WOMEN, GMC & COMPLAINTS
HOW WILL YOU COPE?

SEXISM IN MEDICINE
JUST HOW COMMON IS IT?

www.medicalwomensfederation.org.uk
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Contributors

SPRING 2016

Dr Margo Maine
Taboo Topics, page 26
A medical woman you admire/respect:
Susan Love, a surgeon/author who has dedicated her career to breast cancer, tirelessly advocating for innovative techniques & raising funds for research & prevention.
Five favourite things in life:
• The sunrise
• Being outdoors, especially running, swimming & hiking
• Enjoying our summer cottage
• Time with my husband & close friends
• Helping people, especially my patients.

Miss Liz Ball
Doctors as Patients, page 24
A medical woman you admire/respect:
Lisa Rodrigues CBE – for her work in raising awareness & reducing the stigma of mental health issues.
Five favourite things in life:
• Feeling loved
• Being moved by music
• Baking the perfect loaf of bread
• Cycling up mountains
• Holding hands with my husband

Mrs Liz Allen
In Sickness & Health, page 6
Five favourite things in life:
• Gardening
• Cider making
• Antiques
• Croquet
• Travel

Dr Henrietta Bowden-Jones
Women at the Top, page 11
A medical woman you admire/respect:
Professor Eileen Joyce, Psychiatrist at Institute of Neurology, Queen’s Square. She was my inspirational supervisor when I did my MD.
Five favourite things in life:
• Returning to Italy where I was born & grew up & speaking my mother tongue
• Running long distances on a Sunday morning
• Sailing with my husband & children
• Film & dinner with friends at the end of a working day
• Reading a great novel, preferably in front of a log fire or on a ship

Mrs Amy Peake
Charity Spotlight, page 4
A medical woman you admire/respect:
Victoria Young – a homeopath.
Five favourite things in life:
• The smell of freshly cut grass
• The sound of the larks up on Pen Hill in the Dales
• The taste of lemon & chocolate, equally
• The touch of those I love
• Seeing my beautiful daughters grow up

Dr Angelique Mastilli
Career Focus, page 12
A medical woman you admire/respect:
Elizabeth Garrett Anderson for her resilience and determination & because without her we wouldn’t have had the opportunities many of us take for granted today.
Five favourite things in life:
• My family
• Chocolate
• Sunshine
• The film Cinema Paradiso
• Coffee
Editor’s Letter

How many times have you started a sentence with ‘I’m sorry, but…?’ When a (female) colleague once said, ‘Only you can get away with wearing that,’ I lay awake at night wondering what she really meant. I doubt men will give this sort of comment any thought and they definitely don’t flower up sentences as we do. Who is right? Does it really matter? What does matter is that most women want to be liked. Sheryl Sandberg, Chief Operating Officer of Facebook said ‘Success and likeability are positively correlated for men and negatively correlated for women. When a man is successful and more powerful, he is liked by both men and women. When a woman is successful and more powerful, people of both genders like her less.’

This issue highlights challenging subjects and provides much food for thought: the rise of eating disorders in older women, complaints to the GMC and how to handle them and one woman’s plight to address menstruation in refugee camps, amongst many others. This issue also reveals the results of the sexism in medicine survey carried out in summer 2015. The headline? 63% of female medics experience sexism at the hands of their colleagues but only 6.6% report this. It would be great if these discussions just didn’t need to take place and we discuss great leaders, and not female leaders. Alas, such discussions are needed, and they pave the way forward for things to be just that little bit better for the next generation of doctors – if indeed there are any left in the country after ‘Huntgate.’ Enjoy the issue and as always, please do not hesitate to contact me with your thoughts, ideas and comments.

Jyoti Shah, Editor-in-Chief

Contact me: missjyotishah@gmail.com @missjyotishah

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.

Become a member at: www.medicalwomensfederation.org.uk

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 2 national conferences a year.

MWF is a supportive community which will help boost your CV, confidence and career through to retirement!

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 a large range of organisations, including the Royal Colleges, BMA, GMC, Local Medical Committees and Postgraduate Deanseries.

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

Charity Spotlight

Amy Peake

O n the very same day, Amy’s businessman husband serendipitously showed her a story about an Indian man who had developed a device to make cheap sanitary pads. She immediately connected the two ideas. Such a machine was essential for women in refugee camps where there is little provision for sanitation in general and with this machine women could actually make their own pads. ‘This is not about women buying pads; this is about empowering women to do something for themselves,’ stresses Amy.

Amy began to drum up interest talking to anyone who knew an Indian man who had developed a device to make cheap sanitary pads. She immediately connected the two ideas. Such a machine was essential for women in refugee camps where there is little provision for sanitation in general and with this machine women could actually make their own pads. ‘This is not about women buying pads; this is about empowering women to do something for themselves,’ stresses Amy.

Amy discovered that the man who could help her get into the camp was a member of the local Rotary Club. So, she approached St. Austell Rotary Club in Cornwall and spoke to a room full of men about ‘periods’ – not your run-of-the-mill Rotary subject! As luck would have it, the daughter of the only woman in the audience worked for the BBC. This opened doors to the airways and she was interviewed by BBC Radio Cornwall and the story was subsequently picked up by the various BBC channels.

She has a 1st class law degree and recalls that she wanted to be a shipping lawyer. However, not motivated by money, she declined the offer of a city job and instead became a personal trainer. Eventually, she worked as a pilates instructor, which allowed her to fulfill her dream of being a good mother to her children.

With an abundance of energy and exuberance on a subject matter that many organisations in international development have shunned, Amy describes herself as fun-loving, easy-going and smiley. She is absolutely determined to see this project through. ‘I have made the perfect job for myself,’ she states. She collected 40kg of baby clothes to take with her to Zaatari.

Once there, she discovered that one in four of the camp’s residents needed sanitary pads. But her more shocking discovery was many more women need incontinence pads. Periods and urinary incontinence – two taboo subjects from which so many women silently suffered. The impact was soul-destroying but Amy revealed, “Because I love it,” she states, defiantly. She is currently replicating the Muruganantham model from India for the women in Zaatari. She has set her sights on empowering women all over the world with these machines.

With such undertakings come risks. Amy is a mother and the goals she has set for herself have to be continually reconciled with the stresses she could bear on her family when visiting conflict areas. Nevertheless, she also feels for the refugees: “I think of all the women who walked for days to get out of Syria and who have lost loved ones on the way.” That is the only reality check this tenacious sanitary missionary needs. “I really want to make a difference and tell all women that you are all incredibly powerful.”

You can find further details of Amy’s charity Loving Humanity at www.lovinghumanity.org.uk

Read Amy’s story on the BBC website.

Loving Humanity & Amy Peake

By Miss Jyoti Shah

Have you ever wondered how you would cope with menstruation in the middle of a war zone? That’s exactly what went through the mind of a 41-year-old mother of three girls, Amy Peake, when she saw an image of Syrian refugees queuing for food in a magazine.

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Amy began to drum up interest talking to anyone who knew about menstruation and refugee camps. Her immediate goal was to get to the Zaatari refugee camp on the border of Jordan and Syria. Zaatari is the largest camp in the region and home to over 90,000 refugees. She had privately raised her own funds amounting to around £10,000 to make the journey for her research into sanitary pads.

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O
In sickness and in health: when medical marriages break down

Liz Allen, partner in family law and head of the family law team at Stephens Scown LLP, looks at the issues and challenges that frequently arise when women with medical careers face divorce. Liz has over 25 years experience in family law and is singled out as one of the leading divorce lawyers in the UK by the two independent guides to the legal profession – Chambers and the Legal 500. She was also recognized by the CityWealth Leaders List – an international guide to the most highly regarded figures in private wealth management.

All busy professional women face similar challenges in blending family and professional life but perhaps none more so than medical women. In my experience there are some common themes that medical women face.

Family vs career

Many professional women start their careers on an even footing with their husbands. Medics often marry within the profession and parallel careers can be maintained in many cases (albeit with some difficulty due to geographic moves). For many the crunch point comes if children are born and it is agreed, or with some difficulty due to geographic moves). For many the crunch point comes if children are born and it is agreed, or, if the husband has reduced his hours or worked part time in order to look after the children. There, of course, the reverse applies and it is not impossible, although still unusual, for a high earning wife to be ordered to pay her husband maintenance for himself as well as the children in addition to making a capital settlement and pension provision. Again, early legal advice should be sought to try to ensure that a clean break is negotiated where possible.

The importance of the pension

Pensions are a major aspect of my work as a divorce lawyer. The NHS scheme has historically been regarded as one of the best pension schemes available (although now under attack from Government reforms). Those who have been in the scheme for many years have built up very valuable benefits which are shareable on divorce. It is not at all unusual for the pension benefits of a full time consultant to be worth well over a million pounds and sometimes the pension is the most valuable single benefit. It is vital not to ignore the comparative values of pensions in divorce cases. Since 2000 the courts have had full power to share pension values between a couple on divorce – the process is relatively straightforward, cost effective and tax efficient but as pensions do not ostensibly represent capital (although they always have a capital value) many people forget the huge benefit they can lose when agreeing a settlement. This is one of the main reasons to take professional advice when contemplating divorce – the pension and its true value is of massive importance and the use of an actuary to calculate the fair division is almost always to be advised.

For example, if a consultant wife gives up this role on the birth of her children and becomes part time, her pension value should she divorce in her forties, is likely to be less than a third of her husband’s when she then reaches retirement age. Professional advice should always be sought to make sure the correct level of transfer takes place. I am still amazed to come across cases in which professional women did not investigate and pursue their loss of pension as part of their divorce settlement.

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In sickness and in health: when medical marriages break down

13 Facts about Divorce in 2013

1. There were 13 divorces an hour in England and Wales in 2013.
2. This was a total of 114,720 divorces.
3. The divorce rate has decreased by 2.9% compared with 2012.
4. The median duration of marriage for divorces granted in 2013 was 11.7 years (increased from 11.5 in 2012).
5. Women were granted 65% of all divorces.
6. Almost 1 in 8 divorces were granted as a result of adultery.
7. There were 762 (1%) divorces granted because of desertion.
8. The average age at divorce was 45.1 for men and 42.6 for women.
9. The number of divorces was highest amongst men and women aged 40 to 44.
10. Most divorces (71%) were for first marriages.
11. 48% of couples divorcing had at least one child aged under 16 living with the family.
12. 16% of marriages reach the 60th wedding anniversary.
13. It is expected that 42% of marriages will end in divorce.

Office of National Statistics

Inevitably in a very demanding medical career, particularly at consultant level, the career of the children bears a greater domestic burden than may be the case in a career with fewer hours, and hours which are more compatible with shared parenting. Couples commonly find that something has to give and often it is the wife’s career. Sometimes the decision is made to move into part time and less demanding work whether within medicine or outside it. These decisions have life-long consequences for both parties. For the person continuing with their career, they retain the ability to forge ahead, gain valuable experience and advance themselves, often combining a successful private and NHS career. For the main carer of the children meanwhile, opportunities are lost, promotions missed out on and with part time working and reduced income there is also the serious issue of reduced pension provision in the future.

Fairness for the parties

It is for all of these reasons that the divorce courts recognise the concept of needing to balance the financial outcome of divorce to bring about fairness for the parties. The reality of this can be very difficult, however. The courts have identified the concept of “compensation” by way of enhanced maintenance or capital provision to try to address this, but it has been sparingly used. In some circumstances, wives have attempted to claim compensation where there is no evidence to suggest that they actually gave up a high powered career to look after the family. This has been roundly rejected by the courts. If, however, a woman consultant gives up her career to look after the family, then there is a strong chance of a successful compensation argument being advanced if the couple subsequently divorce. The more successful the career was sacrificed for the family, the greater the potential claims on divorce. In some unusual cases, an enhanced maintenance order has been made to provide for the wife to accumulate some extra capital post-divorce to compensate her for the loss of income, but this outcome is generally only likely when compensation could not be made through additional capital.

Professional advice should always be sought to make sure the correct level of transfer takes place. I am still amazed to come across cases in which professional women did not investigate and pursue their loss of pension as part of their divorce settlement.

The value of early advice

The modern world there are an increasing number of divorces where it is the wife who has continued her career and the husband who has reduced his hours or worked part time in order to look after the children. There, of course, the reverse applies and it is not impossible, although still unusual, for a high earning wife to be ordered to pay her husband maintenance for himself as well as the children in addition to making a capital settlement and pension provision. Again, early legal advice should be sought to try to ensure that a clean break is negotiated where possible.

The pressures of combining a professional career with the care of children can mean that there is little time to devote to legal matters if marital difficulties arise. Failing to stop, pause and protect your position by securing a prescribed position can be a grave mistake, the implications of which will travel far into your retirement. Try to invest time in getting the decisions right for you. Mediation can offer a way of discussing arrangements for children and finances, as can Collaborative Law, but there is no substitute for a full investigation of all the facts and issues before reaching a settlement that can affect you for the rest of your life.

Here are my top tips:

• If you use a solicitor, try to instruct a member of Resolution; their aim is to promote ‘constructive divorce’.
• Get a full disclosure of assets, including pension values, before divorce proceedings begin.
• Prepare a careful budget of your expenditure if you are considering separation (remember to include costs paid quarterly or annually).
• Check which debts or utilities you have signed for and make sure these are dealt with in the divorce.
• If your settlement includes maintenance for yourself or children make sure you have the benefit of insurance on the payer’s life.
• Before you listen to friends or family – they will not be objective even if they try.
• If you inherit or are given money during the marriage, be wary of investing it jointly if you have any concerns about your marriage.
• For a first or subsequent marriage consider a prenuptial agreement to protect any wealth you bring to the marriage – they are now likely to be upheld.

In Sickness & in Health

www.medicalwomensfederation.org.uk
Complaints

about women in medicine

Male doctors are more likely to be the subject of a complaint compared to female doctors, and complaints against them are more likely to proceed to an enquiry. It is encouraging to note that the rise in complaints over the years, fuelled by a diet of negative medical media coverage, higher patient expectations and a paradigm shift in doctors raising concerns about other doctors has declined. In 2014, the overall number of complaints dropped, but it is disappointing that the number of complaints against women has risen.

What remains unanswered is why such gender disparities exist. It is likely that the answer is complex and multi-factorial but may include the fact that female doctors are more likely to work part-time than men and therefore have fewer interactions; the general public may have a greater tolerance for complaining against female doctors; male doctors may engage in more risk-taking behaviours than women, rendering them more vulnerable to complaints; and women may spend more time interacting positively with patients.

In this informative article, Anna Rowland, the General Medical Council’s (GMC) Assistant Director of Policy, Business Transformation and Safeguarding, addresses fitness to practise investigations and complaints involving female doctors.

Jyoti Shah, Editor-in-Chief

We know most doctors provide safe and compassionate care. Despite a rise in complaints in recent years, the number of doctors we take action against is a very small proportion of the doctor population.

However some doctors are at greater risk of a complaint, being investigated and the GMC taking action as a result of that investigation.

Risk factors

Our data tells us that the biggest risk factor is gender. Male doctors are significantly more likely than female doctors to face allegations, particularly for criminal matters.

Male doctors account for 70 - 85% of GMC cases. However, while female doctors overall have a significantly reduced risk of a complaint being made to the GMC, the risk varies according to the nature of the concern. Female doctors accounted for around a third of cases involving health, compared with around 10% of cases involving:

- criminality from employers or the police
- respect for patients and communication from employers and other public bodies.

Age and specialty are also among the risk factors with older doctors more at risk than younger doctors and Obstetrics and Gynaecology, Surgery and Psychiatry carrying increased risk.

Who makes complaints?

Complaints reach the GMC from a wide range of sources, including members of the public, employers, doctors and the police. But doctors also notify us themselves, particularly about health concerns.

The greatest increase from 654 in 2010 to 1,227 in 2014 was in complaints from other doctors, which excludes senior doctors who raise concerns on behalf of the organisation they work for.

The public make the highest proportion of complaints and more than half of those are about clinical competence, including concerns about communication and respect for patients. A GMC investigation can also be triggered by media coverage. For example, a journalist may report an inquest where a doctor is named as being involved in a patient’s death.

Complaints about women doctors

Overall, complaints to the GMC have doubled since 2007 – with nearly 3,500 enquiries made about doctors in 2014. Of those, less than a third resulted in investigations being opened. The majority of investigations close with no further action, with about 10% being referred for a hearing.

The total number of complaints dropped slightly by a little over 2% in 2014 compared to the steady increase of previous years. Interestingly, female doctors received 5% more complaints last year than in the previous year. Of the 1800 complaints made about female doctors last year:

- 35% led to an investigation being opened
- 75% of those opened investigations closed with no further action or advice
- Only one female doctor was erased by the Medical Practitioners Tribunal Service (MPTS) last year for concerns about honesty and clinical competence. To put this in context, fewer than 5% of investigations in 2010 and 2014 resulted in female doctors being referred to a hearing.

Allegations against women are most commonly about clinical competence, professional performance or honesty and fairness. Health concerns account for 12% of investigations about female doctors.

Reducing the impact of investigations

We understand that being investigated can be stressful, so we aim to open an investigation only where we think we may need to take action to protect the public or uphold confidence in doctors. We are currently trying to improve our triage process to help us decide more quickly which cases we should investigate and those we shouldn’t. Following a pilot earlier this year we have started making greater use of enquiries in certain cases. For example, in a case where a patient complains about consultations carried out by a doctor, by getting an expert to look at the medical records for those consultations, we can better assess whether there is a serious concern that warrants a full investigation. Our pilot led to a 70% cut in the average length of some of our investigations. We hope to see similar results now that we have introduced this properly.

We want to build on this next year by applying this same change to how we deal with one-off clinical incidents. We close a high proportion of these investigations with no further action.

What we publish

The GMC’s website includes the outcomes of fitness to practise investigations from 2005 onwards when we introduced electronic records. Older sanctions, while not published online, are available on request. We recently consulted on proposals to introduce new time limits for how long we publish that information and to transfer online the details of investigations from 1994 to 2005, when a doctor is still registered, to give patients more information about their doctors. The outcome of the consultation will be published in early 2016.

Future changes

In 2015 Parliament approved changes to the current Medical Act 1983 which came into force last December. These changes gave the MPTS the full range of statutory powers we requested when the new tribunal was first set up to separate the running of hearings from the investigation of cases. Doctors now have a right of appeal against MPTS decisions and, as a result of that separation, the GMC also has a right of appeal if it considers a decision is insufficient to protect the public. The changes in the law also streamline how cases are prepared and managed. This will speed up tribunal hearings and make them more effective, introducing legally qualified chairs for some tribunals, and giving power to the tribunals to award costs against the GMC or the doctor if either has not complied with directions and has behaved unreasonably.

Work is also continuing to improve the way the GMC treats vulnerable doctors who are subject to fitness to practise investigations and handles cases involving doctors who are whistle blowers. These reforms follow independent reviews commissioned by the GMC.

For more information about the GMC’s fitness to practise investigations in 2014, read the GMC’s latest state of medical education and practice report at www.gmc-uk.org/somestp15.
By Dr David Anderson, Retired Consultant Anaesthetist

HOW TO COPE WITH THAT DREADED LETTER OF ENQUIRY FROM THE GMC

Dr David Anderson has a wealth of both clinical and management experience of the NHS, holding many senior positions including a panel list with the General Medical Council (GMC) and Medical Practitioner’s Tribunal Service (MPTS) for 8 years. He was also Chief Executive of an Acute Trust for 6 years, a member of the Editorial Advisory Board of the British Journal of Healthcare Computing and Information Management, and Lead Member of the Accident Flying Squad for 21 years. In this article he provides readers with his top tips on how to cope with a letter of enquiry from the GMC.

1. DO NOT PANIC: Prevention is always better than cure. Always write good clinical notes, be aware of the guidance in Good Medical Practice and have the support of a medical defence organisation. Remember that only a very small percentage of complaints to the GMC resulting in an enquiry letter to the doctor, end up at a hearing of the MPTS.

2. DEFENCE ORGANISATION: it is essential to involve your medical defence body at the earliest opportunity. Do NOT reply to the GMC about a complaint until you have discussed all the details with the defence organisation first. Remember that they deal with many similar complaints and know how best to frame your response. This response may be the first and only response you have to make.

3. GOOD MEDICAL PRACTICE: Inside the front cover of the latest version of this publication, dated 2013/14, is a list of ‘Do’s and Don’ts’. This guidance is the reference book used by MPTS panels, the contents of which will be quoted when defining any failures by the doctor in front of them. These are the principles on which you need to base your practice as a doctor both for the benefit of patients and to avoid unwanted involvement with the GMC.

4. GOOD RECORD KEEPING: Content of clinical records is clearly described in Good Medical Practice. Record your work clearly, accurately and legibly, at the time or close to the time of events and sign, date and time your entry.

5. WHY RECORDS are primarily intended to support patient care both as a record and a means of communication within the team or with other teams.

6. BUT! The secondary purpose is to support your response to a complaint both at the Trust level and, if necessary, for the General Medical Council.

7. PLUS! Any complaint is very unlikely to have notes made at the time of the event so yours will be the only contemporaneous record of events.

8. Do not get caught out. Beware if your notes are very brief. You may be asked why you did not write fuller notes by a defence lawyer. Do NOT answer “I did not have time to write fuller notes.” The defence will respond with “Oh, so you don’t have time for your patients then, doctor.” This will give a wrong impression to the panel of your attitude towards your patients.

9. CANDOUR: You must be open and honest about everything related to the enquiry. Do not try to hide anything, however unimportant or unconnected with the case it might seem to you. If it comes out at a hearing, even if very trivial that you have not been honest, then that will have a very negative impact on how the panel views your explanation of events.

10. INSIGHT: The GMC expects doctors to show insight into the gravity of what has happened. If you have made a mistake or failed to meet the standards expected, then it is important that you not only accept this fact, but are able to show the panel that you are aware of what you have done was wrong or was not to the standard expected. Non-acceptance implies that you do not accept the standards spelt out in Good Medical Practice.

11. REMEDIATION: Doctors should demonstrate that they have taken action to remedy any deficiencies identified by the complaint. If the case involves issues that can be addressed with educational activity or training courses, then this is an important step. It shows you have learned from the event and learned from the errors made. If you are able to show evidence from the training or that you are now competent to meet the standards set out in Good Medical Practice, then it is more difficult for the panel to say your “Fitness to practice is impaired” but still accepting that your “Fitness to practice was impaired.”

12. BEWARE THE KNOWLEDGEABLE LAY MEMBER: The lay member(s) may ask questions about complex medical issues and you need to reply with care. Never suggest that you are the doctor and they are just the lay member who does not understand medical matters.

13. REHEARSE THE FULL STORY: Before any hearing do your homework. Refresh your memory of all the details of the case. This is all about you so show that you know the whole story from the beginning. Once again you will be reliant on your records. Also have a detailed knowledge of what the complaint was about as well as other people’s records of events.

14. DOCTORS TOUGHER THAN LAY MEMBERS ON PANEL: The lay members on the panel often empathise with doctors. However, fellow doctors expect higher standards. It is useful to be aware of this when responding to questions from the panel members.
Defence unions train many doctors to become medico-legal advisers, who in support, guide and offer assistance in many aspects of medical practice when the road ahead is unclear. There are many stressful times in medical careers when doctors need guidance on how to proceed. Whether it is responding to a complaint, writing a report for the coroner or attending a GMC hearing, it is at these times medico-legal advisers are the first point of contact for members seeking help.

So, I applied for a place to study for an MA in Medical Law and doing the job for the next 30 years, and I was worried that if I continued, I would become disinterested.

Describing her journey from clinical practice into a career as a medico-legal adviser, Dr. Angelique Mastihi has no regrets about giving up her clinical career. Angelique is a senior medico-legal adviser at the Medical Protection Society (MPS), which is the world’s leading protection organisation for doctors, dentists and healthcare professionals. She is based in the Edinburgh office and describes her career now and how she got there.

What do MLAs do?

We advise and support doctors and other health care professionals in relation to a wide spectrum of questions and difficulties that arise through their clinical practice. Essentially, we provide the interface between the doctor and the legal process and examples include advice on:

- disclosure of medical records and the Data Protection Act
- complex ethical dilemmas
- complaints at a local level, under investigation by the ombudsman, or the GMC
- clinical negligence claims
- providing written reports and appearing at inquests
- appearing at disciplinary hearings

Matters may also arise in relation to an individual’s performance or health. The advice is provided by phone, face to face and in writing. Some queries may simply involve a one off telephone call, whereas others may require following a case over a number of years. Every case is different.

From a practical point of view, at MPS we are predominantly office based and deal with correspondence and phone calls. However, we regularly meet with doctors, solicitors, barristers and experts as well as accompanying an individual to meetings and advocating on their behalf. Inevitably, this will, at times, require travel.

There is also a lot of writing and presenting involved, and so a good grasp of the English language is helpful.

What is my advice if you are contemplating a career change?

If you are considering a change in direction I suggest you have a chat to a friendly MLA, get involved and get experience in local risk management, ethics committees and legal departments. In addition, sit in on court proceedings or GMC hearings. Most are public and anyone can sit in the public gallery regardless of whether it is a criminal, civil or coroner’s court.

You will require a license to practice and all MLAs undertakes appraisal and participate in the revalidation process. Remember however experienced you are in your current field, medical law is a specialty of its own and so if you take the plunge you will become a trainee again. Are you prepared for that?

OBITUARY

DR HELEN JEAN STEWART MB CHB, FRCSE, ED, DMTH, FRCR.

Died in Edinburgh on 30 June 2015

Helen Jean Stewart was born in Glasgow in April 1931 to the late Dr and Mrs. Ronald and was educated at Laurel Bank School for Girls. While at school she spent several summers at Strathallan Castle, which provided temporary accommodation when the school had been evacuated during the Second World War.

She studied medicine at Glasgow University and graduated in 1957, after which she started her surgical training at the Western Infirmary in Glasgow. She then became research assistant to Professor Sir Patrick Forrest and moved to Cardiff where she specialised in breast surgery and the treatment of breast cancer. While in Cardiff she obtained her FRCS and was the first woman to be elected to the Surgical Research Society.

In 1968 Helen moved to Edinburgh where she began training in radiography and set up home with her elderly widowed mother. She then worked as a consultant radiographer with a special interest in the treatment of breast cancer. She was chairman of the British Breast Group and was instrumental in establishing and promoting the British Oncology Data Managers Association (BODMA) and was invited to become their first President. Her final post was director of the Scottish Cancer Trials Office where she led large scale projects looking at the effects of various combinations of treatments for both breast cancer and melanoma. During this time she travelled extensively at home and overseas attending and presenting papers at conferences.

She contributed to numerous published articles helping to establish Edinburgh’s international reputation in the treatment of breast cancer. Helen has been described by her colleagues as a great mentor and taught the importance of attention to detail and reveilling in dealing with data and statistics. To family and friends, Helen Jean, as she was known, played down her achievements. Her interest in art was inspired by the fact that her father had been GP to the Scottish artist George Leslie Hunter who gave him a couple of paintings in lieu of payment for medical services. Her mother, an excellent pianist, inspired her love of classical music. Throughout her life Helen was a keen supporter of the Scottish Opera and the Royal Scottish National Orchestra.

Helen accepted the restrictions and ailments which came with ageing and in 1971 Helen joined the MWF and became a life member in 1996. She was a council member and also secretary and President of the Scottish Eastern Association. She was a very sociable person and enjoyed the company of all ages and walks of life. She was known for her rather direct style of communication, her meticulous record keeping, her kindness, her very determined spirit and incredibly positive attitude. Helen accepted the restrictions and ailments which came with ageing with grace and courage. Her pragmatic approach and confident decision making which had contributed to her successful professional life made it a pleasure to care for and visit her in the later stages of her life. She died peacefully, at Strachan House, Edinburgh, on June 30, 2015, after a long illness borne with great courage.

Jane Macfarlane
Facebook, Twitter, LinkedIn, WhatsApp – the growth of online social networks has radically changed how we communicate in the last decade. So much so that, sometimes, it feels like we experience modern life through screens of glass and pixels.

And it’s not just the so-called ‘millennials’ – those born after 2000 – who spend their time exchanging ideas, sharing thoughts and digesting information digitally. From primary school children to grandparents, social media connects the world.

Having the power to broadcast one’s thoughts to potentially millions of others is empowering and terrifying in equal part. We all know that bum-clenching moment when ‘reply-all’ gets hit instead of ‘reply’. If it hasn’t happened to you, odds are you know at least one horror story. But it hasn’t put you off ever sending an email again, right? You’re just that bit more careful?

Well, that’s how to approach social media – so read on for the lesson one: no matter how private something claims to be, it probably isn’t.

In the same way that no email or a conversation with a roomful of people shared photographs of themselves on social media lying down game’ (social media loves a short-lived trend) where people shared photographs of themselves on social media lying down while being photographed lying down on resuscitation trolleys, wards and even the Wiltshire air ambulance helipad.

So far, so harmless.

But unexpected media attention. Some of the more unscrupulous members of the press had managed to gain access to the group and used it to trawl for information about committee members and their private lives. Which leads me to my first lesson two: count to ten.

Hard though it is to believe, seven years ago the BMA didn’t even have a Twitter account, let alone Facebook. These days, all things considered, in this ‘always on’ era of social media, I think there are many benefits of having an active social presence.

It’s 7.30am and you have just returned from a nightshift for unprofessional conduct (they were on duty at the time). The comments were seen by a senior figure on the doctors.net online forum. ‘Scatological’ comments about a senior female doctor on the doctors.net online forum. She was suspended for six weeks after making ‘scatological’ comments about a senior female doctor on the doctors.net online forum.

But the digital platform has allowed doctors to network and engage with each other, share stories and even educate each other on a global level. Indeed, the world has become a very small place. The potential to use social media to enhance patient education and facilitate access to health information and services cannot be ignored. Most of us will be aware of the power to inspire using social media through Kate Grainger’s #hellomynameis campaign, which has made over 1 billion online impressions.

However, the digital environment has led many to question how best to protect patients and how to apply professionalism for doctors. The potential loss of privacy for both patients and doctors is huge but the possible breaches of confidentiality are an even greater risk. It is easy for online exchanges to be perceived as offensive or unprofessional and can adversely blur boundaries.

In this article, Jon Hinchmore, the Social Media Manager at the BMA provides readers with some handy tips when using social media. When he’s not wondering if it’s ok to spend all day looking at Facebook, he’s looking at new ways to enhance the BMA’s social media offering and connect with members in the most engaging way possible. His 5 favourite things in life are spending time with friends and family, New York in the winter, coffee, music and Cold War spy novels.

Jyoti Shah, Editor-in-Chief

Facebook (www.facebook.com) – a social networking site that started in USA in 2004 and now has over 1 billion active users with reports suggesting that over 50% of the adult population now use this site to connect with ‘friends’

Twitter (www.twitter.com) – a service that allows users to send short 140 character ‘tweets’ and was established in 2006. There are over 320 million active users of this service in a month

Google Plus is another social networking site that was launched in 2011

LinkedIn (www.linkedin.com) – launched in 2003, linkedin is a business-oriented networking service with over 200 million users in more than 200 countries and territories

YouTube (www.youtube.com) – this online video sharing service was created in 2005 and is now owned by Google

Dictionaries as websites and applications that enable users to look up meanings and definitions of words of caution…

Lesson one: no matter how private something claims to be, it probably isn’t

In the same way that no email or a conversation with a roomful of people is ever truly private, there is always a chance that things can leak. Don’t say or reveal anything on social media that you wouldn’t be happy to see printed in a newspaper. It sounds extreme, but you never know who might be sharing things without your knowledge or looking at your social accounts.

You may remember a craze several years ago of ‘planking’ or the ‘lying down game’ (social media loves a short-lived trend) where people shared photographs of themselves on social media lying down flat in even more unusual – or dangerous – public locations such as in trees, on mountainsops or in the middle of the street.

So far, so harmless.

Should you become friends with a patient on Facebook? This is a classic social media ethical question and evokes a diversity of responses and much disagreement with no clear guidance. Or is there?

Social media has dramatically increased in popularity over the past few years and many doctors have embraced this digital revolution with enthusiasm. Yet many remain terrified by its perils. Indeed the MDDUS reported a 74% rise in the number of doctors seeking advice on the use of social media towards the end of 2014.

But what really is social media? Described by the Oxford Dictionaries as websites and applications that enable users to share content, or participate in social networking, there are many examples of social media. These include:

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By Jon Hinchmore – Social Media Manager, BMA

By BMA deputy head of ethics, Dr Julian Sheather

- Remember that you have the same duties of patient confidentiality on social media as anywhere else
- Do not say anything on social media that you would not be happy to see in a newspaper
- You have rights to free speech but they are not absolute – do not defame anyone
- Act in a professional and courteous manner – you are still a doctor on social media
- Make it clear your views are your own
- Declare any conflict of interest

Or that’s what the seven emergency department staff who were suspended from a hospital in Swindon presumably thought, before they posted pictures of themselves on Facebook lying down on resuscitation trolleys, wards and even the Wiltshire air ambulance helped.

Despite the photographs being posted in a Facebook group called The Secret Swindon Emergency Department Group, hospital management saw the photos and the staff were suspended for unprofessional conduct (they were on duty at the time). Their actions were considered to be unprofessional and inappropriate.

Lesson two: count to ten

It’s 7.30am and you have just returned from a nightshift (I know, but this is a theoretical situation; we can be optimistic). The consultant who you were working for tonight didn’t stop hassling you, you couldn’t do anything to please them and it was a generally miserable experience all round. Added to that, you are exhausted and running on fumes. So, you decide to log on to the doctors’ online forum that you normally use to ask for advice and support and vent your spleen to anyone who will listen, naming said consultant in the process. Nobody would be so stupid, right? You can guess what’s coming…

In 2008, a junior doctor in Scotland was suspended for six weeks after making ‘scatological’ comments about a senior female doctor on the doctors.net online forum. The comments were seen by a senior figure at the London Deanery who escalated things to NHS Highland, which then issued an indefinite suspension. It was a controversial move, with many claiming that the junior doctor’s right to free speech was being stifled.

Whatever the rights and wrongs of the individual case, the fact remains that you should avoid social media at all costs if you are angry, emotional or drunk.

How do we do it?

At the BMA we are lucky to have a dedicated social media team – 24 hours a day, seven days a week, whose eyes are glued to feeds, dashboards and timelines; ready to reply, advise or duck for cover.

As an organisation, social media has become a key part of our member engagement strategy. We use our @theBMA twitter account as a kind of all-purpose engagement tool – signposting new content on our website, engaging in conversation with our members and other stakeholders.

We are lucky that the BMA recognises the benefits to having an active presence on social media and resources it appropriately (not least because I’d be out of a job if it didn’t), but many organisations do not.

The BMA have made social media more central to their engagement strategy over the past few years and we have learned the dos and don’ts – sometimes the hard way.

Doctors are constantly fed mixed messages about using social media – personal capacity, professional capacity or don’t do it at all? To friend or not to friend? While I think you should bear in mind the aforementioned caution. Some of the more unscrupulous representatives and their private lives. Which leads me to my first lesson two: count to ten.

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Social Media

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So far, so harmless.
MINDFULNESS

A poem by Dr Reena Shaunak
Winner of the Junior Doctor Prize on the subject of Resilience: What this means to me, June 2015

It’s 4am, the hospital sleeps
we juniors race silently
down deserted corridors
As we do, we wonder
How am I going to survive this?

Passion they think,
Perspective I say,
Patients and patience at the end of the day.

The hiss of the lift as it opens its doors
On time, First time!
The hovel of the sleep as it calls out for care,
Comfort, kindness, Crash?

Make sure you see the sun
Make sure you take a moment,
as you walk outside.
People rushing in
but you breathe out…

Remember who you are
Remember why you’re there
Be a friend, a counsellor, a healer
Be mindful of yourself
Pause on that moment
As it passes through.

Next Patient.
**SEXISM IN MEDICINE**

**Report of a Survey of MWF Members**

**Miss Jyoti Shah**
Editor-in-Chief, Medical Woman

**Introduction**

Within the last year or so the issue of sexism has been hotly debated across many different industries and professions. Hollywood icon Meryl Streep publically claimed that she still experiences sexism in every enterprise she knows, gets paid less than her male co-stars and remains ‘enraged’ by the prevailing culture.

An international survey conducted by the L’Oréal Foundation of more than 5000 doctors and women reported that only 10% of respondents believe that women possess the capabilities for science. Indeed, only 3% of Nobel Prizes in the sciences have been awarded to women.

Another survey exploring sexism amongst elite sportswomen across forty different sports in the UK reported that 40% experienced sexism but only 7% reported it. According to the Women’s Sport and Fitness Foundation (WSFF), only 0.5% of all sports sponsorship in the UK goes to women, but men’s sport is heavily sponsored. The Women’s Sport and Fitness Foundation (WSFF) survey found that only 0.5% of all sports sponsorship in the UK goes to women, but men’s sport is heavily sponsored.

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**Sexism in Medicine**

Of the 324 members who replied to the question about sexuality in medicine, over half of them believe that sexuality is an issue for women in medicine (56%). Figure 3 shows the percentage of each grade who think this is an issue and answered yes to the question.

A large proportion of respondents think that the media could do more to promote women in medicine, with 83% of consultants, 80% of foundation year doctors, 79% of core trainees, 77% of registrars and 68% of fully qualified GPs who believe this.

More than 57% of women doctors reported experiencing sexism from patients, and the training grades seem to experience this more than fully qualified GPs (49%) and consultants (43%). By comparison, 80% of foundation year doctors, 79% of core trainees but 85% of registrars report some personal experience of sexism by patients.

Although 63% of respondents have experienced sexism in medicine from colleagues, only 6.6% reported that discrimination.

This figure was much higher for consultants such that 73% of consultants experienced sexism from colleagues.

**Results**

The overall survey response rate was 28.7% (n = 329). Not all members who replied answered all the questions. This may be because the question was thought not to be relevant or due to respondent fatigue.

The demographics are listed in Table 1. The majority of respondents were between 31-40 years of age (n = 82) and in full-time clinical practice (n = 105). Of the respondents, 35.5% were consultants, and five were associate specialists (Figure 1).

**Population**

An anonymous survey was developed to address perceptions of gender discrimination for women in medicine. In preparing this report, the questionnaire was sent electronically to members of the Medical Women’s Federation (MWF) database in August 2015. At the time of survey submission, the MWF database included 1146 members with valid e-mail addresses. The survey was distributed twice to the database, with the second distribution three weeks after the first.

**Survey Design**

MWF members received a 17 question survey to complete using Google Forms® (www.google.co.uk/forms). The responses were anonymous for the author of this report. After providing demographic data, members were asked ten fixed-response multiple choice questions, or no questions, with three additional questions with open field comment boxes to allow respondents to write free text comments about their experiences with discrimination in medicine.

**Data Analysis**

Demographic frequencies were calculated and the frequency of gender-based discrimination by grade determined. The free text answers to why respondents did not report their experiences and the tips/advice given on how to handle sexist comments were stratified by order of frequency and common themes.

**Results**

The majority of respondents do not feel that female doctors are underpaid compared to male colleagues, and 70 respondents were unable to answer this question and completed the ‘Don’t know’ option. Six respondents did not answer this question (Figure 2).

**Childcare**

The results showed that 56% of respondents have children and almost 48% of them believe that the level of childcare support is inadequate. However, 40 respondents who do have children believe that it is adequate. Overall, 48.5% of all respondents completed the not applicable box in response to the question of adequacy of childcare support.

**Pay Discrepancy**

Six members skipped this question, and 25% said they do not believe their governing body supports women equally compared to male colleagues.

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Sexism in Medicine

The Lady Estelle Wolfson Emerging Leaders Fellowships

Clare Wynn-Mackenzie, Careers Support Services Manager, Royal College of Surgeons of England

Despite women now making up over 10% of the consultant surgeon workforce, and approximately 30% of surgical specialty trainees, the majority of leadership roles in surgery are filled by men. This reflects a trend across medicine: only 24% of trust medical directors are women, even though 44% of registered doctors in the UK are women.

T

he Royal College of Surgeons of England works to engage women surgeons and of the 56 elected members of the College Council are women. However, no women nominated themselves to stand in the 2015 election. It appears that there remain either barriers to women applicants or that Council is less appealing to women applicants.

To address this, the College, with the generous support of the Lord Leonard and Lady Estelle Wolfson Foundation has established the Lady Estelle Wolfson Emerging Leaders Fellowships. The fellowship programme aims to encourage women to apply for leadership roles in the College, surgery, and the wider medical profession, by providing information, support and opportunity for them to experience what is involved in these roles. A small steering group, led by Professor Vivien Lees, has designed and organised the programme as part of the College’s priority to attract, educate, develop and support high-quality female surgeons.

In its inaugural year, 13 fellows were appointed to complete a 12 month programme. The programme was advertised in spring 2015 and was open to female consultants, SAS surgeons, and trainees and the majority of places were reserved for consultants having at least five years’ experience in grade. Sixty four applications were received from an initial 2600 expressions of interest, and included 31 consultant applications, 17 trainee applications and one SAS application. Nineteen candidates were shortlisted and, following video conference interviews, 13 were appointed. These were ten consultants, one associate specialist and two senior trainees.

Throughout the programme, fellows will attend at least one meeting of the College Council and be introduced to College governance structures with the opportunity to attend committees and groups, including those regarding the College’s strategic priorities. The fellows can also attend meetings relating to their personal interests, including Specialist Advisory Committees, Membership and Intercollegiate specialty examinations and project steering groups. The fellows will be matched with a Council member who will act as their “link person”, providing information about opportunities and act as a sounding board for their thoughts and plans.

Fellows attended Council meetings in October and December, but met each other formally for the first time at the introductory meeting in December 2015. At this meeting, the fellows received presentations from a number of College leaders describing the many opportunities to get involved in College activities, including Advisory Appointments Committees, Education and, of course, the Council. The meeting ended with a key note address from Celia Ingham Clark who spoke eloquently about both her leadership roles and her thoughts on pursuing these kinds of roles.

As the day progressed, there was a strong sense of the group coming together. It is clear that in addition to the support the College will provide, the fellows will be an important source of support and motivation for each other. By the end of the day, the fellows were highly motivated to apply for leadership roles and understood the need to be selective and targeted in their ambition.

Ana Shrotri, one of the participating fellows said of the meeting and her visit to the College Council:

“It was very useful to get an insight into the working of the Council. Meeting surgeons in leadership positions at the College and listening to their experiences made me feel that I could learn from them and aspire to similar positions myself. There was such camaraderie between other members of the group making it an enjoyable experience overall.”


An emerging leaders fellow said:

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Discussion

The aim of this survey was to determine the extent of sexism faced by female medical students and female doctors in the workplace and provide some ways to tackle this behaviour. The survey has demonstrated that even if women do not expect to face gender discrimination in the workplace, over 60% do so yet only 6% report this. These figures are disappointing in light of significant strides that have been made in the past half century and the very many initiatives such as equality and diversity training, mentoring and support networks abroad such as the Medical Women’s Federation.

More needs to be done to stamp out such adverse behaviour; after all everyone has a right to come to work and be free from any form of harassment or discrimination. Women need greater confidence in speaking out and supporting each other in light of sexist behaviour at work and the silence around the subject must be broken.

It seems that reporting mechanisms are unclear and need to be transparent and robust with no fear of reprisals to those who speak up.

Great workplace diversity, especially ‘at the top’ will reduce the number of sexist behaviour at work and the silence around the subject must be broken.

Although confronting the behaviour was the most frequent recommendation, many qualified this advice with comments such ‘if inappropriate,’ or ‘if you object to them.’ Similarly, many qualified this advice with comments such ‘if recurs,’ or ‘if you feel threatened.’

One respondent suggested setting up a group within the organisation to tackle sexist behaviour with the director of human resources. Another doctor advised against reporting sexist comments and the very many initiatives such as equality and diversity training, mentoring and support networks abroad such as the Medical Women’s Federation.

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Table 4: Some of the reported advice from respondents about how to handle sexist comments

<table>
<thead>
<tr>
<th>Recommended Advice</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confront and challenge such behaviour/comments</td>
<td>58</td>
</tr>
<tr>
<td>Ignore them</td>
<td>37</td>
</tr>
<tr>
<td>Use humour</td>
<td>24</td>
</tr>
<tr>
<td>Report the behaviour</td>
<td>18</td>
</tr>
<tr>
<td>Respondents who gave no advice</td>
<td>14</td>
</tr>
<tr>
<td>Support each other/ use MWF</td>
<td>7</td>
</tr>
<tr>
<td>Be good at your job</td>
<td>6</td>
</tr>
<tr>
<td>Don’t talk about personal matters</td>
<td>4</td>
</tr>
<tr>
<td>Do not ignore it</td>
<td>2</td>
</tr>
<tr>
<td>Document the comments</td>
<td>2</td>
</tr>
<tr>
<td>Have private discussions with perpetrators</td>
<td>2</td>
</tr>
<tr>
<td>Accept this as normal and accepted behaviour</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 4: Some of the reported advice from respondents about how to handle sexist comments

A total of 14 respondents did not have any tips. Suggested responses to perpetrators included:

‘Avoid answering personal questions e.g. kids and marriage…’

‘Don’t invite it – i.e. don’t dress provocatively…’

‘…the dinosaurs are reducing in numbers…’

‘…Never, ever cry…’

‘The best you can do…’

‘…is that the best you can do…’

‘…well that’s a rather sexist comment…not what I expected from you…”

‘…are you aware of how sexist that comment comes across…”

‘You must look to their leaders – that is you and me – to enable this.

‘…is that the best you can do…”

‘…good at your job…”

‘…often that’s a rather sexist comment…”

‘…are you aware of how sexist that comment comes across…”

‘You must look to their leaders – that is you and me – to enable this.

Key Findings:

- 63% of female doctors have experienced sexism from colleagues
- 6.6% have reported it
- 45% of female students/doctors with children believe that the level of childcare support is inadequate
- 79% believe the media could do more to promote women in medicine

Acknowledgements:
Sarah McLoughlin for her help with survey distribution.

“Even if women do not expect to face gender discrimination in the workplace, over 60% do so yet only 6% report this”
Miss Liz Ball, MBChB FRCS PhD PG Dip (Oncoplastic Surgery) was appointed a Consultant Oncoplastic Breast Surgeon at Ipswich Hospital NHS Trust in May 2013. She trained in East Anglia and did the National Oncoplastic Fellowship at the Royal Marsden. She firmly believes that doctors need to look after themselves mentally and physically in order to look after their patients and is a proud supporter of the “Hello my name is” campaign.

The unfortunate irony of a breast surgeon having breast cancer will not be lost on readers. In this candid article, Liz recounts her agonising journey from a healthy, sporty (she is a cyclist and triathlete) professional woman to a cancer patient.

Blog link - http://liz.orriordan.co.uk

I am a consultant breast surgeon, and I have breast cancer. That is something I never thought I would say. I have always had lumpy breasts, and have had a few scares over the years. When I first found a breast cyst in 2011 – just after I got engaged – I told myself: “It’s cancer; you’ll need a mastectomy; you won’t be able to wear a wedding dress and you’ll be dead in 2 years.” As a breast surgical trainee I knew it was just a cyst, but I still thought, for me, and for most of my patients, those lumps are often harmless.

…for me, and for most of my patients, those lumps are often harmless.

No Learning Curve

I have been blogging about what it was like, and for those of you who want to, you can read it here – (https://liz.orriordan.co.uk/BreastCancerBlog.html). I wanted to share a couple of things that surprised me and shocked me, and how I have changed how I will practice medicine again, once I have completed my treatment.

Hair today, gone tomorrow

I wasn’t bothered about losing my hair. I was actually excited to see what I’d look like. What I wasn’t expecting was that I would lose all my body hair. Yes, that right, you get a free underarm and leg wax and a Hollywood (or is it a Brazilian, I never got those the right way round) on the NHS. I was sad when my eyebrows went, and I am hanging on to my few remaining eyelashes, hoping that they will grow back. What I didn’t know is that there is a 30-20% chance that your hair won’t grow back after chemo.

Sticks and stones…

I will break my bones but words will never hurt me.” How often do you think about the language you use? As a patient, it is amazing how one simple word or phrase can affect you. I have two examples. The first is “It will be fine.” I heard this phrase a lot in the beginning from friends and family who didn’t know what to say. As a patient, I got very frustrated. They can’t guarantee that it’s not cancer, or that it won’t come back, or that I won’t die. I know they mean well, but when they tell you that, and it is cancer, it’s hard to take in. The second is, “You have been capped at telling patients as a junior doctor that I am sure their scan will be fine as a means of comforting them. Then, when I had to go back to say “Sorry, we’ve found something,” I felt horrible.

I have also been made acutely aware of some of the phrases that I have used in clinic when breaking bad news, that now make me cringe. A lot of women get recalled from breast screening with tiny low-grade cancers, and I have said “If you’re going to get breast cancer, this is a good one to have,” “You’re lucky that we caught it early.” These phrases were said with good intentions, to try and reassure them that they were unlikely to die of their cancer, and would not need chemo. But, now, it is a good one to have, and no-one is lucky to get cancer.

Information overload

I was given leaflets about chemotherapy, and picked up more from the Macmillan centre. I didn’t read any of them. I found all my information online, from cancer websites and blogs. I find it easier to read things on my phone or iPad, and forward them to people to read. My family live abroad, and could not read the information I had been given, and they wanted to know about chemotherapy.

I dream that one day, at my hospital, all the information we give patients, for every disease, together with links to relevant websites, will be available on the hospital webpage. How easy it would be for me to tell my mum to go to the ‘Breast Surgery’ page and download everything she needed to read. You still need physical leaflets to take away with you after a cancer diagnosis – it helps the morale seem real, but it should all be available online too.

Physician, heal thyself

One of the hardest things for me was to stop being a doctor and learn to become a patient. I self-treated a lot during chemotherapy, and got told off for not calling the nurses for advice. Why didn’t I? Partly the embarrassment of admitting that I might not know what to do when I thought I should. Partly because I don’t like bothering people for something I should be able to fix.

I was admitted with possible neutropenic sepsis during my second chemotherapy cycle, and wrote a blog about how awful it was. But, what I would like to tell you is how to look after a senior doctor who is a patient. On the whole, the medical team were wonderful, but the one person who found it hard to treat me was the medical registrar. I think he had stage-fright at treating ‘my husband’s wife,’ and he was very inappropriate at times. He didn’t ask me about my breast cancer, and scarcely examined me. I know he could get all the information he needed from the clinic letters on the computer, and could read the A&E clerking and assume they had done a full examination, and as a registrar he was generally reviewing things, anyway. However, I was a scared, septic patient with abnormal blood results and he did not do a good job.

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What has cancer taught me? 1) No-one gets a good night’s sleep in hospital 2) The comforting words we think we use may actually be quite upsetting 3) We need to make Breast Cancer information more accessible to patients and their families in this electronic age 4) ‘Physician, heal thyself’ does not apply when you are a patient. That is your medical team is for 5) Cancer can be lonely, and the simple act of sending a regular text to someone will mean more to them than you will ever know, even though you feel like you’re doing nothing.

The Other Side: Doctors as Patients

Medical Woman | Spring 2016

www.medicalwomensfederation.org.uk
Medical Myths: Eating Disorders At & Beyond Midlife

Dr Margo Maine
PhD, FAED, CEDS, Senior Adviser to the National Eating Disorders Association

Growing numbers of women over the age of 30 years are now seeking help for eating disorders, commonly thought to occur only in adolescent girls. The real prevalence is unknown but the chronic and intermittent nature of the disease in this group of women means that they may finally succumb to health issues arising from their condition. It is possible that there is at least one woman you know, as you read this article, who is silently suffering...

In this thought provoking article, Dr Margo Maine PhD, a clinical psychologist who has specialised in eating disorders and related issues for almost 30 years demystifies this taboo topic. She is a Founder, Past-President and Adviser of the National Eating Disorders Association and Founding Fellow of the Academy for Eating Disorders, and co-founder of the Maine and Weinstein Speciality Group. She is senior Editor-in-Chief of Eating Disorders: The Journal of Treatment and Prevention and long-time board member and Vice-President of the Eating Disorders Coalition for Research, Policy and Action.

Dr Maine is author of Treatment of Eating Disorders: Bridging the Research-Practice Gap; Effective Clinical Practice in the Treatment of Eating Disorders; The Body Myth: Adult Women and the Pressure to be Perfect; Father Hunger, and Body Wars. In 2007 Dr Maine received The Lori Irving Award for Excellence in Eating Disorders Awareness and Prevention, and in 2015 she received the NEDA Lifetime Achievement Award. It is a privilege that she has written for Medical Woman.

Jyoti Shah, Editor-in-Chief

“Wealthy women are not at risk of eating disorders”

W hen we hear “eating disorders,” most of us visualise a teenager, but age does not immunise women from these serious illnesses. In fact, between 1999 and 2009 inpatient eating disorder admissions showed the greatest increase among older patients, with women over 45 years of age accounting for a full 25%. Some of these women had a clinical eating disorder in their youth. The peak risk periods for developing an eating disorder are once more at risk. The 30s and 40s come with decisions about retirement, and another 4% met the criteria for subclinical eating disorders.

The problem is less to do with the specific diagnosis but more to do with the patient’s stage of development. Even subclinical eating disorders can have a significant impact on the wellbeing of adult women, negatively affecting mood and self-image, and increasing anxiety and depression. Public health policy agendas must prioritize midlife eating disorders and body image.

Myth 3. Eating disorders in adult women are a less serious public health issue than many others. Although they receive far less attention in the medical community and in the media, eating disorders affect more women than breast cancer does. Whilst 12% of women over age 50 have breast cancer, 13% have eating disorder symptoms. As many as 8% report purging to lose weight, and 60% admit that weight and shape concerns negatively affect their lives. In a study of women over age 60, 4% met the criteria for clinical eating disorders and another 4% met the criteria for subclinical eating disorders. Even subclinical eating disorders have a significant impact on the wellbeing of adult women, negatively affecting mood and self-image, and increasing anxiety and depression. Public health policy agendas must prioritize midlife eating disorders and body image.

Myth 4. Anorexia Nervosa is the most common eating disorder. In fact, Anorexia is the least common. Bulimia is more frequent, but Binge Eating Disorder and the atypical eating disorders (having many but not all of the symptoms of anorexia or bulimia or both) – now called Otherwise Specified Feeding and Eating Disorders (OSFED) are the most frequent, especially among adult patients.

Often for adults, the eating disorder has changed over time, from late childhood into early adolescence and then from mid to late adolescence. These developmental passages come with

“I would walk into the surgery every morning looking immaculate; looking very much in charge and the embodiment of professionalism. No-one would guess my self-destructive secret of eating, well binging actually, and then vomiting. I often excuse myself at meetings and return glowing on the outside. Inside I am in turmoil; I am embarrassed; I am desperately lonely. The binges started soon after my GP partnership and the stresses of juggling a professional job with being a mother; juggling the guilt – never quite making work on time – never quite picking the kids up on time. I would comfort eat, put on weight, then be sick and feel thin again. The perfect diet – or is it?”

– Anonymous Doctor

well recognised external demands and internal stressors as girls move into their adolescent bodies and cultural roles and prepare to move away from the comforts and security of childhood. But eating disorders are not over at age 18.

Adult life is full of turning points and stressors placing women at risk. Menopause, career change, and body image.

Myth 6. The health risks related to eating disorders wreak less havoc on an adult body. Paediatric eating disorders can seriously impact growth, brain development, and general maturation. However, they also exert specific risks to older patients. Depleted fat stores increase menopausal symptoms, and muscle-wasting can reduce metabolic rate and hasten neuromuscular decline. Deterioration is especially risky for the elderly causing increased cognitive impairment and mortality risk.

As with younger patients, every system in the body is affected by malnutrition, and medical complications can emerge quickly despite years of stability. Patients who have struggled for decades often think they have mastered the system and will escape critical medical issues, but the body does eventually break down.

Myth 7. BMI is the gold standard for health and is relevant for evaluation and goal setting for eating disorder recovery. BMI is a population statistic and tells us nothing about an individual’s health or about the presence or status of an eating disorder. Most have very serious longstanding eating disorders despite a weight that is at, or above average, as chronic-caloric restriction can lower the basal metabolic rate. Women’s bodies are complex, with cyclical weight shifts surrounding menses and pregnancy, as well as at menopause, when metabolism slows by 15-20%. Moderate weight gain at midlife is actually associated with longer life expectancy for women. It is possible to be both fit...
and fat – the quality of one's dietary intake and activity level is the critical factor – not weight alone.

**Myth 8. Genetics are the primary contribution to eating disorders.**

While biogenetics predispose some people to eating disorders, genes code for risk and not for a specific disease. Eating disorders are multi-determined, best described as a perfect biopsychosocial storm. Shared environmental influences (intergenerational family attitudes towards weight, food, body image, and emotional expression) and cultural pressures on women contribute equally to genes.

The single best predictor of risk for developing an eating disorder is simply being born female. Women now experience unprecedented stress levels. Rapidly changing social roles in a globalised, consumer culture, strict cultural standards regarding women, weight, and appearance, unattainable media images and a fear of obesity contribute to this stress. We have never had so many opportunities; nor have we ever had more stress and pressure to achieve.

Young women are not the only generation affected by our rapidly changing world. The messages about women's bodies and value also bear down hard on adult women.

**Myth 9. The signs and symptoms of an eating disorder in adult women are easy to identify.**

Most adult women with eating disorders do not have significant weight loss as in anorexia. Their weight may be average or above average, and so their eating disorders stay under the radar. After suffering for decades, they have learned to push themselves through any discomfort, having gradually adjusted to how tired and ill they may feel. They are experts at hiding their symptoms and their true needs and hungers. Most function at a very high level in their personal lives and careers and get constant positive feedback about their accomplishments, appearance, and "discipline" when it comes to eating and exercise. They suffer silently.

**Myth 10. These are chronic illnesses with little chance for recovery.**

Eating disorders can have a chronic course, but, with adequate treatment, most women will recover. However, many factors can interfere with this. First and foremost is the woman's deep shame for having what the medical world sees as a teenager's problem. This is not just the job for paediatricians, obstetricians and gynaecologists, family practitioners, internists, or even geriatricians – we all have a vital role in the fight against eating disorders.

Visit www.nationaleatingdisorders.org for more information.

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**IN Conversation:**

INTERVIEW WITH ANITA ASIMWE

Former Minister for Public Health & Primary Care, Rwanda by Dr Clare Polet, Retired GP

- **What brought you into medicine?**
  When I was a little girl, I realised I wanted a career helping people, especially children. I loved sciences and that allowed me to attend medical school. I was the only doctor in the family but I now have a distant cousin who is studying medicine.

- **Was your school supportive?**
  The school in general was supportive except for one teacher who used to discourage girls from studying sciences.

- **How long does it take to qualify as a doctor in Rwanda?**
  Six years. Initially there were just over 100 students in my class at medical school and I was the only girl. This didn't push me away. I have the sort of character where if someone tells me 'girls don't do this' I would feel as if you were telling me to do it. Soon after, three other girls joined. At the end of six years, there were only 31 students left in my class but the four girls stayed.

- **Where did you qualify?**
  National University of Rwanda, Butari.

- **What have you done since medical school?**
  For about a year I worked in Kigali, in the main teaching hospital on the paediatric ward. I then got a scholarship to study a Masters degree in Public Health in Dundee. When I returned I was employed by the Ministry of Health assuming the role of National AIDS Programme Officer. I have not returned to clinical medicine.

In late 2004, I started working with HIV and AIDS to ensure everyone had access. By 2007 I was running the programme on HIV and AIDS. There is a clinical aspect but there is a huge component for the prevention that is non-clinical and happens outside health facilities. The many stakeholders involved in this programme included the UNAIDS and in-country officials. They were very key partners to us and we would see globally what is being recommended.

Now when I plan my timetable I block off time for the children. It is as important as doing my office work. If you are not strict on yourself then you are sacrificing your children and that is something you will always live to regret.

With special thanks to Phil Cotton, Principal of the College, who arranged the interviews.

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**DID YOU KNOW?**

The most valuable tongue is insured for £10m. This man tastes coffee beans and can distinguish between thousands of different flavours.

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Medical Woman | Spring 2016

www.medicalwomensfederation.org.uk
Advice to a new GP...

Dr Michelle Bedford, GP Tamworth

1. Keep in touch with the colleagues you trained with. General Practice can be a lonely career at times. It is helpful to meet other colleagues who are also new to general practice, discuss ideas, educate each other and just let off some steam.

2. There is no right way. Locum, partner, salaried, salaried partner, there are so many different ways to work and none of them are the "correct" one to do when you first qualify as a GP. Just do what feels right for you and what best fits where you are in your life and with your other commitments. The rest will fall into place.

3. Have a special interest. Even with the best will in the world it can be very hard seeing patient after patient, every day. Find something that interests you, whether it is minor surgery, education, contraception or anything else you can put your mind to. It is vital to have an interest to break up the week. This will help keep you refreshed and interested in general practice.

4. Find your release. As in any medical career you will have times of stress and pressure. Have a way to let go – it may be driving home singing at the top of your voice, running along the beach, fast as you can or just shutting off from the world with a good book. You need to keep yourself well to have longevity in your career.

5. Don’t believe the hype. At a time when general practice and the NHS feature so heavily in the media it can be easy to get bogged down with some of the negative press. Focus on your day to day work and do your best you can for your patients. You are doing a great job and the majority of your patients will really appreciate you.

6. Take your time. The first few years as a new GP can be fairly daunting. Almost overnight, you go from having your trainer around to ask and supervise you, to being out there, on your own. Take your time to find your feet and get used to being an independent practitioner. Perfect your true consulting style. Usually, to get to this point you will have been on a conveyer belt of exams, e-portfolios and assessments. Finally, it is ok to spend some time just taking stock and blossoming into the GP you want to be. Enjoy!

Advice To...
How British Women Became Doctors: The Story of the Royal Free Hospital and its Medical School

Author: Neil McIntyre

This book tells the story of those British women who studied medicine, often without the support of a medical school, and who in spite of this gained the qualifications to register as doctors with the General Medical Council. It links these stories with an account of the Royal Free Hospital (RFH) founded in 1828 by William Marsden and of the London School of Medicine for Women (LSMW). LSMW was started in 1874 and had close links with the Royal Free Hospital. This became the Royal Free Hospital School of Medicine (RFHSM) in 1947 when men were first admitted as students.

In addition to the personal stories of the early women pioneers it follows the details of the changes to the Royal Free Hospital, the beginnings of the National Health Service, the links with the Hampstead Hospitals, including the North London Fever Hospital. Through this it acquired the Lawn Road site, which decades later allowed the rebuilding of the main hospital in Hampstead and the move of the hospital and medical school to this single site. Although the hospital continues to flourish, the medical school ceased to exist as a separate institution in 1958 when it was amalgamated with University College London.

Throughout the 20th century the practice of medicine changed both scientifically and politically and the training of medical students developed in parallel with this. Staff of the RFH and students at RFHSM played an active part in these developments in both the training and research carried out at the medical school. I found the account of the years when I was a student at the RFHSM particularly interesting but other sections since then also reflect the wider changes in medicine and society in general.

This detailed history has been carefully researched and is based to a large extent on primary sources. It will be of interest to all who wonder how women entered the medical profession in Britain and gained qualifications that could be registered with the General Medical Council decades before either Oxford or Cambridge were granting degrees to women, or before women had succeeded in entering any of the other established professions. The RFHSM allowed women to gain senior positions within medicine, which was a catalyst for all other medical schools to admit women students.

Now that the majority of students studying medicine in Britain are women, we should not forget this tale.

Reviewer: Dr Rebecca Say, Doctoral Research Fellow, Newcastle University

Iona sank gratefully into her chair and tapped the mouse to awaken the computer from its lunchtime slumber. She was just scaring down the list of names for afternoon surgery – mmmmmm... OK...oh good... OH NO – when her consulting-room door opened and Iain’s face appeared.

“Can I have a word?”

Iona had begun to dread these conversations. She knew full well what he wanted to talk about, and felt uneasy discussing Maggie behind her back. But Iain was already sitting down.

“Well, we’re no further forward. I can’t get her to focus on anything, she just keeps smiling at me and saying ‘Yes, dear’ and showing me articles about the recruitment crisis and nobody wanting to be a GP any more. I know the patients all love her and she loves them, but that’s not the point. Anyway, I’ve got an idea.”

“What?” said Iona, trying not to notice that the computer screen was telling her that the first patient had arrived.

“That really smart locum is in again today. Abbie Newland. Could you have a chat with her and see if she might be interested in the vacancy?”

“But we haven’t got a vacancy,” Iona replied mutinously.

“Not yet, no,” said Iain, standing up, “but it’s only a matter of time. And it would be really good to have someone lined up, oh, informally. Encourage Maggie to wind down. Make her feel wanted. And it would be really good to have someone lined up in Canada. We’re leaving next month. I don’t want to end up like you guys, stressed to death and looking like you’ve been hit with a sandbag every day. But thanks for asking...”

Iona was mortified. She glanced across at her reflection in the wall mirror, and saw a weary-looking middle-aged woman who in spite of the years had picked up, fiddled through, got absorbed in one chapter or another and said, “What a great book!” Several of these people were doctors, statistically some must have been or will be survivors, but it reminded me that domestic and sexual violence is everybody’s problem. This is an excellent and rich resource for any healthcare professional.

Reviewer: Joan Towrell

Succession Planning

The Sequel

Dr Catherine Harkin, GP, Scotland

Illustration by Laura Coppolaro

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