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## High variability of the current mental health practices around the globe: Twenty days in the lives of psychiatrists and other mental health care professionals from all over the world

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### Abstract

**Introduction:** *The present is the future of the past, and the past of the future. This journal as well as this paper endeavour to document the lives and practices of psychiatrists and other mental health care professionals for the future mental health community and to help the clinicians of the future to understand the history and practice of psychiatry and mental health care in 2019/20. We, therefore, report the current days in the lives of psychiatrists and other mental health care professionals.*

**Material and Methods:** *To obtain reports of days in the lives of psychiatrists and other mental health professionals, we published the request on eight occasions from May 2019 to May 2020. We invited the prospective respondents/participants to send a relevant report of their psychiatric practice in a day with a maximum word count of 750 words.*

**Results:** *We received 20 reports of variable lengths from 10 countries from six continents, including from psychiatrists, psychiatrists in training, clinical psychologists and from medical students about their psychiatric training. The reports revealed a wide and highly variable range of psychiatric and mental health practices, experiences and expectations. Last but not least, the reports we received were informative and provided much information to reflect on.*

**Conclusions:** *There is a common strong commitment to support patients with mental health problems, but the ways this is achieved are so diverse that generalisations about a typical common practice seem impossible. Future studies should focus more systematically on the procedures and practices applied in helping patients with mental health problems in different countries and communities. This knowledge might eventually help identify the procedures and services that are most efficient and helpful in various clinical contexts.*

## Keywords

*Mental health, lived experience, psychiatrist, psychologist, psychiatric practice*

## INTRODUCTION

The present is the future of the past, and the past of the future.  
(RH)

Current psychiatric practice has a long relevant history, which is the basis of current and also of future clinical practice. This journal endeavours to document the lives and practice of psychiatrists and other mental health care professionals currently, for the future psychiatric community with the intention of providing them with an understanding of the foundations of psychiatry that informed their practice. With this endeavour in mind, Global Psychiatry published the personal histories of some of the current notable and more or less influential psychiatrists such as Dinesh Bhugra (Bhugra, 2018), Norman Sartorius (Sartorius, 2020), Christopher Szabo (2019) and Maha Younis (2020, in press).

However, psychiatry is also practiced every day by the less known and less influential psychiatrists, clinical psychologists, and other mental health care professionals. They equally deserve mention. At school, we read the novel *‘One Day in the Life of Ivan Denisovich’* by Aleksandr Solzhenitsyn (1970), which was a report of one day of the protagonist in a Soviet Gulag. It left a great impression on me as a schoolboy (RH), not just for its powerful story and the resilient way Ivan managed all the hardship of a day, but also because this one day offered a comprehensive view into a difficult and very hard life. Psychiatric practice luckily is not strictly comparable, but similarly, a day can also provide a general impression about how we live and what we do to help and support patients.

Consequently, we report the days in the lives of various psychiatrists, trainees and clinical psychologists involved in mental health care.

## METHODS

The call for the enclosed days in psychiatry reports was made via Facebook on eight occasions during May 2019 to May 2020. Due to the limitations of the space available for an editorial,

we asked for a description of a personal day as a psychiatrist or mental health care professional clinician (in 750 words).

The reports are presented unedited – except for spelling and minor grammar mistakes – and thus, provide a lively description of psychiatric and psychological practice around the globe. All authors have agreed that their reports are to be published in one paper.

An anonymous report from an unidentified service user was not included as it fell outside the scope of this editorial, and further, we did not want to publish anonymous content.

## RESULTS

In total, within a year, we received 20 reports from eight different psychiatrists, five clinical psychologists, five psychiatrists in training, two medical students, and additionally, one service user.

Reports were received from six continents and ten countries: Somaliland (1), Colombia (1), the USA (3), Ukraine (2), Pakistan (1), Australia (1), the UK (6), Turkey (1), Serbia (1) and India (3).

The experience ranged from a medical student on his first day in psychiatry to a full professor of Psychiatry with over 25 years’ experience. The working conditions and the professional specialisations in mental health services by psychiatrists and clinical psychologists varied considerably thus making generalisations on common clinical practices nearly impossible.

In-patient and out-patient services and private practices play a major part in many mental health services. Specialisation such as learning disability, forensic psychiatry or alcohol services are found to be of relevance in psychiatric service provisions. Clinicians have different approaches to achieve a healthy work-life balance.

Last but not least, the reports are enjoyable to read and to reflect on.

**REPORT 1****A day in the life of a psychiatrist in Somaliland  
Jibril I.M Handuleh**

Somaliland is a de facto state, internationally recognized as a breakaway region of North Somalia. It has an estimated population of 3.5 million people. Somalia has one of the least developed psychiatric services and has a high burden of mental health disorders. Borama is the capital of the Awdal region of Somaliland having a population of 200,000 people. It shares borders with both Ethiopia and Djibouti.

I established mental health services at Borama Teaching Hospital in 2011 from scratch (Handuleh, 2012). The mental health services started with outpatient office work in the teaching hospital. Outpatient work then rolled into inpatient and consultation liaison services in the hospital covering both inpatient, outpatient and community outreach (Handuleh, 2013). The unit employs three doctors, five nurses and has the support of 50 community health workers (Handuleh et al., 2014).

The mental health service in Borama is one of the most developed and standardized mental health care service in the whole country. A 26-bed inpatient and an outpatient psychiatry unit work seven days a week. These offer community mental health services for Borama residents through the community health workers who do home based visits mainly promoting mental health among the public, referring patients to the psychiatry unit and following up discharged patients.

The outreach services had been offered to school age children, prisoners, women of child bearing age in primary care and community outreaches in the last eight years.

The mental health unit offers a semester based clinical rotation for medical students as a part of their clinical education. Each year, the unit hosts final medical and nursing students of Amoud University to undertake their mental health rotations as a part of their clinical learning. This is mainly case presentations and a journal club on mental health disorders three times a week.

My June working day is a long and busy day. It starts early morning with revision of the written and Objective Structure Clinical Examination (OSCE) final editing and proof reading before I forward it to our King's College London Partners for further assessment and editing before the exam for final medical students. This exam will take place late June for paper exam and early July for OSCEs. I have been the chief clinical

psychiatry local examiner since 2010 for Somaliland medical schools. These exams are comprehensive exams. Since 2008, psychiatry had been a part of medical undergraduate education in Somaliland medical schools.

I went to the hospital starting with a sit down with nurses and other doctors to review the overnight patients' reports. I did a ward round with the mental health unit nurses.

The clinical round of the day was two hours long clinical clerking of inpatients and of handing over management to the nurses. It included documenting their progress notes, write up of discharge notes and engaging with family members of the patients on their management. One of the cases had a comorbid diabetes and bipolar disorder, which is an example of the psychiatry patients. This shows how delicate our working day can look like, which includes working with diverse clinical specialties. This day we had reviewed our case with an internal medicine attendant.

I had four hours of mental health outpatient work and coordinated consultation liaison review of two surgical cases and an emergency room patient.

After the ward rounds at 2 p.m., I discussed briefly with the ward nurses on the patients' management.

I had two hours of free time to take my lunch, do my prayer and had one-hour rest time, which included reading of JAMA Psychiatry paper on the association between air pollution and development of psychosis among young people, which was a very interesting paper. I have this tradition of reading one paper per day on current issues in psychiatry. I mainly choose a research paper or a review of a guideline.

In the afternoon and evening, I had my private mental health practice till 10 p.m., which is a routine daily work for me.

I had to meet several of my follow up cases. I had also managed new cases who had both psychiatry and medical conditions. This also included psychotherapy session for a patient with comorbid mental health and physical health issues.

After the working day was over, I had to go home and spend time with my mother, who is elderly and chatted over her day for 30 minutes.

My night ended watching television for 30 minutes and then I went to bed for a good night sleep.

## REPORT 2

### A day in the life of a psychiatrist

**Juan Evangelista Tercero Gaitán Buitrago**

I am what one would call an early career psychiatrist. While I ended my residency program rather recently, I have been working in psychiatric services for almost a decade (mainly in addiction treatment areas). When I moved to Argentina, I had to learn a really different way to do things, and while it was not easy, it was very rewarding.

Currently, given some economic problems in the country, having a decent lifestyle requires me to work in three different areas: ambulatory consultations, home based psychiatric care and as a teacher of psychosemiology.

In the first one, my day activities are limited to a very standard routine: wake up, get ready and actually walk to the clinic (it is quite near, just ten blocks from my apartment); once there, the strict politics of the place makes me register my arrival (via a fingerprint scanner), and sign some papers (that does make no sense, because that's what the scanner is for), plus the receptionist notifies the human resources department of my arrival at work (a redundancy, as I signed these papers, and again, scanned my fingerprint). Usually, I work in the last room from the entrance, that is because it is modestly bigger, and the air conditioning works a tad bit better (an inescapable necessity, given how cold the winters are in Buenos Aires). On paper, my schedule consists of nine hours of work, and each patient has a time slot of thirty minutes; in reality, they overbook my schedule, and if no patients miss their appointments, I will have like 15 or 20 minutes each; the people I see are drivers of the bus driver guild. While most consults are somewhat rewarding, it becomes kind of tiresome to know that most of them are in my consultation for problems derived from overwork, stress and fear of being victims of the growing insecurity of their jobs. Naturally, it becomes more complicated when they ask continuously for benzodiazepines and I have to license them off their job. This is because the job insecurity in Argentina grows higher by the day, and normally, the drivers that get licensed are ostracized in their work environment if they take long leaves; plus, in Argentina, control over Benzodiazepine prescription is non-existent, and it is a popular sleeping aid for almost everyone. It is important to take notice that unlike many places in the world, mental health related discrimination is rather low, as it is an element deeply ingrained in the Argentinian society (here, almost everyone goes to the psychiatrist or the psychologist, normally from Freudian or Lacanian psychoanalysis tradition). Naturally, it gets to be very frustrating to see patients with Benzodiazepine mega-doses and

a need to work and drive, plus with no real coping strategies, as the focus of their therapies is past trauma, and not mechanisms to face their current situation and any other disruptive experiences they might experience in the future. In that job, I feel there is an inhuman resource department, as given my schedule, I do not have time for lunch (I have to pack it up and eat it between consultations) else they discount the full hour even if I leave for a few minutes to the store across the street for something to drink; this goes on until 18:00 when I can finally leave, sign some papers again and scan my fingerprint once more.

In my other job, I am quite fortunate, it begins at 09:00, and the modus operandi differs greatly; in that job, I am picked up by the company driver. He gives me a bag with the patients' clinical history and files, blank paper and a list of places to go; while it sounds better (and it really is, trust me), it gets tiresome. The car is almost wrecked, is too uncomfortable, and the distances are long (once I had a route of 450 kilometres in order to see a total of nine patients), and while normally they allow me to do my job as I see fit, the fact that the person who assigns the routes is not quite organized (it would be easier if he assigned patients close by, as it would be more efficient) and can be a nuisance. In the end, they take me back home, 12 or 13 hours later and dead tired, but the good thing is that they are very helpful when I need them, and are very responsible with the payment; yet, it is too tiring and inefficient to make a good living, and my calls for optimization of the routes have been unheard.

My last job is as a psychiatry teacher, I teach advanced psychosemiology to some psychiatry residents of a nearby town out of Buenos Aires; the payment is decent, and the fact that my students are very active in the class makes my whole week worthwhile. These students have helped me in the progression of my career as a psychiatrist, I feel motivated by them to give good classes as well to come up with some strategies to keep their attention going while optimizing the time (my time slot is Fridays or 4 hours every two weeks). The problem is that they are quite interested (it is an irony, I know), and so, I end up finishing classes like 30 or even 40 minutes later, even so, I consider it to be a minor nuisance, as they really motivate me to study and study even more, so I can teach them the best I can.

## REPORT 3

### A day in the life of a hypnotherapist in the South-Eastern United States

**Melvin S. Marsh**

While many hypnotherapists work in big urban areas like Atlanta, Los Angeles, or New York City, and primarily work on smoking

or weight loss, I am based in a smaller city (Augusta, Georgia) with a population of only 200,000. However, between my offices in Blairsville and Augusta, my house calls throughout the state, occasional in-patient hospital calls, and my virtual calls that allow me to treat patients throughout the world, I keep myself busy and have developed a reputation of being able to tackle any of the 400+ problems hypnosis has been proven to help.

Of course, I work with smoking cessation and weight loss hypnosis, but my real passion is working with people with problems such as chronic or acute pain (including childbirth) and anxiety. I am grateful that I am also an Emergency Medical Technician (EMT), so I have a better understanding of the medical problems than other hypnotists. I sometimes need to use medical skills with hypnosis clients, and vice versa – yes, I have even performed hypnosis in the back of an ambulance!

As a night owl, I prefer to work a swing shift, from 2 pm to 11 pm. I work primarily Sundays through Thursdays. The combination of non-standard hours and days is beneficial to clients for avoiding conflicts due to work or school. Since I see clients so late in the afternoon, most days I do not use an alarm and instead allow my dogs to wake me up. On days when I do need an alarm that usually means a long drive to Statesboro or even longer drive to Atlanta. If I don't have to go to another office outside of Augusta, I have several hours to do administrative work.

I typically start the day by quickly looking at my client schedule, which usually consists of two to three patient appointments. That might sound like a light schedule, but unlike other therapists who use a standard therapeutic hour, my clients are typically a true 60-minute hour and many clients prefer a two hour, or longer, appointment. What I see day to day as far as clients' primary complaints tends to vary.

After I see my schedule, I check my email and texts. I typically wake up to at least ten contacts, through email, voice, or text. Over the course of a day, a hundred contacts or more is not unheard of. Since clients can self-schedule, rearrange, and cancel their appointments, which is listed in several locations as well as on the voicemail message, I focus on reading and responding to texts and emails, which do not relate to scheduling. Typically, I have several questions, which can be found on the website, a few asking how to book an appointment, usually one or two threats of some form since it's a conservative area, and at least a few requests to be my student.

Once I am finished with overnight messages, I check my personal email and see what google alerts has found as far as

interesting hypnosis articles. I try to read three or four articles a week and often use what I read as a foundation for writing my weekly blog articles, which usually consists of summaries of hypnosis research. Either I will start to write the blog post then, or I will move on to do some continuing medical education (CME), either for my EMT license or for hypnosis. Every day, I work on something relating to education since I will be attending graduate school in fall, or I work on a journal article or book proposal. Over lunch, I review my client notes and review whatever else I need to.

About an hour before my first client, assuming it's virtual or in-office, I shower, shave and get dressed. There is always one unexpected person each day at my door, I always hope it is after I am ready versus coming at non-business hours. I then wait by my front door if the client is in-office or wait in my virtual chatroom if they are not. After the session, I write my client notes and paperwork immediately, lest I forget what I did. My scheduling is set up to avoid back to back clients. In between clients, I continue to check email and if I am lucky, I have time to let friends and family know I'm thinking of them or eat. As soon as my work is done for the day, I see if I need to set an alarm and go to bed.

## REPORT 4 AND 5

### A day in the lives of two clinical psychologists in the Ukraine

**Vitalii Klymchuk and Viktoriia Garbunova**

We are family. We both are psychologists and psychotherapists. We built our career together, learn together, provide pieces of training together and sometimes even provide psychotherapy for couples together. Despite this fact, our regular day can be different for each of us, so we will describe it from different focuses.

Vitalii: My day begins at 7.30–8.00 (it depends on the schedule of our son). I don't have time for breakfast for myself. While Viktoriia wakes our son up, I just manage to prepare breakfast for him, and during his breakfast, I try to prepare myself for the day. As we live outside of the city – we drive together with our son to school and then split up.

I like to have clients in the morning time – from 9.00 a.m. till 12.00 a.m. I have a private practice – so can be relatively free in my preferences. I've got a private shared office – every colleague has his time for work in it. We share rent costs, cleaning and equipment.

Before the beginning of the sessions, I have some coffee – I like to have it near the office, on the street, and look at the people when they go by. It's like morning meditation that helps to start working day and develop plans.

After 12.00, I usually have lunch and then I spend time on self-education – 1–2 hours for reading, on-line courses, supervisions or chat with colleagues. I do it from home or in some cafe or restaurant.

The next part of the day, I use for my second job – I am also a project manager in mental health projects and vice-president of the National Psychological Association. So mostly, I spend time doing some planning, developing implementation models or generation of ideas for future projects, as well as have a meeting with teams in which I work. This second part of the day varies from day to day, so there is never any regularity in it. I like it – it helps me to feel that I am the master of my life, not some other organization or people.

At 18.00, I usually finalize my day, bring everybody home and we have dinner and family activities like chess, school projects for the son or just lying and watching the fire in the fireplace (if it is winter).

So, this is my day – and now you can look at the day of Viktoriia...

Viktoriia: My day starts at the same time as Vitalii's morning waking up our son. I do jogging in the forest near our house. I like it. Every season in the forest is amazing. It is a pleasure to observe the nature changing and seasons' variety – colours, smells, sounds... I try to absorb every bit of morning and fill up myself with freshness and readiness to a new day.

This option works for me if I stay at home to work online with clients or doing some project work or writing articles or books. I am fond of writing homework because of the opportunities to be alone, to concentrate, gather myself and to do something sufficient. Also, I like to work with clients online. My clients live all-around the world, but I can see and hear them in my workroom at the screen of my laptop. Usually, I make a coffee for myself with a bit of spice, settle myself conveniently in the chair and answer the call 'Hello! I can hear and see you well. How are you today?...'.

If my day will continue outside the home, I just dress up and make up myself (a little). If I haven't got any work trip, day-in-town will start from 1.5-hour yoga. I often teach my client to do mindfulness and I guess I could not do it without any

personal experience of relaxation, concentration and freedom from thoughts.

Then – clients. I am used to six client hours per day or 6-hours training work with university students (I'm a university professor) or another audience. I have been working as a mental health expert with medical doctors, journalists, human resources professionals, owners of a business, leaders of non-governmental organizations (NGO). There is a lot of interest in mental health among all kinds of professionals; it is becoming a trend, for example, to develop mental health workplace programs. So, I help them to create an appropriate environment for their employees.

The end of my day is a reunion with family and some warm hours in a cosy atmosphere of our house.

Of course, not every day of our life looks like that. There are days of tension, difficulty in work with volunteers, veterans and IDPs, days of overwhelming work trips (as you might know we have a Russian invasion in the East of our country and Crimea annexation), days of educational activities for ourselves (conferences, training and so on). But we like our lifeline with every predictable and unpredictable event – this helps us stay alive, embrace the life and fight for life and freedom of Ukraine.

## REPORT 6

### **A Day in the Life of a Psychiatrist in a United States Forensic Hospital** **Gillian Friedman**

As I was perusing the list of patients who would be coming for intake to the forensic hospital where I now work, I spied a name I recognized. I had known it would probably not take long for me to encounter, in my new job at the forensic hospital, someone I had previously treated in the community (as patients with severe and persistent mental illness in the United States often float among several institutional systems, including the penal system). I had just not expected it would occur within the first few weeks at my new job.

I work at one of the largest forensic hospitals in the United States. By and large, the patients we treat are at some stage in the legal process for a felony criminal charge or a felony conviction, with the courts determining that they cannot be treated in a less acute setting. Some are still facing criminal charges but are not yet able to understand the charges against them or to assist their attorneys (i.e., they have been determined to be not competent yet to stand trial). Others have already been convicted but need

a higher level of psychiatric care than the prison system can provide; others come to us when they are eligible for parole, but the courts determine they are not yet ready to be paroled directly into the community.

When my former patient arrived, he remembered me, though it had been several years since I had been his psychiatrist in an intensive outpatient program in the local area. His presentation psychiatrically was similar to what it had been in the outpatient setting – but he had eventually left the program. He was cooperative with me, willing to restart treatment in the hospital, but still insistent that he did not have any mental illness and dismissive of the idea that him repeatedly stopping his medications in the community might be related to the series of arrests that now may land him in a substantial prison sentence.

I have long thought about the complicated situation for mental health care in the United States for individuals like this patient. A strong believer that institutional care settings should be a last resort, I am encouraged that my state has embraced funding a wide range of programs to provide intensive care in the community. For almost 15 years, at the beginning of my career, I worked in these programs, where the traditional U.S. model that individuals become patients when they show up to their appointments in the office was turned around. As an Assertive Community Treatment (ACT) psychiatrist, I had a group of patients who were under my care no matter what, and if they couldn't come in to the office, my team and I went driving around the community to find them. I got to know their landlords, families and neighbourhoods, and I saw first-hand why some treatments I might think in the office were a good idea would likely not work in the circumstances where they actually lived. Sometimes we helped people avoid returning to the hospital for years at a time with this support. But these programs are voluntary, and my patient chose to leave this. What is the answer for people who reject the help that would allow them to stay well and independent? I am encouraged that my patient is now in a place where he will receive excellent psychiatric and medical care – but also sad that he has to be there.

The United States faces multiple challenges with access to mental health care: rural areas may not have a psychiatrist within 150 miles or more; patients with psychiatric illnesses make up a large proportion of those individuals who are still uninsured; laws mandating parity for mental health services, so that patients get the same access to care that they would have with physical illnesses, have faced logistical roadblocks in their implementation; the large mix of payors and systems

makes continuity of care across treatment settings difficult; and finally, people with mental illness sometimes make unsound choices about their care, just like all other types of patients. In combination, these factors have led to some sad statistics for mental health care, such as that some of the largest providers of mental health services in the United States are jails and prisons.

For the moment, I set aside these thoughts and return to contributing the only way I can today – by providing the best care I know how, patient by patient.

## REPORT 7

### **A day in the life of a military psychiatrist in Pakistan Ali Munsif**

My name is Dr Munsif. I am a military psychiatrist working in the army medical corps branch of Pakistan Army. I completed my training from 2004–2008 and then cleared my FCPS (fellowship exam) in Psychiatry in 2010. The delay in exam was caused by an interruption in the training when after two years of diploma course in psychiatry, I was sent to serve in the highest coldest battle field, that is, the Siachen glacier. Since the start of my training, I was involved in teaching, on-calls and regular supervision. We are posted to different stations after 2–3 years of period and I have the honour of serving in almost all areas of Pakistan, both rural and cities. During my training, I was part of the team that was dispatched to work in the earthquake hit area of Kashmir in October 2005. We provided Psychological First Aid (PFA) to the survivors and worked together in assisting the World Health Organization's (WHO) staff who along with our mental health professional teams were also among the first responders at the 2005 Kashmir Earthquake site. I have also served in Liberia as part of the UNMIL (United Nations Peacekeeping Mission in Liberia) in 2012 as part of the contingent of Pakistan's Peacekeepers for one year serving as the sole psychiatrist in the Harper County providing mental health coverage to the UN personnel and the local population. My other half, that is, my wife is also a military doctor and a child specialist. We both did our training together at the same time bringing up our four kids who were very young at that age as we were newly married. The stress of all this was tremendous, but now after many years, they are teens now and that side is relaxed now.

Coming back to how we spend our day in the hospital: I am a Consultant Psychiatrist and working as the Head of the Department of Mental Health and Behavioural Sciences at the Airforce Hospital in Karachi. We are seconded to the

Pakistan Air Force and Navy to serve for a period of 3–5 years. There is a shortage of psychiatrists, and therefore, at most stations, there are one or maximum two psychiatrist who provide for the mental health needs of serving personal and local civil population; so, the work load is always high and routine is hectic even for specialities like ours. Plus, gradually, the population of psychiatric patients has been increasing as everywhere else. That also adds to extra outpatients' clinics (OPD) and admissions. We have a 20 bedded psychiatric indoor facility and run OPD on Monday, Wednesday and Friday. We also conduct Electro-Convulsive Therapy (ECT) biweekly. The department has currently one psychologist who conducts psychometric assessments and psychotherapies plus counselling sessions.

I start my OPD in morning at 8 o'clock. Patients start to build up from early morning as some come from far-away areas and want to be seen early so they can go back to their villages during day light. My OPD consists of a mix of patients such as old cases, new cases, males, females, children, adolescents, young and old, serving soldiers, retired servicemen and their families, officers and sergeants.

I have to be gentle to every patient and try to take a session so that they go home satisfied, which I can see on their faces. Rarely, when I am very tired or irritated myself, I may not be able to give enough time to a certain patient whose dissatisfaction I would regret later in the evening. I would recall how my OPD went that particular day. Monday is the most hectic day and a lot of patients are there, so it is essential that I am fresh and active and get a full night sleep. That was sometimes impossible when I had night duty as emergency medical officer, which we used to do before I was a colonel. Friday is for review of ward cases and writing of opinions. Writing opinions and psychiatric reports of serving personnel is also an important aspect of the duties of military psychiatrist. We regularly see patients who self-harm, use drugs or are involved in discipline or violence related incidents. Similarly, patients diagnosed with psychoses such as bipolar or schizophrenia have to be boarded out because of safety concerns. I take the help of the psychologist for the personality assessment of such patients.

We run our OPD from 8 a.m. to 3 p.m. In between, we can have short rapid brief rest periods in which we can have some snacks such as tea or lunch items. But we can never take a long time for these activities as patients start complaining and some go to the office of the hospital administrator to complain. During OPD, I have to decide whether to admit any patients if he or she is severely depressed, manic or suicidal or suffers any other psychiatric emergency.

On non OPD days, we conduct standing and sitting rounds of the ward seeing indoor patients and conduct individual psychotherapy or group therapy sessions. I am a self-taught expressive artist, and therefore, utilize my hobby by doing creative activities with patients like painting, crafts and pottery.

I am satisfied at the end of our day and thank my staff who are there to help me during OPD in running the OPD smoothly. I always thank them and sometimes apologise if I have sounded irritated.

When I go home, my wife still has not come home as she still has a lot of paediatric patients to see and to manage critical emergencies. So, I do my lunch mostly on my own at home and then we have dinner together.

We are always thankful that we are serving our heroes and those who safeguard our borders. If they were not there, we could not have been sleeping comfortably at night in our homes. So, it is a privilege to serve them with full heart, zeal and enthusiasm and we feel proud in that.

We hope to continue to build our skills and compassionate feelings towards our patients so that we can provide them with the best of care they can have. May almighty help us in our goal. Amin.

## **REPORT 8**

### **A day in the life of a psychiatric resident Rishab Gupta**

As a third-year psychiatry resident at SUNY Downstate, a university hospital in East Flatbush, Brooklyn, most of my training time is spent working at Kings County Hospital (KCH), a large community hospital across the street from Downstate, serving one of the poorest neighbourhoods in this rapidly gentrifying borough of New York City. I am confident that all of you must have either read or heard of physician burnout. Maslach and Jackson define it as a syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment that can occur among individuals who work with people in some capacity. In health care settings, resident clinicians are known to be its most frequently affected victims, and literature suggests the highest prevalence in the surgical specialties. Although psychiatry is considered by many as an easy and relaxed specialty, psychiatric trainees and other mental health staff are not immune to burnout. The assumption that mental health professionals can utilize their skills to handle



and cope with their problems is as wrong as thinking that oncologists have a lower risk of cancer.

I would like to familiarize you with a typical day in my life. My entire residency class has been working in the outpatient clinic since the beginning of the third year. We reach KCH by 8 a.m., spending 30–60 minutes commuting one way. We see around seven to ten patients on any given day, some of them for weekly psychotherapy, which requires a 45-minute visit. Our patients – mostly immigrants (sometimes undocumented) and citizens from low-socioeconomic status – present with a wide array of psychological, interpersonal and socio-occupational problems. We all share the emotional baggage that our patients bring as in any human dyad transference and countertransference is unavoidable. It is a challenge to maintain a professional composure with our patients expressing suicidal thoughts and plans, mourning the death of loved ones, describing their traumatic events in grisly details, swearing at us, becoming increasingly animated and crossing boundaries in making threats and sexually provocative gestures. Apart from addressing their clinical issues, we perform the role of social workers and assist them in obtaining social security benefits such as housing, food stamps, employment and health aide services. In addition, rigorous documentation outreach phone calls to no-shows, liaison with insurance staff for pre-authorizations, pharmacies and patients' families (to quell their anxieties), as well as mental and physical fatigue from excessive computer use can all make life quite difficult in the clinic. Apart from being tired, we often feel sad, angry, helpless, anxious, emotionally numb, disillusioned and incompetent. Some of us even experience nightmares involving our patients. There are numerous days when we feel completely drained and just want to go to bed after work. Based on an informal discussion with my colleagues, I estimate that 40% of us would meet the criteria for burnout.

All of us have our own ways of dealing with stress. We are a very diverse group of helping and caring residents who are always willing to support each other and lend an ear. I personally believe in the power of a popular Sanskrit verse from Bhagvada Gita that states: 'karmany-evādhikāras te mā phaleṣhu kadāchana mā karma-phala-hetur bhūr mā te saṅgo 'stvakarmanī,' which translates to 'You have a right to perform your prescribed duties, but you are not entitled to the fruits of your actions. Never consider yourself to be the cause of the results of your activities, nor be attached to inaction.' Whenever I think about it, it provides equanimity and helps me to maintain a healthy distance from my patients' stressors. I also unwind by listening to music and watching movies and TV shows. My classmates cope by going for personal psychotherapy, talking to friends

and family, playing board games, watching funny videos on YouTube, cooking, exercising and taking vacations. They find these outlets rejuvenating and it gives them an impetus to continue their everyday work.

I would like to finish by confessing that not all our patient interactions bring negative emotions. Many of them fascinate us with their stories, inspire us with their resilience and reward us with their improvement. Despite the occupational hazards of psychiatry, there has never been a day in my brief career when I regretted embarking on this exciting journey that traverses the interface of medicine, psychology, neurosciences, sociology, anthropology and philosophy. I feel extremely gratified and fortunate for being a lifelong student and practitioner of this subject.

## REPORT 9

### A Typical Day in the Life of a Psychotherapist Emil Barna

I turn the handle to the church vicarage-turned-clinic and step inside to tick my name off the sign-in sheet. 'Hi guys,' I say to my colleagues as they look up from their computers and salute back. I make my way to my small consulting room where there is a blue couch in the corner, a small table with tactile toys like fidget spinners and block puzzles, and a jug of water with some plastic blue cups beside it. I place my bag on the consulting chair – it's the same design as my clients' – and use my standing desk to log in before I make my way towards the kitchen and mix my morning matcha tea. 'Hi Emil, how was your weekend?' a colleague asks. 'Good, I think..' and I search my mind for what I actually did those few days ago. 'I think I've got early-onset dementia, 'cos I'm not sure I remember,' I laugh. We engage in chit-chat for a few minutes until I'm back at my desk, sipping my tea. I open my case management system and check which clients I'm due to see that day (I usually book about four-to-five a day) and that way, I know who to send a reminder to. Then, I review my clients' case notes so that I'm not only relying on memory to continue the therapeutic work. I squint at the screen, shuffle back and forth, sip my tea, take out the files from my drawer, and lay them out. Every year I schedule upwards of 900 sessions – most of my work is done within the community health sector, and I work predominantly with addiction – just over half of them attend. I might finish some leftover administrative tasks from the Drug Court the day before (Perhaps one of my clients is finished serving sanctions ...) – prior to considering what's up for the sessions of the day. These 50-minute sessions (sometimes they're more, or less) usually begin with a focus on how the person's past week has

been, only to continue our work to address any underlying issues that have brought them to therapy. With addiction, common co-occurring conditions include anxiety, depression, and the highest diagnosed mental health condition in Australia: posttraumatic stress disorder. In therapy, there are often tears, laughter, contemplation, disagreement and frustration (some of this even comes from the clients!); I remind myself that these are all ingredients for a meaningful session. Case notes follow not long after and I'm reminded of John Naisbitt's quote: We are drowning in information, but starved for knowledge. The more notes I get done immediately after the end of the session, the happier I am – I do hate unfinished business. I stretch my legs after I eat lunch, walk a few blocks, clear my mind, listen to my audiobook or podcast episode I've got playing at the time. Then I'm back on-site for the afternoon; perhaps another tea before my next session. Between these sessions I make phone calls, follow-ups, carry out admin, more admin, and then I top it all off with admin – sometimes I might even engage in secondary consults, sometimes even hearty office banter. Depending on cancellations, I can even look into new therapy modalities to incorporate into my practice. I love integrative psychology and find that as time goes by, I infuse many different therapies to fit the person in front of me. Today looks like many others in my career (I've been in the field for about 5 years now, following the arduous process of undergraduate and postgraduate studies in psychology, counselling, and psychotherapy – 10 years of my life I'm glad to have behind me!). Regularly though, I attend training (continual development is primary in this field), meetings, supervision, or office celebrations. I manage my day, my caseload, book my own clients, plan my own treatment methods – I'm blessed to have the ability to do this because I know many of my colleagues don't. Then, I farewell my colleagues, pick up my children from school, and begin the process of preparing dinner for them before my wife arrives home. I like to work on my writing and I might even find time to write an article like this one once the kids are in bed and I have music running in the background! This is a day in my life, as a psychotherapist.

## REPORT 10

### A day's and night's work as a psychiatrist Demilade Agebeleye

I can sense in my bones that it's going to be a long day; whether this feeling is from experience or just the excitement of being on call I have never been able to tell. I persuaded my spouse to excuse me from school runs; as you can expect I'm trying to conserve my energy as I suspect my batteries would have to run for the next 24 hours. Driving to work, I listen to songs

by Sinach as I mentally prepare myself for my day as a trainee psychiatrist.

The multidisciplinary team (MDT) meeting is at 9:30 a.m., and before this, I take a quick peek at my portfolio; sighing at work place-based assessment targets yet unmet, scowling at unseen senior colleagues yet to complete assessments sent to them but then I see that I have got the required number of responses for my multisource feedback. This gives me the needed motivation to record details of my last supervision session.

Oops!! it's 9:28 a.m., and so, I make a quick dash for the MDT room. You see it's a large team and coming late means walking through with that courteous yet apologetic smile plastered to my face while my GPS frantically searches for the closest empty seat. However, on this occasion I am on time, I share pleasantries with colleagues and we get straight to business. We run through pending new referrals, requests and discuss long waiting lists for different services. The team lead assures us of management efforts to resolve these.

I like the safety that decision making by an MDT offers as well as the diversity of opinions that this kind of gathering gives. On the contrary, I sometimes come from these meeting feeling like a well-prepared solicitor who has had their client's case thrown out of court by the judge despite a passionate and evidence-based argument for the client. Yes, requests are turned down or at times put on that never-ending waiting list as resources are finite and demands seem to be infinite.

My clinic runs simultaneously with that of my clinical supervisor between 11:30 a.m.–5 p.m., so I have barely 15 minutes after the MDT to get a drink, log on to the computer and set the scene for my first patient.

I listen with rapt attention and empathy, very conscious of non-verbal cues as patients bare their souls, unburden themselves and tell me things they had never ventured to mention before. I offer tissue papers and at times offer to get a drink. Healing is definitely not here but hopefully we have started a journey and this I emphasize when it is appropriate to do so. I explain the need to work and walk together through the hoops of pharmacotherapy, psychology, social interventions and whatever is needed and can be advocated for on the way to reach our goal: their recovery.

It's quite a draining process physically, emotionally and cognitively and by the time I have reviewed my cases with my clinical supervisor, I am ready to call it a day. Unfortunately, my on-call rota does not agree with me on this.

I head to the on-call room and promptly fall asleep. At 8 p.m., I get a call from the ward about new admissions and I say to myself- ‘the Armageddon is here’. Hunger pangs are on me like I didn’t have lunch, which I definitely did; I head to the nearby café as I have 45 minutes from the call to get to the ward.

Fully refreshed I head on to the acute mental health wards and I won’t bore you with the diagnosis of the patients seen. The night is long as I juggle 5 new admissions – repeatedly muttering to self ‘why don’t admissions come during regular work hours?’ – alongside discussions with patients who insist on leaving the ward, considerations of the appropriateness of a section 5(2), deal with physical health problems, blue light a patient to the A&E and encourage staff to deal with a patient’s increasing agitation in a stepwise manner before resorting to rapid tranquilisation.

The ward is particularly challenging tonight but the team is also particularly great; members ensuring patients are cared for with utmost dignity while also looking out for the welfare of each other. My jobs are completed at about 6 a.m..

I walk off the ward joyfully waving at colleagues who are also close to the end of their shift, hoping to catch a three-hour nap and drive home at 9 a.m. when my call would be over.

Please don’t ask me what time I woke up.

## REPORT 11

### A day in my life Vani Kulhalli

I am a Psychiatrist working in Mumbai, the commercial capital of India. This bustling metropolis of 15 million has a very poor public healthcare system. The major part of the healthcare service is provided by stand-alone clinics, small hospitals called ‘nursing homes’ and large commercially run corporate hospitals. I am a mid-career, female professional and have a stable and clean (read ‘no commission’) practice.

I start my day whenever I wake up, which varies between 5 a.m. to 7.30 a.m. I put in a solid two hours of housework in the morning itself. This I do so that my family routine doesn’t get upset even if I have to step out for attending emergency or am delayed in returning due to more than usual workload. Three days a week I reach the out-patient department (OPD) in the forenoons and twice a week I start in the late afternoons. On Saturdays, I start work at 10 a.m. and continue typically till 5.30 p.m. I see between 4–10 patients in the OPD daily and

up to 25 on Saturdays. Throughout the day, I get calls from the three nearby hospitals I am attached to and I will attend to the calls whenever I get the time. I try to travel on foot or by public transport as that saves time and also addresses my concerns for the environment.

Between 1–3 hours in the afternoon are for a nap, spending time with my child and doing my study reading. I order all my groceries home and it helps that all the grocery, vegetable vendors, tailor, etc. are on very good friendly terms with me and are always eager to help me. Evenings are for dance, walks in the park with my child, chatting with my mother, just relaxing, gardening or sometimes catching up with friends. By 9 p.m. we have dinner, then its family time and reading again. Sundays are for just lounging around doing nothing, so my family says, ‘don’t cook’ and we go out for meals.

All days are not the same – sometimes I work so hard that I have only the energy to get into my house-clothes and dive into bed. I sometimes travel to conduct lectures, training programs or have talk shows or give sound-bites for TV and radio. On some days, I have plenty of free time which I use to write articles like this or do needlework and some things that give a good diversion. I have to take leave to get to my own doctor if I am sick or have to take a family member there. Then there are mundane things like conferences, bank work, shopping, visiting the beauty salon, parent-teacher meetings for the child, which also require much planning and leave taking. I am lucky that my best friend is a psychiatrist – and we help each other through talking about our problems with patients.

Because I am the wife and don’t worry about being dependent, I get to work as much as I want to without fretting about my pay. Though, it is also true that I actually earn well. I am proud of that-because earlier in my life I worked extremely hard and earned my degree from a premier institute and never ever stopped working completely – even if at times I had no job, or I had not much money to start my own practice or I had a tiny baby to care for.

## REPORT 12

### A day of life for a Syrian Psychiatrist in Turkey Wissam Mahasneh

I am a Syrian psychiatrist and EMDR-practitioner based in Turkey. I was the first Arabic Psychiatrist, who came to Turkey after the Syrian Crisis as the Organization of Islamic Cooperation (OIC) sent me a contract to establish the first centre in Turkey for psychosocial support and mental disorders for the Syrian

Refugees in Kilis (a Turkish city) on the Syrian-Turkish southern borders where most of the refugees moved to.

I was waking up at 7 o'clock, then had a bath and my breakfast.

Then going to the centre on foot (about 25 minutes).

The first training I provided was Psychological First Aid (PFA), then several trainings to my team (three psychologists and four volunteers) as the crisis was the first one they faced.

I work five days a week (three days in the centre and two days in the camps).

When I arrived at the centre, I had a meeting with the team to discuss our day plan, because at that time, we had outreach visits to the Syrian Families to provide psychosocial support.

When I enter my clinic, I check e-mails. During this time, the secretariat prepares the schedule of the appointments, although many of the clients come without any appointment due to the emergency and dramatic situations in the Syrian crisis .

The patients prefer an Arabic-speaking psychiatrist because of the language barriers and the difference of cultures.

I see many poor patients who have suffered a burn-out, PTSD, suicidal thoughts and plans, self-harm, drugs abuse, ... because of the death of their relatives and for many other reasons.

In the last hour of my working day, I meet with the team again to share experiences then do breathing and relaxation techniques, as well as perform the Safety Place Procedure.

After that, I have my dinner with some friends in a restaurant as I am single, then go home to have some rest and listen to music.

In the evening, I go to a café to read articles, research papers and news about what has happened in Syria.

After that, I go home again and watch the news on TV, and talk with my family inside Syria.

All days are not the same, sometimes I conduct lectures in the Turkish universities and Syrian associations, about the Syrian culture of mental health and on mental health during the conflicts.

Sometimes talk shows for TV and radios. Sometimes, I provide training in several Turkish cities, participate in research and

conferences in Europe to talk about the Mental Health of Syrian Refugees. Finally, I pray for peace for my home Syria.

## **REPORT 13**

### **A day as a professor of psychiatry Dragana Ristic**

I work at a University Clinic in Serbia. For 25 years, I have worked as a psychiatrist. I am also a full professor of psychiatry. It was clear to me early on that I would be a doctor; even earlier, it seems even then I knew I would become a psychiatrist. How does the present correspond with what I was dreaming of?

Monday is my outpatient day. Patients do not have set appointments, everyone who shows up at the clinic that day will be evaluated. Other than the patients I have been treating for a long time, there are also those for whom it is the first encounter with psychiatry. Despite years of experience, my discomfort is enhanced by patients who are escorted by the police or arrive with an ambulance. These patients often have no desire to be at the clinic, sometimes they have no home address, no family, and you have no information about what has happened to them until now.

I have been working as a doctor since 1988, and as a psychiatrist since 1995. I have been teaching at the University since 1990. As is the case with many others, I knew early on that medicine is my professional choice and within medicine – psychiatry. I believe I knew this even before the rational decision about my professional choice was made. Something in my nature made this connection to psychiatry possible. But the rational is often followed by the intuitive, which is, in turn, often connected to a personal destiny.

Work begins at 7:30 a.m. with a morning meeting. I listen to a report about the events at the clinic that took place during the weekend. At 8 a.m., we check on our inpatients. After we are done, I have a cup of coffee with my closest associates while we make plans for the following week. These moments fill me with optimism and represent the much needed support. I am sitting there with our small multidisciplinary team – a psychologist, social worker, nurse, resident. Afterwards, I proceed to the ambulance.

Most of my patients have psychosis spectrum disorders (PSD). Among them, many receive clozapine since they belong to the group of therapy-resistant schizophrenia patients. Those patients are doing very well. They have not been hospitalized for years, and are still somewhat functional

and participating in family activities. Most of them come to check-ups on their own. We evaluate their progress and make plans for the future.

Some patients encounter psychoses for the first time. Most of the time they are young, and we are still just getting to know each other. Beside those patients, there are patients with depression, anxiety and bipolar disorder. There are family members who are taking care of their parents who have dementia. As I grow older, I tend to become more patient and detailed in my explanations about taking care of demented patients. In my country, dementia is recognized better and earlier. Since parents rarely go to nursing homes, most often they are being taken care of by their family members. Resources that the government allocates to the families who diligently take care of their elderly should be much bigger; this could ease the burden for the families and provide them with ways for easier handling of every-day problems of caretaking.

Since I am a trained family therapist, I try to implement some of the techniques when working with individuals or families. Sadly, the setting in which I work does not allow for structural engagement in psychotherapy, so I am predominantly oriented towards pharmacotherapy.

The clinic in which I work in is a part of a university hospital, which is an educational base for students of medicine, stomatology, pharmacy and nursing. I am engaged with students on Tuesdays and Wednesdays.

When I end my outpatient clinic, I check on the patients that are in the clinic. I am the chief of the department of emergency psychiatry. This includes patients who call for heightened observation, and many of them also have somatic diseases.

Afterwards, I usually see another patient as a part of the clinical study. In the clinic, there are many multicentric, multinational research programs. Thus, we become part of the scientific community, while our patients have a chance to contribute through participation to discoveries, which will be significant for future generations.

I am not an on-call consultant on Mondays. On the days when I am on-call consultant (twice a month), I receive requests from co-workers from the hospital and examine patients who are manifested with psychiatric symptoms during their treatment on other wards. Those are commonly delirious patients belonging to the geriatric population, but I often see patients whose lives are endangered after suicide attempts while they are temporarily being taken care of in the emergency room.

There are a growing number of psychiatric consultations, which are actually clinical ethical consultations. For example, a situation where a patient refuses the suggested treatment or procedure or wants to cease treatment before this is optimal. In cases such as these, their decision-making capacity needs to be assessed.

Clinical ethical consultations are something that fulfils me in this phase of my career. In Serbia, ethical problems are solved on an everyday basis while balancing a multitude of ethical principles and dilemmas. The Ethics Committee is concerned with the oversight of clinical research, but I would love to work more on the promotion of clinical ethical consultations.

At the end of the first part of the day, we have a meeting similar to the morning one. Other psychiatrists arrive for their afternoon duty and we are going home.

Later in the afternoon, I turn on my laptop and write. Sometimes it's expertise for the court, sometimes I correct students' papers, I search for literature or prepare my classes, I respond to emails. At the end of the day, am I fulfilled? Mostly, I am.

Tomorrow is Monday. It comes after a short weekend since I was on duty during Saturday. My ambulance patients are waiting for me.

## REPORT 14

### **Life in the day of a Psychiatrist...trust me it is definitely interesting!**

**Saumya Singh**

Hello there, I am a Psychiatry trainee working in Addiction services, based in the UK. First of all, I would like to thank you for showing interest and taking out time to read this article.

Now, keep reading and stay calm. Yes! It is one of the things we do as a psychiatrist. I bet a lot of people would be curious to know how psychiatrists spend their typical day. Let us make it even more interesting and a bit humorous; let us see it from the eyes of a psychiatry trainee.

6 a.m.: The alarm goes off. Time to wake up and get ready

6:15 a.m.: Shower is always a good idea!

7 a.m.: Dressed up and ready to go. You must be thinking I missed my breakfast...well on most of the days I have breakfast at my workplace.

7:15 a.m.: I switch on my car engine and take off!

8:50 a.m.: I reach my workplace. Yes! You read it correctly. On most days, my average time spent on road each way is 1.5 hours. On good days, it is better and on bad days... you can guess, right?

9:00 a.m.: I have breakfast at my workplace; toast with a cup of coffee. Nothing beats a cup of hot coffee!

9:30 a.m.: Patient Mr A arrives. I have a medical student with me this morning. I ask him to take a history and present it to me. He goes on like 'Mr A is a 50 year-old male who appears tired and dishevelled... we all owe this to Mental State Examination, where we tend to add some palpable adjectives to our patients.

Mr B takes drugs... he is known to inject and share needles. He refuses to have any intervention, but is here in the clinic with some hope to get better! Sometimes, as a Psychiatrist I think what next!

Next patient is an interesting 20 year-old who has just come out of prison and has broken a legal order. He has some interesting stories to talk about. After him, I see a few more patients and then I sort out my paperwork.

1 p.m.: quick lunch

1:30 p.m.: I drive to the addiction inpatient ward where we have multidisciplinary team (MDT) ward reviews with other team members. Every team member has a different specialist role and contribution to patient care. It is interesting and challenging as we get to work with different minds and still manage to come to a unified decision on a matter.

One of the aspects I like about psychiatric ward reviews is that we have discussions with a cup of coffee whilst we see our patients. I often hear from my seniors that in the olden days, psychiatrists used to sit near a fireplace with a cigar! What a posh way to do ward reviews!

About 4:30 p.m., we finish the ward reviews and prepare to sort out last bit of paperwork.

5 p.m.: Leave work for home.

I reach home at about 7 p.m.; I use the rest of the time to relax and spend time with my family.

10 p.m.: Dinner. Well yes, that is late dinner. I agree.

11 p.m.: Bedtime

That was a typical routine day. Let us talk a bit about an on-call day as a Psychiatry trainee. Whilst on call, we cover different sites. The on calls include provision of routine, urgent and emergency care to our patients.

9–9:30 a.m.: Handover time.

9:32 a.m.: Phone rings! The Armageddon begins!

10:30 a.m.: No calls so far!

10:34 a.m.: Call from old age ward; Mr A had a fall and he is on Warfarin!

3 p.m.: Call for chest pain!

3:01 p.m.: Mr B wants to leave the ward (he was admitted with psychosis).

3:05 p.m.: Mr C is agitated and has punched Mr X.

3:06 p.m.: Ms D has cut herself.

3:06 p.m.: Ms E has swallowed a blade.

Hmm... time to prioritise now!

I barely manage to have lunch after this.

5:00 p.m.: Three new admissions.

6:00 p.m.: Ms F escaped from the ward!

8:00 p.m.: Finally, sit down for a cup of coffee.

8:30 p.m.: Phone rings... Mrs G is unconscious! Action time!

9:00 p.m.: Mr H is on Lithium, bloods to be taken.

9:00 p.m.: Night doctor arrives. Relief!

9:30 p.m.: Home time.

Every day in the life of a Psychiatrist is different; interesting and challenging. I love psychiatry because it is predictably unpredictable. Thank you for your patience.

**REPORT 15****A passionate day in the life of a psychiatrist  
Seshni Moodliar-Rensburg**

Hello all, I am a Learning Disability consultant psychiatrist originally from South African, Indian origin but residing in the United Kingdom and author of Pass the CASC book used worldwide by psychiatrists for the MRCPsych CASC exam, RANZP OSCE in Australia and New Zealand and Irish Psychiatry CFME and OSCE exams.

I love being a psychiatrist and so grateful to have the opportunity to share my passion of a day in the life of a psychiatrist.

My day starts with meditation as soon as I open my eyes, it's switching my timer on and I start meditating for 20 mins.

I then complete my self-care for the next hour and in between seeing to my husband and three wonderful kids. If I do get a chance, I do some exercise or yoga as I'm a firm believer in healthy body, healthy mind.

Then it's breakfast time and I like to make sure we all have had breakfast whether it's cereal, toast, eggs or a green smoothie and I know my family loves food and breakfast.

I feel it's so important as a psychiatrist with the knowledge and understanding we have of mental illness to raise awareness about these conditions. Therefore, I'm a regular at least once a week on hospital radio Bedford from 6–8 a.m., so it's an early start with a cup of coffee with Opoku Opare on his radio show and it's our 7th radio show and we talk about corona virus, psychological impact, reducing panic and fear, preventative measures and UK government battle plan.

I then drive to work and start ward rounds from 9 a.m. till 1 p.m. in an inpatient unit, in which I take care of eight adult patients with learning disabilities and neuropsychiatric needs. The beauty of psychiatry is that we see the holistic approach and full multidisciplinary approach in its purest form, so we discuss our patients, and as a team, decide on the best approach to ensure their well-being and recovery.

I do in between see to other emergencies, like one of our patients was presenting during ward rounds with swelling of his legs and redness and after discussion with the on-call junior doctor, we arranged to get him seen at the general hospital to have blood investigations and to exclude a diagnosis of

neuroleptic malignant syndrome (NMS), cellulitis and deep venous thrombosis (DVT).

I have a lunch break for about half an hour and have a jacket potato with tuna and drink plenty of water in the day.

The hospital I work in has plenty of grounds to walk on so I make sure I walk during my break and during my day.

I walk to my office and then start to complete any online paperwork, update clinical notes on the IT system and complete any ward action plans.

I have a Care Programme Approach (CPA) meeting from 2 p.m. until 3 p.m. discussing a person's progress and plans for the next six months. It is usually an opportunity to meet the people from the community involved in their care. Also, their families are invited.

The next two hours are spent looking at emails, updating notes, administration work and seeing my secretary to ensure I'm up to date with my work and meetings.

I also contact the ward to check up on my patients and to find out how my patient was who was sent to the general hospital. The nursing update was that he was settled and he has returned to the ward on antibiotics and E45 cream.

That's a relief and I reinstate his antipsychotic medication, which we stopped in case it was a NMS.

When it's 5 p.m., I start my journey home and reach within 35 minutes. I get to prepare dinner for us all and we all have supper by 7 p.m. when everyone reaches home. The evening is spent seeing to my kids, homework, reading, washing and then putting the children to bed.

I usually have time after they have gone to bed to spend time reading or writing, which I love. I reflect on my day, do my prayers and my gratitude list. I usually sleep early by 9 p.m., however, some evenings I might have a Skype CASC coaching and teaching booked with psychiatrists in the UK and worldwide. Tonight, it is with a doctor and psychiatrist from Egypt. We finish at 10 p.m., then it's off to bed with 20 minutes of meditation again.

My work as a psychiatrist is the most rewarding, enjoyable and fulfilling. Every day is different and I enjoy the flexibility of doing clinical teaching and seeing to emergencies.

Thanks for reading my day in the life of a psychiatrist and I hope it inspires others to become psychiatrists to help others and to raise awareness of mental health issues, which are real and treatable with the holistic approach.

## REPORT 16

### A Typical Day in the Life of a Psychotherapist – Medical Student's Perspective

Jack Wellington

The alarm chimes at 6 a.m., startling my deep slumber. I realise that today is the beginning of my psychiatry case-based learning, a system of teaching unique to my medical school where we rotate and spiral the standard medical undergraduate curriculum from preclinical to clinical phases of my study. Having two weeks dedicated to psychiatry was just what I needed after cases wholly fixed and concentrated on the inner pathophysiological workings of the lower gastrointestinal tract, from vascular anatomy of the Inferior Mesenteric Artery to Familial Adenomatous Polyposis Coli. I was ready, driven and motivated to sink my pearly whites into something new, something novel, something that I had no prior experience to on the wards.

Psychiatry, in particular neuropsychiatry, has been a field of medicine I have found both fascinating and appealing since I was diagnosed with depression and anxiety following my battle with chronic pain following an emergency surgery. Having the opportunity to seek help and guidance from my local general practitioner and consultant surgeon who both adopted the art of patient-doctor relationships and William Osler's doctrines, I felt relieved that I could do something about depression and anxiety through simply talking to my doctors and being prescribed a selective serotonin reuptake inhibitor. These are some of the factors that have influenced my passion and attraction to the areas encompassed by psychiatry.

I get to my psychiatry placement bright and early for morning lectures starting at 9 a.m., the bus journey fostering my excitement and dread for the day I have in front of me. I was nervous, anxious of what awaited me when I stepped into the hospital, the lecture I was anticipating filled my thoughts with questions, questions of how was I going to cope with the harsh realities that psychiatry embraces daily, from treatment-resistant conditions, which require more extreme forms of medical management to positive and negative symptoms an individual with schizophrenia experiences whilst being treated with atypical antipsychotics. All these questions felt

unanswered and prior to my lecture on the pharmacology of psychiatry, I was feeling intimidated.

At 11 a.m., the lecture concluded, my questions answered and ready to get onto the wards. The hospital, a general district hospital going through recent scheduled maintenance work and refurbishments, was a complete maze of tortuous enamel-like walls and marble-esque corridors. The smell of medical-grade alcohol and bleach dominated the aroma in the air. By the time I arrived at the correct out-patients clinic, I was late by approximately 5 minutes, my punctuality accounted for by the error of circulating around the wrong department due to a mistaken left turn in the central atrium of the building. The consultant I had been assigned was a middle-aged gentleman with impeccable taste in clothing and extremely well-groomed. Rather intimidated, I approached the outpatient reception, looking for someone to assist me in locating my allocated mentor and was told to wait until he has finished consulting with the already-present patient in his examining room.

I stared at the clock religiously, the little hand passing by ever so gracefully was the big hand stayed regimental until my gaze met with the consultants. After introductions, I was asked to consult with patients prior to their actual outpatient appointments to gather experience in simply 'chatting to patients', taking medical histories and even conducting psychiatric evaluations with the mental health nurses. This was a daunting prospect as I had never been given this opportunity before but was willing to embark on this nerve-wracking challenge. After formal introductions with patients, I began to recite my simple but efficient medical history proforma, the past medical history, the family history, the drug history, all swiftly being regurgitated whilst making informal small-talk at particular intervals to build a rapport. Then I followed this with a psychiatric evaluation, which wasn't part of my clinical calibre at that present moment. With the assistance of a mental health nurse of which I believe to be the backbone of psychiatric practice, I conducted the ever-essential psychiatric evaluation of which apparently, I 'excelled at naturally'.

After piloting my first psychiatric outpatients' clinic, I reported my findings and case reports to my tutor, the consultant psychiatrist I hope to aspire to be in the future. A gently-spoken clinician, I began to recite my running commentary on the intricate observations and examination findings I could identify at the time and he applauded my persistence in trying to recognise the fundamental symptoms of significant psychiatric disorders healthcare professionals face on a daily basis.



Following the outpatient's clinic, I was asked to assist in several ward consultations and told to take both a neurological history and examination of the upper limbs of which went surprisingly smoothly. Then, when 5 p.m. chimed from the ward clock, I began to evacuate my life as a medical student and make my way home via the dreaded 40-minute bus journey.

When home, I concluded that my first day on my psychiatry block was unpredictably astonishing and lying in bed trying to enter a deep slumber, I realised that maybe psychiatry was for me after all. This epiphany I hoped would continue into the next couple of weeks in my psychiatry placement

## REPORT 17

### A day in the life of a psychiatrist during COVID-19.

Naomi Shorthouse

I'm a CT1 psychiatry trainee doctor and have been fascinated by the discipline from my induction into medical school. Every case is unique and individual to the patient and the intricacies of the mind and how it affects us I find intriguing. I have reflected upon my current experience in mental health and the changes we have faced since the COVID-19 pandemic hit.

The alarm goes at 7:30 and I leave the house at half 8. One of the very few positives of the current Covid-19 pandemic is that the roads are clear and I am able to get to work without getting caught up in traffic. Arriving at the Doctor's Mess, I receive a handover from the night doctor and take the 'bleep' – current policy dictates that we are effectively 'on call' on every shift. I have noticed the night doctor is often enthusiastic to see a friendly face, as social distancing measures have diminished the normal social interaction between staff. To me, this start to the day acts as an informal, therapeutic conversation. It is important to listen to others in this time as everyone is adjusting at their own rate. There is usually some light-hearted humour thrown in, as working in psychiatry, a sense of humour is a must.

I never thought I would have to wear scrubs again upon entering psychiatry. However, this is the uniform needed to face the Covid-19 battle on our hands. So, I adorn my scrubs, wash my hands and begin the day by wiping the shared surfaces clean. If my bleep has not made that heart-sinking buzz, I usually check my emails, as at present, policy is everchanging and this is the primary means of communication with colleagues throughout the trust.

Throughout these tumultuous times, there have been numerous acts of kindness from the community; donations of home-made washbags for the staff made from pillowcases and curtains, sweet treats and food for staff, which gives us that little bit extra when we need it most. These acts do not go unnoticed and we are most grateful.

On being called to the wards, personal-protective equipment (PPE) must be worn on entry, so I put on my mask and apron.

Despite the pressures the staff are facing, you are still greeted by good spirits and smiling faces from the ward staff. Teamwork is vital. There are obvious challenges of trying to isolate patients who lack capacity, particularly on the old age ward. I imagine it must be frightening for some patients to see us approach, with unusual uniform, masks and aprons. It can often exacerbate conditions in patients who are very unwell. Perhaps unsurprisingly, there are still frequent admissions as this pandemic has the ability to draw on underlying anxiety and paranoia in patients. It is still paramount that we are able to keep patients safe whose risk is too high to manage within the community.

I contact the medical registrar to discuss some blood abnormalities for a patient who has several physical health comorbidities and implement the advised plan. As I am finishing a review on the older adult ward, I notice that there's a quiet excitement building throughout the staff as the word on the grapevine is that the local police will be attending to clap for us at 8 p.m.

A patient approaches the office door and asks, 'Are you joining in?' and I give him the nod. I leave through the back entrance, removing my gloves, apron and mask, and then wash my hands. I walk towards the crowd of staff and although a mild look of disappointment emerges, as I discover the police have not been able to make it, the crowd claps and applauds, smiles beam all round, and most importantly everyone is 2 m apart.

There is a real sense of gratitude and pride amongst the team that is palpable. One silver lining of the pandemic is that it most certainly has brought our communities together. I head back to the Doctors' Mess and prepare to hand over to the night doctor, reflecting that although we are dealing with challenging times, there has never been a stronger sense of team spirit that I am proud to be part of.

## REPORT 18

### A Fourth Year Medical Student's Perspective of a Day in Psychiatry

Robyn-Jenia Wilcha

Following summer, I was jolted back into reality by the commencement of medical school. Observing my timetable, I noticed that my first placement was psychiatry. Apprehension began to bubble inside of me; after all, my previous encounters with psychiatry were limited to sensationalised television shows. Despite an awareness of the media's tendency to aggrandize psychiatric conditions for dramatic effect, I still couldn't help but envisage the worst. A degree of panic set into my body – how would I fare in the face of the distressing sights where patients were completely detached from reality? Would I be able to mentally overcome the things I was about to witness?

I arrived at the psychiatric centre at 8:30 a.m., where I was greeted by the receptionist. After explaining that I was a medical student, she nonchalantly handed me an alarm. An alarm? I thought. They must be needed. Negative thoughts began to filter through my head. Taking a deep breath, I attempted to calm myself down and, with gritted teeth, advanced through the locked, heavy doors.

Trepidation washed over my body. I sprinted to a locked glass box in the middle of an open room. Cocooned by the protection of the nurses' station, I observed the expansive room scattered with chairs, tables, games and crafts. To my surprise, the patients were openly interacting – no one appeared 'out of control' as I had imagined. I began to relax. On conversing with the nurses, their passion for mental health was evident – the nurses exclaimed that they genuinely struggled to envisage doing anything different. The degree of authentic enthusiasm displayed forced me to consider: why do they enjoy it so much? I was intrigued (to say the least).

At 9:00 a.m., my tutor arrived; a female psychiatrist – flawlessly dressed, soft-spoken and above all, immediately amicable. She ushered me to a private room to discuss the objectives of my placement. In conversation, she proceeded to question me about my preconceptions of psychiatry. She listened to my thoughts, without any judgement, continuing to assure me that I was safe and, to my relief, that the feelings I had were normal. She publicly shared her admiration for psychiatry, elaborating on the range of work, to people and to the interesting, yet slightly intrusive, history taking technique. All things that I was looking for in a future career for myself.

10:00 a.m.: Ward round. I gave my legs a shake, reminding them of what it feels like to be standing for 6 hours. However, surprisingly, I caught sight of a room with chairs, biscuits and different healthcare professionals. The MDT component was impressive; I enjoyed how relatives, doctors, nurses, social care workers and the patient worked together to provide the best holistic care, something which I had not seen in other specialties, and with a slight gentle push from my tutor, I found myself taking histories and connecting with patients, something that delighted me. As ward round progressed, I found myself becoming more fond of psychiatry.

Lunch! I was hungry, not only for food, but to learn more. The second time that I entered, I was far more confident. Standing calmly in the bay, I found myself being approached by inquisitive patients. I conversed with many, even reassuring some that I wasn't a spy, only a medical student. In the afternoon, I eagerly took the opportunity to clerk a male patient. He agreed and I began my first psychiatric history.

The history flowed smoothly, I was well-rehearsed in gaining the presenting complaint, followed by the other components. However, I started to become hesitant when enquiring about more personal aspects of the history. With a deep breath, I began asking questions about the patient's birth, school and occupational history, as well as psychosexual, relationships and forensic history. Questions that I had never thought of asking a patient before. I was met with openness and honesty to each question – something which was truly refreshing. My curiosity was unrivalled, especially when the patient spoke of his auditory hallucinations. Rather than the anxiety I had previously felt, I was filled with a passion to learn more about the underlying biochemistry.

The end of my day was marked by 5 p.m.. On my journey home, I remember feeling very grateful to have such inspiring role models around me. For me, psychiatry was a speciality that I had never considered, however, very quickly, it became a speciality that I grew to adore and one day would like to be a part of.

## REPORT 19

### A Day in the Life of an Early Career Psychiatrist Udayan Bhaumik

I am an early career psychiatrist from India. I work at Pramukhswami Medical College in Anand, Gujarat. The town is famous for its cattle and dairy products.

Early career psychiatrists have a unique perspective to offer. They are fresh from their days in residency and cannot help but remember those days with a bitter-sweet experience. On the other hand, there is the challenge to grow and learn every day and strive to fulfil their dreams and careers!

On an average weekday, the alarm clock rings at 7 a.m., snatching me from the arms of my beloved slumber. Time to get ready! Fresh home-made breakfast is ready in 30 minutes, and an hour after that, I am ready to leave for college and start my day's work.

Work typically starts at 9 a.m. It begins with daily rounds of in-patients (we have a 26 bed ward) where all the admitted patients are diagnosed (some reviewed) and management aspects discussed. As I am the junior most faculty, I am responsible for summarizing the management for each patient each day and implementing them. This typically takes up to 10 to 10–30 a.m..

Time for tea! Our department then takes a stroll to the canteen in the hospital premises for freshly brewed tea or coffee. During this time, we catch up on what is going on in the world of psychiatry and with each other. I have four senior faculty members to look up to. After tea, there is the outpatient department to go to.

We typically get 50–60 patients daily. Some days, I end up seeing 10–12 patients, and on other days, it may go up to 25–30 as well. Cases that require the intervention from our clinical psychology team are discussed with them and a management plan is then ready. Meanwhile, the clock ticks on and it is 1–30 p.m..

Lunch break!

I get to return home and eat a nice lunch prepared by myself. On occasions, when the schedule is more packed, there is only time to grab a quick bite from an eatery near the hospital. Not to worry, there are enough options there to prevent one from getting bored.

The outpatient department welcomes me back at 3 p.m. and there is a slow trickle of patients in the afternoon. The time wears on and at 5 p.m., we are done and ready to go. Before leaving, I review the inpatients and take care of their needs.

Back from work!

It is time to catch up with my family. It is also time for career development and catching up with what is happening in the

world. I glance through the latest news on my mobile phone. Then I immerse myself into reading articles on the latest in my field or planning and writing writeups for various journals (such as this one!). There is also time to pursue online courses delivered by some of the best in the field. Besides that, on occasion, there is work from the department to be completed.

Occasionally, the silence of the night is shattered by the phone ringing. A patient has been brought to the emergency! On the days I am on-call, I quickly go and evaluate the patient. They are usually discharged after an outpatient management plan. On some occasions, they may get admitted.

An integral part of working in a tertiary institution is training and mentoring juniors. As part of a monthly roster, I have the chance to give classes for undergraduate students in medicine and physiotherapy students. The best thing about those classes is seeing their eagerness to learn and question. They show interest in working on research projects as well, and when they do, I get to mentor them sometimes. It reminds me of how I was in my undergraduate days. Those days are now gone, not long gone, I hope! It gladdens me to think that I am contributing to building the minds of these young ones so that one day they are ready to step up and serve the society.

There is no end to learning in medicine. Psychiatry is an ocean, and every day we try to gain drops of knowledge so that one day they may be useful. Learning psychiatry is also fun. It is only this branch in the medical field that individual perspective matters a lot. That is why I love this subject and hope it showers its love on all mental health professionals.

## REPORT 20

### **A day in the life of a mid-level career Clinical Psychologist Prerna Sharma**

I work in one of the oldest hospitals in India established by the British. After India gained independence, it eventually became a prominent Medical College in the capital city, New Delhi. There is a centre of Excellence for Mental Health and people from all over the country come to seek treatment here.

My typical morning begins getting up at 7:00 a.m., get my 5-year-old daughter ready for school, and drop her to the bus stop. I get ready and dash out of the house. I live in a different city and a typical drive is of 1.5 hours in traffic before I reach my workplace. Mornings are usually hasty, I see most people in a hustle while driving. There is a reflective pause often on signals

when I see outside my car; with what kind of race against time we humans have found ourselves in.

I reach the OPD and there is a sudden paradigm shift from reflection to action. I have 3 days in a week designated for OPD but due to the influx of patients and burden of care in tertiary care hospitals, I end up seeing patients all 6 days. As a consultant, I have typically 1–2 Clinical Psychology residents posted with me along with a few interns. A lot of my work involves supervising the residents for psychological assessments and therapies, and teaching and training them during the practice of attending to patients. There is a huge shortage of mental health workforce in India, and the utilization of services in tertiary care hospitals is also more. The infrastructure is scarce in most of the biggest setups also. To give an idea, the budget allocated for mental health is only 0.05 percent of the total healthcare budget in India.

I work from a room with another consultant with a minimum of 3 residents and interns. Our first lesson is to learn to work with the resources we have and logistically manage our time and space. There is less opportunity to go by the books on maintaining boundaries and privacy, hence my colleague and all the residents accommodate patients and learn to set psychological boundaries if not physical ones while seeing individual clients in the same room. I typically do 3–4 therapy sessions and 1–2 cases for psychological assessments during the day along with supervision of 6–7 patients whom residents are attending. One skill that we all learn more by force than by choice is multitasking in a day. I often step out for faculty meetings and administrative responsibilities but sometimes time does not allow me to take a break in between, which makes me feel like the one sitting on the ‘Freudian couch’ forever!

I try to take out 30–35 minutes for lunch with colleagues. That brief time is the informal peer discussion around challenging cases (without breaking anonymity) or challenges faced as a therapist or supervisor. It helps provide validation for the work since sometimes being a therapist can be a lonely journey. Few afternoons in a week are dedicated to academic activities like seminars, journal clubs, and psychotherapeutic case discussions presented by residents.

It takes nearly an hour to reach home and one thing that helps me unwind is making a cup of tea and sip it mindfully often sitting in the safe place that I have identified in my home. I have made a deliberate choice of not discussing patient-related work with my husband, but we do like to share our days with each other just to check-in. I take my daughter to the park and interact with other mothers. It is time to make dinner and help my daughter sleep, for which I and my husband take turns in a week.

At night, I spend time checking assessment reports, therapeutic case submissions of residents, updating on some newer therapies, which help in the supervision of cases as well. There are a few weeks and months when a particular area interests me and I start reading, researching on it more, and formulate the therapy cases from that lens. It helps me stay updated with my skills and supervision that I provide. The therapists’ job does not end at the end of the session but often there is space in the mind of a therapist that is always reflecting back on the space shared with the patient. These moments of epiphanies help me with what I do next with a particular client and these reflective thoughts generate empathy that the quiet time allows processing. While retiring, I watch TV to tune out of the day and sleep in hope of the sun rising again.

## DISCUSSION

We received a series of 20 reports comprising variable formats and content. The reports came from all over the world and captured the high variability of psychiatric and mental health practices.

We did not receive reports from social workers, occupational therapists or psychiatric nurses even though we had requested for reports over a six months period, as initially we had struggled to get sufficient reports from psychiatrists or clinical psychologists.

Students and trainees from the UK were the most prolific group who contributed to this endeavour.

The working conditions and approaches described were very different from service to service even though out-patients and inpatient services are a common appearance. This variability raises the question of its justification: Is it the type of disorders, the severity, the disease concept and understanding of the clinician, a clinical necessity, culture, tradition or other factors that cause the implementation and differences in clinical practice?

A few psychologists worked in private practice. A considerable proportion of psychiatrists and psychologists are involved in teaching. There seems to be a willingness in mental health services to collaborate with multidisciplinary teams and to learn and adapt new practices based on learning and research.

Those who work in mental health and contributed to this series shared both pride and enthusiasm for their work.

However, psychiatrists are not immune to the challenges of mental health problems. The series reflects this and notes the strains and the risk of burnout in mental health services.

Due to the variability of working conditions and the described patient groups, generalisations on a common working practice are difficult.

## CONCLUSIONS

The reports of a day in psychiatry were lively and informative, each report was very worthwhile and even enjoyable reading. The authors are to be admired for their hard work and commitment.

Even though we provided a framework of a day to be documented in 750 words, the reports we received were very variable. One may wonder what are the common ingredients of a good service, what are the best models of care provision in different settings and environments?

Further studies documenting the day to day practice of psychiatry and mental health in different conditions and countries would be helpful to identify what type of clinical approach might be the most efficient and most helpful for patients with different disorders and under different conditions. To do this, one would need to be more systematic in assessing clinical practice and service provision.

However, learning globally from each other and finding the best ways to design and provide services seems to be a long road ahead. Research on service provision needs to be intensified. The current content has demonstrated the rich diversity that comprises mental health practice, and will hopefully lead to studies that identify core underpinnings of such practice based on real world experience.

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