Psychiatria Danubina, 2017; Vol. 29, Suppl. 3, pp 504-511 *Conference paper*

WORKING IN PSYCHIATRY IN NEW ZEALAND: EXPERIENCES OF INTERNATIONAL (NON-NEW ZEALAND) MEDICAL GRADUATES

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SUMMARY

On the 11th of February 2016, the Health Secretary in the United Kingdom (UK) Jeremy Hunt announced his plan to impose the Junior Doctor Contract despite thousands of healthcare professionals storming the streets of Westminster in defiant protest. A leading member of the Royal College of Psychiatrists Psychiatric Trainee Committee described the Junior Doctor Contract as 'poisonous', exclaiming that it would be a 'disaster for mental health' and that it would 'disincentivize doctors to work in an already desperately under-resourced specialty'. The number of doctors who applied for documentation to work abroad surged by over 1000 per cent on the same day that the Health Secretary made the Junior Doctor Contract announcement. Not surprisingly, Jeremy Hunt was accused of acting as 'a recruiting agent' for hospitals in Australasia. This paper provides background information about working conditions for Junior Doctors in the National Health Service in the UK and the anticipated effects that the Junior Doctor Contract will have on their morale, well-being and occupational functioning. Our paper then provides a brief overview of mental health services in New Zealand with a focus on a Maori mental health service provider in the North Island. We conclude our paper by offering insights from International Medical Graduates from the UK and from South Africa working as a Royal Australian and New Zealand College of Psychiatrists Psychiatric Registrar and Consultants in Waikato District Health Board (DHB) in Hamilton, New Zealand, respectively.

Key words: *psychiatry – training - Junior Doctor Contract - New Zealand - International Medical Graduate - United Kingdom - South Africa*

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Dedicated to Dr Andrew Darby and Dr Mangala Wettasinghe (both based at Waikato DHB, two truly inspirational psychiatrists and individuals who I will never, ever forget. Thank you immeasurably for your unwavering support during a tough period in my life (AH)

Introduction

In a candid and courageous interview with Bryony Gordon for *the Telegraph*, Prince Harry disclosed that he sought professional help after struggling with psychological distress for over two decades of his life following the death of his mother. (http://www.telegraph.co.uk/news/2017/04/16/prince-harry-sought-counselling-death-mother-led-two-years-total/). Childhood parental death, according to Raj Persaud and Adrian Furnham in their blog entitled, '*Does Prince Harry reveal the secret of how to cope with loss*?', is regarded as, '*one of the most severely stressful life events that a child can ever experience*' (https://www.doctors.net.uk/blog/psych-eye/2017/04/19/does-prince-harry-reveal-the-secret-of-how-to-cope-with-loss/).

Persaud and Furnham surmise that what protected the royal from developing a debilitating psychiatric disorder following the death of Princes Diana was a quality known as 'dispositional gratitude', (https://www.doctors.net.uk/blog/psych-eye/2017/04/19/does-prince-harry-reveal-the-secret-of-how-to-cope-with-loss/) an attribute that research has revealed is associated with psychological well-being and resilience. Psychologists argue that a person can develop a '*dispositional gratitude*' by maintaining a gratitude diary and by, '*actively counting one's blessings*' (Green et al 2017).

The blessings of working as a doctor in the UK

As doctors working in the National Health Service (NHS) in the United Kingdom (UK), we should start off by '*actively counting our blessings*' since developing a '*dispositional gratitude*' is in our best interests, after all, and we certainly have plenty to be grateful for. Medicine is the most competitive course to apply for at university and many individuals are not successful with their applications despite obtaining the necessary grades and demonstrating the required virtues which can be a huge disappointment for them (and even, in some cases, cause 'heartache'). Being a medical student can be an expensive affair and there are those who have the

intellectual prowess and empathy to study medicine however they do not have the resources to enrol in university and thus may never realize their dream to qualify as a doctor. Many graduates struggle to secure a job due to a shortage of employment opportunities in their respective fields however doctors do not usually experience this problem (indeed, there is a shortage of doctors in the UK with a surplus of vacancies being advertised in specialties such as General Practice and Psychiatry (Baker et al 2016), see below).

We are incredibly fortunate to be able to help other people and for them to allow us into their lives and for us to listen to their fascinating stories (Hankir et al 2013). Although it might not feel like it at times, medicine continues to remain one of the most reputable and revered professions in society (https://www.forbes.com/sites/niallmccarthy/2016/03/31/americas-most-prestigious-professions-in-2016-infographic/#14188dea1926) and this has clear effects on an individual's status and on their quality of life (introducing yourself, in a social setting as a doctor will generally elicit positive response, (Hankir et al 2013)). Indeed, the list of our blessings working as doctors in the UK can go on but just because there is much to be grateful for it doesn't necessarily mean that we, as a workforce, should not be valued or that we should accept policies that we feel are unfair.

Feeling valued in the workplace, occupational performance and psychological wellbeing

The results of a recent survey conducted by the American Psychological Association (APA) revealed an important link between feeling valued at work and well-being and occupational performance. The APA survey was carried out online and recruited 1,714 adults residing and working in USA. The survey uncovered that employees who feel valued are more likely to report better physical and mental health, as well as higher levels of engagement, satisfaction and motivation, compared to those who do not feel valued by their employers. (http://www.apa.org/news/press/releases/2012/03/well-being.aspx).

Almost all respondents (93 percent) who reported feeling valued said that they are motivated to do their best at work. This compares to just 33 percent of those who said they do not feel valued. The APA study revealed a specific finding that may be of relevance to the current climate for doctors working in the National Health Service. Among respondents who feel valued, just one in five (21 percent) said they intend to look for a new job in the next year (vs. 50 percent of those who said that they do not feel valued). A variety of factors were linked to feeling undervalued at work, including having fewer opportunities for involvement in decision making (24 percent vs. 84 percent) and being less likely to say they are receiving adequate monetary compensation (18 percent vs. 69 percent). (http://www.apa.org/news/ press/releases/2012/03/well-being.aspx).

Feeling valued as a doctor working in the UK

Health Education England (HEE) collaborated with the British Medical Association (BMA) Junior Doctors' Committee, the General Medical Council (GMC), NHS Employers, the Academy of Medical Royal Colleges and trainee representatives to formulate a review on working conditions for juniors doctors in the UK and employee morale and well-being. The report published by HEE concluded that, '*Significant work needs to be done to make junior doctors in the UK feel valued at work*'. (http://www.nationalhealthexecutive.com/Health-Care-News/hee-significant-work-still-do-to-make-junior-doctors-feel-valued).

Feeling valued, doctor well-being and policy

As the APA survey revealed, feeling under-valued at the workplace can contribute to both physical and psychological health problems. West and colleagues conducted a systematic review and meta-analysis published in *the Lancet* revealing that physician '*burn-out'* and '*emotional exhaustion'* have reached epidemic levels (West et al 2016). Health ministers must act with urgency to improve working conditions for junior doctors if they are serious about reducing the morbidity and mortality associated with psychological problems in this group.

The Junior Doctor Contract proposed by UK Health Secretary Jeremy Hunt and imposed by the British Government in August 2016, however, seems to have done quite the opposite and sparked anger and righteous indignation among many of the 53,000 junior doctors working in England, thousands of whom resorted to taking industrial action and protested in their droves in Westminster to express their collective outrage (many junior doctors were brandishing placards with the slogan, '*Devalued, Demoralized, Depressed*'). (https://www.theguardian.com/society/2015/sep/29/junior-doctors-contract-row-nhs-explainer-health).

The Junior Doctor Contract in England and its effects on psychiatry

The Health Secretary and the BMA were at loggerheads over changes to the Junior Doctor contract which can be summarized succinctly as: more work for less pay. The BMA argued that the changes to the Junior Doctor contract will compromise patient safety and that it will have a negative impact on the morale, health and well-being of junior doctors working in the NHS. (https://www.theguardian.com/society/2015/sep/29/junior-doctors-contract-row-nhs-explainer-health).

But what effect, if any, will this have on junior doctors working in psychiatry in the UK? The Royal College of Psychiatrists Morris Markowe Prize winner Alex Langford, a junior doctor specialising in psychiatry in Oxford and a member of the RCPsych Psychiatric Trainee Commitee, passionately argued in an article for

the Guardian that the Junior Doctor contract will be a '*disaster for mental health*' and that it will '*disincentive doctors to work in an already desperately under-resourced specialty*'. A recent article published in the *Lancet Psychiatry* by a member of the BMA Junior Doctors' Committee also supported Langford's opinion (Keynejad et al 2016). With only 78% of core training year 1 posts in psychiatry filled in 2012 (Mukherjee et al 2013, Hankir et al 2015), if Langford's foreboding turns into a reality this will plunge recruitment into this specialty into an even deeper crisis. Langford unflinchingly described the Junior Doctor contract as '*poisonous*' and concludes by exclaiming, '*We want to attract doctors to the vital and satisfying work of helping people with mental health problems... A [junior doctor] contract that is so insultingly meagre will do nothing for that*…'

An imminent exodus of Junior Doctors leaving the UK for greener pastures?

The number of doctors who applied for documentation to work abroad surged by over 1000 per cent the day Health Secretary Jeremy Hunt announced he would impose a new contract on them. 300 doctors applied for Certificates of Good Standing on Thursday 11 February 2016 – up from an average of 26 a day in February before the announcement. In 2015, when the industrial dispute began, 8,627 certificates were issued to doctors – up from 4, 925 in 2014 and around 5,000 in the previous 3 years to that. The Health Secretary has even been accused of acting as *'a recruiting agent'* for hospitals in Australasia. (http://www.independent.co.uk/news/uk/politics/doctors-leave-country-work-abroad-leaving-nhs-jeremy-hunt-contract-1000-per-cent-a6878776.html).

Factors that influence doctors to migrate from South Africa

The provision of healthcare services in South Africa and the working conditions for doctors in this nation has been subject to scrutiny over recent years. Factors such as long working hours, poor remuneration and a standard of care that compromises patient safety have all contributed towards the mass migration of medical graduates in South Africa (Erasmus 2012).

The Junior Doctor Association of South Africa (JUDASA) states that doctors in training should not work more than 80 hours per month of overtime. The Ministry of Health in South Africa, however, not only disagrees with JUDASA regarding this but they also state that doctors who do work overtime above 80 hours per month should not receive any extra pay for it. Several studies have shown that junior doctors in South Africa work 120-200 hours of overtime per month (De Villiers et al 2004). This not only compromises patient safety but also has an adverse effect on doctors' health and wellbeing. Physicians in training in South Africa are more vulnerable to developing mental health problems such as alcohol misuse, depressive symptoms, depression and suicidal ideation and completed suicide. They are also prone to acquiring HIV infections through needle-stick injuries due to the high rates of this infectious disease in this country (Labonte et al 2015).

Despite the conditions for doctors working in the private sector reportedly being better than their counterparts working in state hospitals, research has shown that doctors in both settings are likely to seek work overseas (Bezuidenhout 2009).

The 'Push Pull Theory' has been linked to the migration of doctors from South Africa. Push factors such as working conditions, violence within the country, lack of stability in politics, and ineffective education system all influence a doctor's decision to migrate to work overseas. Research has also revealed that a major factor for the emigration of doctors is salary. Despite the enormous workload and level of responsibility, doctors are generally underpaid (Kotzee 2007).

The pull factors that contributes doctors in South Africa wanting to emigrate includes: more job opportunities, higher income, better education for their family, better living and working conditions, and safety for them and their family (Kotzee 2007).

Working as an International Medical Graduate in Psychiatry in New Zealand

Against this backdrop, the remainder of this article will focus on working as an International Medical Graduate in Psychiatry in New Zealand and will provide case studies from a Junior Doctor who qualified from the UK and Consultants who moved from South Africa.

The idyllic country of New Zealand

New Zealand has been inhabited by the indigenous Maori people for more than 1000 years. The first settlers arrived in New Zealand by canoe and established tribal boundaries between chiefs. The iwi (tribes) were made up of several hapu (subtribes), which were composed of several extended families. Today, Maori still identify themselves with iwi and hapu according to their ancestry. The marae is a traditional focal point for iwi and hapu and as such was the place of meetings, prayers, celebrations, and discussions. Visitors wait to be called into the marae and after their intentions have been established as harmless via sung questions and replies they are welcomed by pressing noses (hongi) and sharing food. This is the powhiri (Chapman 2007).

The English explorer James Cook, who landed there in 1769, was responsible for New Zealand becoming part of the British Empire and, later, the British Commonwealth. In 1840, the Treaty of Waitangi was signed between Maori leaders and Lieutenant-Governor Hobson on behalf of the British Government. The three articles of the Treaty gave powers of Sovereignty to the Queen of England; guaranteed to the Maori Chiefs and

tribes full, exclusive and undisturbed possession of their lands, estates, forests and fisheries; and extended to the Maori people Royal protection and all the rights and privileges of British subjects (Joyce 2002).

The population of New Zealand is now approaching 5 million people. Most are of European descent (*called Pakeha*), but about 15% identify themselves as Maori. Pacific Islanders constitute another important group, and immigrants from Asia are increasing in number. Auckland is the only city in New Zealand with a population above 1 million. Wellington, located at the bottom of the North Island, has a population of over 300 000 and is the capital city and seat of government.

Mental Health Services in New Zealand

The biggest issue in mental health services in New Zealand is the lack of an adequately trained workforce. Indeed, there are currently less than 150 doctors training in psychiatry in the whole of New Zealand and the chronic shortage of psychiatrists is why vacancies in mental health services are constantly advertised in the UK, Ireland and North America (Joyce 2002).

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) was established in 1978 and is the professional body that regulates psychiatrists in training and fully qualified psychiatrists working in Australasia. The President of RANZCP, Dr. Kym Jenkins, is an IMG who graduated from Manchester University, UK currently based in Melbourne, Australia (https://www.ranzcp.org/Home.aspx).

The past two decades have seen the gradual development of psychiatric in-patient units in general hospitals and the integration of mental health services into mainstream general health care. This period has also seen the gradual growth of community psychiatry and community mental health teams (CMHTs). Child and adolescent psychiatry, substance misuse services, forensic psychiatry and psychogeriatric services have also been developing. For all these sub-specialties, however, recruitment and retention of trained psychiatrists continues to be a major issue (Joyce 2002).

Maori mental health services

Hauora Waikato in Hamilton, New Zealand, is a kaupapa Maori non-governmental organization that provides a range of inpatient and community psychiatric services. The word “kaupapa” has several different meanings but, in this context, is referring to policies and practice. Te Aka Toro (which is taken from a proverb about a vine searching for sustenance and genealogy), is an early intervention in psychosis service provider contracted by Waikato District Health Board that operates under the auspices of kaupapa Maori and is charged with assessing and treating anyone, Maori and non-Maori, presenting with a first episode of psychosis (Chapman 2007).

Every morning at Hauora there is a ‘whakamoemeti’, which literally means thanksgiving. It involves singing of Maori hymns and prayers (‘karakia’) to start the day positively. Karakia are also used during consultations with patients if they request/accept it and in multidisciplinary meetings called ‘whiriwhiris’ (http://www.rcpsych.ac.uk/discoverpsychiatry/studentassociates/newsandevents/sablogs/electivepsychiatryplacement.aspx).

Hauora Waikato covers a population of 180 000 within the Waikato, of which about one in four is Maori. Considerable health disparities between Maori and non-Maori contribute to the 8-10-year reduced life expectancy for Maori, but they are less likely to access medical services. Almost 30% of Maori recently surveyed had experienced a mental illness in the preceding 12 months, compared with 19% of non-Maori, but less than half of those with a serious psychiatric disorder had contact with mental health services (Chapman 2007).

The previous two centuries of Maori displacement and disempowerment undoubtedly contribute to today's alarming statistics, but the situation can be successfully ameliorated only when cultural differences are addressed. For example, Maori traditionally emphasize health rather than ill health and believe that it is maintained when various aspects of the person and their environment are balanced. The Whare Tapa Wha model (see below) conceptualizes these as structural components of a house (whare), which are all necessary for stability. A service that operates within this health paradigm is therefore more likely to meet the needs of and be more accessible to Maori (Chapman 2007).

Although the underlying medical treatments for mental illness are like UK practice, there is certainly a stronger emphasis on the patient’s cultural needs and background at Hauora. For example, a Maori patient may attribute the hearing of voices to being possessed by 'makutu' (evil spirits), which may present during a 'tangi' (funeral). Kaitakawaenga are members of the multi-disciplinary team in mental health services that are well-versed in Maori culture and are often consulted when a patient from Maori background presents with psychological problems.

(http://www.rcpsych.ac.uk/discoverpsychiatry/studentassociates/newsandevents/sablogs/electivepsychiatryplacement.aspx)

The Whare Tapa Wha Maori model of health encompasses all aspects considered to contribute to illness and disease:

- Te taha wairua (spiritual)
- Te taha hinengaro (mental)
- Te taha tinana (physical)
- Te taha whanau (family)
- Te taha whenua (land, environment) (Chapman 2007).

Beth Chapman, a British doctor who worked as a psychiatry trainee for 3 months at Hauora Waikato, described her experiences as follows: ‘The motif for the

Best Practice Unit perfectly symbolizes the approach throughout the whole of Hauora Waikato. The koru symbol through dark to light reminds us that "only with a vision based on balance and harmony and true conviction will the koru grow"'. (Chapman 2007).

Case study 1:

An IMG working as a Psychiatry Registrar in Waikato District Health Board, Hamilton, New Zealand.

The case study below is written in the first-person by AH who worked as a Psychiatric Registrar in New Zealand.

I qualified from Manchester Medical School in 2011 and completed my Foundation Training in the Royal Oldham Hospital in the North of England. I subsequently worked as a National Institute for Health Research Academic Clinical Fellow (NIHR ACF) in Old Age Psychiatry with Manchester University. After completing one year as an ACF in Old Age Psychiatry I took a couple of years out of training to conduct full-time research with collaborators at Cambridge University and to scale up an anti-stigma program that I had developed with them.

I was always curious about what it was like to work as a doctor in Australasia and therefore I searched for psychiatry job opportunities in New Zealand. I found the details of a recruitment company online (MedRecruit (https://www.medrecruit.com/)) and after conducting a simple Google search, I sent them an email. The agency responded within 24 hours and asked me to send them my CV which I duly did. The next day the agency called me and informed me that they had forwarded my CV to Waikato District Health Board (DHB) and that Waikato were very keen to interview me for a RANZCP accredited training post in psychiatry with them. The following week a telephone interview was arranged and within 48 hours they had made me an offer to work as a Psychiatric Registrar.

The Waikato DHB offered to pay for my flights to New Zealand and cover the costs of accommodation in a hotel and pay for my registration fees for the Medical Council of New Zealand. I would also receive an unlimited number of 'chips' that I could use to claim for meals in the hospital cafeteria as often as I wanted to. The agency provided me with full assistance with migrating to New Zealand which was a lot easier than I thought it would be (since there is a chronic shortage of psychiatrists, I applied for an 'Essential Skills Visa'. Being a bearer of a British passport expedited the process that took only 7 days). Graduates from UK and Ireland medical schools would simply complete a tick-box form which took no longer than a few minutes and this would exempt them from taking any further exams to register with the Medical Council of New Zealand.

This offer was very attractive indeed so I took the plunge, signed the contract, and a few months' later I packed my bags and boarded a long-haul, one-way flight (approximately 29 hours) to Auckland.

Upon my arrival in New Zealand the first thing I noticed about the country was just how friendly the people were, particularly the indigenous Maori people (although the site of them walking around in bare foot did take some getting used to!) The scenery in New Zealand immediately lived up to my expectation and was truly captivating. Although, I didn't get to spend as much time in the capital as I would have liked to, Auckland struck me as a vibrant and dynamic city and you could immediately tell why it consistently ranks highly in, 'Most liveable cities in the world' tables.

Hamilton is approximately a 1.5 -hour drive from Auckland. Although, it is the fourth largest city in New Zealand it is considerably smaller than metropolitan cities such as Leeds, Manchester and Bristol and is certainly not as developed. Waikato DHB, however, is one of the largest tertiary teaching hospitals in Australasia and can hold its own against some of its counterparts in the UK. I was based in the Henry Rongomau Bennet Centre, the Acute Adult Mental Health Ward. Induction lasted for a fortnight and then I commenced my clinical duties as a Psychiatric Registrar. A day would typically start with a Circle of Care (CoC) meeting which is the equivalent of a Multi-Disciplinary Team meeting in the UK. The workforce was truly multinational: there were members from Australia, USA, South Africa, Singapore, India and the UK. Kiwis (New Zealanders) were under-represented in our team and I soon came to realize that psychiatric services in New Zealand are heavily dependent on International Medical Graduates.

In the CoC meetings, the team would go through the list of patients on the ward and prioritize which patients required reviewing and complete a full assessment of the patients who were admitted out-of-hours. Minority ethnic groups in New Zealand, particuarly the Maori people were over-represented in mental health services and there were palpable issues with substance misuse in this group.

We would then break for lunch and afterwards return to the wards to complete clinical tasks. A day of the week would be dedicated for teaching since Waikato DHB offers a training scheme which is accredited by RANZCP.

Another highlight of working as a psychiatry trainee in New Zealand is that the DHB would pay for you to attend and present in RANZCP conferences which included, covering the costs of flights, hotels and conference fees. I was fortunate enough to deliver an oral presentation at the RANZCP New Zealand National Conference in Christchurch which was a thoroughly enjoyable experience.

Due to personal reasons, I returned to the UK and re-entered the RCPsych training scheme. Composing this narrative has certainly made me nostalgic and working as a Psychiatric Registrar in New Zealand has, without a doubt, given me a different perspective and I believe made me a better doctor. For example,

working with Maori patients and colleagues in the Henry Rongomau Bennet Centre in Waikato DHB enabled me to develop my cultural competency skills. Although Junior Doctors in Psychiatry in New Zealand receive more money than their counterparts in the UK, the RCPsych training scheme has been around for much longer than the RANZCP training scheme and is, in my opinion, more developed and advanced and this of course has its advantages.

I am extremely grateful for the opportunity to gain working experience in New Zealand as a Psychiatric Registrar but I am also very happy to be back in the UK and look forward to applying the skills that I acquired in New Zealand.

Case study 2:

An IMG working as a Consultant Psychiatrist (Dr Mohammad Shuaib) in New Zealand

The case study below is written in the first-person by MS who works as a Consultant Psychiatrist in New Zealand

I have been practicing in New Zealand as a consultant Psychiatrist since 2000 when I emigrated here from South Africa. The main motivating factor for me to leave South Africa was the lack of law and order. After completing my postgraduate training in South Africa, I started my private practice in Pretoria, which soon became a very successful practice. However, this was accompanied with a high workload, working six days a week from 7 am to 9/10 pm. Moreover, my work environment was getting less and less peaceful with dangers seemingly ubiquitous. I found my house robbed twice on our return from overseas trips and I soon realized that I had to say goodbye to the country, which had given me so much. I had to do this for the sake of my young family, which included my wife and two children age 2 years and two months. I had to think about their future. I could not even think about raising my children in such a violent society where you must always look over your shoulders to guard against any unexpected physical attacks that could prove fatal.

I started searching what options were available to me and soon discovered that I could go to Australia, New Zealand, Canada, Ireland and the UK. After some searching, I chose New Zealand because of its wonderful weather, friendly people and good education and health system. I have never regretted this decision since.

It was a huge surprise for me to see houses in New Zealand which did not have barb wires and did not need to be in secure gated compounds and indeed, there was no need to worry about security as much. I had to learn to walk around town without being hyper vigilant. As I was practicing in a private set up in South Africa my income dropped significantly however I accepted this since a peaceful lifestyle was more important to me.

In relation to psychiatric practice in New Zealand, I had to get used to the PHARMAC (Pharmacy Advisory Council) rules as they control which drugs are subsidised and they keep changing the list on an ongoing basis. I had to learn the various funding criteria of medication and the preferred list of medication to be used. I noticed that I was not at liberty to choose the medication as freely as I was in South Africa. There was a lot more emphasis on psychosocial aspects of recovery compared to the predominantly biological model in South Africa.

I first started in a community clinic and Maori mental health services "Oranga Hinengaro" in Palmerston North. Learning about the "Whare" model was fascinating. I learnt a few "karakias" (prayers) and would say twice a day in congregation, once at the start of the day and again at the end of it. Most Maori patients preferred their consultation to start with a karakia and end with it. I found this had a calming effect on them and they trusted me and considered me as one of their own. We visited Marae and learnt about Maori culture and New Zealand's "Bicultural" society.

I had to familiarise myself with the Mental Health Act and the local resources available to our patients. The Mental Health Act was totally different to what we had in South Africa. I believe New Zealand's Mental Health Act is more effective in guaranteeing patients' human rights. It ensured sufficient input from the judiciary and close monitoring of the powers given to the psychiatrist under the Mental Health Act.

I found that the mental health services in New Zealand were more community based with no asylum type psychiatric hospitals. New Zealand did away with asylums in the 1990s. Each patient had a key worker allocated to them and were seen regularly by a psychiatrist, free of charge. Patients also had regular multidisciplinary input from various disciplines including nurses, social workers, occupational therapists, psychologist and psychiatrist. The rest of psychiatric practice was not too dissimilar to South Africa and I adapted to local psychiatric practice fairly quickly.

New Zealand is an awesome country and has a lot to offer. It is very peaceful and the people are very friendly as most were immigrants themselves one or two generations earlier. I found it fascinating when people would stop on the footpath to talk to you as if they knew you for a long time. They hardly say "bye" when they leave. They instead say "see ya later". These are small gestures but meant so much to me.

Over the years I developed my own practice and have worked very closely with my colleagues and community in general which I have enjoyed. I love people here. My children enjoy it here and are getting a good education. My parents have moved in with us and are living with us and enjoying beautiful New Zealand. New Zealand is a very good country to raise children and above all is clean, green and "100% pure".

Case study 3:

An IMG working as a Consultant Psychiatrist (Dr Sohail Akhtar) in New Zealand

The case study below is written in the first-person by SA who works as a Consultant Psychiatrist in New Zealand

I have been working as a Medical Officer/Consultant Psychiatrist in Psychiatry in New Zealand since 2003 when I migrated to New Zealand from South Africa. Originally I qualified as a doctor from Pakistan and migrated to South Africa in 1994. I obtained Diplomate in Mental Health from College of Psychiatrists of South Africa in 2000, and was appointed as a Medical Superintendent of Thabamoopo Psychiatric Hospital in South Africa, which was an institution for chronic psychiatric conditions. Whilst working there, I obtained a post graduate Diploma in Public Management. I was living with my family in Pietersburg, (now Polokwane) in South Africa. I was then promoted as a Senior Medical Superintendent of Mankweng Campus of Polokwane/Mankweng Hospital Complex. I was very satisfied with my job and was awarded with best hospital performance award by the Minister of Health. Whilst I was very happy with my job, unfortunately, personal and family safety always remained a concern. The major event leading to my migration to New Zealand was my car hijacking on gunpoint. I and my 5-year-old son were held on a gunpoint by three men who fled with my car and my wallet. As a result, my son suffered severe psychological trauma and was shaking with fear. Indeed, this was a very scary experience and concerns for the safety of my family multiplied. Subsequently, I decided to leave South Africa for New Zealand.

I was offered a job as a Medical Officer Special Scale in Psychiatry in Taranaki Hospital, New Plymouth, New Zealand with a relocation package that made the move smooth.

Upon arrival in New Zealand my first impression was that it was a very beautiful and green country. There was less traffic on the roads and people were generally friendly and helpful.

Working in New Zealand was a learning curve for me. I had to learn the processes and policies of the mental health service and the legal framework of the Mental Health Act which were very different from South Africa.

I worked in Taranaki Mental Health Service for 5 years. I worked in the inpatient unit, covering the crisis slots, doing cmmunity clinic in Hawera once week. Overall, I had a good experience working in Taranaki Mental Health. However, subsequently, I resigned from this postion and started working as a private locum. I worked in adult general psychiatry for two years in Waikato District Health Board, (DHB) and Auckland DHB.

In 2011, I then transferred to the Addiction services of Waikato DHB. I enrolled in postgraduate studies in addiction with Otago University, New Zealand and completed Post Graduate Diploma in Addiction and Co Existing Disorders in 2013. I continued with my postgraduate studies and completed Masters in Mental Health. I am satisfied working in Mental Health and Addiction service. We have a multinational team of doctors and have good collegial relationship and we also participate in RANZCP CPD events.

Living in New Zealand is a peaceful and safe experience. New Zealand is one of the most livable countries in the world, less populated with no or very little corruption. Weather is mild, environment is clean and food is pure. Most Kiwis are friendly peoople and they respect cultural and religious diversity. We love living in New Zealand.

Conclusion

In this article we have covered number issues relating to doctors/psychiatrists practicing in the UK and South Africa. Over the years, a growing number of doctors have moved to Australia and New Zealand both from UK and South Africa. However, the reason for moving for South African doctors appears to be different from that of UK with economic as well as security factors playing important parts for the former. For the UK doctors, the recent Junior Doctor contract, unfortunately has had a negative impact on their morale and led to a spike in numbers considering moving to countries such as Australia and New Zealand. We have given a brief description of health system in New Zealand with some exploration of Maori population's relationship with health providers of New Zealand. We have concluded the article with personal descriptions by two consultant psychiatrists moving from South Africa to New Zealand in which they both describe their concerns about the security situation in South Africa as well as by a psychiatry trainee from the UK who describes his short experience of working in New Zealand, a country all three describe in unequivocally positive terms.

Contribution of individual authors:

Ahmed Hankir conceived the idea for the paper, conducted the review of the literature on junior doctor working conditions in the UK and provided a case study.

Mohammad Shuaib and Sohail Akthtar conducted a review on the working conditions of psychiatrists in New Zealand.

Aala Ali conducted a review on the working conditions for doctors in Sohail Akthtar.

Rashid Zaman supervised Ahmed Hankir, revised the manuscript and ensure that the information was factual.

Acknowledgements:

We would like to thank Waikato District Health Board for being an exceptional employer.

Conflict of interest: *None to declare.*

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