the columns

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-