Dr. Niall Crumlish

Dr. Niall Crumlish, Senior Registrar in Psychiatry in St. James's Hospital, spent "eighteen of the happiest months of his career" in the town of Mzuzu, northern Malawi. Along with his fiancée Sharon Brady, a nurse, he worked with St. John of God (SJOG) Community Mental Health Services in the African country – a country home to only one psychiatrist in total.

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How did you come to work in Malawi?

I went to Malawi first in March 2005 as a research registrar working with Prof. Eadbhard O'Callaghan in SJOG in Dublin. I went for a week to set up a trial of carer education for families of people with schizophrenia. When I got home, I kept talking about the place and after a few days of this, Sharon said "You really want to go back, don't you?" She was keen to go too.

What was your post there and what role did you play?

My post there never had a title so I made one up: Clinical Lecturer in Psychiatry. My main job was to provide teaching and clinical supervision to five junior clinical officers. I also taught in the College of Health Sciences.

Sharon did an immense piece of work. Alcohol and cannabis abuse are huge problems in Malawi – Malawian cannabis is world-renowned and super-cheap – and to address this Sharon set up the first outpatient alcohol and drug treatment programme in Central Africa. It's still running.

What are psychiatric services like in the country?

Psychiatric services are, inevitably, underdeveloped. There are only two functioning services, the SJOG service and the service run by the sole Malawian psychiatrist the south. There is little money and a shortage of staff. You can see the restrictions that applied when you look at the drug cabinet – in terms of antipsychotics, we were mostly confined to chlorpromazine; risperidone was costly for us, but unavailable elsewhere in the country. Although we often treated mania, we couldn't use lithium because we didn't have labs that could test levels, and we couldn't be sure that people would have enough access to drinking water that they would avoid dehydration and lithium toxicity. Also, I would have loved to be able to scan people, but the nearest CT scanner was in the south of the country, and the nearest MRI scanner in Johannesburg, South Africa.

How does the perception and treatment of mental illness in Malawi compare to that here?

In northern Malawian culture most illnesses – not just mental illnesses – are considered to be caused by witchcraft, or ulowi in Tumbuka. (In fact, anything can be blamed on witchcraft – even a car accident where the driver was going at 120mph on the wrong side of the road!) The treatment for an illness then is to try and reverse the bewitching. This can take many forms; herbal medicines, traditional dancing, prayer. I met a man in his forties who had been psychotic for twenty years and treated traditionally for all that time. Twice he had to drink the blood of one of his cows, from the cow's neck, then hand over the irked-but-alive cow to the healer.

Did your Irish training translate well in an African setting or were the predominant issues different?

Severe mania or psychosis looked much the same as it does in Dublin and most of the patients that we saw were manic or psychotic. We saw much less depression and much fewer primary anxiety disorders than we see here – my guess is that they usually stay in the village with the traditional healer and the family. You have to be careful transporting your training across cultures; beliefs are not delusions if they are culturally appropriate, and in a culturally diverse region like the north of Malawi there was always the chance that a bizarre-sounding but culturally appropriate belief would be treated with hundreds of milligrams of chlorpromazine.

What did you find most difficult and most rewarding about the experience?

What was most difficult was not being able to financially help everyone you would have liked to help. We became well known quickly in Mzuzu, and often had to turn down people's requests for support; for school fees and such. You have to make your peace with this if you are going to live in one of the poorest countries on earth; you have to acquire a tougher skin than you'd like to have. You find ways to give back but you see abject poverty everywhere and you have to not despair.

What was most rewarding was seeing clinical officers and nurses improving over the eighteen months – people with immense potential, compassion and dedication who flourished and became even better than they were when I got there. Also, getting the word "ulowi" into the British Journal of Psychiatry was a kick.

How were you received by local people?

I have disappointingly few stories about the challenges of cultural dislocation. On leaving, a friend of ours called Austin (who also delivered fresh pumpkins and tomatoes to the house every week) gave us a home-made painting made mostly of millet; the painting spells out, in sunflower seeds painted white, "FEEL AT HOME". You have to try very hard to be a fish out of water in Malawi.

What advice would you have for medical students considering humanitarian work in the future?

Go. Get memberships out of the way – at that point, you're experienced enough to take on whatever comes your way – and go. Take a year, don't worry about your career, and don't worry about the rat race. The rat race will be waiting for you if and when you return.

Just go. ■

▼ *St. John of God Community Mental Health Services, Mzuzu, Malawi.*