MEDICAL WOMAN

VOLUME 35: ISSUE 2
AUTUMN/WINTER 2016

INSPIRATION! LIFE BEYOND MEDICINE

HAPPY TEAMS
Celebrities give their top tips

ARE YOU SITTING COMFORTABLY?
Create your signature work outfit: The Amanda Wakeley Way

www.medicalwomensfederation.org.uk

Contents

Medical Woman, produced by the Medical Women's Federation

Editor-in-Chief:
Miss Jyoti Shah (missjshah@gmail.com)

Editorial Assistants:
Ms Anji Thomas
Miss Sarah McLoughlin

MEDICAL WOMEN'S FEDERATION
Tavistock House North, Tavistock Square,
London WC1H 9HX
Tel: 020 7387 7765
E-mail: admin.mwf@btconnect.com
www.medicalwomensfederation.org.uk
@medicalwomenuk
www.facebook.com/MedWomen

Patron:
HRH The Duchess of Gloucester GCVO

President:
Professor Parveen Kumar CBE

President-Elect:
Dr Henrietta Bowden-Jones

Vice-President:
Dr Olwen Williams OBE

Honorary Secretary:
Dr Clare Gerada MBE

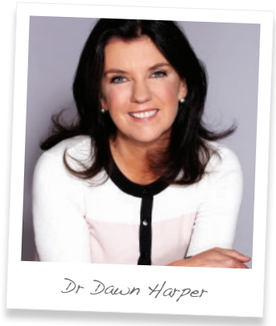
Honorary Treasurer:
Dr Heidi Mounsey

Design & Production:
The Magazine Production Company
www.magazineproduction.com

This issue's cover photo & central pull-out feature by Paresh Solanki
www.psview.media

Contributors

AUTUMN 2016


Dr Dawn Harper

Dr Dawn Harper

A medical woman you admire or respect:

Elizabeth Blackwell. She really paved the way for women in medicine in this country & didn't let anyone dissuade her. We could all learn a lot from her dedication & determination

Your five favourite things:

- Kindness
- Humour
- Friends
- Family
- My dog

Dr Fiona Godlee

A medical woman you admire or respect:

Professor Averil Mansfield for being delightful, brave, funny, lovely, self-deprecating & having achieved so much. She has really paved the way for others

Your five favourite things:

- Swimming in the sea
- Spending time in my beach cabin in Dorset
- Family time
- Reading, especially literary biographies
- Work


Dr. Fiona Godlee


Amanda Wakeley

Amanda Wakeley

Your five favourite things:

- Family, including my partner
- Being in the elements – water skiing, country, by the sea
- Nature
- My dog
- Beauty

Tess Gerritsen

A medical woman you admire or respect:

Virginia Apgar for being a doctor as well a musician, & even making instruments

Your five favourite things:

- Food
- Travel
- My grandchild
- My garden
- My family, especially my husband


Tess Gerritsen


Dr Catherine Calderwood

Dr Catherine Calderwood

A medical woman you admire or respect:

Dame Hilda Rose who was the first female president of the Royal College of Obstetricians & Gynaecologists. She showed tremendous perseverance

Your five favourite things:

- Spending time with my children
- Cycling, running, swimming
- Dinner with friends
- Talking to doctors about now & the future
- My new standing desk

Dr Sonia Swart

A medical woman you admire or respect:

Dame Carol Black for managing to excel as a clinician, as a medical leader & for her focus on the value of employment

Your five favourite things:

- Spending time with my family
- Home design
- Arranging flowers & gardens
- Listening to music, especially when my children are playing it
- Short breaks in beautiful places


Dr Sonia Swart

Contributors cont'd


Dr Susan Kersley

Dr Susan Kersley

A medical woman you admire or respect:

Dr Sarah Jarvis, BBC Radio doctor: she gives down to earth advice, has an amazing knowledge of all things medical & beautiful blue eyes

Your five favourite things:

- My three grandchildren
- Walking on the cliffs in Cornwall
- Painting abstract pictures
- Yoga
- Sunshine

Ann Maxwell

A medical woman you admire or respect:

Professor Helen Cross, The Prince of Wales' Chair of Childhood Epilepsy for her commitment to childhood epilepsy, her determination to improve outcomes & her relentless & abounding energy that enables her to give so much

Your five favourite things:

- My husband & three sons
- My home in Scotland & in France
- Entertaining friends & family
- Seeing the world through travel
- I have an absolute passion for fashion


Mrs Ann Maxwell


Dr Hannah Gaston

Dr Hannah Gaston

A medical woman you admire or respect:

Elizabeth Garrett Anderson who pioneered medical training for women, courageously & effectively. Also because she founded (with others) the Royal Free Medical School, where I trained

Your five favourite things:

- Babies (especially my newest seven-month old grandson)
- Children (my three older grandchildren & my own grown-up children)
- Reading (anything, anywhere & everywhere)
- Sewing
- Sitting at the seaside

Dr Hannah Aldean

A medical woman you admire or respect:

My mother, who was a specialist nurse in the NHS for many, many years, who managed work, six children, several moves around the country & a surgeon as a husband!

Your five favourite things:

- Chickpeas (I couldn't really start this list with red wine)
- Lie-ins (sadly a rarity)
- Etymology (especially of the English language)
- Scary movies (it's a love/hate thing!)
- Football (if only the United team of 1998 would come back…)


Dr Hannah Aldean


Dr Rebecca Viney

Dr Rebecca Viney

A medical woman you admire or respect:

Naureen Bhatti who is gentle but strong, kind but fair, a quiet leader who leans in. She sees the bigger picture, reflects & innovates. Teams & organisations thrive under her leadership. The NHS is safer & better for having her – a role model to watch as she ascends

Your five favourite things:

- I am a home maker & love to cook
- Sharing art & music, especially opera with friends
- Watching people I know fulfil their potential & do things they never imagined they could
- Enabling the NHS to really value its workforce & thereby get the best out of people
- Getting people together to enable collaboration & partnership

Karen Webster

A medical woman you admire or respect:

My line manager, Fiona, who demonstrated extraordinary team management skills in supporting us in our frenetic caseloads. As a result, I have always tried to demonstrate a similar approach to my teams. I believe we are too often quick to criticise but don't praise or acknowledge good practice readily enough

Your five favourite things:

- Family & friends
- Chocolate
- Wine (to be shared with the family & friends)
- Exercise (to combat the effects of the chocolate & wine!)
- Holidays (preferably to action-filled destinations as I don't like to sit still for very long)


Karen Webster

Contributors cont'd


Dr Karen Morton

Dr Karen Morton

A medical woman you admire or respect:

Dame Carol Black. She got into medicine via a third class history degree. Her ethos of the importance of work, & her changing of the 'Sick note' into a 'Fitness to work note' fits well with my own view on life

Your five favourite things:

- Being outdoors, preferably on my bike or hitting a golf ball
- Chocolate
- Live music of all sorts
- Skiing
- My work

Dr Kim Holt

A medical woman you admire or respect:

Drs Francesca Silman & Nadia Masood, both of Justice for Health, for their campaigning against the imposition of the junior doctor contract

Your five favourite things:

- Spending time with my children & grandson
- Theatre – especially in London (last amazing experience was Jesus Christ superstar in Regent's Park Open Air Theatre)
- I love yoga
- Walking on a beach or in the hills
- Venice


Dr Kim Holt

JOIN US! JOIN US! JOIN US!

You can now pay for membership and events on the MWF website! So, what are you waiting for? Pass this magazine onto your friends, family and work colleagues, it's about time they took advantage of what MWF has to offer.

WHAT YOU GET FOR YOUR MEMBERSHIP FEES:

MEDICAL WOMAN

Our in-house magazine is issued twice a year in both paper and online formats.

GRANTS, PRIZES AND BURSARIES

for both students and junior doctors.

SUPPORT WITH AWARDS

We are a nominating body for ACCEA and give support with individual applications from women. We also nominate medical women for the Women in the City Award and the Woman of Achievement Award.

NETWORKING OPPORTUNITIES

We hold small networking events in our local groups and hold two national conferences a year.

Become a member at:

www.medicalwomensfederation.org.uk

Editor's Letter

It has been a rollercoaster summer of marvellous sporting successes and the occasional failure. All this in the midst of Brexit which has caused universal unease and even a kerfuffle by inadvertently parachuting our second ever female Prime Minister into Number 10. Once again, the seductive subject of women and power is at the forefront of everyone's minds and making headline news in the press. Can women achieve success and be happy? I don't think they are mutually exclusive!

In this issue, I have weaved a theme about having just that: a happy and fulfilling, successful life and career in 'Beyond Medicine…'. This series profiles some dazzling and inspirational medical women of our time who have cut the proverbial umbilical cord with medicine and achieved their dreams with parallel careers, on their terms. The names read like a who's who: internationally renowned suspense thriller writer, Tess Gerritsen; Channel 4's Embarrassing Bodies media medic, Dawn Harper; Editor-in-Chief of one of the world's oldest general medical journals – the BMJ – Fiona Godlee; Scotland's Chief Medical Officer Catherine Calderwood, and style advice from fashion icon Amanda Wakeley. I am very excited about this issue and if you have lost that va-va-voom, then this should definitely re-ignite your passion.

There is a buzz in the air in the MWF office as well, as we approach our centenary celebrations in Spring 2017. I hope that you will join us in marking the centenary and perhaps even pick up some of our special centenary souvenirs? Meanwhile, I do hope that you will enjoy reading this issue.

Jyoti Shah, Editor-in-Chief

Contact me:
missjshah@gmail.com @missjyotishah

Meet the Team

Professor Parveen Kumar

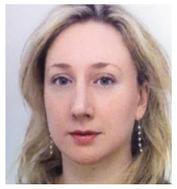
Dr Henrietta Bowden-Jones

Dr Olwen Williams

Dr Clare Gerada

Dr Heidi Mounsey

Dr Farah Jameel



Dr Aurelie Hay-David

Ms Anji Thomas

Ms Sarah McLoughlin

Background to MWF

The Medical Women's Federation – Working for women's health and women doctors since 1917.

The Medical Women's Federation (MWF) was founded in 1917 and is today the largest and most influential body of women doctors in the UK.

The MWF aims to:

- Promote the personal, professional and educational development of women in medicine
- Improve the health of women and their families in society

The MWF consistently works to change discriminatory attitudes and practices. It provides a unique network of women doctors in all branches of the profession, and at all stages from medical students to senior consultants. We aim to achieve real equality by providing practical, personal help from members who know the hurdles and have overcome them.

Achievements:

MWF has campaigned for many years for:

- the development and acceptance of flexible training schemes and flexible working patterns at all levels of the profession
- recognition and fair treatment of sessional doctors in general practice
- the need for continuing medical education and a proper career structure for non-consultant hospital career grade practitioners
- family-friendly employment policies and childcare tax relief
- proper treatment for women who suffer sexual abuse or domestic violence
- abolition of female genital mutilation
- ensuring the needs of women patients and women doctors are considered in the planning and development of services
- ensuring women doctors are active in professional life – MWF members are active in a large range of organisations, including the Royal Colleges, BMA, GMC, Local Medical Committees and Postgraduate Deaneries.

Much progress has been made, but much more remains to be done!

Join MWF to boost your CV, confidence and career through to retirement! medicalwomensfederation .org.uk/about-us/join-us

NEWS & EVENTS

Swansea 'Training as a Doctor with a Family' Event, June 2016

Dr Carol Sullivan, MWF Wales Chair

Following the success of last year's medical students' evening, the Wales MWF chair, Carol Sullivan and Junior Doctor Rep, Dr Shabeena Webster arranged for a meeting on 22nd June at Morriston Hospital, Swansea, entitled 'Training as a doctor with a family'. The event was free and open to everyone, including men, to promote MWF. After all, the family is a whole unit! There were various attendees, including a two month old!

The evening started with refreshments to allow informal networking, followed by four short talks:

- **'Life as a LTFT trainee'** by Dr Fidan Yousuf, Gastroenterology ST7 trainee and MWF member, Newport. Fidan has recently moved back to Wales and is about to return to work after her second maternity leave.
- **'Training full time with 2 children'** by Dr Joanna Webb, recently appointed Consultant Neonatologist, Swansea.
- **'A whole lifetime (10 years plus) of training LTFT in paediatrics'** by Dr Dana Beasley, ST7 Paediatrics, Swansea.
- **'LTFT training – opportunities and challenges'** by Dr Alison Finall, Consultant Histopathologist, Swansea, Wales Deanery LTFT training advisor in pathology and an MWF member.

There was plenty of time for questions and we were fortunate to have Dr Melanie Jones, MWF Past President, present her wealth of experience and knowledge in this field. The evening was a great success with all requesting further such meetings and possibly careers events, which we will aim to roll out across other venues in Wales to continue to raise the profile of MWF, provide support for women doctors and their families, and get a core group for social events.

Airedale Medical Women's Federation Supper Club, March 2016

Dr Eleanor Checkley, MWF Yorkshire Representative

After twelve years as a consultant in ITU and Anaesthetics in Manchester, I moved jobs. I had always fancied working at Airedale General Hospital, which is in the beautiful Yorkshire Dales, but wasn't actively looking for a new job. Little did I suspect that I might find a new job at an MWF conference!

I bumped into Claire Murphy, a Consultant Breast Surgeon at Airedale and an old friend whom I had previously worked with. She told me they were looking for an anaesthetist. I got the job and was faced with a big career change and a whole new region to get to know.

So, after two years of being North-West MWF rep I moved to Yorkshire and began to build a new network. In my work in intensive care I come across many different specialities, so gradually found that there were several consultant MWF members in our small hospital. This network has been great for making me feel at home very quickly, and many colleagues have been really supportive.

We organised a convivial senior medical women's dinner at a local restaurant in Skipton, on 9th March so that we could introduce some of our colleagues to MWF. We had a great time and vowed to repeat it, as many wanted to come but couldn't. We found the opportunity to get out of our specialty silos outside of work really useful. I heard many stories of inspirational flexible working, including running an online e-consultation service in the evening after putting the children to bed. It requires a lot of notice for busy women with evening clinics and on calls, as well as children to get to bed or pick up from nursery – so I need to arrange the next one soon!

I hope to encourage some of these colleagues to become members and to come to a conference to truly experience the fantastic networking and out of the box thinking that goes on when women doctors get together.

DATES FOR YOUR DIARY

October 2016

MWF Elective Bursary opens

11th November 2016

MWF Autumn Conference: 'Women Doctors: Equity or Equality?' at The Light, London

November 2016

Dorothy Ward International Travelling Fellowship opens

December 2016

Katherine Branson Student Essay Prize opens

10th – 13th May 2017

MWF Centenary Celebrations: '100 Years of Medical Women: The Past, Present and Future'

Muir Maxwell Trust

by Mrs Ann Maxwell

When Ann Maxwell's son Muir was finally diagnosed with a rare form of epilepsy leading to severe quality of life issues, she teamed up with her husband, Jonny to set up a charitable trust. The Muir Maxwell Trust is now the most significant charity raising funds for epilepsy in the UK. A cancer survivor herself, Ann's determination to continue her pledge to help other families is reflected in the millions the charity has raised. Ann was named Charity Mum of the Year in 2015, the same year that she was awarded an OBE and invited to a special reception at 10 Downing Street.

The Muir Maxwell Trust (MMT) was established by myself and my husband in 2003. MMT is a Scottish registered charity based just outside Edinburgh and from there our small team support the UK's 120,000 children (under age 21) with epilepsy and also their families who often struggle to cope. My husband is the Trust's Chairman, supported by fourteen trustees. I am the Trust's full-time volunteer fundraiser, supported by two full-time and one part-time employee. Although we are a small charity, we 'punch way above our weight' and our reach is wide, having successfully raised over £9 million in the course of the past ten years for our cause.

I am mother to three sons. Our middle son Muir is profoundly affected by Dravet Syndrome originally diagnosed as Severe Myoclonic Epilepsy in infancy. Muir had his first seizure when he was just four months old. As we rushed him into hospital that night I had no idea what we were about to embark on; a journey that would alter the course of our lives forever and that Muir would grow up severely learning disabled, with speech and language difficulties and a prognosis for a short life. Muir will never live independently. He will never work or marry. He requires care 24/7, including personal care.

The work of the Trust has always followed our experience of raising Muir, providing services we discovered were lacking, but always finding a funding partner to continue that service once the need had been established. Our own lack of sleep whilst watching over Muir meant that we began by distributing potentially lifesaving epilepsy alarms that alert a parent or carer to a child's seizure during the night. The use of an epilepsy alarm reduces the risk of Sudden Unexplained Death in EPilepsy (SUDEP) and provides peace of mind, as well as restoring long-lost sleep for families. In the course of ten years, the Trust has distributed approximately 3000 epilepsy alarms at an equivalent retail cost of over £2m.

Other funds raised have provided seed capital for many world-class services under the Muir Maxwell Trust banner. The Neville Medical Centre at Young Epilepsy, Surrey, has a diagnostic unit named after the Trust and accommodates state of the art video telemetry funded by us. We also made a significant contribution to the video telemetry service in the new Neuroscience and Neurosurgery Koala Ward at Great Ormond Street Children's Hospital (GOSH) in London, as well as many other paediatric epilepsy centres of excellence across the UK.

The early days also saw MMT launch ketogenic diet clinics in Scotland and fund the arrival of specialist nurses and dieticians in GOSH and Young Epilepsy. The ketogenic diet service has now been pioneered by another charity, Matthew's Friends, and the ongoing funding of specialists has been absorbed by the NHS.

In 2005, Muir's consultant suspected a mutation in the SCN1A gene causing Dravet Syndrome. We agreed to send his DNA to Australia at a cost to the NHS of $2000 and two long years later the diagnosis was confirmed. As a consequence, through the Trust we decided to establish the UK's first dedicated genetic diagnostic service for childhood epilepsy based at Yorkhill Children's Hospital in Glasgow. The service initially focused on Dravet Syndrome and the results took just 40 days. Today, it tests for a panel of epilepsy genes. Over 500 children and young adults in the UK have now received a confirmed genetic diagnosis of Dravet Syndrome and world class research has been published by our MMT funded Fellow, Andreas Brunklaus, on the serious quality of life issues in Dravet Syndrome. A much unknown and misunderstood but severe epilepsy syndrome is now at the forefront of epilepsy research because of the cohort group the service has created.

More recently the MMT has formed a partnership with Edinburgh University College of Medicine and Veterinary Studies to establish the Muir Maxwell Epilepsy Centre (MMEC), a collaborative research centre focused on finding

and addressing causes, cures and the serious quality of life issues in epilepsy. As part of the University's world class Neurosciences Service, the head of MMEC, paediatric epilepsy consultant and epidemiologist, Dr Richard Chin, together with his team, is leading the way on collaborative research across a variety of neurological conditions also affecting children, including Autism and Fragile X Syndrome.

All of these essential services are now established and thriving and families across the world are benefitting from improved diagnosis enabling earlier intervention, more effective treatment and a better prognosis in epilepsy for our children.

They say that an effective charity will eventually make itself redundant – in our dreams that would be our aim.

My Needlestick Injury Journey

by Dr Simone Teniola

June 19th this year was a normal surgical working weekend for me: I was the house officer running ragged between various surgical specialties, reviewing poorly patients and executing the jobs generated by the weekend ward round. Little did I know that this day would change my perceptions of the health system, our patients and how I would practice clinical medicine in future.

On this particular day I was asked to review a patient who was clinically unstable but without a working diagnosis. Could she have a pulmonary embolism? The patient had a normal CXR, was tachycardic, hypoxic, and had an altered mental state. I discussed this with my seniors, and took blood from her for d-dimers. With my ungloved hand, I tried to re-sheath the needle that had immediately exited the patient's vein. I accidentally pricked myself with the same needle and my finger bled.

I looked for the needlestick injury protocol, which was difficult to find, and followed it. I encouraged the wound to bleed; I consented the patient for a blood borne viral screen and asked a colleague to take my blood. In the midst of all this, my bleep just kept bleeping; again and again. As I tried to stop myself from completely breaking down on the ward, I realised my attention was still required as a doctor around the hospital. Had I been busier than I actually was, I would have carried on ploughing through my endless jobs as a doctor. Of greater concern is that I would have ignored the high risk I had been subjected to and neglected my own health by not taking blood from the patient.

The following day the microbiologist called me to notify me that the patient was a previously unknown and newly diagnosed case of HIV. My heart sank as this news was being delivered; I suddenly became numb and immediately went to the GU department. I started a 28-day long treatment of post exposure prophylaxis (PEP), followed by serial HIV tests.

Without my injury, the patient would not have discovered her HIV status. Nevertheless, I cannot deny my complacency about the risk they can pose to us. Oftentimes I would take blood without wearing gloves, remove the safety devices off the vacutainers and re-sheath needles, trusting my own clinical practice. Washing blood off my fingers without a thought or an appreciation of the infectious nature blood carries was commonplace.

In spite of taking PEP (an ordeal in itself), I tried to carry on with my daily work and life in a normal fashion. But, I was amazed by the lack of support amongst my fellow colleagues. Everyone kept telling me that only 1 in 300 people are at risk of HIV after a needlestick injury, and therefore I had nothing to worry about. "Just carry on; you'll be fine," was a common platitude. But only I knew how hard it was to carry on as though nothing had happened. What if I got HIV? What would happen to my relationship? What about my career? So many questions. But no answers and very little sleep. There was an expectation for me to carry on with my normal duties without any pastoral support when on anti-retrovirals, which are notorious for a high side effect profile. Worst of all was living in fear that I could have contracted HIV in the workplace which would alter my future not only within medicine but within my personal life, too.

I have learnt that sick patients can pose a significant risk to us as health care professionals and we are not invincible. We need to exercise caution when involving ourselves in their care with a view of ultimately protecting our own health. For example, if a patient is suspected to have TB, the staff should wear surgical masks to reduce their risk when in close contact with the patient. Finding support through work colleagues, occupational health or confiding in friends and family who are able to adequately support you through your career is important. Medicine is a career that is highly strenuous and incredibly altruistic, so we need to offload and tap into a support network during times of need. This is essential. Put yourself first; protect your health and know your limits. I had to take some time out from work as not only was I feeing constantly nauseated and dizzy from the PEP, but I had become dreary and demotivated to carry out my duties as a doctor. I was also very angry: at her for the risk she posed to me; at my seniors for not supporting me and not indulging my grief; at the system, that had failed me; but mostly at myself for doing what I did. I learnt that we are expected to 'put up and shut up'. No-one should complain about their exhaustion or discuss the pressures we work under.

After many tests, I finally received the all clear – I had not seroconverted. I am HIV negative. But the experience has tarnished me as well as enlightened me. I view patients with a degree of scepticism – what risk does this one pose to me? By contrast, I am more empathic and safer in how I practice medicine. I am also formulating support mechanisms for myself for those times in need… there will be more, won't there?

Needlestick Injury: the facts

- Approximately 40,000 needlestick injuries are reported per year in the UK by NHS employers (may actually be double this in reality due to under-reporting)
- Account for 17% of accidents to NHS staff
- Second most common cause of injury after moving & handling accidents (18%)
- 45% of injuries are reported by nurses, HCAs & midwives, & 41% by doctors
- 65% of injuries occur during a clinical procedure
- Risk of seroconversion after percutaneous exposure:
  - 0.3% for HIV infected blood
  - 0.5-1.8% for Hepatitis C virus
  - 30% for Hepatitis B if patient has HBSAg-positive blood

Eye of the Needle Report, 2012

WOMEN **AT THE TOP**

Catherine Calderwood

MA Cantab MBChB FRCOG FRCP (Edin), Chief Medical Officer for Scotland

In this feature we profile medical women who have demonstrated reaching a senior position within medicine...

Catherine Calderwood studied at the University of Cambridge and graduated with her medical degree from the University of Glasgow. As a junior doctor she worked in medical specialties in Glasgow Royal Infirmary and at the Royal Infirmary of Edinburgh and then completed her specialist training in obstetrics and gynaecology and maternal medicine in South East Scotland and at St. Thomas' Hospital, London.

She became a medical adviser to the Scottish Government in 2010 and has been instrumental with the work involved in reducing stillbirths and neonatal deaths in Scotland and in reducing avoidable harm in maternity services. More recently her role expanded to include major trauma services and the introduction of robotic surgery for prostate cancer to Scotland. Until her recent appointment as CMO, Catherine was also the National Clinical Director for maternity and women's health for NHS England.

She continues to work as an obstetrician, seeing pregnant women in a regular antenatal clinic at the Royal Infirmary in Edinburgh. Her research interests include thromboembolic disease in pregnancy and she is an investigator on the AFFIRM study, which is examining whether increasing focus on the importance of movements of babies in the womb will help further reduce stillbirths across the UK and Ireland.

Catherine launched her first Annual Report as CMO for Scotland in January 2016, which focuses on 'Realistic Medicine' and challenges modern medicine to rethink priorities. It has been well received by doctors, nurses, pharmacists, paramedics and other allied health professionals, and has been read worldwide. The report also recognises the importance of valuing and supporting staff as vital to improve outcomes for the people in their care. Catherine believes that these improved outcomes must also include what the priorities are for that person (formerly known as a patient) and their family. She regularly blogs at blogs.scotland.gov.uk/cmo/ and you can follow her on Twitter @cathcalderwood1

Name: Catherine Calderwood

Approximate age: 47 years

Lives: Edinburgh

Medical School: University of Cambridge, University of Glasgow

Year Qualified: 1993

Speciality: Obstetrics and Gynaecology

Place Currently Works: The Scottish Government and Royal Infirmary of Edinburgh

First Ambition: I always wanted to be a doctor – my parents were both doctors (orthopaedic surgeon and psychiatrist) and I found their discussions at meal times fascinating.

Other Career Related Interests/Roles: As a clinician my interests are in maternal medicine and high risk pregnancy. My first Annual Report as CMO focused on Realistic Medicine and I have been engaging with clinicians since its publication on how can we change our approach to shared decision-making, build a personalised approach to care, manage risk better, reduce unwarranted variation in practice and outcomes, and become improvers and innovators. It has been very well received in Scotland and around the world.

Challenges along the way: Every day is different and presents its own challenges. As CMO I am responsible for clinical leadership and leadership of the medical profession in Scotland, which can feel like an enormous responsibility but is also a huge privilege. I have been greatly supported in my role by the wealth of expertise from my fellow clinicians and the wider workforce.

Rewards of your role(s): Being able to influence change is a huge reward. Standing up for the clinical voice in speaking to and treating the people who come to us for help within the NHS is also important. Of course, working with and alongside so many great colleagues – nursing, pharmacists, allied health professionals in the Scottish government and NHS team. I am sure with their help we will realise the realistic medicine agenda, see improvements in our public health and in outcomes for all the people who come into the reach of Scotland's health and care services.

Inspirations/influences: I have learned from many colleagues I have worked with – midwives, doctors (from many specialties) and managers. The best are excellent communicators, transparent and working to the agenda of improving care for patients and not for their own interests.

Quotas for senior positions for women in healthcare – yes or no? This is difficult as I believe that these positions should be awarded on merit regardless of gender. However, we have not achieved equality in numbers of women applying for or being appointed to senior positions. We need to explore further why this is the case and then rectify the issues. Currently two of the four UK CMOs are women and I am the first female CMO appointed in Scotland.

ADVICE AND HOW TO GET THERE:

DOs: See yourself as a role model and leader of change wherever you are in the system.

Find an area of medicine that needs you. Be approachable, open and willing to listen. Recognise that you will not get it right all of the time. Be prepared to receive advice as well as give it. Perform your role like you really mean it – every day. Smile – a lot...

DON'Ts: Don't feel threatened by others. Remind yourself and them that you should all be working towards the same goals. Don't underestimate honesty and communication. Don't tolerate bad behaviour, poor choice of language, or undermining of others.

HOW TO GET THERE:

Hard work, a passion for what you are doing, great colleagues and support from within and outside of the work environment.

Beyond Medicine...

Author

Tess Gerritsen

by Jyoti Shah

What makes an attractive, eloquent and gifted doctor write nail-biting, squeamish and often disturbing thrillers that have dubbed her the medical suspense queen?

Tess Gerritsen, who saw herself as a writer, who became a doctor, and then a full-time writer because she became a mother, has done just that. As a child, Tess was a voracious reader, especially of her heroine Nancy Drew. She dreamt of being a writer. At the age of just seven years, she wrote her 'first book' and bound it herself with needle and thread.

Coming from a traditional Chinese family where job security reigned over creativity, Tess's father told her that writing was no way to make money and steered her towards science. Following on from her anthropology degree, she graduated from the University of California with an MD in 1979, primarily to please her father. Although this was not her ideal career, it allowed her to meet her, now retired, husband at medical school. Tess spent the next five years working as a physician and reading as much as she could to unwind from her long and hectic days.

While on maternity leave, and grateful for a son who slept a great deal, Tess revisited her childhood passion and began writing again. She was instantly rewarded with a first place win in a literary competition. Her subsequent success was an incremental one, with two unpublished novels. Tess's first 'official' novel, Call After Midnight, was published soon after. Eight more romantic thrillers followed before Tess switched gears to write medical thrillers.

A chance conversation over dinner with a former police officer who had been travelling in Russia haunted Tess. The Russian police believed that the mafia was kidnapping children and shipping them to other countries as organ donors. Horrified and disturbed in equal measure, Tess had to do something. She called a relative who was a reporter and asked him to investigate. Meanwhile the plot of Harvest, her first medical thriller, was born.

Now a successful, best-selling author, she has a reputation for chilling details, intrigue, edge-of-your-seat, heart-pounding suspense with menacing tension, all richly entwined with careful and meticulous research, cerebral knowledge of medicine and the human psyche; written clearly and effectively. Tess gets into the mind of a killer and under the skin of the reader. Her briskly paced novels have sold thirty million copies in over forty countries and have been translated into thirty-five languages. Her books have repeatedly hit the New York Times best-seller lists and she has written an original screenplay that was made into a film. Her two leading female characters have prompted the long-running and popular TV series, Rizzoli and Isles, which is currently in its seventh season. Through television, Tess has found a home for her novels.

"I don't plan my stories," she says. "The inspiration comes from real stories, articles I read, travel and real people." She talks of a close family friend, who was the sweetest and the gentlest man she knew, and a steadfast and seemingly safe influence during her childhood; much like a second father figure. "When I turned eighteen, Uncle Michael was arrested for killing his sister-in-law in a gruesome manner after torturing her, and then drowning her in the toilet." Despite her shock, Tess was able to channel her emotions into questions: the 'what if's' and what drives a 'normal' man to do such a thing? "You never really know somebody. I would have trusted him with my life," she reflects.

When she read an article about thousands of sheep killed overnight in a military gas accident in Utah, she questioned what would happen if such an event killed an entire town? This premise led to another best-seller, Ice Cold.

While reading a newspaper article about a young woman found dead in a bathtub after an overdose, put in a body bag and taken to the morgue, where she then woke up, the seed for Vanish was sown.

Behind the scenes of these famous books, however, is a real labour of love. Working in a dedicated home office above her garage, her personal space is littered with paper. Tess is a reluctant adopter of technology, preferring to write her first draft with paper and pen. She spends a lot of time on her first draft, trying to figure out the plot. "I don't outline. It spoils the surprise for me. Often I don't know who the villain is until I am two-thirds of the way through my first draft," she says. She describes the process of writing as slow and one that involves a lot of procrastination. She tries to push aside her distractions as she starts her day around 9.30am. Like many, she finds that time is frittered away with emails, the Internet, coffee and the mesmerising view of the ocean from her desk before words start to flow on a page. However, the story beckons and helps her to maintain focus. As her characters evolve, Tess finds that she can hear their voices. She becomes so fascinated by them that she is totally immersed in her environment. She must write in silence with no background music, despite her love of music, so that she can hear the voices. Tess is an accomplished musician.

She aims to write a thousand words or four pages a day but many of her days are instead filled with pure frustration. Tess then types her handwritten pages to produce her first draft, which is revised multiple times before her husband reads and critiques her final version. Her meticulous attention to detail in doing her research means that it takes, on average, eight months to produce a book. The longest and her personal favourite book is Gravity which took almost two years to research and write. This challenging project led Tess to visit the Johnson Space Centre and the Kennedy Space Centre, where she interviewed dozens of NASA engineers and program directors. She filled her shelves with books on astronaut training and dreamt of being weightless every night. It was also with Gravity that Tess had her brush with Hollywood and courted controversy.

Tess has developed two characters Rizzoli and Isles in eleven of her novels. Jane Rizzoli was first introduced in the Surgeon and


Tess Gerritson with Jyoti Shah

was supposed to die at the end of that book. However, Jane, a homicidal detective working in an all-male world was a fighter working against many prejudices, and she started to grow on Tess. She had to live to continue fighting. Jane Rizzoli is the composite of every female police officer Tess has ever met – tough, an outsider and with a feeling that she has to be better at what she does than the men. Tess experienced similar emotions as a female doctor but recognises that "being a female cop is perhaps harder than being a female doctor." This is the only similarity between Jane and Tess. However, the relationship between Maura Isles, a medical examiner, and Tess is more intimate.

"Maura is very close to me. She was supposed to be a secondary character, but I didn't have a good vision of who she was. So, I transplanted myself into her: she went to my medical school; she drinks my wine; she drives my car; she plays the piano – she is me. She is logical and scientific."

The concept of two strong, intelligent, courageous colleagues who have grown to be close friends has proved to be a successful recipe for Tess. "I try to keep their lives always evolving – just like real life, and this keeps them fresh. I follow their stories, and their evolution keeps them interesting. As long as they are still struggling, there is still a story to tell," says Tess.

Tess loves having complete control of her day and being a multitude of people – an astronaut or an archaeologist. For her, the best part of being an author is the research where she learns "such cool and wonderful things." This is evident in the masterpieces that she creates, but she is under no illusion about how hard it is to break into the industry, especially for medics. "Being a doctor is a hindrance to writing because we learn to be so objective, but writing fiction requires you to go with your emotions. It requires you to throw away the objectivity and just become completely subjective. Scientific writing is also in the passive voice. As doctors, we say 'an incision was made', whereas in fiction we say 'he cut the skin'. So, doctors becoming a novelist have to unlearn a lot of things."

However, doctors do have a lot of stories as hospitals, in particular, can be dramatic places with such a range of human behaviour, all of which provide material for a good story.

Her advice to medics considering a move into writing is:

- Read a lot
- Stay curious and keep asking 'what if?'
- Go outside and get some sunshine
- Travel a lot – get a fresh perspective
- Indulge your hobbies in feeding your curiosity
- Hear the voices of your characters
- Let your characters evolve and change
- Learn to develop a protective shell
- Just keep writing…

What next for Tess Gerritsen? She loves reading, writing and travel and has successfully managed to combine all three passions in her books. She struggles to decide what her favourite book is but concedes that it is probably the Tolkien novels. She is equally excited about reading non-fiction with The Botany of Desire by Michael Pollan as her top read. "How can one write so beautifully about crops?" she asks.

One thing is for sure: Tess will never retire. Soon to be free of publisher imposed deadlines, she is looking forward to writing and then selling and not the other way around. This amazing writer thinks outside the box, embraces life and loves to explore… for fun.

Beyond Medicine...

Business

Dr Karen Morton

MA MRCP FRCOG

Consultant Obstetrician and Gynaecologist

Royal Surrey County Hospital, Guildford

Founder Dr Morton's – the medical helpline©

I am blessed with a father who understood the importance of education and there was no inequality between my older brothers and myself. But, what would have happened if I hadn't obtained an eleven plus free place at Croydon High School? This is one of those 'sliding doors' moments. Anyway, I did. Science teaching was strong and I enjoyed it. I don't remember working excessively hard, just doing what I was told, and being told by my headmistress that I should be a doctor, not a nurse. Then came the complete surprise (I say that genuinely as I have been victim to the 'imposter syndrome' all my life) of being head girl, and learning that I was therefore expected to apply for the school travel scholarship. Not knowing where to go, my biology teacher suggested that I go to Tanzania to work in Mwanza with Dr Richard Evans, an obstetrician.

It is hard to imagine that my parents waved off their only daughter, alone, to go to a place they could never have dreamed of and to people they had never met.

Whilst in Tanzania, I saw a young woman die of postpartum bleeding and I returned from that trip saying that I was going to be an obstetrician.

And so my career was set: Cambridge; Addenbrooke's; Oxford; Queen Charlotte's and Chelsea; St. Thomas' and finally Guildford. It couldn't have been more charmed. I loved my work and I still do.

But all along I have felt frustrated by the increasing regulation; the prescriptive nature of tomes of printed pathways where most pages are left blank or the enormous waste inherent in policies to prevent a rare occurrence. Examples would be too numerous to mention and may seem trivial but include TED stockings for the tiniest procedure in healthy and active women; MRSA screening for caesarean sections; camera covers for a quick in and out hysteroscopy; I could go on. In my opinion, regulation and matters of data protection have had a stultifying effect on common-sense.

Then we come to the arrogance of medicine. It may be that it is defensiveness, but arrogance seems a more appropriate term to me. When a medical registrar with a stethoscope slung across his shoulders emerged from the CCU and told my mother, (who left school at the age of 14 years), "your husband has a dysrhythmia", I knew that I had to do something.

She looked at me perplexed. I looked at him, angry. He did not know that I was a fellow medic. Why didn't he say something like "I'm so sorry but your husband's heart has started to flutter and when it does that it doesn't pump the blood very well, which is a worrying and serious thing."

My father died.

I vowed that I would never use Latin, Greek, or an acronym ever again and would make it one of my life's missions to teach juniors and students to use plain words. I felt strongly that we should empower people with our knowledge so that they can take control of their health and get on with their lives. We should not paralyse them with anxiety.

I realised that doctors have been slow at adopting the phone to speak to patients, unlike banks and other professions who use the telephone and email to communicate all the time. Why do we feel so worried about giving advice to patients in the same way as we would if a friend or family member rang us up?

My next blue sky moment was when I was trying to look after many gap year girls who were troubled by their first attack of cystitis in Thailand, and realised that they should travel with medicines, as we would. I put together my Travel Packs, with an additional option to ring or email for advice, and from this simple idea, the rest has grown.

The Travel Packs are only 1% of a much bigger project. In 2015, I set up an innovative private company, Dr Morton's –

the medical helpline. This provides remote consultations for a fee and the bespoke IT now recognises the customer's phone number and the screen pops up their medical history in front of the doctor. We have over fifty excellent GPs, and in due course it will recognise a female customer's number and ask them if they wish to speak to a gynaecologist.

Women constitute 70% of adult visits to a GP. Why should they need to take time off work to go for a repeat contraceptive pill prescription? Instead, couldn't women have their blood pressure measured at their local gym and their pill posted to their office? It costs over £5 billion per annum for employees to go to their GP in the UK. This is a terrible waste of everybody's time and money, particularly when 70% of problems can be solved on the phone with no examination needed.

The NHS, which we all love, is drowning. We must save it for important things like childbirth, trauma, cancer, and other major illness. Fortunately, most people do not need continuity of care but a solution to their problem and so this sort of service is essential.

So, don't be shy. If you have an idea, 'have a go', as Dame Carol Black, Principal of my old college, Newnham, and past President of the Royal College of Physicians, recently said on Desert Island Discs. People who become doctors could have chosen any profession they wanted to and should not be bold about learning another trade.

Surround yourself with bright young people who want to make their mark. As someone who didn't own a computer until I was 28 years old, the language of IT has been difficult for me, and marketing and business are no less confusing. However, once you have learned about URLs and caches, SMEs, B2B vs B2C, and SEO start to trip off your tongue, you can then hold your own with the Angel Investors or the crowd funding platforms. Just be brave!

Beyond Medicine

Beyond Medicine...

Chief Executive

Dr Sonia Swart

Northampton General Hospital NHS Trust

by Jyoti Shah

Dr Sonia Swart is reassuringly calm, confident and impervious. She is one of only a handful of chief executives who is medically qualified, and was appointed in September 2013 by Northampton General Hospital NHS Trust. A haematologist by background, Sonia has refreshingly shepherded the hospital with quality care and safety as top of her agenda.

Sonia qualified from Cambridge University in 1976 having done her clinical training at St. Mary's Hospital in London, and then moved to Leicester for her house jobs in the professorial units. With diverse experience in various medical specialties, she considered a career in General Medicine/Diabetes and Endocrinology. However, it was after she was awarded an MD in a subject that has always fascinated her – haematology – that she found her clinical niche.

All her jobs were in Leicester and she defied the prevailing wisdom that moving around was essential. By the time she was ready to take up a consultant post, it was no surprise that she wanted to stay in the area that she considered home, and where her husband was a GP.

Sonia showed a flair for clinical management from an early stage in her career, taking up her first Consultant Haematology post in North Warwickshire in 1986. Her challenge was to set up a clinical haematology service from scratch. By the time she left, eight years later, the haematology service was well established with Sonia working a 1:1 on call and only taking four weeks off for maternity leave each time she had her two children. Her passion and enthusiasm for her profession is evident and remains a powerful force that drives her.

In 1994, she was expecting her third child but chose to move somewhere she could commute from Leicester without uprooting her family and to a larger hospital where haematology services were more viable. So began her marriage with Northampton General Hospital.

Her work as a consultant was mostly clinical but a large component was concerned with improving services and developing patient-centred services. As she strayed into clinical management, this continued as her passion: "I always tried to do things I really believed in, and along the way learned that sometimes I had to work out what the levers in the current systems were that would align to the things I wanted to do."

Sonia's management path has been fairly traditional with a Head of Service role, followed by Clinical Director, Associate Medical Director, and Medical Director (MD), until she

took the final and unusual leap of becoming a medical Chief Executive (CEO). Even today, only approximately 5% of the chief executive community are medically qualified.

As MD, Sonia worked hard putting in long hours at the expense of her family time. An MD must wear many hats and please many people, and the professional duality of manager and clinician seemed, at times, contradictory. Despite her best efforts, she did not feel that she was juggling her roles with the aplomb of a seasoned circus performer. Others disagreed and encouraged her to take up the CEO role; a thought that scared Sonia as she did not feel that she had the requisite skills or knowledge. Does this sound familiar?

After multiple changes of CEOs in her six years as MD, and even more changes in the executive team during this time, Sonia was persuaded. Her hospital needed her. She decided that having a new boss every year or so was not just frustrating but bad for her and bad for the hospital.

Sonia has learned how to make things happen by persuading others and found that the basic skills needed to be a good doctor were often those that were helpful in management. As MD, she learned that the real trick was to inspire others to want to lead the 'doing'; something that remains a huge challenge.

Sonia always knew that it would be difficult to be a CEO and increasingly so, as the financial pressure on the NHS mounts. It is down to the CEO to balance the books. However, being medically qualified and working in the same organisation does give Sonia one great advantage – she knows the business of the hospital. She recognises that she may not always be popular. "Some of the doctors probably feel that I have not promoted their interests enough but I know that I need to be fair and transparent with all." In a field that is constantly changing, one thing that has remained constant is how much Sonia cared for her patients as a doctor and how, as a medical manager, she now cares about the patients and the staff.

It is notable that many CEOs come through various forms of graduate training schemes and many shape their careers with short spells working in parts of the NHS, which is often overseen and facilitated. Not so for Sonia who recognises that her managerial experience is less than many of her colleagues. The experiences that have shaped her professional life are very different to non-medically qualified CEOs resulting in Sonia occasionally feeling like an 'imposter.' She is not afraid to ask others for their advice and goes about her daily work with a large dose of humility.

Leadership for Sonia is personal and is "lived and breathed and part of your essence. It takes over and you can't switch it off at the weekends. In general terms I am more prepared to be humble than if I had come up the 'normal' path," she says.

Sonia's seemingly arduous job is made a little easier with support from her organisation, the Board and the Chairman, but in keeping with comments from other CEOs, Sonia has found that the regulators tend to be very critical.

Her daily schedule involves around six hours of fixed meetings with other smaller catch up meetings. In between, she prefers to communicate by the personal touch of making phone calls over emails. This is further followed by meeting staff in person by doing the 'rounds' in the various departments, making her accessible and approachable – an aspect of her job she treasures. Sonia endeavours to leave the hospital by 7.30pm – an often impossible feat, as she is frequently at her desk much later. She also works most weekends.

Her greatest achievement is succeeding in getting the support of the Executive Board to build an organisation and a team who put quality at the heart of everything. There is a strong desire to see more clinical involvement in management at all levels to produce a positive, engaging and vibrant workforce. Alas, this remains a utopian dream.

"There are times when one feels that the job is impossible and that is depressing – I keep going by doing the best that I can but sometimes that external environment seems hostile and I feel powerless," she says.

She is most upset by the realisation that her staff are demoralised and that keeps her awake at night. Unfair accusations against individuals or the hospital and difficult issues such as when people are in conflict also consume a lot of Sonia's energy, and she tries to tackle these at an early stage so that she can develop a truly resilient workforce. "For me, patient safety trumps all other considerations," she says defiantly, and "I still get that sinking feeling every single time we have a serious incident or a serious complaint."

Sonia believes that future CEOs should be drawn from people who have executive experience, who have the right values and demonstrate resilience in their careers to date. For her, the best preparation was watching different people in the role and being an active MD. At a time when CEO turnover nationally is high, it is important to note that the best organisations have stable leadership. "More doctors should become CEOs as they understand services, are naturally inquisitive and have good training in scientific methodology," she explains.

Sonia has enjoyed being CEO a lot more than she thought that she would. But, in line with many other women, she has made many compromises in her career that have limited her opportunities: she did not move around; she did not take on roles that involved travelling; she worked hard clinically and developed her own leadership skills, including being "very straight, very transparent and very focused on value and what matters to patients and it has definitely been worth it," she says.

The best antidote to the pressure in the NHS? "Do things at home and spend time with the family. Making time for this is a priority."

Sonia's tips for budding medical leaders:

- This is a job you do because you want to make a difference
- Question your motivation for moving into management roles
- You must be resilient
- Have conversations with CEOs, especially those who are medical
- Do you enjoy diversity and meeting people?
- Do you enjoy strategic conversations?
- Can you balance many different things and not be phased?
- Complete an aspiring CEO programme
- Women have good interpersonal skills, are able to listen and be empathic – these are essential to be a good leader
- Approach each situation with a mixture of optimism, opportunism, and compromise

Beyond Medicine...

Editor-in-Chief

Dr Fiona Godlee

The BMJ, Tavistock Square, London

by Jyoti Shah

Armed with a medical degree, the first female Editor-in-Chief of a 176-year-old medical journal is as proficient with words as she is cycling through the busy lanes of Cambridge.

Dr Fiona Godlee was born in California to a medical pedigree. Her paternal grandmother, Barbara Lodge, was one of the six daughters of the physicist Sir Oliver Lodge. Her great great great grandfather, Joseph Lister, pioneered the compound microscope, and his son, who was also called Joseph Lister, was the 1st Baron Lister. Fiona's father was a cancer specialist and it comes as no surprise that her three older siblings are also doctors. Although there was no pressure to follow in these big footsteps, she says that it was "a good thing to do and inevitable" that she did. In fact, she describes it as an 'inherent' step.

Fiona's early memories include wanting to train guide dogs for the blind and to marry a farmer. She eventually fulfilled one of those ambitions. Educated at Cambridge, she graduated as a doctor in 1985 and soon realised that she could not be a GP as she enjoyed life as a hospital doctor much more.

After her SHO years, she began a general medical registrar rotation at Whittington Hospital and completed her fellowship of the Royal College of Physicians. It was at this stage that Fiona started thinking about her sub-specialty interest but instead spotted a one-year editorial internship at the BMJ (formerly known as the British Medical Journal), which piqued her interest.

After completing her year, the BMJ offered her another year, which she duly accepted. She negotiated with her employers to keep her clinical job open for a further year with the intention to return to clinical practice. She never did.

Fiona did not go to medical school intent on being the Editor-in-Chief of one of the most influential medical journals in the world. Instead, her years doing the BMJ internship helped her find a career where she could feed her passion for medicine, science and also support the scientific enterprise. Even now, she says that the BMJ feels very medical with lots of doctors around and she still feels "embedded within medicine."

Fiona has a passion for words and ideas. She was editor of the school magazine at senior school and loved writing, although she admits that she doesn't have many publications. Her experiences as an intern under former BMJ greats such as Stephen Lock and Richard Smith reaffirmed that she enjoyed information and knowledge. She has never regretted leaving clinical medicine stating "I have thought about going back at various points, such as after children, when I missed it a lot. But I still feel like I'm in it."

With a CV that is peppered with extensive experience in the editorial field, Fiona has held many key roles. As Editorial Director for Medicine from 2000 - 2002, she helped establish BioMedCentral, an online open access publisher. She is on numerous advisory and executive boards, which include Alltrials, a project advocating that clinical research adopts the principles of open research and that all trials should be listed and shared as open data, and the Peer Review Congress. Another initiative Fiona is involved in is the International Forum for Quality and Safety and Healthcare, which is now in its 21st year. This biannual meeting is jointly organised by the Institute for Healthcare Improvement and BMJ, with the ambition to improve healthcare and outcomes for patients. Other enterprises include Evidence Live, Preventing Overdiagnosis, and the cross-professional, international initiative, the Climate and Health Council, an organisation that recognises the urgent need to address climate change to protect health and

well-being. She was also President of the World Association of Medical Editors from 1998 – 2000 and Chair of the Committee on Publication Ethics (COPE), which she helped set up, from 2003 – 2005. She is, however, cautious about being involved in other roles since taking up her current position as Editor-in-Chief of the BMJ, in 2005, to prevent any conflict of interest. Integrity is important to Fiona.

Her current job is both varied and extensive, but her absolute love for her work is evident. Fiona explains how she critically appraises research, commissions articles, re-writes articles, learns and embraces print as well as digital technology, and learns about the commercial and business angle of publishing. She is the charismatic, engaging and intelligent front face of the BMJ, fronting awards and public speaking engagements. She particularly enjoys meeting people and chairing discussions, especially discussing issues around the table and garnering something that appeals to the readership and presenting it in a cogent way. She loves "creating debate."

For anyone considering a career in medical editing, Fiona advocates the BMJ internship path that she took. The editorial registrar position was established to get junior clinical staff into the journal and, over the years, 25 editorial staff have trained in this manner. Many of the skills and values required are common to medicine and the transition from clinical work to editing can be seamless. Fiona explains how despite different languages and cultures the health community works with a single voice for a common purpose. "My job is about people and communication. Clear writing and clear thinking are also essential. It does feel like the ethical and professional values of medicine impact on how we work at the BMJ," she points out.

Under her direction, the BMJ has increased both its readership and its international influence. But Fiona doesn't want to stop there. Her ambition is to make the BMJ an even bigger and better international journal. She recognises that with this ambition comes challenges and her biggest challenge is to retain her precious home audience.

She is also leading several campaigns to change the way science is reported. A firm believer in transparency, Fiona is not afraid of controversy. Under her direction, the BMJ has crusaded against US dietary guidelines, the efficacy of Tamiflu, and the safety of paroxetine in adolescents. She has also taken a firm stance against politicians.

When the BMJ published an article about a rise in mortality amongst patients admitted to NHS hospitals during the weekend, Jeremy Hunt seized the opportunity to use the data to justify his argument for weekend working. This was the time the junior doctor contract negotiations were in full swing. A staunch advocate of "Bad science can be dangerous," Fiona took on the establishment and wrote to Hunt accusing him of misrepresenting the data.

"It's not my job to be popular," she says. "I take the job and the journal seriously, but not myself." She describes herself as passionate, fair and challenging of herself and others. She never really switches off because "it's such a pleasure; it's always there, and it is so important." It's the direction of the journal that keeps her awake at night: "Are we making the most of the opportunities that journals provide? Are we effective enough? What should we be doing?"

As the first female Editor-in-Chief of the BMJ, Fiona has rarely felt that being a woman in medicine is a disadvantage, and even less so in the field of editing; "it's a very egalitarian culture," she says. She has been fortunate to have a husband who has brought up their two children. Her advice to aspiring editors is that it is an advantage to have a multi-tasking brain, be a "deadline person" and knowing what can be done and when. She explains how it is important to know what needs your full attention; what can be delegated and what can be done just "good enough." Doesn't this sound like clinical medicine? Good administrative support is essential as is embracing technology to make life easier.

Her final advice – and true words of wisdom – is to marry the right person who will always support you.

DID YOU KNOW?

The most expensive mobile phone number was 666-6666, which sold in Qatar for the equivalent of £1.46 m

Beyond Medicine...

Life Coach

Dr Susan Kersley

For me, the change from doctor to a life after medicine was a metamorphosis. In 1997, after thirty years as a doctor, I decided to retire early and leave medicine. I was fed up with the bureaucracy and the lack of time for anything except medicine. However, it was a big step and it took me a year to finally resign.

How I moved from medicine to life coaching

I trained to be a Louise Hay workshop leader in 1999 and ran workshops based on her book 'You can heal your life'. The aim of these was to enable participants to understand themselves better, (especially in relation to how childhood experience influences adult behaviour), and move forward more positively.

Coaching appealed to me because it motivates people to make positive changes to achieve their goals. I trained to become a life coach by way of conference calls over a couple of years. Since I was comfortable using the telephone for coaching I never met my clients face to face.

I realised that my experience as a doctor gave me special insights about life as a doctor and I therefore focused on coaching doctors.

How did I get my clients?

I wrote 'Is there life after medicine?' hoping that it would be published in 'Personal View' in the BMJ, but the panel rejected it. Maybe because the message was, 'Yes there is!'. However, I was contacted by Rhona MacDonald, the then editor of Career Focus, which is part of the BMJ group. She encouraged me to write a series of articles about life coaching and how it enables doctors to have a life.

As a result, every month, for several years, I wrote and published about personal development topics such as: how doctors could have more time and a better work-life balance, how they could look after themselves, and ways to achieve their goals.

The biggest challenge about leaving medicine?

I didn't realise how challenging it would be to leave the medical profession. Of course, I was still 'me' but I no longer had the label 'doctor', which for thirty years had been very much part of my identity. Socially this is one of the first things people ask: "…and what do you do?" There is a status attached to the answer: "I'm a doctor". So, when I said goodbye to medicine, I had to find out how to define myself without this label.

It has taken many years to stop thinking of myself as 'doctor' and even longer for my friends to stop introducing me as such. Even now, annoyingly, people come up to me on the beach and ask my opinion about their symptoms. I sometimes revert to the title myself if an unhelpful outpatient appointment clerk is frustrating me and I say: "…I'm a doctor…" to get the

response I want. Medical identity sticks rather like a phantom limb! However, life coaching training helped me move away from medicine, to a new identity as a 'life coach'. I started to listen to doctor's challenges and enabled them to find solutions. I used my medical and life experiences as I developed the niche of coaching doctors.

How does coaching differ from medicine?

When I qualified there was a very paternalistic attitude to the patient/doctor relationship. Consultations consisted of the patient saying, "Here is my problem, what can you do about it?" I was expected to know the answers and decide the source of the problem, what investigations were needed and how to treat the patient.

As a life coach I learned to use a different approach to encourage my clients to find their own answers. This approach enabled them to discover for themselves, with my support, how to do what they wanted. They could eliminate 'time-wasters', delegate tasks, be more efficient and drop some 'to-dos' completely and enjoy a more

balanced life. They realised that what they dreamt of doing was within their grasp.

I shared my own experiences, if relevant, but no longer assumed that my way is the only way because, instead, I was a catalyst for people to make changes in their lives.

For those wanting to leave medicine, whether at retirement age or to pursue another career, I facilitated discussion following their agenda not mine, about what had been missing during their working years and what they dreamt of doing. I avoided telling someone that what he or she dreamt of was possible or impossible. I asked challenging questions so they could discover for themselves their own way forward.

What I have learned is that life is an on-going process of change with similar solutions along the way, both for myself and for my clients, whether working as doctors, or deciding to leave medicine altogether.

Coaching tips for female medics

1. Decide what you want in your life and work out what to do in order to achieve this.
2. Manage your time, including self-care, rest and relaxation, but also keep focused on what you want to achieve.
3. Be willing to find out what is really important for you.
4. Notice how your focus may move away from success at work and more towards family, friends, community, looking after yourself and what you want to learn and do each day.
5. Take regular action to change. Nothing shifts unless you are pro-active.
6. Get support. Have someone such as a coach or a mentor during your transition. It is very powerful and helpful to have a non-judgmental and non-involved person as a sounding board for your ideas.

Avoid the following:

1. Agreeing to do whatever you are asked to do. 'No' is a small word that has a powerful effect. Try it when you are asked to do something that you don't have to do, or should be done by someone else: set your own personal boundaries and keep to them.
2. Not using time productively/wasting time. If you regularly fail to achieve what you set out to do, plan realistically at the start of each day.
3. Doing everything yourself at home and work. You are probably doing things that could be delegated, don't have to be done at all, or could be done more efficiently.
4. Not having interests outside of medicine. Plan to spend time with your partner, friends and family or get involved in other activities. Do things just for you, such as regular exercise and nurturing your creativity.
5. Not having support. At all stages of life it is a luxury to be able to talk to someone not directly involved in your day-to-day life.

Finally, my BMJ/Career Focus articles evolved into books for doctors: 'Prescription for Change – for Doctors who want a life' and 'ABC of Change for Doctors.' It took a few more years for 'Life after Medicine – for Doctors who want a trouble free transition.'

I have retired from coaching as well as medicine and enjoy living by the sea in Cornwall, visiting my grown-up children and grandchildren, and travelling. I write and publish books, e-books and audiobooks, personal development books for doctors, self-help books and novels.

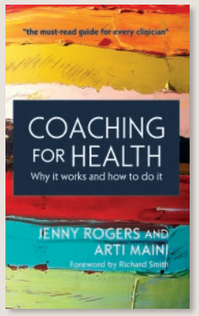
http://www.books.susankersley.co.uk

Book Review:

Coaching for Health: Why it works and how to do it?

Author: Jenny Rogers & Arti Maini

Publisher: Open University Press, 2016



Jenny Rogers and Arti Maini's book, Coaching For Health: Why It Works And How To Do It puts forward a recipe and a dialogue on how to coach effectively.

Medicine in the 21st century is different from what it used to be in many ways and some of the health problems and illnesses we see are related to lifestyles; many more have no magic cures, which is where I feel coaching can help.

Rogers and Maini provide an easy-to-read guide on coaching principles for healthcare, with examples and evidence to support. I particularly liked chapter two on the origins of coaching and the conclusion that we, as human beings function at our best when we make and live with the results of our own decisions.

Chapter three provides useful information on communication and building a rapport with the patient. It also discusses the need for avoiding the "why" questions and encouraging active listening, which is crucial in coaching so that one can be non-judgmental.

The authors have put forward the argument that coaching is more a mind-set and a collection of values rather than a series of techniques, and some of the values may prove challenging.

The book is full of useful and insightful information and the chapters on empowering the disempowered patient, managing long-term conditions and coaching for recovery in mental health will appeal to many clinicians.

As modern day doctors, we need to have an armamentarium of skills when looking after our patients and coaching for health is one of them. This book gives the reader a flavour of what coaching for health is all about. It invites you to understand coaching and where these skills can be used in practice, such as encourage patients to self-care, identify treatment goals with them and empower them towards behavioural change – for themselves.

I would highly recommend this book to medical students and clinicians in all specialties as well as to allied health professionals.

Reviewer: Ms Beryl De Souza

MEDICINE AT THE MARGINS

Creative Solutions to Healthcare Challenges

The Spring Conference in Edinburgh was one of the most inspirational, diverse, and friendly conferences that I have ever attended. I spent a day listening to women I could listen to for a month... and I am not known to be a listener. Medical students and doctors from across the UK and from as far afield as Surrey and Northern Ireland attended. We were in esteemed company with two doctors who had OBEs, the Scottish Chief Medical Officer (CMO) and a Minister of Scottish Parliament (MSP) who is also a consultant breast surgeon. **by Emma Isabella El Makdessi BA MSc**

The first speaker, Dr Christine Goodall, experienced so much violence in the course of her training that she and her colleagues set up Medics Against Violence. This charity has over 250 members and it was no surprise that she was en route to Buckingham Palace to receive her OBE.

Dr Rosie Hague gave a wonderful talk on her career in paediatrics, wittily entitled 'Small Island, Small Specialty', stressing that children are not just little adults, telling of her work in Nepal and asking us all to consider 'what does the developing world actually need?'

Dr Jacqueline Andrews, the only female clinical director of 19 others at the Leeds Teaching Hospitals NHS Trust, presented her abstract about gender equality in the workplace, and the power of role models and informal networking to counteract the feeling that "there don't seem to be people 'like me' that do these jobs". She has set up the Leeds Female Leaders Network (men are welcome too).

Alison Cameron gave a moving history of her life with honesty, sharpness, and humour. A Russian graduate, Alison worked in the area affected by the Chernobyl nuclear disaster running medical, scientific and humanitarian projects. She told of her diagnosis of Post-Traumatic Stress Disorder in 1998 after the death of many of her colleagues and the subsequent consequences. Alison fell between gaps in services and ended up homeless, although she slept in "the nicest parks in London, especially in Kensington!" At that time, all she wanted to do was to be in hospital filled with Valium, painting, and eating nice food. Today she is a senior Leadership Associate at the King's Fund, and an adviser to Jeremy Hunt. Her talk examined power as 'the elephant in the room' and highlighted the simple truths that complicate medicine – the draining of energy, insight and resources resulting in boxes of "professional" and "patient".

There were lots of prizes and the Katherine Branson Essay prize winners were Miss Helena Fawdry and Miss Karthika Velusamy. Over lunch, seven medical students and doctors presented poster abstracts on various topics and the Elizabeth Garrett Anderson Poster Prize was awarded to Alison Howe for 'Together We Can End Female Genital Mutilation'. The joint winners for the Elizabeth Garrett Anderson Oral Presentation went to Dr Jacqueline Andrews for her presentation 'The Leeds Female Leaders Network-Partnership Working in Action' and Dr Yesim Karapinar for her engaging presentation on 'The Treatment Room: Prepared 'Procedure specific' Trays'.

The next speaker, Ann Maxwell, shared her personal story of setting up the Muir Maxwell Trust (MMT), named after her son, in 2003. Muir is 19 years old and had his first seizure at the age of four months leaving him profoundly disabled. Mrs. Maxwell stressed the clinical need for improved epilepsy management and surprised much of the audience with the UK statistics: of those with a profound learning disability, 66% have epilepsy, and 120,000 people under the age of 21 have epilepsy – almost four times greater than those with Type 1 Diabetes. She was awarded an OBE in 2015 for her hard and passionate work with the MMT, which despite having a mere fourteen trustees and 1.5 employees, has raised £9 million to date. Her inspirational final words: "As long as there is a breath in my body I will keep working to make sure that the children coming behind my son have a better outcome."

Dr Philippa Whitford, a Locum Consultant Breast Surgeon, and as of 2015, MSP for Central Ayrshire, was told in her third year of medical school that women cannot be surgeons. "For the first four hours I thought they were just winding me up," she said. Naturally, she became a surgeon. Dr Whitford spoke about getting the female voice into politics, and talked the audience through her fascinating career treating breast cancer in Gaza, arriving to the UK in 1991 and returning to Gaza in 2016 to an even worse situation. She gave an eloquent testimony detailing the impact of politics on the survival of women with one of the most common cancers.

Scottish CMO, Catherine Calderwood, gave the Dame Hillary Rose lecture, starting her talk with the revelation that the first female surgeon was Dr James Barry, who concealed her gender until her death, after which evidence of the 'scandal' was buried by the British Army. This fact became public 100 years later. Women remain disadvantaged in many ways including a 14.2% pay gap, poorer health in older age, and a historical exclusion from clinical trials. A recent study highlighted that "the science that informs medicine – including the prevention, diagnosis, and treatment of disease – routinely fails to consider the crucial impact of sex and gender." It is important to remember her advice that we should all look out for each other, as no-one else will.

Interspersed between innovation, charity work, and medical insight, was a sense of humour and humility that pervaded the entire day. I am already looking forward to the next conference in November, 'Women Doctors: Equity or Equality?' and encourage anyone to attend for the knowledge, insight, and laughter from some of the most extraordinary women I have had the pleasure to meet.

MWF SPRING CONFERENCE

13TH MAY 2016 – EDINBURGH

MWF DINNER

13th May 2016, Edinburgh

After a bracing walk with Charlotte Gath to the top of Arthur's Seat, I was delighted to be welcomed to yet another splendid room in the John McIntyre Conference Centre for our MWF Dinner. The ambience was upbeat and relaxed and everyone was feeling exhilarated following the success of the day's meeting. **by Dr Fiona Cornish**

In true MWF style, the dinner was another opportunity for members, their spouses and guests, to enjoy each other's company, establish new connections and catch up with old friends. The Fabre family were certainly the winners in terms of numbers- Clarissa's husband, daughter and son-in-law all came to the dinner. We were honoured that so many of the Scottish organising team and their spouses were sporting their kilts and tartans. A toast was raised to Philippa Whitford, MP, as we not only persuaded her to stay for the dinner, but twisted her arm to join MWF. The feast of Scottish salmon and Drambuie Cranachan prepared us for the after dinner musical feast provided by the Alpeggios Band.

This wonderful Scots music group consisted of accordions, violins, cello, ukulele and tin whistle, and their music enticed many of the guests, even the normally reluctant, to take to the floor. Some unstoppable dancers deserve a mention – the Indian and Italian combination of Parveen and Henrietta, our President and President Elect, extemporising their Gay Gordons Scottish steps was a highlight for me! Contributions were requested from the audience, and we were treated to an Ode to a Deep Fried Mars Bar (my idea of the worst nightmare), with its gruesome description of being belly flopped in batter. The tunes also reflected the local health climate, with the Cholesterol Song, written by the former GP leader of the band, who filled us with the horrors of the health preferences of local patients, choosing to "eat black forest gateau and die." Another highlight was our two Welsh officers, Sally and Olwen, letting their hair down in a rendition of shrieking Welsh goats – apparently high culture; to the uninitiated in Welsh, like me, easily mistaken for a farmyard squabble!

Many thanks to all the organisers of the wonderful dinner and entertainment, and a special mention for Jyoti's long suffering husband (Paresh), our MWF photographer, who has preserved all the festivities for posterity.

Beyond Medicine...

Management Consultant

Dr Hannah Aldean

Making God laugh. So here it is, my life plan at age 15, in no particular order:
- Move to France
- Have 7 children
- Become a surgeon

Needless to say, Woody Allen was right about making plans. It sounds like an underachievement to say that I only managed one of the three, and I suspect that anyone with seven children would say I chose the easy one.

I grew up with medicine; hospitals, blood, illness didn't scare me. In fact, by the time I was ten years old I had assisted in more operations in Iraq than I did as a house officer in Oldham. Back then, I used to insist that I attend emergency theatres with my father to help when he was called in, and he would occasionally oblige. I recall standing at the head end each time, intently watching the staff at work, and supporting the ET tube as instructed by the anaesthetist, with the belief that if I let go I might ruin everything. I felt integral. I loved it.

Twenty five years (and a few real operations) later and here I am; a management consultant in London. Leaving clinical practice after five years in medical school and ten years of training was a shock to most people – myself included – and it was one of the hardest decisions of my life so far. For all my years in surgery I had the same feeling that I had as a kid holding the ET tube; I was part of a team, doing something important, loving it. As I became more senior during my registrar years, I became more aware of the wider system around me, the changes happening in the NHS, and how they started to change my job. This sparked a desire in me to understand the complex dynamics of healthcare services. I began my adventure by moving to Shanghai for a year and studying for my MBA. On my return to London, and armed with shiny new perspectives, I felt excited to get involved in some thinking around how we might do things differently in the NHS. I noticed that, beyond the Faculty of Medical Leadership and Management, there were very few formally recognised or supported programmes available for trainees with an interest and skills in health systems leadership and management. From this opportunity was born the McKinsey and Royal College of Surgeons Fellowship, which I was lucky enough to co-create and undertake.

After returning to surgical practice, I eventually took the decision to continue on my journey in the wider healthcare system, and I applied for a specialist role in healthcare consulting.

In my current role at McKinsey, I have the privilege of working with some of the most interesting people from around the world on some of the most important challenges in healthcare, and that is what now drives me. It is a role in which you work alongside

organisations to explore both the difficulties and the opportunities that lie within our complex health systems; defining the challenge ahead, learning from local and global examples of excellence, developing solutions and implementing change.

The decision to leave clinical practice was a difficult one, and there was no shortage of outside opinions as to whether I was doing the right thing for my future. So, for anyone thinking about exploring a different path in healthcare, my personal view is this: plan for now and solve for the future. If you choose to pursue the thing you love now, the thing that excites you, you will always be making the right decision.

For anyone interested in pursuing a similar path, please contact Hannah by email: hannahaldean@doctors.org.uk

Beyond Medicine...

Media Medic

Dr Dawn Harper

MBBS MRCP DCH DFFP

There is no shortage of people who are willing to appear on television to bare their hearts and souls to the public, and even bare their bodies; anal warts, haemorrhoids and much more. Practising GP and media celebrity Dr Dawn Harper sees an endless stream of people who do just that in Channel 4's hit television series Embarrassing Bodies, which she presents. However, to these people, their conditions are not embarrassing or voyeuristic; they are incredibly moving and personal tragedies, says Dawn.

Educated at the prestigious Bath High School, where she enjoyed and excelled in languages as well as science, Dawn trained at Charing Cross and Westminster Medical School. After completing her hospital training and becoming a member of the Royal College of Physicians, she chose to become a GP. As the only female partner in her practice, she naturally started to see the majority of patients with women's health issues and obtained a Diploma of Child Health and a Diploma of the Faculty of Family Planning. It was after she responded to a query from a magazine journalist that the seeds of her media career were sown. She has since become a household name.

She still continues to work as a part-time GP in Gloucestershire as her media career has gone from strength to strength over the years. She now also presents an accompanying series, Embarrassing Bodies: Live from the Clinic, which was first aired in summer 2011 and featured Dawn giving live consultations to patients in the comfort of their homes using Skype, a technology that she believes many GPs could use in their daily work.

She features on the BAFTA award-winning interactive website www.channel4.com/bodies, which helps with self-diagnosis, and is resident GP in ITV's 'This Morning' show as well as numerous other television programmes.

As though clinical practice, public speaking, and regular television and radio shows are not enough to fill Dawn's working day, she has written a series of books under the banner of Dr Dawn's Health Guides on subjects that include heart health, digestive health, diabetes and many others.

A wonderfully warm, kind, friendly and hugely energetic and passionate person, Dawn is well placed to advise medical women about how to become a media medic.

Jyoti Shah

My name is Dr Dawn Harper. I am an NHS GP and today I split my week between practising medicine and talking and writing about medical issues in the media. I am often asked by other doctors how I got into media work and how others could follow in my footsteps. If it's a career path that interests you, then here are my top ten tips on how to embark on a career in media.

1) KNOW YOUR SUBJECT
This may sound daft but I am very glad that I had twenty years of clinical experience before I started in the media. You would be amazed how often you can be booked to talk on a given subject and then breaking news means a presenter will suddenly throw you a curve ball and ask you something completely off subject. I think to really enjoy media medicine it is essential to have a breadth of clinical experience first.

2) BE PREPARED TO DO "LOSS LEADERS"
A career in the media is becoming increasingly popular and the media know that, so don't expect to be offered big money! My first television job was working on a news programme that involved me driving myself at silly o'clock in the morning to the studio. My fee didn't even cover my fuel, but it was a good launching pad.

3) START LOCALLY
It's a generalisation but local television and radio are more likely to be gentle with you during interviews and so it's a good way to cut your teeth and you never know where it might lead.

4) BE TRUE TO YOURSELF
There will be times when you will be pushed by editors or producers to say something that you don't really agree with. I have a simple rule - I won't say to a microphone or camera or put in print anything that I would not say to one of my patients in my consulting room.

5) ALWAYS APPROVE YOUR COPY
When you submit an article it is often sent to the "subs" department where it can be tweaked. In the world of medicine omitting just one word can alter the message significantly and at the end of the day it is your name on the piece when it comes out in print. I once resigned as a columnist from a woman's magazine because they started sending my copy to print without my approval and whilst nothing awful happened, there were occasions when I felt the message being conveyed wasn't quite what I wanted and it was only going to be a matter of time before mistakes could have been made.

6) NEVER GIVE UP THE DAY JOB
I am often asked why I still work in the NHS. The honest answer is that it is what I trained to do. I love medicine and I feel that I need to continue to contribute. But there are two other reasons. The first is that to be credible in the media I think you still need to be practising, and the second is that media can be very fickle. You may be flavour of the month one moment and then a change in management could mean the phone just stops ringing but you will still have bills to pay!

7) BE PREPARED FOR SETBACKS
This follows on from point 6. You may be very good at what you do but sometimes the face just doesn't fit. It's as simple as that. It may not seem fair but it's what happens. Life in the world of media can be a bit of a roller coaster.

8) GET READY FOR THE "REQUESTS"
As soon as you are working in the media all sorts of people will come out of the woodwork asking you to speak at a dinner, open a branch surgery or take part in an event. I feel very strongly about charity and work closely with several charities that are close to my heart. For me, this is one of the most positive things about working in the media – it gives you a voice beyond your own patient list and it's really rewarding to be able to give something back. But I have also been asked by people who claimed to know me at medical school to travel half way across the country to speak at a patient participation group meeting. Whilst I do that for my own surgery, I simply cannot say yes to everything. Be prepared, and have reasons to explain why you can't be everywhere, all of the time.

9) KEEP UP TO DATE
I am often asked how I juggle clinical work with my media job, and in truth, I find they work hand in hand very well together. My media work means that I have to keep up to date. If I give advice to Mrs Smith in my consulting room which I subsequently realise is out of date, I can ring her up and explain things to her. But if I have given that advice to a few million people in a live phone-in, I can never reach everyone to correct myself. It also works the other way round too. The clinical side of my week keeps me up to date with issues in the NHS and keeps my feet on the ground in terms of what real people are worrying about.

10) CHECK YOUR INSURANCE
It is important that you inform your defence organisation of any media work that you are doing to make sure that you are covered medico-legally.

Follow Dawn Harper on Twitter @drdawnharper or visit www.twitter.com/drdawnharper

TOP TIP

Hold a steam iron above a dent in the carpet (from say, heavy furniture) and use the extra steam button to force steam onto the dent – the carpet fibres should spring back very quickly. Mind you don't touch the carpet!

Beyond Medicine...

Mentor

Dr Rebecca Viney
Rebecca Viney Associates, London

How I became a champion of mentoring

Unleashing potential and enhancing lives has always been my passion. My natural leadership style is focused on noticing the potential within people, even when they have no idea themselves. I have always helped them to look for opportunities to allow them to access that potential and encouraged them to step out into the unknown, to take some risks, affirming them when they have and allowing that person to be in the spotlight.

My school believed that getting a place at medical school would be impossibly difficult and encouraged me to do something different. In those days only 10% of medical students were women. So I studied art for seven years. I was an artist's dyslexic daughter, had been to eight different schools in many different countries and was rather unconventional.

At age 24, I went to night school for a further A level and then self-funded myself through undergraduate training at St. Bartholomew's Medical School. I also had three sons during my medical student and GP training. To prove that mature women artists with babies can achieve, I came first in my year, which helped me secure the most family friendly house-job.

I was a GP Tutor in Tower Hamlets in 1991, a year before I completed my GP training. The first half-day workshop that I ran was on time management that used the 'wheel of life' to help local GPs consider a better balance and improve their working lives. Many mentors will be familiar with this tool.

Dr Bitty Muller, one of my mentors, once described a woman's career as being less of a ladder and more of a garden. We recurrently start to climb, see something that needs nurturing in our garden, go down, nurture it and then climb back on the ladder. This has been my experience and I have loved it.

When I left my first GP partnership in 1995 I realised that locum and salaried GPs had no contract, no pension, no CPD and were invisible. This seemed a senseless waste of the workforce. Within three months I found 400 of these doctors, just in north east Thames. In the months that followed I became the second chairman of GP non-principals at the BMA and a tutor and course organiser at the London Deanery. I met Richard Fieldhouse and worked with him as he launched the hugely successful National Association of Sessional GPs.

As Associate Dean in London from 2001-2014, I led the GP Retainer Scheme and observed some amazing women choose to focus on their families but return to do astonishing things. In 2002-2006 I led the Flexible Career Scheme in London which was devised and launched to retain the workforce. Over 400 GPs joined and it helped people at all stages of their career to have flexibility, a portfolio career, and to feel valued.

My most rewarding role, however, has been creating and leading the award-winning coaching and mentoring community at the London Deanery. I was in post from 2008-2014 and during that time over 2000 doctors applied to be mentored. The feedback was tremendous and humbling. The vision was to embed a coaching approach across the NHS in London and beyond, which was achieved.

In 2010 I found a small pot of money to roll out training in "Coaching for Health". Inspired by American studies to coach patients back to health, I was impressed by their validated significant health outcomes, achieved by empowering patients to make changes.

With two entrepreneurs, we trained over 300 people within a few months. A movement had begun and spread across London. It has been a formidable communication mindset change.

However, my career and life has not all been a bed of roses. I was a single mother for twenty years, which was a challenge. I have also worked in toxic environments where I have been subjected to undermining and often much worse. I have learned from these events, and only working to my passions and with people I value, respect and admire is my secret.

I now have two passions. Firstly, to embed the coaching and mentoring approach throughout the NHS including primary care, secondary care and the communities that they serve. Secondly, I plan to harness doctors and other healthcare workers in their last five years in the 'expert' stage of their career, to consider using their expertise, knowledge and innovation in different settings and contexts after they retire from the NHS. I would like this cohort of professionals to continue to learn and to do things that they feel passionate about. This is an opportunity to do things that they never imagined they could do and to achieve the best work-life balance.

I have set up a not-for-profit company, Rebecca Viney Associates, to pay those who run conferences, coach, mentor or train for me. I personally run coaching and mentoring tasters. I choose the best trainers and am the lynchpin for quality assurance. I offer mentoring of leaders to create a strategy to grow coaching and mentoring in their communities, for healthy futures. Coaching and mentoring alumni from all parts of healthcare can together be leaders of communities of health.

Even though my children have grown up, the happiness of those I love is still paramount. And so I continue to use backseat leadership, and not the top down model to release the potential of the workforce.

What is mentoring?

There is no universal definition of mentoring. In 1998 a UK report on mentoring for doctors proposed the following broad definition, which I believe still holds true:

"The process whereby an experienced, highly regarded, empathetic individual (the mentor) guides another individual (the mentee) in the development and re-examination of their own ideas, learning, and personal and professional development."

There is much debate in the literature about the differences and similarities between coaching and mentoring and they are often defined together.

What is it not?

It is not teaching, telling, advising or instructing. Neither is it counselling or therapy.

Why is it important?

Developing mentoring as a cultural norm within the NHS will increase job satisfaction, improve morale and reduce absence. Mentoring also improves recruitment and retention of doctors as the organisation becomes a safe place to train and work.

How do you become a mentor?

If you are interested in empowering people to take charge of their own development, then you will never regret getting substantive training in coaching and mentoring skills. An unintended consequence of training is that mentors frequently proceed to transform their own lives and careers.

Where can you get a good course?

I commission providers to roll out coaching and mentoring courses over a minimum of 3-4 days. Look for a structured course run by a faculty that combines an expert coach, who has trained thousands of doctors, working alongside a doctor who is an educationalist and coach. This combination is powerful. It takes two days to get the mind-set change and a further day to embed the approach after practice on real clients. Institute of Leadership and Management accredited courses are preferable.

What makes a good mentor?

This requires a combination of core skills and qualities.

Core skills:

- **Active listening** – the ability to engage with and respond to what the client is saying. Listen to what is being said and manage distractions.
- **Observation** – the client will at times display much of what they are thinking or feeling using their body language. The mentor should notice this, especially when there is a mismatch between what is being said and the non-verbal cues that are being displayed.
- **Questioning** – the ability to use questions to help the client to develop their thinking and to explore the issue/topic in depth.
- **Challenge** – the mentor must be able to challenge the client's thinking either through questioning or through observation and comment.
- **Feedback** – providing specific and constructive feedback is a necessary part of helping a client to develop.
- **Reflection** – the mentor needs to practice reflection and to foster a reflective perspective in their client.

Mentor Qualities:

- A high level of self-awareness is essential so that a mentor is aware of their own reactions and weaknesses in order to manage the impact of these on the mentor – client relationship. It is one of the reasons that supervision is essential.
- A genuine interest in others and a passion for helping them to develop, as the focus of the discussion will be on the client's issues or goals.
- An open and approachable style so that the client feels that they can trust the mentor and feel safe to say what they really think. Creating that rapport is central to successful mentoring.
- Humility. An excellent mentor will never consider that they have learnt everything and will always be looking for new challenges for themselves. They will foster a relationship of equals with their clients.
- Integrity. The client should feel that hey can believe in and trust the mentor. There has to be a degree of transparency with no hidden agenda.
- There should be an explicit commitment to confidentiality.

Coaching and mentoring are part of the same continuum. The objective of both is to facilitate the client so that they are able to develop personally and professionally.

What does a quality mentoring service look like?

The principles should be a voluntary, confidential, preferably face to face interaction between mentee and mentor, with mutually agreed boundaries, and a choice of trained, assessed and quality assured mentors at the start.

Mentors cannot act as advocate or write reports or references for the mentee. It is dedicated time for reflection, during which the mentor "actively" listens and challenges the mentee's thinking, but does not give advice or problem solve for them. The mentee drives the agenda, benefitting from support as they work through their own strategies resulting in increased self and professional confidence and job satisfaction.

My quality assured London scheme was evaluated by Oxford Brookes University. It demonstrated that only 2-4 sessions of quality coach-mentoring via the London Deanery significantly improved doctors engagement, self-efficacy and self-compassion at work.

Where do I find a mentor?

I would recommend you contact your local Leadership Academy, CCG, Trust, LMC or Royal College for availability of mentoring in your area.

Contact Rebecca Viney for more information at rebecca@rvassociates.org or visit www.rvassociates.org

Twitter Tips

By Sarah McLoughlin, MWF Communications and Administration Officer

The ever changing face of social media means now, more than ever, we're part of a huge online community. The world of Twitter can at times be daunting, and it's easy to fall into information overload, but with the right approach you can make it work for you.

Some definitions:

Tweet – a basic Twitter message. Tweets can have a maximum of 140 characters of text, but you can also tweet photos, videos, and other forms of media. Remember these are public.

Retweet – a tweet that has been shared with followers of an account. You can retweet another user's (or your) tweet, with an added comment. A tweet that has been retweeted begins with RT @originaltweeter, where @originaltweeter is the name of the user you retweeted.

Handle – a username selected by anyone using Twitter. Must contain fewer than 15 characters.

Hashtag – refers to a topic, keyword or phrase and is preceded by the # symbol. They serve as labels and allow users to search Twitter to find tweets relating to a certain subject.

Direct Message (DM) – a private tweet message that can only be sent to one of your followers.

Trending topics – these are a list of the top keywords or hashtags that are being discussed on Twitter at that moment.

@ sign – an important code that is combined with a username to link to a Twitter account. When used in a tweet, it becomes linked to that user's profile.

Blocking – this prevents someone from following you.

1. Customise your profile
Your profile is where other users get their first impression of you, and is therefore important. Have an up to date profile picture and write a little bit about yourself in your bio. If you are tweeting in a personal capacity, let people know.

2. Privacy settings
Remember that everything you post is public! Twitter is great for debate and discussion but you are speaking to an audience. Anything you say on Twitter you should be comfortable sharing publically. Don't tweet something you would not be prepared to say to someone's face. If in doubt consider starting off with a private account and make it public once you've got to grips with everything.

3. Use your 140 characters wisely
Keep it brief. With Twitter, short, snappy and to the point is a rule to live by. Keep your tweets informative, funny or useful to others and avoid mundane or boring tweets. Try not to be too negative – people do not want to read complaining, whinging tweets. Focus on quality. However, try to leave some room for mentions and comments through retweets.

4. Keywords
Include words that can be found on Twitter to appropriately connect with others.

5. Lists
Twitter can be overwhelming at times and can be information overload. Making use of the really handy 'lists' tool, you can separate the people you follow into subject specific groups. Set up Twitter lists so that you can group your friends into specific lists so that you can refer to them quickly to catch up with your tweets.

6. Frequency
There is a fine balance between tweeting too much or not enough. You should tweet once a day, if possible.

7. Hashtags (#)
Use hashtags to categorise your tweets and to make them easier to search. For example, all tweets using #MWFConf2016 refer to our autumn conference. Only use 1-3 per tweet and not more. Try not to start your tweet with a hashtag – let people know your thoughts, ideas or comments first.

8. Stay "on brand"
You might be really excited about that delicious lasagne you've cooked for dinner; not so for your followers. Only tweet what's relevant to your audience.

9. Schedule your tweets
Your time is precious. Attending a conference and want people to know you'll be there? Make use of social media management tools like Hootsuite and Tweet Deck. These platforms allow you to plan all of your tweets for the week ahead, and schedule what time and date you want them to go out. First thing in the morning and lunchtime are the best times of the day to get attention on social media.

10. Get to know your fellow tweeters
Twitter is a great way to meet other medics. Dive in and engage with other tweeters, start a conversation or join in the debate. It's called 'social' media for a reason.

11. Repeat yourself
Twitter is a rolling feed of information, meaning that only a small percentage of your followers who happen to be online at the time are likely to see your tweet. If you're tweeting about an event or want to share an important article, tweet it again later in the day to maximise your audience.

12. Engage followers
Don't follow too many people. When connecting, remember that tweets must be relevant, reach the target audience, and resonate. To get more followers, think about making your profile more visible, posting tweets that get attention (images really help with this) and engage with other users. It is regarded as Twitter etiquette to consider following people who follow you. It's all about engagement not followers.

13. Images
Did you know that you can post more than one image per tweet? In fact, you can attach up to four images to a single tweet.

14. Direct Message (DM)
Want to get in touch with someone but don't want the world to know about it? Direct Message is your friend! This allows you to send private messages with no word limit.

15. Be responsive
If you get a direct question, it is considered appropriate to respond.

16. Retweets
Don't retweet every tweet that you are mentioned in. It suggests that you are doing so to crave attention.

17. Tweet etiquette
Don't tweet TV show spoilers or sports results and spoil it for others. Say 'thank you' (a lot) and use the @reply to publically thank someone. Don't start an argument on Twitter. Be informal and don't hound influential people. Be truthful. Talk about others more than yourself.

Dressing Professional Women

by Amanda Wakeley OBE

I have always believed that when dressing for work, regardless of how formal the dress code may be, you should always feel as though your work attire it is an extension of your off-duty wear... and for a profession as altruistic as medicine, I believe that you deserve to maintain a sense of luxury and comfort as you work. I truly believe that dressing for work does not always have to feel boring or practical.

Here are my tips for staying stylish while working...

When you know that you have got a long day ahead of you and a hectic schedule, finding a way to bring a little luxury to your day will make all the difference. Whether it is a cashmere sweater or a silk lined skirt, this will give you that added touch of elegance and a much appreciated luxurious feeling.

It is also vital that these luxury pieces are easy shapes to throw on and go, requiring little effort when transforming from off to on duty. Chunky sweaters that don't need ironing and leather and suede leggings that are instantly wearable are all absolute wardrobe essentials.

Not forgetting the key accessories. Invest in a good forever bag, taking you stylishly day-to-day for all your everyday essentials and when you're on your feet all day mix it up between a powerful heel and a comfortable, chic, flat.

Finally, for those days of presentations and meetings boost your confidence and power dress in tailored lines and suits.

Make dressing for work a pleasure.

Top Workwear Tips

1. Build your wardrobe around pieces that you wear all of the time. Don't force a look that isn't really you.
2. Get rid of things that you never wear – they just take up space in your wardrobe and it becomes difficult to create quick looks in the morning. As a rule, if you haven't worn it in the last year, then you probably never will.
3. Whatever you wear, you must be comfortable.
4. Try using a single outfit in many ways – put a jumper over a dress to use it like a skirt.
5. Try to buy the best quality that you can afford.
6. Different colours give off different impressions:
   Black – makes you look thinner and gives an air of authority
   Grey – this colour exudes sophistication and confidence
   Navy – calm, control and loyalty
   Purple – another sophisticated look and one that epitomises wealth and luxury
7. Wear a silk blouse or silk scarf with a suit to soften the look and feel good all day.
8. Avoid anything too low cut or too tight when choosing a top.
9. Use accessories to bring your outfit to life – a belt, brooch, or simple jewellery. A good watch is an investment as is an expensive bag.
10. What size heel? The answer is simple – one that you will feel comfortable in for the working day. A medium heel will lengthen your legs and so you will walk better.

MEDICAL MEMOIRS

Ruth Bensusan-Butt 1877-1957

by Dr Elisabeth Hall, Founder of St. Helena Hospice and member of the Civic Society

Ruth Bensusan-Butt, known as Ben, was born in Surrey in 1877 and was one of five children. On learning that as second daughter she would be expected to care for her parents, she enrolled at Sydenham High School for Girls and was the first student there to sit exams.

She qualified from the Royal Free Hospital in London and obtained her MD in 1908. She gained a lot of experience from her many jobs in Newcastle, Zurich, Dublin, the children's hospital in Derby and obstetrics back at the Royal Free Hospital. She then started general practice training long before it was an official training scheme and was an assistant to a GP in Wales. She conducted home visits on horseback, even though she had never ridden a horse before!

Ben was always a socialist and a member of the Labour Party and met her husband, Geoffrey, at a Fabian Summer School. They were married in Naples in 1909 when she was 32 years old. Theirs was a happy marriage. She always referred to him as 'my dear boy', and Geoffrey often referred to her as 'that damnable woman'!

She established a thriving practice in London but moved to Colchester in 1910 when her husband, who was an accountant, joined a partnership there.

She set up practice in a number of venues before finally, in 1915, moving to The Minories, a large house in the centre of the town. As the first woman doctor in the town, it was not easy. She visited every doctor and left her card but only got two replies.

There is a lovely story of a doctor's wife recounting how her husband was shocked that Ben saw male patients. Ben's reply was typical: 'If your husband gives up his women patients, I will give up my men.' She notes in her diary that she only had two patients and they were just curious.

She built up her practice, cycling everywhere even when pregnant. She delivered a boy in 1911 and twins in 1914, returning to work within a month. She was a loving mother but her children felt that she was always busy. They learnt that the only way to get her attention was to help her make medicines in the dispensary in the evenings.

In 1913 she bought her first car and was the first woman in Colchester to own one. One lesson and she was off, often found driving in the middle of the road! She drove her family all over the UK and Europe, cataloguing these holidays in a notebook. She was once caught without a tax disc but got off with the explanation, 'I was so busy, I just forgot!'

In Colchester she was a woman of many firsts: the first woman doctor; the first woman to own a car; the first woman to stand for election and be elected to the Borough Council – for Labour, of course! She was also the first woman guest at the famous Colchester Oyster Feast, an annual feast that has its origins in the 14th century.

She was always a champion of the underdog and tackled landlords about improving poor housing. She also started the first day nursery in her own home for two years, which was eventually taken over by the Council. She was on the Board of Guardians, which was responsible for workhouses and 'boarded out' children. She was diligent in her visits to these children and not afraid to criticise her fellow Guardians.

Ben was instrumental, with her partner Dr Gwyneth Hugh-Jones, in setting up the Colchester Maternity Hospital. She attended home births, started ante-natal clinics and referred those with normal pregnancies to their GPs.

Colchester is a garrison town and in WW1, she volunteered to work at the military hospital and was asked to run another hospital from a local house. The authorities objected because she was a woman and to her fury appointed a retired eye specialist. She visited every day and transferred anyone seriously ill to the Military Hospital! The MWF archive contains many letters detailing her fury at gender discrimination by the army. Despite this, she opened several social clubs for soldiers.

She also noticed severe infections following vaccinations as no dressing was applied and they just put on their dirty shirts. Realising the seriousness of this in the pre-antibiotic era, she wrote to the War Office after which strict procedures were introduced.

Ben was a founder member of MWF and founded the Colchester branch and was President of the Colchester Medical Society (the second oldest in England) in 1934. She retired at the age of 77 years, continuing a few appointments and her many interests, saying that she would rather 'wear out than rust out'.

In 1956, whilst playing croquet, her left foot started to drag; the start of a stroke. She recovered sufficiently to return to work, but died after breaking her femur. Her ashes were scattered in the garden of the house where she brought up her family and had worked for so many years. The Essex County Standard encapsulated her contributions:

'Dr Ruth – a pioneer who wrote a page of Colchester history. Fought prejudice with spirit and enthusiasm, solved problems with hard work and charm. She lived in the town for 47 years and worked for every one of them.'

The history of this pioneering, formidable, vibrant and generous woman was collected from her diary, doctors and patients who knew her, and the wise documented comments of her son. A blue plaque, erected by Colchester Civic Society, commemorating Dr Ruth was unveiled on Sunday 5th June 2016.

Remote & Rural

Dr Amanda Owen, MWF National Coordinator for MWIA

As the UK Coordinator for the Medical Women's International Association (MWIA), I was delighted to attend the Central Asia Regional Congress in Kolkata (formerly known as Calcutta) in December 2015. The conference was organised by the Association of Medical Women in India (AMWI) and I was graciously invited by Dr Usha Saraiya, whom I previously met at the North East European Congress in Copenhagen in September 2014.

The MWIA has 117 member countries and was formally launched in New York in 1919. The thriving AMWI was inaugurated in 1907, ten years before MWF and I was thrilled to publicise our forthcoming centenary celebrations. The welcome I received was incredibly hospitable and they kindly honoured me with a book called 'The Firsts', detailing the history of Medical Women in India.

AMWI has 'Enhancing Healthcare for Humanity' as its constant goal with a motto of 'Duty and Devotion', with three branches in Kolkata, Nagpur and Mumbai. The two-day conference focused on wide ranging topics including obesity and reproduction and the Sustainable Goals of the United Nations 2015-2030. The guest lecture on Domestic Violence was given by Dr Kyung Ah Park from South Korea, President of the MWIA.

Members had travelled from far and wide including New York and Japan. The Thai contingent engaged the forum in singing a patriotic song and the cultural programme included a group specialising in traditional dance from many regions of India. Dr Chaitali Dutta Ray sang an engaging West Bengali chanting song, which was truly mesmerising. The food was excellent and the fish curries and soup were delicious. I was honoured to chair the Homai M Colabawalla oration and present a scarf to Dr Vandana Walveker from Mumbai for her presentation on Syndrome X and the Gynaecologist.

The conference had been organised by a team from the Mission Hospital next to the 'Mother House,' as Mother Theresa's convent is locally known. A tour of this women's hospital revealed operating theatres but only seventeen beds and a long queue of patients waiting to see a single handed lady doctor in the outpatient clinic. A beautiful baby had just been delivered by caesarean section and the mother was the only one occupying a bed.

I met many dedicated doctors in Kolkata and made many more new friends. I hope some will travel to the UK for our centenary celebrations next year and that MWF can reciprocate the fantastic hospitality I was privileged to receive.

The Mission Hospital is keen to receive any donations of money, or equipment specific to obstetrics and gynaecology.

The Other Side:

Doctors as Patients

Dr Hannah Gaston is a retired Consultant Ophthalmologist who trained mainly in Hampshire. She is married with four grown up children. Dr Gaston wrote this previously unpublished article many years ago when she was an ophthalmology associate specialist. The article is an account of her experience as a clinician having surgery in her own specialty. Writing the article, as stated by many others who share similar experiences of being a medical patient, helped her to get the episode out of her head and therefore to move on.

A year or so ago, I began to notice slight blurring of vision in my right eye. This was more noticeable with my mono-vision contact lenses, where I used my right eye for distance, than with the varifocals I used in the evenings. I knew that I needed more light and more contrast than my juniors, but attributed this to my age. At my annual contact lens check that year, the optometrist seemed to take a long time over the refraction and studied my right eye intently with her ophthalmoscope. Then she dropped the bombshell. There was a lens opacity – an early cataract – in my right eye.

On my way home, an internal dialogue developed fast and furiously: I CAN'T have! Patients have cataracts, not me. I'm finished. I mustn't let anyone know. I won't be able to operate now. Why? Why me? Why my dominant eye, etc. I was 51 years old; not diabetic; there was no family history; there was no trauma to my eye.

I told no-one for the first few months, as I was coping well with only a minor change in my prescription. But then at my re-examination, the opacity had increased and the vision in my right eye had deteriorated.

It was an effort, after months of silence, to start telling those who needed to know. Although I was advised to stop performing intra-ocular surgery I continued to work. Knowing that it would soon be "my turn" made advising patients about cataract surgery and talking them through an operation that was done under local anaesthesia, pretty nerve–racking.

By day, I could console myself with losing my cataract and four dioptres of myopia (short sight), but at night, the fear of complications – and I had seen them all – kept me awake. Even with a good result, how quickly would I be able to adapt to a change in refraction and the inevitable loss of focusing? How quickly could I get back to work? Would I ever be able to operate again? So many questions flooded my mind.

I worried about who would do the surgery and about patients not knowing. I had spent many years working part-time and so we were not that well off financially. It was therefore a huge relief to be offered private care for free. I grappled with this decision as well, as I had always been happy with NHS care.

I opted to have surgery under a local anaesthetic block, but felt a complete wimp for not being up for the much newer, topical procedure, where only drops are used. I felt a little better when a friend said that she would demand a general anaesthetic if ever she needed a cataract operation. Still, I worried. My sister-in-law, a nurse, told me that I was a complete hypocrite for being so worried, when she had heard me reassuring an elderly cataract sufferer that she would be fine. But I felt that it was rather different for me as my future employability was at stake.

I started reading our patient advice leaflets with new 'eyes' and discovered that intraocular lenses were not licensed for use in the under 60s. Yet I would need just such an implant to get a good result.

I continued to work until the day of surgery. The last patient I saw before I signed off had a severe complication of her local anaesthetic injection – the type I was about to undergo – although for different pathology. This was not a reassuring case to end with and of course I ran late, trying to arrange ongoing care.

Ultimately, it was relief to stop seeing patients and become one myself. There was still a feeling of unreality about what was happening to me. It was educational to find out how much the pre-operative cyclopentolate drops stung; and then, anxious and with blurred vision due to the drops, how difficult it was to sign the consent form, intelligently. The block was virtually painless and was immediately effective. My mouth was so dry that it was an effort to talk, but I was glad of the gentle questioning by my anaesthetist; talking helped to pass the time and calm me down.

During the operation, I was only aware of the surgeon's hand on my forehead. I remember a minimally unpleasant sensation on my cheek when saline was dropped on to the eye to moisten it and a vague feeling that the eye was being "stirred". I focused all of my attention on the surgeon's running commentary and managed to exclude the noise of the machinery and the background music. Previous concerns about being hot and bothered under the drape which was over my face proved groundless. As the eye pad went on at the end of surgery, relief set in. I confess that I have never prayed as hard as I did during that short procedure.

That evening, I was in danger of breaking all the usual rules for day-case patients: I poured my own tea and went up and down stairs unaided. I longed for a stiff drink as I was restless and unable to relax.

My eye was acutely uncomfortable and disturbed by strange lights as the block wore off. It was a relief to remove the pad the next morning and to find that my vision was amazingly clear. At a clinic check later I was delighted to discover that I had the longed for 6/5 vision. It was amazing to be able to read a clock on the other side of the room without glasses for the first time in over 40 years.

On the second day after surgery, I began to feel unwell and my vision seemed blurry. For a few moments I was convinced that I had endophthalmitis, which is a sight threatening complication. However, a quick look in the mirror showed a mucus thread on my eye, which when removed, restored my clear sight. Also, I had a chesty cold.

By day six after my operation, I was much more comfortable and able to catch up on paperwork at the hospital, although I still remained fearful of anything that might hurt my eye. The dread of complications was receding and I was soon out and about and driving again. It was an immense relief to be given the all-clear at my two week check. By day fourteen, I was back in the swing of a busy clinic and insanely happy to be working again. An operating list a few days later was harder than ever – not visually – but because the running commentary from my own operation replayed itself.

Once the euphoria of a safe passage through surgery had worn off, I began to feel emotionally exhausted, as the experience finally caught up with me. In the optically perfect conditions of the eye clinic and theatre, I was fine, but outside I occasionally had problems. I was frustrated at being more dependent on spectacles for near vision and music and my right eye was as presbyopic as would be expected of a seventy year old. For a while, I had difficulty adapting to my new varifocal glasses, which I needed when I wasn't wearing my contact lens, especially for going downstairs. I also needed a laser capsulotomy, only seven months later, to reduce glare when driving at night.

I learnt first-hand the near miraculous effects of modern cataract surgery and its potential for rapid rehabilitation. Nevertheless, I discovered the hard way, that recovery was not quite as instantaneous as some of my colleagues made out and that rehabilitation for a "young and fit" patient could be harder than for the average over seventy year old cataract sufferer. Like any other operation, this one can also have risks and inconveniences and does not restore complete normality.

Later, I pushed for our hospital patient information leaflet to be rewritten and took greater care over pre and post -operative advice and counselling. Fitter patients often asked if they could drive, swim and play sport the day after surgery and I would tell them that they might not feel up to it and should avoid injuring the eye. In contrast, my colleagues were often much more cavalier in their advice.

What I learnt:

Patients need to know why

I was obsessed with why this had happened to me, but never got a definite answer. Those caring for me were more concerned with sorting out the problem, and getting me back to work. Whilst I acknowledge this, we should always try to anticipate our patients' need to know "why?" and to reassure them that it is not their fault, where possible.

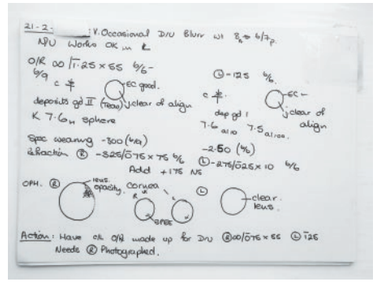
The importance of touch

I am not really a touchy-feely person, but the hand shake from my surgeon when he saw me just before surgery, and the reassuring hand on my shoulder from the anaesthetist, were immensely comforting at a worrying time. After this I have tried especially to do the same for my patients.

How to treat a colleague turned patient

The best colleagues were those who just looked sympathetic, reassured me that all would be well, and of course, the one who offered to do the surgery and looked after me afterwards.

The worst were those who added to the burden by saying things like "the other eye will go; you'll need a laser capsulotomy and so on". I knew all of this. But at that time I was thinking about the operation, which



was worrying enough. One colleague made me call the College to find out whether they would sanction my operating afterward my own operation. Wouldn't it have been so much kinder if he had done it for me?

Another consultant colleague advised me not to tell anyone, in case patients found out and thought that I would be unsafe to work. I could see the point, as we lived near the hospital and there was an overlap between patients, neighbours and fellow church members. This was a tough call. I badly needed to talk at this stage and I soon discovered that all the hospital staff knew anyway. My husband found not talking about it even harder than I did.

Others wanted me to go further afield, to London, to have my operation but I wanted to stay near my home; I had a husband and two teenagers still at home. I needed a consultant I could see afterwards, for check ups and problems, without a long journey that was probably going to be by public transport if I could not drive.

Nevertheless, I was immensely grateful to all those who helped me through the experience, whether by galvanising me into action, rearranging timetables or simply by sympathising. Treating a colleague can be especially stressful and those who took on this responsibility can never be thanked enough.

It's not easy treating someone you know, but my anaesthetist said reassuringly "It is an honour to assist a colleague" and it should be our aim to demonstrate this.

Postscript

My left eye did not need surgery for another ten years, by which time I had retired; on this occasion I had topical anaesthesia which was fine, and again I had a good result, but with much less angst.

Hannah Gaston DM FRCOphth

Whistleblowing

Dr Kim Holt
Consultant Paediatrician, London, Founder and Trustee of Patients First
@PatientsFirst UK


© BBC/Mike Abrahams

In 2012, Patients First co-organised a conference on whistleblowing hosted at BMA House – a watershed moment in the campaigning journey of Patients First[1]. Patients First is a network of campaigners, who came together in December 2011 to raise awareness about the failures of the health service and to protect those who spoke up about poor care.

Personally, I gave evidence to the Mid Staffs inquiry team on the challenges of speaking up, and Patients First provided data to Blueprint for Free Speech, who examined the evidence of our concerns about the failures of whistleblowing legislation, as well as to the Health Select Committee[2,3]. The Blueprint report confirmed what many of us felt: that the Public Interest Disclosure Act (PIDA) does not actually protect a whistleblower from retaliation before it occurs, even though it was created by Parliament to protect whistleblowers from detrimental treatment, victimisation or dismissal from employers as a result of whistleblowing. This is no longer in doubt and was acknowledged in the conference in BMA House.

My own whistleblowing experience was of victimisation having challenged low staffing and budget cuts in the paediatric team at St. Ann's Hospital in Haringey. The detriment that I experienced included removal of support and, basically, just being ignored. There is nothing more damaging to the human spirit than being repeatedly stonewalled. I succumbed to depression and went on sick leave in February 2007. My experience was one of brick wall after brick wall; my endless optimism being pushed back by yet another organisation or authority prevaricating, whilst avoiding the underlying issues.

St. Ann's was chronically understaffed, and the culture was toxic with people arguing in corridors, rivalries, and a lack of respect for professional opinion. Just like Mid Staffs, the bottom line was the budget, and as long as the budget requirements were met, management were happy. The impact upon patient care was not evaluated.

During my absence, Peter Connelly was seen by a locum paediatrician, Dr Al-Zayyat, who was inexperienced in the field of child protection. She misinterpreted the cause of his bruising. She was the last professional contact before Peter Connelly died and bore the brunt of public anger along with Sharon Shoesmith, who was the Director of Children's Services in Haringey. Dr Al-Zayyat became suicidal and was abandoned by her employer, Great Ormond Street Hospital. The failures in regulation, believing what the managers said, and the failure to look beyond the superficial data presented to them, were not criticised. There was a general lack of understanding of how difficult and complex child protection is, especially if working alone with minimal support. All of this was brushed aside whilst the angry public looked for someone to blame. As I watched the news stories whilst at home, I could not believe what I was seeing. Had nobody realised that however good an individual doctor may be, unless services are adequately resourced, the system will fail at some point? Could I hand on heart be sure that if I had seen Peter Connelly I would have stopped him going home that day? We cannot be sure. There were also some very real questions about whether Great Ormond Street Hospital had tried to hide the health failings as part of the serious case review[4].

In the aftermath of Peter Connelly's death, I commented that the department had seemingly lost its humanity. The hospital did not seem to care about standards of patient care, but those in authority were ruthless against anyone who had either made a mistake or tried to speak the truth to senior managers. I began to think that I was mad in raising these issues. But, I am now vindicated, and I was right to do so. Private Eye featured the whistleblowing stories of many of us in 2011, and detailed the patterns that happen across the NHS[5].

The same themes come out time and time again in many NHS scandals that have been reported. There is a prevailing lack of compassion and too often financial constraints impact upon standards of care. All NHS staff are employed to provide care, free at the point of delivery, to all, and without discrimination. For frontline staff to be able to do this, they also need to be treated fairly and listened to. It is obvious that the people doing the job will know where the gaps in care provision are. So, why is it so hard to listen and hear them?

I don't pretend to have all the answers, but unless we have transparency and candour about what has gone wrong, we shall still be hearing stories of bullying and suffering of those prepared to speak the truth to those in power.

When we spoke at the BMA whistleblowing event we hoped that the union would align behind the campaigners for a change in legislation, so that the current 'under protection' of whistleblowers would be remedied. Sadly, despite the Chair of Council agreeing that the law fails to protect whistleblowers, the BMA have since remained silent. Patients First has campaigned for a public inquiry into the failures of the NHS when it comes to patient safety, and I wrote about the benefits of a truth and reconciliation commission. It would be helpful if the unions also backed our campaign.

I am not able to stop other whistleblowers from being punished, because the health system has not yet learned from the mistakes of the past. There is still a need for the whole system to change and this starts with an acknowledgement from government, unions, and regulators that we are no further forward than we were post Mid Staffs. Ending bullying in the workplace requires management teams that mean to end those behaviours. It's not about management talking the talk but walking the walk, and unions backing their members to end bullying when it is reported.

My personal campaign has been to raise awareness in the workplace about the impact of bullying on teams, and the associated negative outcome for patients. This was acknowledged by Sir Robert Francis in the Freedom to Speak Up review[6]. Although statements have been made, such as that by the Secretary of State regards a zero tolerance of bullying, they need to be followed through with tough penalties for those who subject staff to humiliation and suffering[7]. What can we do? Backing the Patients First campaign and lobbing unions and politicians to bring about effective change is a good start.

References

1. *BMA calls for review of whistleblowing laws. 8 October 2012. HSJ Shaun Lintern*
2. *Protecting Whistleblowers in the UK : A new Blueprint. Blueprint for Free Speech. Thomas Reuters Foundation*
3. *House of Commons Health Committee the fourth report on complaints and raising concerns session 2014-2015. Published 21 January 2015*
4. *Great Ormond St and Baby P : was there a cover up? Clare Dyer BMJ 2011;343:d4691*
5. *Shoot the Messenger – How NHS whistleblowers are silenced and sacked. A Private Eye special by Dr Phil Hammond and Andrew Bousfield*
6. *The Freedom to speak up review. A review into whistleblowing in the NHS in England chaired by Sir Robert Francis QC. Published 11 February 2015*
7. *Hunt calling time on bullying in the NHS. BBC news. A review into the treatment of NHS whistleblowers has called for a change in culture in the health service in England, February 11 2015*

Women at work
THE BALANCING ACT

by Karen Webster
Moving & Handling Practitioner, Burton Hospitals NHS Foundation Trust

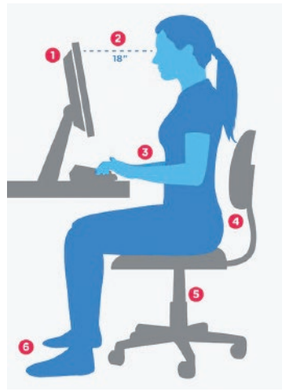
An average day at work may involve prolonged static postures whether sitting or standing. Good postural principles are essential to prevent back and shoulder injuries. Follow these ergonomic tips so that your work doesn't become a pain in the neck!

STANDING

- Stand tall. This will instantly make you look younger!
- Keep your shoulders back and relaxed
- Pull in your abdomen
- Keep your feet about hip distance apart
- Balance your weight evenly on both feet
- Think of aligning your ears over your shoulders; your shoulders over your hips; your hips over your knees and ankles

TIP:
Imagine a string is pulling you upright from the top of your head. Try yoga.

DESK WORK



Good and correct posture when sitting using a computer is crucial to avoid pain in the neck, back, shoulders, legs and feet. This involves changing bad habits and adopting good ones.

- Try not to perch on the front of your chair
- Move your chair closer to the desk so that your back is always on contact with the seat back
- Sit with your bottom at the back of the chair to avoid slouching
- Do not dangle your legs or cross them
- Adjust the chair so your hips and knees are at 90 degrees of flexion
- Rest your feet flat on the floor
- Keep your elbows at your sides and keep your forearms resting on the desk
- Don't reach for the mouse
- Keep the top of your screen at eye level and slightly tilted up so you only need to move your eyes to view the screen
- Keep your head straight
- Sit about 18in away from the screen and face it directly – no twisting

TIP:
Stand up briefly every 30 minutes or so for a stretch to avoid stiffness and muscle aches. Use a lumbar support or pillows to maintain the normal spinal curvature.

KILLER HEELS

Standing and walking in heels can lead to back pain due to posture imbalance: the pelvis is tipped forwards and the upper spine is then thrown backwards to compensate. This can lead to the lumbar vertebrae sliding forwards (spondylolisthesis) and shortening of the calf muscles and Achilles tendon can also occur.

- Stand with your pelvis in neutral position when wearing heels
- Keep your abdominal muscles pulled in so that you have a strong core
- When wearing heels, you will naturally take smaller steps, which gives more control and stability

TIP:
Buy a wide variety of shoes and vary your footwear from day to day. Avoid wearing high heels for prolonged periods of time.

HANDBAG

Carrying a heavy bag on one side depresses the shoulder so we tend to hitch up that shoulder and lean away to compensate. The end result is muscle fatigue and strain across the neck and shoulder.

- Don't carry too much weight in your bag
- Don't hold a bag in the crook of your arm as this can cause elbow injuries
- Don't carry a bag on one shoulder all the time – alternate shoulders frequently
- Try not to lean or hitch the shoulder

TIP:
Buy a lightweight bag (nylon or fabric bags are lighter than leather; use soft leathers if looking for a leather bag) to minimise weight. Use a cross-body bag which distributes weight more evenly. Buy bags with at least 2 inch wide strap. Buy a small bag to force you to carry only what you need.

The Handbag Diet:

- Check your handbag daily to remove excess weight, especially pennies, change and extra cards
- Remove any keys and key chains that are not required daily
- Do you really need all those coupons and store cards all the time?
- Minimise your make-up or buy miniatures
- Have two sections to your handbag – one with everything that you permanently need (money, phone, keys, essential make-up) and the other side for temporary items (work related items, post and so on)

MOBILE PHONES

Long periods of time spent hunched over a phone or keyboard can lead to round shoulders and poking chin.

TIP:
Avoid 'text neck' by gently lengthening your neck upwards as you tuck in your chin. Keep your phone at eye level. Use the voice feature on your phone to reduce the use of the keyboard.

'Cradling' your phone between your ear and shoulder for prolonged periods of time can lead to muscle strain and imbalance.

TIP:
Hold your phone in your hand or use a hands-free device.

PREGNANCY & BREASTFEEDING

Being at work when you are pregnant or breastfeeding can be tiring enough, but remember that your ligaments are much softer due to a change in hormone levels and therefore you are more prone to joint injury.

- Don't wear high heels
- Avoid standing for long periods of time
- Try not to lock your knees

TIP:
Be especially careful of your posture when pregnant. Practice your pelvic floor exercises regularly. If you are going to stand for a long time (such as when ironing or washing up), then use a foot stool or preferably sit.

WHO REPORT - JUNE 2016

Dr Clarissa Fabre – MWIA representative to WHO

The World Health Assembly in Geneva in May was, as usual, an inspiring experience. I attended with Dr Shelley Ross, Secretary General of MWIA; Dr Shafika Nasser, Vice President of the African region of MWIA; and Dr Natalie Yap, a junior doctor from Australia.

We had a meeting with Professor Anthony Costello, the new Head of Maternal, Neonatal, Child and Adolescent Health at the WHO, and he discussed the main priorities they are currently facing. Top of these is the Zika virus, which is now prevalent in 60 countries and rising. There is strong evidence of a link between maternal infection with the Zika virus and microcephaly, and associations with severe brain damage, heart defects, stillbirth and neonatal deaths. As a consequence, the WHO has recently advised young women in Latin America and the Caribbean to avoid becoming pregnant during this epidemic, although these areas, unfortunately, have a very high incidence of unplanned pregnancies. Pregnant women returning from an affected area need an ultrasound scan, which should be repeated every four weeks for the rest of the pregnancy as the initial scan could be normal. The virus spreads by mosquitoes and may also be sexually transmitted. Men have been advised to use condoms while in an endemic area and for four weeks after their return. For partners of pregnant women, the advice is to use condoms for the duration of the pregnancy.

Professor Sir Michael Marmot is the current President of the World Medical Association (WMA) and chaired a session on Conflict and the Social Determinants of Health. Youth unemployment is both one of the causes and consequences of conflict, and is an urgent global crisis. Conflict poses a huge burden on women and has a major impact on the future psychological and physical well-being of children. It is important that education is available for children in conflict situations. We saw a very moving montage showing the effects of attacks on health workers and health facilities.

Every year we have a meeting with Dr Claudia Garcia Moreno, who is leading on Violence against Women and Girls (VAWG) at the WHO. She is lead author of the WHO Clinical Handbook on the subject, which has now been translated into Spanish, French and German. The WHO is developing a medical student curriculum and a training manual for practising doctors, as well as a parallel handbook for managers on how to organise a system for coping with VAWG and how to finance it. Claudia was very interested in the online training module which MWIA has been developing over the last three years. She felt that MWIA could play a very useful role in disseminating the materials being developed by the WHO (www.who.int).

At one of the fringe events on Women and Leadership, we heard Dr Margaret Munghera, a psychiatrist from Uganda and a former president of the WMA give outstanding talks about setting up Hope after Rape with eleven other women doctors in 1994. Encouraged at the time by Dr Shelley Ross to form a women

doctors' organisation in Uganda, Dr Munghera said that universal primary education has made a huge difference in her country, but the challenge is keeping girls in school as early marriage and the 'bride price' are a problem. In some medical schools, women are excluded if they become pregnant – a practice that must stop. Dr Munghera explained that it is important to work with leaders who are there in the community, to train, support and protect them. Role models are very important. In Uganda they have begun to work with young men in order to change attitudes towards women. Dr Munghera said 'we would like to work with men as partners. Men can be part of the solution', a sentiment with which I entirely agree.

Dr Bernice Dahn, a Minister for Health in Liberia then spoke about the Ebola outbreak, after which there was a lot of fear and denial, and many health workers fled the country. Women started delivering their babies in the streets. Fortunately, the epidemic is now under control, and the emphasis is to prioritise the new Sustainable Development Goals.

DISPELLING MYTHS

For all chocolate lovers, research has shown that people who consumed the most chocolate (up to 100g daily) reduced their risk for cardiovascular disease and strokes compared to non-chocoholics

Celebrity The Wall of Wisdom

TOP TIPS FOR A HAPPY & SUCCESSFUL TEAM

Every single person in the team feels appreciated; has a voice and an ear

Amanda Wakeley, British Fashion Designer

Take time to actually meet the team. Everyone needs to buy into the dream

Sir Clive Woodward, 2003 Rugby World Cup Winning Coach

If 'leader' ensure ideas enticed from ALL members and that recognition and ownership given to team members

Dr Philippa Whitford, MP for Central Ayrshire & Locum Breast Consultant

Communication. Keep talking and always give praise where praise is due. It's too easy to only comment when things go wrong

Dr Dawn Harper, GP & Media Medic

Spend enough time to have a collective view for any mission

Lord Ian Blair, Former Metropolitan Police Commissioner

Good leadership

Admiral Sir Trevor Soar, Former Commander-in-Chief of the Royal Navy

Respect. Respect for each other

Niall Dickson, Chief Executive of GMC

Value your team. Encourage and enable respect for all the roles within the team. Get to know them and what makes them tick. Make time for fun

Dr Catherine Calderwood, Chief Medical Officer for Scotland

Regular huddle to check in on people, which is much better than e-mail. People feel more connected with each other

Vijaya Nath, Director of Leadership Development

Making sure there is a clear vision and each person's role towards this vision is clear

Dr Fiona Godlee, Editor-in-Chief, BMJ

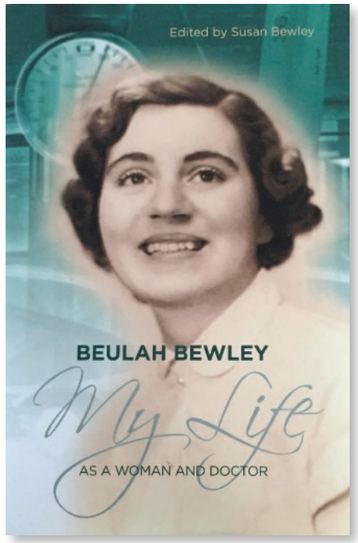
Listen to everyone – especially the one with the quietest voice

Tess Gerritsen, American Author & Physician

Book Review:

My Life as a Woman and Doctor

Author: Beulah Bewley
Editor: Susan Bewley



Memoirs are more fun than autobiographies, and it is a pleasure to listen to the voice of a pioneering female friend reminiscing.

Beulah Knox was born into a wealthy upper-middle-class Protestant family in Northern Ireland. She lived in various parts of Ireland as her father, a bank manager, moved due to his work, and due to her own educational situation.

She was a feisty girl; one of her earliest memories being of emptying a wastepaper basket over the head of a boy for bullying another small girl. There were doctors in the family, which was an advantage both as role models and for career connections, and Beulah soon decided that she wanted to become a doctor, and so looked on illnesses as an opportunity.

After qualifying from Trinity College, Dublin, she met and married Dr Thomas Bewley and they moved to England to further their careers. She successfully 'boxed and coxed' children and careers, and became an academic in epidemiology, with a special interest in smoking research. The study of numbers was no doubt of use to her later as Treasurer of the GMC – the highest rank any woman has achieved there. She reflects modestly that her greatest service to patients was probably family planning advice, and one of her greatest pleasures was teaching. In her private life, family, friends and music were of the greatest importance to her, and gave her much pleasure.

Beulah earned a damehood for 'services to women' and we can be proud that she was also President of the MWF from 1986-7.

Reviewer: Fiona Subotsky, Emeritus Consultant South London and Maudsley Trust, Past President and Current Co-archivist of the MWF

OBITUARY

DR ALISON BUSH

Died 18th November 2015

Alison Bush was born in Geneva, the second of three daughters to Bertram and Irene Pickard who ran the Geneva Quaker International Centre. She was in her teens when the family escaped to England during the fall of France, but subsequently joined the Quaker community in Philadelphia, USA. They returned to England after the war.

Although Alison had no medical relatives, she was drawn to medicine and became one of the first female medical students at Barts (St. Bartholomew's Hospital) in the early days of the NHS. She took a keen interest in paediatrics, especially deafness, autism and mental handicap, while working at the Children's Hospital in Birmingham.

After her marriage to fellow student Ian Bush in 1951, she followed in the footsteps of many medical women and had three children. Alison was fortunate to meet Dr Rosemary Rue (later Dame), champion of retaining women doctors at a time when their loss to the profession had come under the radar of workforce planning in the 1950s and '60s. Alison, like many others, was encouraged to persevere, and, as a single parent with three young children, she had several years of frenetic juggling of child care, breast-feeding, and family life, sandwiched between SHO posts, diplomas in Obstetrics and Child Health as well as occasional GP locums and some research work.

This scenario will be familiar to many women doctors of that vintage, and has formed a core impetus for the transformation of medical training and careers by the MWF, of which she long remained a keen member, many years after retirement.

With typical tenacity and dedication, Alison rose to the challenges and successfully entered general practice in Colchester. Her greatest sense of achievement was probably setting up her own practice on Mersea Island, which serves a population cut off from mainland Colchester by the high tide each day. Living and working in this environment among appreciative patients and supportive colleagues were some of her most fulfilling years. Her warm personality and genuine interest in people made her well suited to general practice, where she will long be remembered.

Alison died peacefully on November 18th 2015 at the age of 89 years. She leaves behind her son Fabian and daughters Philippa and Caroline, eight grandchildren, and many friends.

Irene Bainbridge

Third Time Lucky

Dr Catherine Harkin, GP, Scotland
Illustration by Laura Coppolaro

They were in really good time. Iona felt pleased at her own efficiency, having managed to pick her mother up at the appointed moment. But as she turned her car into the hospital grounds, a new obstacle presented itself.

"Where the hell's the car park gone? Sorry, Mum."

Iona had felt it to be considerable progress to have got this far. The first time they attended, the clinic had been cancelled, and the second appointment arrived two days after her mother should have been there. Forbearance was not Professor Forth-Bridges' strong point, and the waiting was not making her any easier to deal with. So Iona's heart sank as she surveyed the array of Portakabins, fences, diggers and other industrial-looking objects that now occupied the space where the car park used to be. A tiny sign that said 'Temporary Car Park' pointed them towards the back of the hospital where Iona joined the queue of cars, buses, taxis and the occasional bicycle that was slowly snaking its way past the main door, hoping against hope that they might still make it on time.

The minutes on the car clock ticked relentlessly towards the scheduled appointment time as the queue crept forward by only a few inches.

"At this rate we're not going to make it, Mum," said Iona. "Why don't you just hop out and go along to out-patients and I'll come and find you once I've parked?"

Iona was aware even as the words passed her lips that this proposal included a number of events that were unlikely in the extreme, such as her mother hopping anywhere and herself finding either the out-patient entrance, her mother within the hospital, or a parking space during visiting hours. But Professor Forth-Bridges was already out of the vehicle and heading for the main door. Iona turned on the radio. Soothing music filled the interior of the car, as the queue continued to crawl forward.

Iona's thoughts drifted off... must get milk... I hope that lady I referred this morning will be OK, wonder if she's still in A & E... oh God I was supposed to have written that protocol for the staff meeting tomorrow...

"Is she all right?" said a distant voice anxiously.

"Of course she's all right", snapped her mother's non-dulcet tones.

"Iona! Wake up!"

Iona lifted her head groggily from the steering wheel where, for some reason, it seemed to be resting and slowly surveyed the scene. The figure of her mother sitting regally in a hospital wheelchair swam into view and behind it the concerned faces of a porter and a car park attendant in a fluorescent jacket.

"Sorry to disturb you, love, but you're causing an obstruction," said the attendant, gesturing to the stationary bus behind Iona's car. "I'll show you where to park; then you can help your mum."

Beetroot with embarrassment, Iona started the car and directed it towards the indicated parking space, then got out and took the handles of the wheelchair. At that moment, she felt, she looked like the one more in need of help.

100 YEARS OF MEDICAL WOMEN:
THE PAST, PRESENT AND FUTURE

A SERIES OF CELEBRATORY EVENTS TAKING PLACE ACROSS LONDON

Wednesday 10th - Saturday 13th May 2017

CENTENARY EVENTS:

Evening Drinks Reception
Wednesday 10th May 2017
EGA Museum, UNISON Centre, London

Lectures And Workshops On 'Medical Women: Putting Yourself Forward'
Thursday 11th May 2017
BMA House, London

Lectures on 'Medical Women: The Past, Present and Future'
Friday 12th May 2017
The Great Hall, BMA House, London

Evening Opening Ceremony
Thursday 11th May 2017
Royal Society Of Medicine, London

Centenary Dinner
Friday 12th May 2017
House Of Lords, London

REGISTRATION OPENS FROM SEPTEMBER 2016

www.medicalwomensfederation.org.uk
www.facebook.com/medwomen
@medicalwomenuk

SOCIAL EVENTS:

Thames River Boat Trip & Dinner at the Trafalgar Tavern, Greenwich
Saturday 13th May 2017

OTHER EVENTS:

MWF Annual General Meeting
Saturday 13th May 2017
Royal College of Surgeons of England, London

MWIA Northern European Regional Meetings
Saturday 13th – Sunday 14th May 2017
Royal College of Surgeons of England, London