

Four International Residents' Perspectives on Working Overseas as Part of Residency Training: Liberia, Myanmar, and Saint Vincent/Grenadines

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INTRODUCTION

Residency training is an integral transition point in a doctor's life when he or she transforms from being a student into an independent physician. It is during this time that trainees in psychiatry gain their own voice as well as learn how to evaluate, interpret, and conceptualize the varied voices of mental illness. The opportunity to integrate at least 3 cultures—American, family of origin, and that of the global health site—is an experience that these residents were excited to explore as part of their training. The privilege to further their training by participating in mental health work abroad enriches their experiences as trainees and forever changes their perspectives. The unique understanding of the role that culture plays in how mental illness manifests as well as the ability to treat mental illness within the constraints of the environment plays a crucial role when treating the mentally ill. Additionally, having to work with limited resources teaches young physicians how to manage symptoms efficiently and effectively without compromising care. This in turn makes them better physicians at home when they return with additional tools, knowledge, and cultural sensitivity that they otherwise may not have had without work experience abroad.

HIWOT WOLDU: ST. VINCENT AND THE GRENADINES

In many ways, going to the island of St. Vincent was like a homecoming for me. Everything from the languid pace of life and close-knit community, to the vegetation, scents, and sounds, was very much like the Ethiopia of my youth.

Months after returning, I still browse through my trip journal and see that I had approached the everyday life and social interactions of St. Vincent through the eyes of

an Ethiopian. In contrast, I am struck by how all my entries pertaining to work sound decidedly American; no doubt a result of my having trained in the United States.

My Ethiopian social outlook made it quite easy to fit into the culture and share the Vincentian way of life. By comparison, my New Yorker work ethic of type-A drive and neurotic organization was less easily adapted to my new surroundings. I arrived excited to be useful and teach, armed with all sorts of slide shows, handouts, and know-how, but to my surprise, it took a near-paradigm shift of organization to get things done with any semblance of a plan.

In time, I learned to “go with the flow” and adopt the Vincentian (and ironically, also Ethiopian) fluid sense of time at work. I started to enjoy making the best of whatever surprises the day held for me. Luckily, on most days things somehow worked themselves out.

It was both flattering and unsettling to have my role suddenly transformed from trainee (as a resident in the United States), to a country's “leading expert” on mental health (as 1 of 2 psychiatrists in St. Vincent) where the most complicated cases were especially selected for consultation with me. I feel this was one of the more sobering situations that highlighted the significant unmet need for mental health providers in St Vincent and the Grenadines.

In stark contrast to a one-time medical or surgical mission, a psychiatrist's version of global health work has very few immediate and dramatic results; it often requires long-term partnerships and scaling up of services to develop meaningful changes. I am grateful that I was able to participate in training community health workers in basic psychiatric diagnosis and treatment as a way to continue creating sustainable improvements in the mental health care of St. Vincent and the Grenadines.

In the end, it was exhilarating to think that in some small way, I was helping maintain healthy communities and increase awareness in this small island nation.

BENJAMIN ANGARITA: MYANMAR

As a third-year resident I traveled to Myanmar to meet with the Myanmar Mental Health Society. This trip also had the added benefit of allowing me to experience a new culture with an insider because I was traveling with my wife, who was born and raised in Myanmar, and our

2-year-old son. In contrast, I was born and raised in Queens, New York in a Colombian-American home. My experiences traveling to Myanmar, growing up in Queens and training at an academic medical center have made me think more deeply about my identities as a Colombian, an American, a psychiatrist, and a trainee.

In both Queens and Myanmar, my ability to practice psychiatry is affected by the system in which I am working. When visiting my family in Queens and my in-laws in Burma I sometimes recommend that a person see a psychiatrist for treatment. However, the ability of both sides of my family to follow up on my recommendation is limited. In Queens, access to a well-trained psychiatrist may be limited due to the patient's socioeconomic level. In Myanmar, there are simply too few psychiatrists. According to the World Health Organization, in 2006 there were 89 psychiatrists in Myanmar to serve about 50 million people, or 1 psychiatrist for 500,000 people.¹

During my time in Myanmar, I was also struck by the country's poor digital infrastructure. The Internet was available in roughly 5% of the 20 upper-middle-class homes I visited with my wife and son. Furthermore, no one I met in Myanmar had Internet access on their cell phones. The lack of the Internet service in Myanmar resonated with me because of my identity as a trainee and as a Colombian. As a trainee, I use the Internet on a daily basis to answer questions that arise while performing my clinical duties at Mount Sinai in New York City. Similarly, psychiatrists in Myanmar commented to me that if given better access to a fast and reliable Internet connection they would have greater access to up-to-date continuing medical education resources. Finally, as a Colombian, I use the Internet on my phone on a daily basis to listen to Colombian music. If I lived in Myanmar, I would have less access to continuing education resources as well as the music I grew up listening to. Without a digital infrastructure I would feel less connected to my ethnic background and to my identity as a trainee.

BLESSING IGBOELI: ST. VINCENT AND THE GRENADINES

I was not sure what to expect, but I suspected that there would be similarities between St. Vincent and the Grenadines (SVG) and Nigeria, where I was raised. Once I arrived in SVG, I noticed how as a country, it appeared more developed than Nigeria in a number of ways. The electricity was seemingly uninterrupted and access to Internet on par with the United States; while the economy was far more stable, there was significantly less congestion and a greater sense of safety when compared with Nigeria.

I remember my landlord saying, "Saint Vincent is the safest country in the whole world," and then

subsequently reminding me to lock my doors and windows. The chains on the door, the bars on the windows, and the attentiveness used to ensure they were locked when you left the house and at night were all aspects that were reminiscent of my childhood in Nigeria.

I found the Vincentians to be kind, warm, and friendly. One of the nurses, Sister J, brought home-baked bread nearly each week. The people seemed to have time to ask of each other, and seemed to know their neighbors as if they were family. This was a welcome change to the solitude and seeming indifference often encountered stateside.

It was initially difficult to assimilate to the work environment in SVG as there did not seem to exist any set schedule. I was not prepared for this but I soon realized how having a flexible schedule made sense considering there was 1 psychiatrist caring for the country's population of about 100,000.¹

SVG's psychiatric hospital was the first I had seen outside of the United States and it stood in sharp contrast to what I was accustomed to. There were not enough accommodations for the number of patients admitted, insufficient staff to adequately care for the patients, high turnover of nurses, and no security to ensure safety of patients and staff. There was limited access to medications that are considered routine and on formulary in the United States. I quickly saw the deficiencies in the system, and its ripple-down effect on patient care.

Considering the limitations of the mental health system in SVG, I was astounded by how the dedicated members of this system were able to do more with less. They always strove to provide the best care for their patients on the political and social levels within the limited confines of society.

DIANA SAMUEL: LIBERIA

Early in my childhood it was clear to me that I was different from many of my peers, despite being raised in a diverse suburb of New York City. I struggled to understand if I was Indian or American and what culture to identify most with. As a first-generation Indian, I soon realized I was both American and Indian. To put myself into one category did not feel right nor fit the person I had become. Appreciating the stigma toward mental illness within the Indian community in the United States is what ignited my interest in psychiatry and specifically global mental health.

My passion for global mental health was nurtured during my residency training when I traveled to Liberia during my fourth year. The opportunity to be immersed in the Liberian culture while working with various mental health clinicians using the skills and knowledge I had obtained as a physician left me feeling in awe. I had traveled to India numerous times at various stages in my life and had grown up in a household where being

strongly bonded to the Indian community was fundamental. As a result, I felt fairly comfortable in understanding the norms and social caveats of the South Indian culture, and even mental health.

Throughout my time in Liberia, I found myself making comparisons to my experiences both in India and in the United States. What was most striking was the ease with which Liberians interacted with strangers, as though they were family members. Their sense of community resonated with the one I had grown up with. It was these interactions among the Liberians that helped me understand how being closely connected to one's community was essential to daily life. Living in a post-civil war era, Liberians survived by relying on each other for assistance with their basic needs and once these needs were met, their willingness to address their mental health issues was apparent. Given that the desires or needs of one's family and community seem more important than that of the individual's, the psychiatrists involvement of the family unit and community is almost imperative. While in Liberia and since having returned to the United States, I am reminded of the limitations of their mental health system as well as the surplus of resources available here at home. Having had this experience as a trainee, it has permanently changed the path I envision for my future endeavors professionally. I now foresee global work as integral to my future career.

CONCLUSIONS

The opportunity to travel overseas as part of residency training is a unique and rewarding experience. Although the 4 of us come from different cultural backgrounds (Ethiopia, Nigeria, Colombia, and India), there is a common thread in our ability to understand various cultural perspectives and integrate them into the new experiences we had while abroad.

We believe the medical knowledge from residency training coupled with our cultural sensitivity from our upbringings helped us provide educational and clinical service in ways that are culturally suitable and respectful. An important element to our success while abroad was collaborating closely with motivated members in the host country that shared the same vision. It was through these liaisons as well as our patients that we came to understand how cultural aspects affect clinical presentation, how the community perceives mental illness, and subsequently, how we could be most effective as clinicians and educators during our time abroad.

The lens through which we view another culture and mental health concerns differed from many of our colleagues in that we each had at least 4 perspectives: American culture, family of origin's culture, being a trainee, and that of a psychiatrist. We took note of the distinctions that made the communities abroad different from the ones we had been accustomed to while still considering our own cultural backgrounds as well as our American culture. One of the common problems we each faced while abroad was the scarcity of resources available in comparison to the United States. The ability to adapt our skills to resource-poor communities while learning a different culture's values, traditions, and experiences, inevitably bolstered our overall experiences. The time we spent overseas strengthened our training in a way that could not have been possible by reading a textbook or watching a video. The level of growth achieved both professionally and personally through these journeys is one that cannot be fully described in words but nonetheless is one that has left a lasting impression on each of us as young physicians.

Reference

1. Taw NP. WHO-AIMS Report on Mental Health System in Myanmar. Myanmar: WHO, Yangon, and Ministry of Health, Myanmar; 2006.