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Foreign report

A week spent working in a psychiatric hospital in Latvia (Part 1)

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I obtained an opportunity to spend a week working in the Jelgava Psychiatric Hospital in Southern Latvia from Imants Eglitis, the Professor of Psychiatry in Riga.

The ward psychiatrist's day

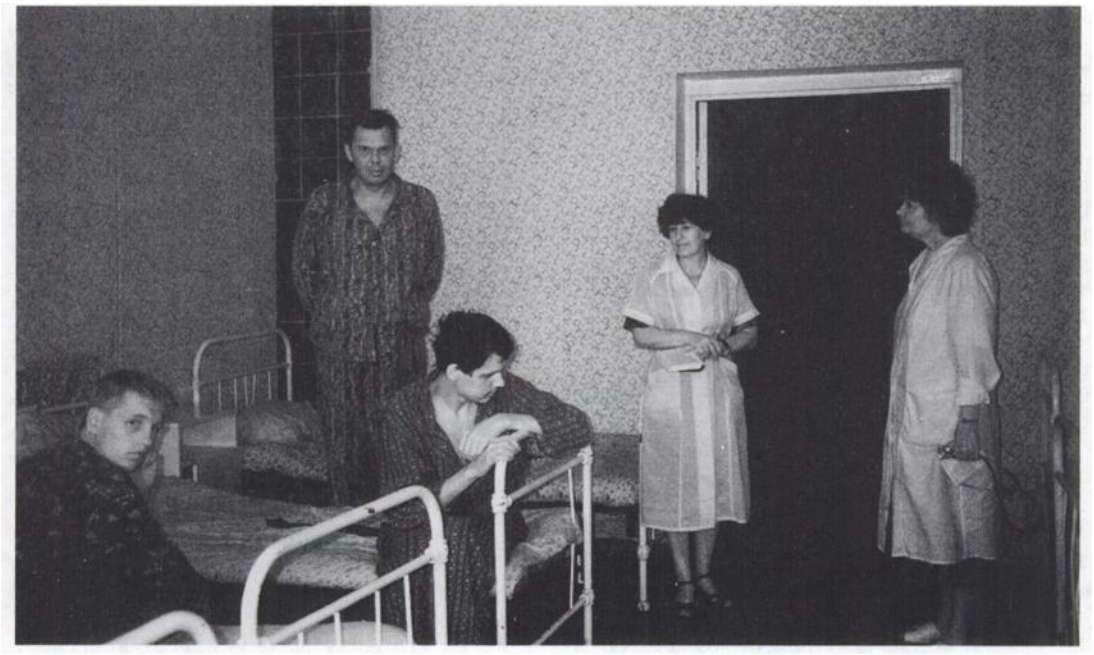
The day began at 9.30 a.m. in one of the psychiatrist's, Dr Liepina's, office with a brief staff discussion about medication and the previous night's events.

A ward round followed. As we strolled round the ward in our white coats, the familiar smell of stale cigarette smoke and unwashed bodies assailed me. All of Dr Liepina's 40 patients had a couple of moments to express their complaints. One patient wanted his mother contacted, another wished to change beds because the devils were getting at him. The other patients laughed and so did he. The long-stay patients had little to say. Dr Liepina was of the opinion that if she missed her round the ward became considerably more disturbed.

A few administrative phone calls followed and then, each day, we saw a couple of patients who were causing concern.

Lunch, which was eaten on the ward as the staff canteen was closed for some unknown reason, was in general stodgy. In many public institutions the best food is almost certainly removed by kitchen staff.

In the afternoon we saw the two or three 'new' patients. In my week these consisted of unremarkable re-admissions of patients with schizophrenia and hypomania, one overdose patient and one



On the ward round.

elderly man who was felt to be having psychiatric symptoms in relation to transient ischaemic attacks.

Work with families should form an important part of the service as many people live in over-crowded flats. However, relatives were to some extent fended off because of the lack of time available.

A large proportion of the psychiatrists travel down daily from Riga and a combination of transport difficulties, and the need to get back before the shops have emptied completely, leads most to leave at 4 p.m.

On-call duties

On-call for the doctors, out of office hours, occurred three or four times a month. One of these occasions might be an over-night period, this often being followed by a free afternoon, with the other two day-shifts at the week-end. Most doctors I talked to were quite shocked by the on-call system in England.

The on-call room, which contained a bed, television and telephone, was comfortable and conveniently close to the reception area to which patients arrive.

Anything from two to 15 patients came to the hospital in a 24-hour period. A very brief history was taken by the on-call doctor. Additional tasks while on duty included breathalysing suspected drunken drivers and checking the quality of food available for the patients at the weekend. The latter involved going to the steam-enveloped and rather foul-smelling kitchens and eating what was on offer there.

The manner of working

The style of work was a paternalistic 'doctor-knows-best' approach based on years of clinical experience and working in the same catchment area. Some things were withheld from the patient and an air of mild optimism reigned. At times, Dr Liepina contrasted this with sharp challenging of the patient, particularly if there was some doubt as to diagnosis. I was impressed by her nose for alcohol abuse. She felt I trusted the patients too much.

In general, I was left with the sensation of a slower pace. There were no bleeps (however, the psychiatrist does spend almost all of her time on her ward); blood tests, even in more pressing cases, were left to the following day when a phlebotomist came in.

Training

To become a psychiatrist one completes medical school and a compulsory 'house-officer type' period of two years before applying for a permanent post in a psychiatric hospital. Learning mostly occurs from colleagues.

Recently there have been specialist courses in Riga, but before that psychiatrists went to Moscow for up to two months at a time. In general, training is rather random and how seriously it is taken depends very much on the individual.

The psychiatrist's salary

The salary of a typical doctor is low compared to those for many other occupations. Employment as a security guard, which is much favoured by chronic schizophrenics, is often better remunerated. In Jelgava they have addressed this by paying the psychiatrists for one and a half shifts even though they actually work only one.

Additional payments based on such factors as the psychiatrist having a higher degree seem to be distributed in a rather arbitrary way and one has to have the right connections to get them. There are psychiatrists in Latvia who do not speak Latvian who are on the highest level of payment.

To complain about these and other forms of discrimination, such as it being almost impossible for Latvian psychiatrists to get jobs in Riga, or poor standards of work is, even now, a risky business as the same people still occupy many influential positions.

The question as to whether medical practitioners should regularly receive 'small presents' from their patients is a complex one both for the doctors themselves and their patients and if mishandled can lead to considerable difficulties for the doctors involved. Meanwhile, some psychiatrists have started semi-official private practice.

Many doctors have a second and better income from such activities as cultivating bulbs, but despite this a large proportion cannot afford a car.

Morale

The majority of psychiatrists felt over-worked though the hours they spent practising psychiatry were considerably less then those of an average registrar or consultant in England. The cultivation of vegetables and poor pay are the most pressing issues for many. In addition, though top posts are usually filled by men, psychiatrists in Latvia are predominately women, and a significant number are victims of the exhausting 'double-burden' of being almost solely responsible for domestic duties and child care as well as having a full-time job.

But I felt that low morale was also explained by the need to carry all the responsibility for their patients without the aid of a multidisciplinary team and by the strains of coping with a severely under-financed service.

In Part 2 (August *Bulletin*) I will be outlining how the service functions.

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