PROBLEMS OF FOREIGN BORN PSYCHIATRISTS

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This paper describes problems incurred by those psychiatrists practicing in the United States who were born outside of the United States of America. It describes issues related to practice, politics, and understanding of a culture alien to them. It also focuses on some of the advantages of being a foreigner in the field. In conclusion, the paper recommends specific training to be incorporated in residency programs to address issues identified by the author.

It has been estimated that about one-third of psychiatric residents in the United States and Canada are foreign medical graduates (FMGs) and that in some public psychiatric institutions over 90 percent are FMGs. In 1970, two countries, the Phillipines and India, accounted for almost 33 percent of all FMGs in the United States graduate programs (not only those in psychiatry), and 64 percent were from all Asiatic countries combined. These data indicate that FMGs represent a large segment of our medical specialists in training and that many of these FMGs are from cultures quite markedly different from that of the United States. Obviously, FMGs encounter a number of problems in making the required adaptations; however, being foreign born also has some attendant advantages. An examination of these advantages and disadvantages may help administrators to understand FMGs and to utilize them to their best advantage.

An immediate and obvious problem facing the FMGs is that of fluency and knowledge of the English language. I know of several foreign-born psychiatrists who have done very fine work in specific areas but who have had difficulty in gaining recognition largely because of communication and language problems. FMGs encounter difficulty not only with respect to the grammar of the language but also with regard to accent, colloquial use of words, and local humor—all of which play a significant role in developing any facility with a language. Knowledge of slang and colloquialisms is useful for all who adapt to a different culture but are essential if one is to make

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diagnoses based largely on verbal reports or if one is to be effective in using the verbal modes of therapy. In this regard, I am reminded of an instance told to me of a FMG interviewing a black outpatient in New York City. When the patient stated that during the past week he had seen some “cats,” the interview by the FMG pursued a line of questioning as if the patient had experienced a visual hallucination when in fact the patient was merely using this expression to indicate some of his friends. The FMG was quite embarrassed when one of his American colleagues felt compelled to interrupt the interview to correct his misinterpretation. The existence of this type of problem is indicated by the fact that in some centers there are courses in American slang for FMGs.

In addition to language difficulties, there are problems associated with differences in psychiatric knowledge. FMGs must adapt to differences in diagnostic emphases, differences in the availability and trade names of psychotropics, and differences in what are regarded as the classic psychiatric texts and theories. Lin, for example, notes that most developing countries give low priority to psychiatry in medical and public health programs or pay little respect to modern dynamic psychiatry and community psychiatry. Many other countries follow a much more medical-organic model of psychiatry, and verbal therapies do not receive as much emphasis as in the United States. Thus, the FMG must become familiar and comfortable with a new set of intervention techniques.

Related to this, but perhaps more difficult to learn are differences in the application of this knowledge and issues associated with this application. For example, I know firsthand that in India (and in many other foreign countries) psychiatry is much less accepted by the general public. A dramatic example of this is provided by Jilek-Aall who notes that the Coast Salish Indians of Northwest Canada “appeared virtually petrified when coming for their first interview” and perceived the psychiatrist as “an overwhelming authority figure, in collusion with law-enforcement agencies, ready to lead the patient along the road of incarceration or confinement in the mental hospital.” In contrast, one finds in the United States that psychiatry and psychoanalysis have a tremendous cultural influence evidenced in peoples’ thinking, in their art, novels, and movies. So much is this true that patients have the expectation that a psychiatrist will be fairly knowledgeable and willing to apply not only the various dynamic theories of psychoanalysis, but also the communication techniques that have evolved from studies of communication and sociocultural processes. In addition, patients in the United States are much less inclined to regard the psychiatrist as an all-knowing authority figure and will have little reluctance in telling the psychiatrist that he does not fulfill their expectations. Although native-born psychiatrists can accept this feedback and even utilize it in their therapy, many psychiatrists who have been raised in different cultures find themselves very ill at ease in this setting.

Associated with the issues of communication and therapy are an understanding of the history of a nation, its mores, its standards of behavior, and its literature. Since cultures are different, the expectations,