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 lecture-ships. During an academic clinical fellowship, trainees will be expected to secure an externally funded training position 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 the clinical lecturer grade, which will offer opportunities for postdoctoral level research or career progression in medical education.

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 clinical officers or specialist registrars, depending on the grade of trainee the programme can accommodate. Will old style clinical lecture-ships 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.


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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 hypertensive, 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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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-
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). Smoking has no place in psychiatric hospitals, and that a smoking ban can only improve the well-being of patients, staff and visitors.

The above evidence shows that smoking 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.


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 if 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.


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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 Zippy 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.theparrotscocietyuk.org) who produce a
Forensic telepsychiatry

We read the article by Jones et al on setting up a telepsychiatry service (Psychiatric Bulletin, December 2006, 30, 464–467) with interest and optimism, having developed the first forensic telepsychiatry service in Nottinghamshire in 2005 (Saleem & Stankard, 2006). To date, we have undertaken 30 forensic assessments, 4 of which have resulted in hospital admissions. Assessments were primarily undertaken using existing video-conference facilities within local magistrates’ courts and HM prisons. We support the opinion that this saves time, cost (Zollo et al, 1999) and improves access to psychiatric services (Zaylor et al, 2000).

However, although Jones et al describe the development of services, they do not state whether they have assessed patients themselves using videoconferencing facilities. If they have, it would be useful to establish links between telepsychiatry services within the UK, forensic or otherwise.

At the College’s invitation, we are conducting a workshop on this subject in Prague, at the Annual Meeting of the Forensic Faculty in February 2007. We have also developed a forensic telepsychiatric steering group, with a research sub-committee, in Nottingham. We are coordinating several research projects, which are exploring the use of teleconferencing facilities within forensic psychiatry. We would welcome any additional views and opinions on expanding this work.

It is crucial for services across the UK to share experiences and promote practices. The promotion of telepsychiatry has the potential to change current practice positively. This is particularly important if we are to succeed in delivering timely, easily accessible and clinically sound psychiatric services, with the additional spotlight on cost-efficiency with respect to health service delivery.


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Mental healthcare for psychiatrists

We read the article by White et al (Psychiatric Bulletin, October 2006, 30, 382–384) with great interest, as we have conducted a similar postal survey of 1640 general practitioners and psychiatrists in Devon and Cornwall regarding depression and stigma. We also achieved a high response rate (75%), indicating the importance of this issue to doctors. When we asked about sources of help, respondents would turn to if they were experiencing excessive stress, more reported that they would seek help from family and friends (95%) and from colleagues (85%). Our slightly different findings might be because we asked about ‘stress’ rather than ‘mental illness’, but the overall trends are similar.

The barriers to disclosing mental illness reported by White et al are supported by our findings. However, we found that barriers to seeking help very often included concerns about letting colleagues down and confidentiality, with concern about career progression cited by only 16% (although women were twice as concerned about this as men).

White et al found that 20% of psychiatrists admit to self-prescribing for mental illness, but in our study the rate was only 7%. The fact that our respondents were more willing to disclose stress to colleagues and reported less self-prescribing perhaps reflects a more open culture in Devon and Cornwall since the introduction of an effective occupational health service.

Overall, our study in the South-West confirms the findings of White et al in the West Midlands. Both studies address the poorly researched but important area of doctors’ attitudes towards mental illness and we agree with the recommendations of White et al. There is still a long way to go in terms of educating doctors about looking after and improving their own mental health and in reducing stigma within the medical profession.

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Bye-Laws Section XII. The Other Honorary Officers

1. The Central Executive Committee shall, in accordance with the Regulations, make its nominations for the offices of Dean, Registrar, Treasurer, and Librarian\(^1\) at the first meeting after the name of the President for the next ensuing College year has become known. Written nominations\(^2\) for the above Honorary Officers, accompanied in each case by the nominee’s written consent to stand for election, may also be lodged with the Registrar at such time as may be prescribed by the Regulations, provided that each such nomination is supported in writing by not less than twelve Members of the College who are not members of the Central Executive Committee.

2. The Dean, Registrar, Treasurer, and Librarian\(^1\) shall be elected by the Members of the College, in each case in accordance with the procedure prescribed by the Regulations.

Regulations XII. Election of the Other Honorary Officers

1. The method of electing the Dean, Librarian,\(^1\) Registrar, and Treasurer shall be the same as that for electing the President, save that nominations from Members of the College who are not members of the Central Executive Committee shall be lodged with the Registrar between the first day of June in any calendar year and the date which is four clear weeks after that meeting of the Central Executive Committee which is the first held after the name of the President for the next ensuing College year has become known. The Editor, the Deputy Registrars, the Associate Deans and the Vice-Presidents shall be appointed following advertisement and interview.

2. The Dean, Registrar, Treasurer, and Librarian\(^1\) shall be elected by the Members of the College, in each case in accordance with the procedure prescribed by the Regulations.

Background to the proposal

Mentally disordered offenders are a group for whom therapeutic treatment often involves a complex approach, drawing on many areas of psychiatry. Psychotherapeutic treatment has to work at the interface of the criminal justice system and often takes place within secure settings. Most patients have complex problems often involving comorbid disorders such as mental illness, personality disorder and addictive disorders, as well as their violent and offending behaviour. Managing these patients can take its toll on staff and institutions. Applying psychotherapy to the treatment and management of this group is a developing field. For these reasons there is a recognised need to support forensic psychotherapy as a specific sub-speciality both of forensic psychiatry and medical psychotherapy.

Given planned changes according to Modernising Medical Careers, which will have a significant effect on dual CCT training, the National Strategy in Forensic Psychotherapy has been working with the College to ensure that the sub-speciality of forensic psychotherapy maintains and develops its presence. Although forensic psychotherapy is often described as a dual-interest specialty between the disciplines of forensic psychiatry and psychotherapy it also extends to other branches of psychiatry such as general psychiatry, addiction psychiatry, child and adolescent psychiatry and learning disability.

If we were able to form a special interest group in forensic psychotherapy we would aim to:

- share knowledge and work in the field to help develop the specialty
- bring together psychiatrists from allied specialties with an interest in the field
- contribute towards training and continuing professional development for psychiatrists
- support the discipline during changes in training and the implementation of Modernising Medical Careers, and ensure that the field remains visible and supports interest across a wide College membership

- help support educational and training initiatives for psychiatrists working with particular patient groups; for example, people with personality disorder, learning disability and addictive disorders
- act in an advisory role and resource, if appropriate, for other College Faculties.

We would hope to establish an ongoing forum for psychiatrists, via regular meetings and events, to develop professional networking, research and educational opportunities in this field. We hope very much that you will be able to support this proposal.

Members are invited to write in support of this group and express willingness to participate in its activities. Interested members should write to the Registrar care of Miss Sue Duncan at the College. If 120 members reply to this notice within 4 months of publication, then the Central Executive Committee shall formally approve the establishment of this special interest group.

Professor Sue Bailey  
Registrar, Royal College of Psychiatrists

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Honorary Fellowships

Nominations for the College’s Honorary Fellowship will be discussed at the October meeting of the Education Training and Standards Committee.

The regulations of the College state under Bye-Law Section V that ‘Subject to the Regulations the College may elect as an Honorary Fellow any person, whether or not that person is a member of the medical profession, who either is eminent in psychiatry or in allied or connected sciences or disciplines or has rendered distinguished service to humanity in relation to the study, prevention or treatment of mental illness or to subjects allied thereto or connected therewith or has rendered notable service to the College or to the Association.’

Nomination forms are available from Miss K. Hillman, Department of Postgraduate Educational Services (email: khillman@rcpsych.ac.uk), to whom nominations for Honorary Fellowship should be sent by 30 June 2007. Such nominations must contain recommendations by no fewer than six Members of the College, and include full supporting documentation.

Robert Jackson  Head of Postgraduate Educational Services, Royal College of Psychiatrists

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1. The Central Executive Committee agreed in October 2006 that there should no longer be an Honorary Librarian; the Bye-Laws and Regulations are currently being amended to reflect this.

2. Nomination forms may be obtained from Candace Gilles-Wright, email: c.gilles-wright@rcpsych.ac.uk.
Smoking has no place in psychiatric hospitals

Faouzi Dib Alam

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References
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