implementation. However, management training is best done with colleagues, to ensure mutual support and advice is available.

With continued practice you should now become a good clinical manager, and know whether management in the health service interests you. You will have to become a consultant before you can take on an ongoing management position, but you will be very well trained to give an excellent service to your patients when you gain that post, and you may then consider whether you wish to leap into new areas of management knowledge.

Read a bit

If the topic interests you, you will want to do some reading. A handbook *Management Training for Psychiatrists* (1992) has recently been published. For insomniacs interested in the workings of the business world Tom Peters' books make thought-provoking reading, especially *Thriving on Chaos*, which seems particularly appositely titled for the NHS in the '90s (Peters, 1989). If you can digest the term 'Total Quality Management' the two articles by Berwick *et al* (1992) describe the essential integration of management with clinical services.

If you wish to consider a more specific course on a discrete management topic such as financial management or business planning, you will be in a better position to take advantage of the new material you learn because of your previous experience.

Management training is much like clinical training, you see a bit, do a bit, read a bit and go on a course. I hope that for you it is as productive.

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Trainees' forum

Overseas doctors' training scheme

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About a year after applying to come on the Overseas Doctors' Training Scheme (ODTS), I was offered a post. The letter arrived about two months before I was to start work in the UK; it contained pertinent information about my job, the training programme, and the community I would live in. The information and its early arrival enabled me to make adequate preparation for my trip.

I arrived in the UK ten days before I was to start work and so had enough time to register with the General Medical Council, and get to know about my job, the hospitals and the community. This was a crucial period, particularly because I came with my family and needed to sort out many things as part of settling down that could become difficult once my work had commenced. The issues of importance were accommodation, finance, and job orientation. When I learnt of my post, I wrote to my UK employers requesting suitable accommodation and before I left my country they had informed me of the accommodation arrangements. As soon as I was certain I made known the day I would arrive, which made it easy to check me in within minutes of my arrival. A financial predicament was prevented by

the urgent attention of my clinical tutor and employers with the provision of a salary advance. On the advice of my tutor I went to the Citizens' Advice Bureau where I was informed about other things I needed to do; for instance, registration with a general practitioner and the Department of Social Security.

My job on the North Wales Training Scheme would involve a lot of travelling, which was clearly stated in the information sent to me before I came over to the UK. I therefore decided to bring my driving licence, which would entitle me to drive while I made arrangement to get a UK licence within 12 months. My many years of driving experience notwithstanding, I was quite apprehensive about driving on the left. I got over this problem by arranging for driving lessons and means of transport before I started work.

There were no major difficulties in my assimilation into a new system of health care as I had guidance from my tutor, consultant, and other colleagues who soothed the complex gamut of feelings peculiar to such an initial adjustment. I had to feel my way around and I admit to some trepidation while doing so. I could have used more guidance, which is why the orientation programme organised by the College for the February 1992 batch of overseas doctors is a welcome development.

Some of the experiences of an overseas trainee are common to all immigrants while others are peculiar to the profession. The crisp air and the sun-kissed fields on a bright summer afternoon depict my first encounter with the weather in Wales. However, the appearance belied the real temperature as I discovered on stepping out of the vehicle. For one who has spent his entire life in a tropical climate even a summer afternoon could be quite cold. The booklet on how to keep warm that I picked up from the Citizens' Advice Bureau was helpful.

Like change in climate, language is a common source of problems for immigrants. For the psychiatrist, language is more than just a tool for social interaction; as a major vehicle for communicating thought and emotion, a good command is a *sine qua non* for the degree of understanding necessary for a therapeutic relationship. My main problem has been in coping with the different accents of the English language. With time, repeated interactions sharpened my ability to pick words. Since I spend some time on the road, listening to the car radio stations with their various accents reflecting the different ones in the different localities has been of much assistance. And when I have the time, I don't miss the soaps on television; they help too!

While appreciating that personality traits are universal, psychiatrists in training come to terms with the reality of each individual's unique and complex features, which are often difficult to unravel. In the field of medicine there are subtle nuances across cultural boundaries which assume a profound dimension in psychiatry. A basic tool of the psychiatrist is empathy, thus in living in a new culture he or she has a lot to learn in viewing idiosyncrasies in the context of the whole. This for me has meant a high tolerance for seeming ambiguities and every effort to learn more about this new culture. In the assessment of a patient and determination of a management plan, an intimate familiarity with the culture is needed to understand the relative contributions of various factors like upbringing, occupation, marital relationship, financial problems and housing to the psychiatric condition. Listening to patients and relatives, working in the community with the mental health team, and interacting with people in a non-professional status in the community has improved my knowledge of the culture in making therapeutic input relevant to the individual's needs.

There is a unanimous view by world experts that basic training in psychiatry should be acquired in the individual's country of origin. It is recognised that while there is much that is good in modelling that results from training in a foreign setting, there is the potential danger that such modelling can render the individual unfit professionally and emotionally for life and practice in his or her own country (German, 1986). The ODTS has addressed this issue by ensuring that doctors who come on the scheme have some basic training in psychiatry and so training in the UK builds on a foundation already laid. This is being achieved by placing well selected candidates in good training posts and providing appropriate preparation for work in their own countries (Sims, 1989). Doctors on the ODTS with whom I have spoken, are of the opinion that basic training in their indigenous setting would serve to sift and adapt the training in the UK to suit their perceived requirements when they go back home.

Coming to the UK for training in psychiatry has entailed a reappraisal of my decision to specialise in the field. My experience thus far has underscored the fact that it is most fascinating, though often enigmatic; the latter lending a hue that enhances its allure. It remains, ultimately, its own reward. I have come to agree with Thomas Carlyle that "Blessed is he who has found his work; let him ask no other blessedness."

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