what our colleagues are doing in centres other than our own ? In fact how much do we know about what colleagues within our own centres, divisions and departments are doing ? From a research perspective, my personal observation is that such output in South Africa has tended to be about individuals more than groups. And yet we are ''resource constrained'', so how do these individuals and, such as they are, research groups, do it ? Are we existing in a culture of individualism where it is everyone for themselves ? Is a collective agenda desirable, beyond our capacity or maybe it does exist and such concerns are unwarranted ? Is it not time for an Imbizo of sorts, to explore this issue ? Maybe the forthcoming SASOP congress in Swaziland is such a gathering that would allow for such engagement.

The intention of the editorial (and initially the lecture) was simply to challenge. This has clearly been an opportunity to do so which loosely corresponds to the title and proposed content of the original lecture: ''South African psychiatry: challenges and opportunities''. It would appear that a significant challenge facing South African psychiatry is to decide, through an inclusive process, what it's aims are and how they are to be achieved. A quote from Warren Buffet, the US investor, [cited in The Weekender (Business Day) editorial of the 6-7 May 2006 edition] seems pertinent: ''It's when the tide goes out that you learn who's been swimming naked''. Lets have our costumes on, because as surely as you are reading this editorial the tide is on it's way out.

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