patient safety with independent nurse prescribing. This type of OSCE may be an appropriate addition to the assessment of junior doctors. Additionally, it could form part of revalidation, making a significant contribution to ensuring continuous fitness to practise for doctors as demanded by the White Paper *Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century*.[8] It may be that, in time, a similar system of ensuring continuing fitness to practice for independent prescribers is implemented.

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Declaration of interest

None.

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NORMAN POOLE AND PETER HUGHES

A training experience to remember: working in Ghana

AIMS AND METHOD

As part of a pilot project, one of the authors spent 3 months undertaking clinical work, teaching and research in a large psychiatric hospital in Accra, Ghana. The other acted as a UK-based mentor. Both report on the training value of the experience.

RESULTS

It was possible to assimilate into the local healthcare system and effect some modest but sustainable changes. The experience broadened the trainee's understanding of psychiatry, cultural influences and healthcare systems, while also developing autonomy and resilience.

CLINICAL IMPLICATIONS

The post is now an option available to trainees on the rotation. Projects in training and service delivery to benefit the host institution have been identified.

Lord Crisp's Report *Global Health Partnerships: The UK Contribution to Health in Developing Countries* (2007) has called for UK organisations to foster partnerships with colleagues in low- and middle-income countries that will lead to sustainable improvements in services.[1] In response, the Royal College of Psychiatrists and South West London & St George's Mental Health NHS Trust, with support from Challenges Worldwide, a non-governmental organisation, have developed a scheme that enables specialist registrars to work in Ghana for 3 months as an accredited part of their higher training, though they must sacrifice 1 month's salary. One of the authors (N.P.) has recently returned from the pilot study, investigating whether such placements can fulfil Lord Crisp's aims while at the same time benefiting the trainee. Here, we discuss the project from the perspective of the trainee and training programme director for specialist registrars at St George's Hospital; P.H also acted as UK mentor.

Psychiatry in Ghana

Mental health problems are widespread in all of Africa[2] but epidemiological research in Ghana is lacking. There is one psychiatrist to 1.5 million people in Ghana and they are primarily based in the urban centres of Accra and Kumasi.[3] The three dedicated psychiatric hospitals lie

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within two administrative districts, with psychiatry being delivered by 150 community psychiatric nurses in the eight other more rural districts and quarterly clinics performed by the psychiatrists. The rural psychiatric nurses are mainly senior clinicians whose younger colleagues are less keen to work autonomously in isolated communities. Soon, even fewer psychiatric nurses will be working in these remote areas. Treatment of mental illness is, like malaria and HIV, provided free of charge by the government but lack of funds bedevils this admirable policy.

Trainee's perspective

I (N.P.) was based in Pantang Psychiatric Hospital, a 500-bed facility set just outside the capital Accra built in the 1960s with the ambitious aim of being the principal psychiatric hospital for the whole of West Africa. My work plan mirrored that of a specialist registrar in the UK, with 3 days for clinical work, 1 day for research and another for preparing teaching sessions. Clinics are much busier and despite being markedly slower than the local psychiatrists I saw 20–25 individuals in a clinic. Assessments, carried out with the aid of an interpreter, had to be focused on the mental state examination and immediate psychosocial context. My experience was that the patient's relatives tended to answer for the patient and used confusing terminology – whereby all the older generation are 'mother' and 'father' and extended family all 'brothers' and 'sisters' – making this a frustrating process.

Those at risk to themselves or others are admitted and remain under the care of the admitting doctor. An inconsistent supply of medications can undermine the treatment regimen but with time most can be discharged back to the community. However, highly stigmatising attitudes to the mentally ill[4] mean families are often reluctant to take the individual back. Causality is attributed to religious and spiritual forces rather than biomedical ones, so psychiatrists are often consulted once traditional methods have failed. It is thus not uncommon to see people with psychosis of several years duration who have never received an antipsychotic. Relatives can be sceptical of recovery after so long and the husband of the first person I admitted found himself a new wife in the interim.

Early on I found myself frustrated and angry at the poor condition of people brought from church-run prayer camps, which charge families to drive out malevolent spirits by means of prayer, starvation and burning. I discussed this with P.H. in supervision and was helped to appreciate that some of these feelings derived from my own avowed atheism. I was encouraged to visit a camp and spoke with traditional healers about their conception of madness and its treatment. I was surprised to find some common theoretical ground and an openness to work with orthodox psychiatry to reduce shackling and restraint. I also saw the number of patients under their care and realised the governmental healthcare system would buckle if these camps were to close. Supervision therefore enabled me to acknowledge my anger, understand its origin and develop a strategy of collaboration rather than confrontation.

A week was spent conducting clinics in the rural north west region. The arrival of a psychiatrist is advertised through the local radio stations and churches for weeks beforehand. As a result the clinical work was overwhelming – one day I saw 76 individuals. This kind of clinical work does feel unsafe and I would have rather focused on teaching the community nurses about the management of severe mental illness. However, it was fascinating to see the challenges to the delivery of psychiatry and an honour to work with such dedicated colleagues.

While at Pantang I conducted a piece of research with the help of a fellow British psychiatric trainee also working in Ghana, although on a different project. We studied the relationship between insight and psychopathology in people with schizophrenia. Our findings, that insight is inversely correlated with positive and negative symptoms while at the same time being positively correlated with anxiety and depression, are broadly in keeping with studies previously performed in the West and will be published elsewhere. The research was certainly easier to conduct here as a result of the large number of people with psychotic disorders and the assistance we received from nursing staff. Doctors still command an authority and respect in Ghana so long eroded in the UK it made me feel uncomfortable.

The aim of the pilot project, however, is to achieve sustainable benefits for the Ghanaian health service. Having established that much of the psychiatric care will in the future be delivered by medical assistants, nurses with an extra year of training in general medicine, I was keen to train those based at Pantang. I gave tutorials on the assessment and management of depression, psychosis and epilepsy, and provided clinical supervision. I initiated teaching ward rounds on the chronic wards, which are managed by the medical assistants. This worked well while I was present but fizzled out shortly after my departure. A protocol for the identification and acute management of aggression that I developed and made into a large laminated poster for each ward is, however, still in use. The experience taught me that the organisation of a system is just as important in psychiatry as the analysis of the individual.

Training programme director's perspective

The process of supervision by me (P.H.) began before departure. This involved advising on how to obtain 'out of programme experience' status from the deanery and training approval for the placement from the Royal College of Psychiatrists. It was also important to discuss the trainee's preconceptions about the host service and expectations for the placement, both professionally and personally. The motivations for working in a low- or middle-income country are diverse and it is important the trainee is realistic about what can be achieved. A vague

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desire to 'save the world' will inevitably lead to frustration and anger, potentially undermining the project. It was useful that N.P. had worked as my specialist registrar so I knew his personal attributes well.

It was a challenge to supervise a trainee through the medium of email because the important dialogistical aspect of supervision is lost. Emails tended to be lengthy and could not always be scheduled. The supervisor had to anticipate the challenges that would be faced and contemplate the local situation and the personal qualities of the trainee before offering advice. A broader range of issues could be expected to arise, such as difficulties adapting to the local culture (both at work and generally), coping with a much larger case-load but fewer resources and managing expectations, which demands a more pastoral approach. My personal experience of working in Africa and Pakistan were invaluable to me in this regard. One issue that came up in mentoring was the core role of church and religion in life in Ghana, particularly the prayer camps. This was quite alien to N.P. Although I did not realistically expect him to embrace a religious theology during this project, I did need to reflect back to him the dynamics of why it caused him such discomfort. It was a process of gradual assimilation into the local culture and respectful understanding of the role of the church in Ghana. This may have been easier for me to appreciate coming from Ireland. N.P. was open and honest and was eventually able to distance himself from his initial frustration and alienation to an accommodation and respect for local feelings.

The process continued after the return of N.P. to ensure that there was a psychological adjustment back to the training scheme and to look at systems of ensuring a legacy of effect back in Ghana. The trainee is now expected to act as ambassador for the principle of training overseas among the other trainees. The supervisor sometimes felt overwhelmed by the vicarious challenges but was there to help the trainee find the answers within himself.

The advantages for the trainee are that it stretches them to rapidly develop their ability to manage challenging situations, broaden their awareness of psychiatry and its international aspect, and makes them a more sympathetic and knowledgeable doctor. This will help them cope with the rigors of the modern National Health Service (NHS).

The future

The pilot project was a great success. The Ghanaians were excellent hosts and welcomed N.P. into their service. Some useful projects were undertaken and future directions identified. We would like to construct a curriculum for the medical assistants that can be delivered by the next set of trainees. The introduction of a Kardex system and more robust physical health protocols would improve the functioning of Pantang Hospital. Although the ward rounds did not outlive N.P.'s time there, a more regular stream of trainees could supply the needed impetus. The rural clinics were arduous and in themselves do not lead to sustainable improvements. However, this was an excellent experience and we should work towards making these a better combination of teaching and clinical work. N.P. has benefited from first-hand exposure to psychiatric presentations in a different culture and the experience of working in and influencing a radically different system. This has helped him feel more ready to face the challenges of consultancy in the NHS and provide services to a culturally diverse community. Three trainees on the St George's & South West London rotation have already applied to work in Ghana. This pilot project represents a good start but it is only by assuring a regular supply of trainees that truly sustainable change can be achieved. We hope others will commit to this excellent training opportunity.

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