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correspondence

Changes to training in academic medicine

Changes to training in academic medicine might cause problems for trainees who are interested in pursuing a career in academic psychiatry. The new system comprises academic clinical fellowships and clinical lectureships. During an academic clinical fellowship trainees will be expected to secure an externally funded training fellowship in research or medical education. After the attainment of a higher degree, trainees might enter the clinical lecturer grade, which will offer opportunities for postdoctoral level research or career progression in medical education.

My concerns are related to the stages at which recruitment will take place. The Modernising Medical Careers website states that the next allocation of academic clinical fellowships will be for appointment to posts at the ST1 level, to commence in August 2007 (http://www.mmc.nhs.uk). A recent article stated that until these cohorts emerge from training there will be interim arrangements to fill 'new' clinical lectureships (Dimitri & Stephenson, 2006). However recent advertisements for new clinical lecturer posts have stated that candidates should already have national training numbers and an MD/PhD. This does not appear to be an interim arrangement but rather the introduction of the new model.

Where does this leave a current trainee who (under the old system) hoped to pursue a higher research degree in a clinical lecturer position, who is now definitely not eligible for a new clinical lecturer post and is at too high a training stage to apply for an academic clinical fellowship at ST1 level?

A Department of Health publication (2006) is helpful although vague, stating that applications for academic clinical fellowships will be invited from senior house officers or specialist registrars, depending on the grade of trainee the programme can accommodate. Will old style clinical lectureships continue to exist and be advertised as such until the new system is underway? Will all academic clinical fellowships in August be at the ST1 level? It would be useful to have clarity on the availability of such fellowships in psychiatry at the ST4 level.

DEPARTMENT OF HEALTH (2006) *New Academic Training Pathways for Medical and Dental Graduates*. Department of Health. http://www.mmc.nhs.uk/download_files/A-pocket-guide.pdf

DIMITRI, P. & STEPHENSON, T. (2006) New careers in academic medicine. *BMJ Career Focus*, **333**, 138.

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doi: 10.1192/pb.31.4.153

Prejudice within

Recently during one of my on calls I had to ring the emergency medical number because a young patient on clozapine suddenly became hypotensive, hypoxic and unresponsive. The attitude of my medical colleagues who came to attend the patient left me feeling perturbed and belittled. I have had similar experiences while covering the A&E department and was often asked how we managed to engage patients with psychosis and obtain information from them. I was never sure if this was praise for me or put down for my patients.

Antipathy towards psychiatry among medical professionals is well known. Silence and resignation from the psychiatric community have done nothing to decrease the stigma or the discrimination and prejudice. Psychiatry also faces stigma from within. I say this because I had difficulty coming to terms with my own mental illness.

My symptoms of depression started in early 2004, but I attributed them to a number of causes – house move, new job, bad week, a stressful day and even bad weather. I was diagnosed with depression a few months later and prescribed antidepressants. I was not willing to accept that I had depression. Comments that I had heard about others like 'it doesn't take her long to flip' and 'it's not depression, it's personality disorder' echoed through my mind. I stopped taking my antidepressants and even asked a colleague if she thought I had personality disorder.

Things came to a head and I had to take time off work. A close friend, on finding out that I had depression remarked, 'I thought you were a strong person.' I was ashamed and did not want people to know about my illness. Then came the anger. I was angry because I did not have a scar or a deranged report to show for my illness. Why was psychiatry still in the dark ages? I had failed me. My fraternity had failed me. With time and help I improved and then came the guilt. I realised that I had no right to lecture people about stigma and recognition of mental illness. I was as bad as them – no I was even worse. I had doubt about my suitability as a trainee psychiatrist, but with time came acceptance. I realised how lucky I was to get timely help and thought of people who for months and sometimes years do not get any validation of their suffering.

Now, a year later, I am comfortable with my illness. I hope to come off my antidepressant in the near future. I would not wish it on anyone but it has taught me a lot. I have grown as a person. I hope I don't have a relapse but if I do, I am confident that I will overcome it with the help of my family, friends, my doctor and last but certainly not the least my will power, because I am a strong person. Depression has made me strong.

Acknowledging the existence of prejudice is the first step towards overcoming it. Reticence is the next hurdle.

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doi: 10.1192/pb.31.4.153a

Health shop treatments for depression

Reed & Trigwell (*Psychiatric Bulletin*, October 2006, **30**, 365–368) raise important issues about treatments recommended by health shops for symptoms of depression. The use of herbal medication, as alternative or complementary medicine, is equally relevant in low- and middle-income countries. The practice of Ayurvedic medicine and the use of herbal remedies are deeply rooted in Eastern cultures. It is common to see patients using herbal medications along-

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side Western medicine. This certainly does not differ in patients with psychiatric illnesses. Herbal remedies are sought for symptoms of depression, phobias and other psychiatric disorders. Advertisements that offer a herbal remedy for any sexual problem are abundant in the newspapers. Memory boosters are also much sought after.

Most people obtain these herbal remedies from small shops in villages and towns. Some obtain them from the village 'medicine man'. Herbal remedies are also sold in larger shops with minimum regard to the legislation in place. A survey carried out in the out-patient psychiatry clinic at the North Colombo teaching hospital found that 25.5% of psychiatric patients had used herbal medication at some point. A longer duration of psychiatric illness was related to the greater use of herbal medication. A majority of patients who used herbal remedies were not aware that there can be harmful interactions with other medications. This can have disastrous consequences when herbal medication is used in a complementary role.

Use of herbal remedies as alternative medication may also contribute to a delay in seeking treatment. Patients may prefer to use herbal remedies, which are less stigmatising than psychotropic medication. This may result in a delay in treatment which may have negative effects on prognosis.

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doi: 10.1192/pb.31.4.153b

Smoking has no place in psychiatric hospitals

O'Gara & McIvor (*Psychiatric Bulletin*, July 2006, **30**, 241–242) address the issue of smoke-free legislation and mental health units and endorse the view that smoking cessation should be encouraged in psychiatric hospital settings. The concern remains that some psychiatric units will be exempt from the smoking ban. This can only further alienate psychiatry from medicine and increase stigma against psychiatric patients and services. Admission of smokers with mental illness to smoke-free psychiatric units may lead to behavioural deterioration, but some evidence refutes this argument. The implementation of a smoking ban, establishing a smoke-free psychiatric service and abolishing tobacco products, created minor management difficulties on a locked psychiatric unit (Ryabik *et al*, 1994). The effects of prohibiting cigarette smoking on the behaviour of patients on a 25-bed psychiatric in-patient unit were assessed immediately after implementation of a smoking ban and 2 years later. No behavioural disruptions were observed after the ban, and discharges against medical advice did not increase immediately after the restriction on smoking or 2 years later (Velasco *et al*, 1996).

Signs and symptoms of nicotine withdrawal and alterations in psychopathology were evaluated among psychiatric patients with acute illness admitted to a hospital with a smoking ban (Smith *et al*, 1999). Despite patients' reports of feeling distressed and of experiencing nicotine withdrawal symptoms, abrupt cessation of smoking did not affect psychopathological symptoms during admission (Smith *et al*, 1999).

The above evidence shows that smoking has no place in psychiatric hospitals, and that a smoking ban can only improve the well-being of patients, staff and visitors.

RYABIK, B. M., LIPPMAN, S. B. & MOUNT, R. (1994) Implementation of a smoking ban on a locked psychiatric unit. *General Hospital Psychiatry*, **16**, 200–204.

SMITH, C. M., PRISTACH, C. A. & CARTAGENA, M. (1999) Obligation cessation of smoking by psychiatric inpatients. *Psychiatric Services*, **50**, 91–94.

VELASCO, J., EELLS, T. D., ANDERSON, R., *et al* (1996) A two year follow up on the effects of smoking ban in an inpatient psychiatric service. *Psychiatric Services*, **47**, 869–871.

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doi: 10.1192/pb.31.4.154

Access to articles for hospital journal clubs

Evidence-based critical appraisal of articles in journal clubs forms an essential part of psychiatric training. The College emphasises the importance of journal clubs as part of the postgraduate teaching programme (Royal College of Psychiatrists, 2003) and a journal club presentation will be one of the workplace-based assessments undertaken by trainees to demonstrate competencies in the new curriculum (Royal College of Psychiatrists, 2006).

However, since the loss of the National Health Service licence regarding copyright privilege it has become increasingly difficult to organise journal clubs. Previously, once a paper was identified, it could be photocopied and sent out in advance or handed out at the session. Now each individual attending must be sent details of the paper, and they must download and print their own copy. This involves excessive time and also increases cost (as printing is more expensive than photocopying). It also means that many trainees fail to have a copy of the paper for discussion, either because of lack of computer access, lack of time or perhaps through laziness. This certainly does not facilitate good-quality teaching and learning.

We wonder if other teaching programmes have had similar experiences and it they have found a more convenient way to organise access to journal articles. One way forward would be for the College to authorise the reproduction of its own publications for members organising journal clubs, allowing photocopying of articles from several peer-reviewed, hopefully high-quality journals.

ROYAL COLLEGE OF PSYCHIATRISTS (2003) *Basic Specialist Training Handbook*. Royal College of Psychiatrists. http://www.rcpsych.ac.uk/PDF/bst.pdf

ROYAL COLLEGE OF PSYCHIATRISTS (2006) *Curriculum Pilot Pack*. Royal College of Psychiatrists. http://www.rcpsych.ac.uk/training/curriculumpilotpack.aspx

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doi: 10.1192/pb.31.4.154a

Parrots as therapy for psychiatric patients

I would agree with Pease & Brown (*Psychiatric Bulletin*, December 2006, **30**, 463) that parrots are probably not suitable for health centres, not because of confidentiality problems but because they can be noisy and it is unfair to keep them constantly caged. When parrots breach confidentiality it is with phrases they have heard repeatedly and with emotion. There are cases of parrots squawking lovers' names and leading to the break up of both human and parrot relationships (for example, the sad story of Ziggy in *Daily Telegraph*, 17 January 2006).

I have kept pet parrots for 20 years and can recommend them for the house bound, the lonely and patients with depression, especially middle-aged women suffering from the 'empty nest syndrome'. They can be extremely loyal and loving, providing companionship and better quality entertainment than television. They are highly intelligent, social animals, and African Greys can learn to use words in a meaningful way. They do, however, have complex needs and some species, such as cockatoos, should be avoided as they become neurotic if their emotional demands are not met. Amazons (the green ones) are a good bet. Their longevity can also be a problem (for example when elderly owners require nursing home care). It is important to purchase an English-bred bird, preferably one that has been hand-reared. I would advise prospective owners to contact The Parrot Society UK (http://www.theparrotsocietyuk.org) who produce a