# MEDICAL WOMAN

VOLUME 35: ISSUE 1
SPRING/SUMMER 2016

## WOMEN, GMC & COMPLAINTS HOW WILL YOU COPE?

## A Sanitary Pad Missionary LOVING HUMANITY & AMY PEAKE

## 13 facts about divorce

## SEXISM IN MEDICINE JUST HOW COMMON IS IT?

www.medicalwomensfederation.org.uk

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Dr Angelique Mastihi

# 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:
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## 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 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

## East Midlands Medical Women's Federation: An Electives Evening

**Dr Reena Shaunak (MWF East Midlands Junior Dr Representative)**

On the 30th September the East Midlands MWF ran an evening of talks on elective planning and bursaries for medical students of all year groups. The evening was open to all and attracted around thirty students across all years. There were three talks covering a range of topics and elective experiences. Dr Shaunak discussed planning an elective in the developing world and Dr Ellis spoke about electives in Canada and the USA. Dr Simmonds, last year's winner of the MWF Elective Bursary, debated electives in the UK and gave advice on applying for bursaries. The slides from the evening as well as contact details for the speakers were distributed so that students who did not attend could benefit from the event.

Everyone enjoyed the evening and many students stayed behind to ask questions about arranging their own electives. It was a fantastic opportunity to raise awareness of MWF and promote upcoming events.

## Nottingham University Careers Evening

**Louisa Chenciner, MWF Nottingham University Student Representative**

The MWF careers evening on the 22nd October at Nottingham Medical School was an inspiring and engaging event. The speakers were from many medical and surgical specialties and of various training grades. The evening was open to all medical students at the University of Nottingham and junior doctors working in the local area, and was well-attended by both groups. The programme included a large panel discussion with questions from the organising committee, followed by break out groups in medicine and surgery with opportunities for more informal discussions, questions and networking. I would like to thank the Medical Defence Union for generously sponsoring the event.

## DATES FOR YOUR DIARY

**March 2016**

**National Clinical Excellence Awards are due to open**

**13th May 2016**

**MWF Spring Conference in Edinburgh, "Medicine at the Margins: Creative Solutions to Healthcare Challenges."**
**MWF AGM and Presidential Address will take place directly after the conference**

**14th May 2016**

**MWF Council Meeting in Edinburgh**

**June 2016**

**The MWF Junior Doctor Prize opens**

**October 2016**

**Join MWF now and don't pay again until 2018**

**MWF Elective Bursary opens**

**11th November 2016**

**MWF Autumn Conference in London**

**November 2016**

**Dorothy Ward Travel Fellowship opens**

**December 2016**

**Katherine Branson Essay Prize opens**


# 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.

**On 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 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.

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 fuelled Amy further.

Her next goal was to visit South India to meet the man whose sanitary pad machine inspired her for call for action. Arunachalam Muruganantham showed her his invention – which took her only fifteen minutes to learn the basics of compressing wood pulp through a grinder to make the pads. The resulting fluffy material is then shaped into a mould, wrapped in anti-bacterial fabric and placed under a UV light for 30 seconds to be disinfected. Amy could already envisage such machines being used in camps like Zaatari.

However, the cost of shipping Muruganantham's raw materials from India to Jordan was prohibitive. She needed to rethink this and approached some sanitary pad companies, which she describes as akin to the mafia. All doors closed shut and no-one would speak with her.

Around the same time, a BBC journalist who followed Amy around the camp published her story on the BBC website propelling her vision onto worldwide attention. Such positive publicity resulted in a European Union delegation contacting Amy and her vision is now finally unfolding. Many NGOs have offered to help her and there are at least 50 seriously interested people around the world.

Through her journey, and perhaps her vocation, Amy has founded a charity 'Loving Humanity' to epitomise her philanthropic endeavour of devotion to humanity – it is her way of self-defining her role in the world. The hard work, dedication and passion for finding solutions for the silent and needy women all around the world are the drivers that keep her going.

Most people she talks to about the subject matter are very positive. But now and then, she gets strange remarks; "One Middle Eastern man called me crazy and asked me why I don't just buy them and sell them on?" He had missed the point she stressed. Another man stated, "You really are at the dirty end of it."

Despite the ignorance, she keeps herself focused. Why? "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.**

**TOP TIP**

**Keep eye cream, nail polish and perfume in the fridge to preserve them and extend their shelf life**

# 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**

**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 he medical profession. Despite 61% of doctors under the age of 30 years being female and 46% of those aged between 30 – 50 years, senior women are still in a clear minority. Indeed, in 2015 women made up only 10.5% of consultant surgeons in England.

With such career challenges before them, it is perhaps unsurprising that in my work as a divorce lawyer I meet many female medical professionals facing separation and divorce.

The issues vary, of course, depending on each situation but 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 perhaps more commonly it happens by default, that the wife will prioritise the family over her own career.

Inevitably in a very demanding medical career, particularly at consultant level, the carer 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 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.

### 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 who held the equivalent post but continued to work as a consultant after the birth of their children. Inevitably, therefore, the wife will be able to ask the divorce court to equalise, at the least, the pension funds accumulated during the relationship, and, likely as not, the whole funds the couple have accumulated. Usually this would take the form of a transfer of a share of the husband's NHS fund into the wife's fund. Although this sounds straightforward, complications can arise over different pension schemes within the overall NHS umbrella, and any age gap between the couple can have implications for pension sharing. 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

In 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 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 negotiating a settlement.
- 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.
- Beware of listening 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.

**To contact Liz, please call 01392 210700, email solicitors@stephens-scown.co.uk or visit www.stephens-scown.co.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 9,500 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 between 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, where 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/somep2015.**

# TOPTIPS

**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 panellist 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 "Duties of a doctor." 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.

**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.

**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.

**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.

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.

**5** **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.

**6** **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.

**7** **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 accepted the need to learn from the issues raised. More importantly, if you are able to show evidence from the course or training 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."

**8** **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.

**9** **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.

**10** **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.





# WOMEN AT THE TOP

## Dr Henrietta Bowden-Jones

Consultant Psychiatrist, Founder & Director of National Problem Gambling Clinic, Vice-President, Medical Women's Federation

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

**Dr Henrietta Bowden-Jones** is the Founder and Director of the National Problem Gambling Clinic in the UK, the only NHS service designated for the treatment of pathological gamblers and their families.

She specializes in addiction psychiatry and is Honorary Senior Lecturer in the Division of Brain Science at Imperial College. In 2014, she was elected as Vice President of the Medical Women's Federation.

Her doctorate thesis was on Ventromedial Pre-frontal Cortex Impairment in Alcohol Dependent Subjects as a Prognostic Indicator. Impulsivity, behavioural addictions, decision-making and prognostic indicators in addiction are areas of particular interest.

Henrietta has been a member of the Government's Responsible Gambling Strategy Board since 2009. She is also a Member of the World Health Organisation (WHO) Behavioural Addictions Advisory Group and the Royal Society of Medicine Psychiatry Council.

She is the Royal College of Psychiatrists' spokesperson on Behavioural Addictions and having spent 9 years (2005-2014) as a member of the UK's Executive Committee on Addictions Faculty at the Royal College of Psychiatrists, she is now a co-opted member on the Board. Henrietta also runs the UK Problem Gambling Research Consortium, a group working on projects within the National Problem Gambling Clinic.

Her textbooks A Clinician's Guide to Working with Problem Gamblers and Gambling: Cultural Attitudes, Motivations and Impact on Quality of Life were published in 2015.

**Name:** Dr Henrietta Bowden-Jones

**Approximate age:** (very) early 50s

**Lives:** London

**Medical School:** Pavia Medical School, Italy

**Year Qualified:** 1996

**Speciality:** Addiction Psychiatry

**Place currently works:** National Problem Gambling Clinic, London

**First Ambition:** My role model was Lucy from the cartoon Peanuts. When other children her age were selling lemonade from homemade stands, Lucy's wooden stall in the playground announced the psychiatrist is in. She would sit smiling in a chair, her feet up on the counter, looking totally content and offering advice to school friends on how to overcome difficulties. That image has never left me and I have grown up with Schultz's playground as the perfect metaphor for our world. I was attracted to the ease with which Lucy ran her life and identified with the certainty the character had of knowing where she belonged.

My childhood home was full of books about the mind especially psychology and psychoanalysis. A combination of textbooks and cartoons have led me to my career choice!

**Other Career Related Interests/Roles:** For the past 10 years addiction psychiatry has become my main clinical and intellectual focus. In 2008 I set up the first and only NHS clinic for the treatment of pathological gamblers. It is a busy and exciting place to run and I love it! I have a national role on the Government's Responsible Gambling Strategy Board; a role as spokesperson on Behavioural Addictions for the Royal College of Psychiatrists and a new role on the WHO Board for Behavioural Addictions.

Being Vice-President of the MWF has been a real highlight over the past two years and I have treasured the meetings and the new friendships that have come with this role.

**Challenges along the way:** Setting up a new national clinic is very stressful. I look back on those early years and remember staying up all hours to work into the night trying to do all I could to persuade people this clinic was needed. At times it felt like an unsurmountable obstacle and I needed all the optimism I could muster.

The other big challenge was working for my MD in neuroscience whilst doing a full time job and having young children: I would advise anyone against this!

**Rewards of your role(s):** I really enjoy nurturing the many committed and hard working young doctors and psychologists who are training in behavioural addictions at my clinic. I love to listen to their ambitions and try to offer advice as well as inject some optimism when they feel overwhelmed by interviews and tests. I really love the teaching aspect and insist they all attend my Friday morning ward rounds.

**Inspirations/influences:** Dr William Shanahan has been a lifelong mentor in addictions and the first person I would always discuss career plans with.

Everyone should have a mentor; someone who gives you the confidence to aim high and is there to support you during times of career transition. The true inspiration for me in the world of behavioural addictions came from trips to the US and Canada when the international community of pathological gambling treatment was there to support me as I launched my clinic.

My recent appointments as advisor for the International Society of Addiction Medicine and the WHO Behavioural Addictions board are a direct result of my wish to give back all the help and advice I have benefitted from over the last decade. The world seems smaller and a friendly place when, in each country you have colleagues whose lives are similarly driven by the same interests.

**Quotas for senior positions for women in healthcare – yes or no?** I am not in favour of quotas without the right academic credentials. I think it belittles female achievements.

**ADVICE AND HOW TO GET THERE:**

Have 5 year plans, work towards your goals and make sure all that you do professionally is aimed at getting you to where you want to be.

Find an area of medicine that needs you.

Develop a niche interest and become an expert in that field. There is truth in the 10,000 hours approach.

Show initiative and participate in committees. Network. Join MWF!

Above all, be kind and respect the people you work with, your bosses, your juniors and your admin staff. You will enjoy working with them more.

# Career Focus

**Dr Angelique Mastihi** – Senior Medico-Legal Adviser at MPS

Defence unions train many doctors to become medico-legal advisers, who support, guide and offer assistance in many aspects of medical practice when the road ahead in 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.

Describing her journey from clinical practice into a career as a medico-legal adviser, Dr. Angelique Mastihi says she 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.

## Why did I move?

Taking the plunge, was it scary? Looking back I am not sure it was, although family and friends were worried that I was throwing away a coveted SpR number. But, despite working with great people, something was missing. I just couldn't envisage doing the job for the next 30 years, and I was worried that if I continued, I would become disinterested.

## How did I do it?

So, I applied for a place to study for an MA in Medical Law and Ethics at Kings College. Initially I worked as a locum to pay the bills and later worked as a part-time paralegal for Kennedy's solicitors. This provided me with great experience and confirmed that I had made the right decision. I gave birth to my first child three days after my end of year exams – much to the relief of my fellow students who joked nervously about what would happen if my waters broke mid exam! After successfully completing the degree I took up the post of Clinical Risk and Claims Manager at an Acute Trust, and started putting into practice what I had learnt in theory. It was a useful grounding and after a couple of years, and another child, I moved on to MPS in London.

Although I had already obtained a postgraduate qualification in medical law and had a fair bit of experience under my belt before arriving at MPS, that is not always the case. Defence organisations provide their own in house training programmes and individuals will often study part time for a relevant qualification and for membership with the Faculty of Forensic and Legal Medicine (FFLM) whilst in their training period. The programme is very much an apprenticeship.

The Faculty of Forensic and Legal Medicine was founded in 2006 by the Royal College of Physicians with the aim to develop and maintain high standards of those who practice in forensic and legal medicine. It includes three different groups: Forensic Medical Examiners, Medically qualified Coroners and Medicolegal Advisers (MLAs). The creation of this faculty has been crucial in defining standards within our specialist area.

## 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 a 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.

## Are there any pitfalls?

It is a challenging but rewarding job, helping clinicians through what is often one of the most difficult times in their life and career. As well as the diversity of the requests for advice and assistance we receive, there is also the diversity that arises from the variations in law across the different countries that we operate in and the fact that the law is constantly evolving. Occasionally we also have the ability to influence these changes.

It is important to take a holistic view of the role. This is not just about defending individuals, but also helping them to reflect on what has happened so that lessons may be learned, and whether there are any steps that can be taken to lesson any risk in the future.

The career structure is relatively flat. However, there are plenty of opportunities to develop interests over time, such as becoming a specialist in a specific area of the law or jurisdiction, teaching, training, or writing. Over the 11 years that I have been at MPS I have been fortunate enough to undertake a variety of roles. I have advised members in Malaysia, which provided me with an opportunity to learn about the differences in the healthcare structure and the law compared to our own, and also learn about the culture. I have been Editor-in-Chief for one of our publications, spoken at National Conferences, and represented the MPS at meetings with external stakeholders.

More recently I have taken on a management role overseeing the medical department's service delivery across two of our offices. This has been a great opportunity to develop another side of my practice. I have taken on a leadership role within the division and helped to ensure that we deliver a continued and consistent high quality service, whilst also developing and coaching other colleagues within the team.

Although highly rewarding, the role is intellectually and emotionally demanding and the nature of the work and the travel required means that it can extend beyond office hours. However, there is flexibility and the ability to work from home. Additionally, we provide an on-call telephone advisery service but this is not onerous in comparison to doing a clinical on-call!

### Essential Personal Qualities

- Excellent communication and people skills
- An eye for detail
- High level of commitment
- Effective time management
- Empathy
- Ability to work in a team
- Ability to analyse information and solve problems

## 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 undertake 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, FRCS ED, DMRT, 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 years at Strathallan Castle, which provided temporary accommodation when the school had been evacuated from the city during World War II.

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 radiotherapy and set up home with her elderly widowed mother. She became a consultant radiotherapist 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 largescale 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 revelling 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 orchestras and Scottish Ballet.

Helen remained active in her retirement and was involved with the Edinburgh Society for Glasgow University Graduates, the Royal College of Surgeon's Ladies Club, Laurel Bank Old Girls Club and the Scottish Wild Life Trust.

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.

*Janet Macfie*

# SOCIAL MEDIA for Medics

**By Jon Hinchmore** – Social Media Manager, BMA

**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:

- **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 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

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, 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 good, the bad and the cautionary.

## Pitfalls

Social media is not without its risks. Several members of a private junior doctor Facebook group, set up to discuss the recent contract negotiations, found themselves the subject of unwanted and 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 representatives and their private lives. Which leads me to my first 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 ever more unusual – or dangerous – public locations such as in trees, on mountaintops or in the middle of the street.

So far, so harmless.

## Ethical top tips for social media

*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 helipad.

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).

### 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 cautionary tales, I think there are many benefits of having an active social presence.

Hard though it is to believe, seven years ago the BMA didn't even have a Twitter account, let alone Facebook. These days, the main account has 62,000 followers, plus several other accounts including the press office and a dedicated account for medical students.

All the writers have BMA accounts and the committee doctors often use Twitter and Facebook to communicate. In fact, all things considered, it's hard to know how the organisation ever functioned without a presence on social media (although I would say that, wouldn't I?).

With the real-time reach our communications now have and the speed with which we can disseminate messages to our members, we are more efficient than we have ever been.

## It's not all bad – social media is great too

Want to communicate with a trust at the other end of the country but don't have any contact details? Send them a tweet. Got a rally coming up and want to spread the word? Send a tweet.

Consider the storm last autumn that arose when talks between junior doctors and NHS Employers broke down. The BMA used it to monitor sentiment, to keep up-to-date with grassroots events and keep an eye on government and press announcements. As important as this was for us, it was arguably even more valuable for doctors. A private group set up on Facebook by junior doctors to communicate with one another about the contract dispute found itself with 50,000 members within a week or two of being set up.

Grassroots doctors were able to communicate directly with representatives from the junior doctors committee as well as one another, to organise rallies, coordinate the manufacture of banners and other promotional materials and share stories and experiences via image, text and video.

In short they created a virtual community with far more members, geographic reach and influence than would have been possible in the pre-social media days.

Radical in a different way is junior doctor and dedicated Twitter user Natalie Silvey's Twitter Journal Club. Set up in 2011, the Twitter Journal Club is a virtual study group, which 'meets' every Sunday evening at 8pm on Twitter to critically evaluate and discuss academic articles.

Doctors, researchers, authors and students from every geographic location join in using the #twitjc hashtag (hashtags are a way of filtering messages which makes it easier for users to easily find content relevant to a specific topic). Each discussion lasts for two hours and a summary of key themes from the discussion is circulated at the end.

What I am most impressed by with things like the Twitter Journal Club is that you do not need money, a venue or any special technology (beyond a computer and an Internet connection) to get them going. All that is required is a bit of imagination and a lot of dedication. The @twitjournalclub account has 3484 followers at the time of writing.

## WHAT THE GMC SAYS

The GMC has comprehensive guidance on doctors' use of social media which states explicitly that standards of conduct expected of doctors do not change because the communication is happening through social media rather than face-to-face. It goes on to say that if doctors do want to engage on social media, they should use their real names. This has caused a bit of a stir among doctors who felt it was stifling their right to free speech.

Doctor and author Ben Goldacre worries that the GMC guidelines could 'deny the entire medical profession the right to mutter' and I am inclined to agree with him. As with many things, it comes down to being informed and being aware of the risks, but there is nothing to stop doctors having an active and engaged social (media) life.

**Junior Doctor Competition 2015**

# 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
through 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 howl of the bleep as it calls out
for care, comfort, kindness,
Crash?

Take a breath. Relax.

Tomorrow's coming
You can see it on the horizon
Spotted briefly out the window,
In the dash.

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 manager, a salesman, a detective
Be a friend, a counsellor, a healer
Don't be afraid.

Be mindful to yourself
Pause on that moment
As it passes through.

Now, Breathe In.

Next Patient.





# MWF AUTUMN CONFERENCE

## BUILDING RESILIENT LEADERS on FRIDAY 6TH NOVEMBER 2015

**By Caroline Sheldrick, Ophthalmologist**

**Having just returned home from London, I can truly say that the Medical Women's Federation National Conferences (November and May) are one of the highlights of my calendar. If you have never attended one then you have a treat in store and I would heartily recommend booking for either Edinburgh or London in 2016. They are well organised and flawlessly run with totally amazing speakers and the chance to network with doctors from all specialities and grades. It is so refreshing to take my "ophthalmology blinkers" off for the day and concentrate on medicine from a wider perspective – definitely a worthwhile experience!**

The theme this autumn was "Building Resilient Leaders" and Professor Amanda Howe from the University of East Anglia asked us "Why resilience matters?" It matters because being a doctor is stressful but her 5Cs and 1M formula gave us a helpful coping strategy. Namely: confidence, co-ordination, control, composure, commitment and making adversity meaningful.

Vijaya Nath, Director of Leadership Development at the King's Fund then explained her "Tips on how to become a resilient leader" with self-belief being of supreme importance. She recommended that we all watch the film Tootsie with Dustin Hoffman in which he plays a man learning to be a woman. However, she felt that being proactive, curious, trustworthy and willing to take a risk were key elements for a resilient leader. A "cheerleader" in your corner will also help a lot!!

Niall Dickson, Chief Executive and Registrar of GMC looked at "Safe doctors in a safe system." He explained that this is, of course, a challenge for all of us, especially with rapid developments making our work more effective yet more complex. However, with these developments the potential for danger grows. The audience then had the opportunity to put questions to Mr. Dickson. Many of these questions were poignant and covered a wide variety of topics, and he answered them all!

After lunch we were treated to a whistle stop tour of a "Year in the life of a Royal College President." Dr. Suzy Lishman is one of the seven current female Royal College Presidents. She described her first year as President of The Royal College of Pathologists. I felt exhausted just listening to what she has achieved, and her energy and enthusiasm was infectious. She was a true inspiration.

We were then treated to an unforgettable career interview with Dr Dora Black, a child psychiatrist. Dora is an unassuming lady who showed such humility whilst describing her many achievements. When asked what she was most proud of, she said it was managing to get widowers and children included in the CRUSE bereavement counselling service and establishing a traumatic stress clinic for children. These clinics help children to cope with and overcome psychological trauma. Dora had a particular interest in children who had experienced the murder of one parent by another and established the first clinic of this kind in the UK. Dora also established mother and baby units in prisons to help inmates learn how to care for their babies. She continued working up until the age of 81 years. What a role model she is!

The Dame Rosemary Rue lecture was given by Professor Wendy Reid, Director of Education and Quality for Health Education England. Professor Reid trained in obstetrics and gynaecology and talked about her career and the change of healthcare delivery. In the United States, healthcare screening robots can be found in Walmart! She felt it was important to adapt and respond to innovation altough prevention and quality must remain the key components of future healthcare planning.

Once again, several abstracts were presented by junior doctors: something the MWF is keen to encourage. The winning abstract was "Three Good Things" by Dr Samiramis Saba. Samiramis's abstract followed in the theme of the conference as she looked at how to improve resilience and hence reduce sick leave and improve morale in a group of obstetrics and gynaecology trainees. Her recipe included looking after themselves at home and at work, having lots of sleep, thinking of 3 good things that happened every day, and tea breaks with homemade cakes.

The winning poster was by Ceen Ming Tiffany Tang and entitled Professional Development Through Participation in a Medical Student and Junior Doctor Led Medical Education Project.

The MWF conference dinner was held at the Hilton Hotel near Euston and the after dinner speaker was Clive Anderson.

# MWF AUTUMN CONFERENCE

BUILDING RESILIENT LEADERS ON FRIDAY 6TH NOVEMBER 2015

# 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 men 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 receives the lion's share at 61.1% and the rest goes to team sports.

So is medicine any different? There are few studies in the UK to illustrate the extent of the problem amongst female students and doctors and this study aims to provide some idea of how prevalent sexism is in the workplace.

### 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, yes 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 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 = 165). Of the respondents, 35.5% were consultants, and five were associate specialists (Figure 1).

| | Number | Percentage |
|---|---|---|
| **Age (years)** | | |
| 20-30 | 75 | 22.9% |
| 31-40 | 82 | 25% |
| 41-50 | 38 | 11.6% |
| 51-60 | 59 | 18% |
| >61 | 73 | 22.3% |
| Rather not say | 1 | 0.3% |
| Omitted to answer | 1 | 0.3% |
| **Working Practice** | | |
| Medical student | 27 | 8.3% |
| Part-time | 63 | 19.3% |
| Full-time | 165 | 50.5% |
| Retired | 51 | 15.6% |
| Career break | 6 | 1.8% |
| Other | 15 | 4.6% |
| Omitted to answer | 2 | 0.6% |

Table 1: Demographic distribution of survey respondents

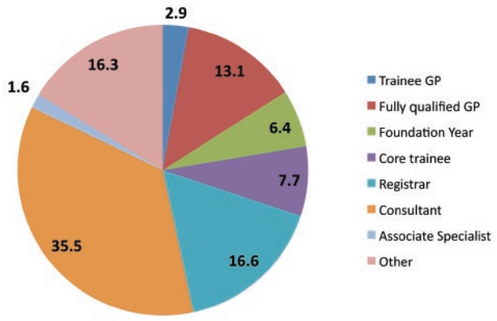



Figure 1: Percentage distribution of respondents by grade

### Childcare

The results showed that 56% of respondents have children and almost 45% 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

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).

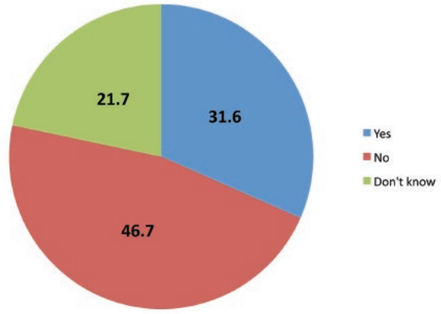



Figure 2: Percentage responses to the question "Do you feel that female doctors are underpaid, and financial rewards inadequate compared to male colleagues?"

### Governing Body

The majority of respondents (n = 149) believe that their governing body supports women equally compared to male colleagues. Six members skipped this question, and 25% said they do not believe their governing body supports them and their male counterparts alike.

### 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.

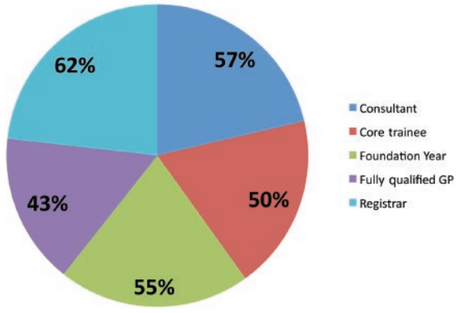



Figure 3: The percentage of each grade who believe that sexuality is an issue for women in medicine

Most women in medicine consider themselves to be a role model for other women in their field (67%) and in general, the percentage of women who believe this increased with seniority. The results show that 91% of consultants, 52% of registrars, 73% of fully qualified GPs, 67% of core trainees, and 45% of foundation year doctors see themselves as role models for other female doctors.

A large proportion of respondents think that the media could do more to promote women in medicine (79%), 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. Table 2 indicates the proportion of each grade that experienced sexism from colleagues and the percentage of each who reported it.

| Grade | Percentage of respondents who experienced sexism from colleagues | Percentage of respondents who reported sexism |
|---|---|---|
| Consultants | 73 | 11 |
| Fully qualified GPs | 54 | 0 |
| Registrars | 48 | 7 |
| Core trainees | 58 | 4 |
| Foundation year doctors | 70 | 5 |

Table 2: The percentage of each grade who experienced sexism from colleagues and who reported it

**Many themes lay at the heart of why respondents did not report their experiences of sexual discrimination (Table 3). A total of 171 respondents provided 184 free text comments, which included:**

*'Didn't want to get a name for being belligerent…'*

*'Would not have been taken seriously…'*

*'Too nebulous…'*

*'…commonplace and accepted behaviour…'*

| Factor | How frequently reported |
|---|---|
| No point | 35 |
| Comments too subtle | 33 |
| Fear of reprisal | 29 |
| Poor organisational culture/ lack of transparency/accepted behaviour | 26 |
| Accept behaviour and keep going | 19 |
| Lack of process for reporting | 14 |
| Fear of being negatively labelled | 11 |
| Personal reasons, including being too exhausted, embarrassed, shy or lucky to have a job | 10 |
| No consequences to perpetrators from reporting | 4 |
| Reporting behaviour unlikely to change it | 3 |

Table 3: Frequent reason respondents gave for not reporting sexist behaviour in the workplace

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

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

**One hundred and fifty-three respondents provided tips on how to handle sexist comments in the workplace and Table 4 shows the common themes that emerged. Comments 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 number…'*

*'…Never, ever cry...'*

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

*'…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…?'*

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 suggested reporting such behaviour, but this was frequently qualified with comments such as '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 behaviour and described how the repercussions were far worse and that she would not do it again.

One respondent felt that racism in medicine was worse than sexism, and another gave the following advice:

'…for a female considering a career in surgery and wanting to have a family would be to have a very nice holiday or go on a shopping weekend and come back feeling refreshed and resolute to choose a different career path. In hindsight, this is what I would do…'

> "Even if women do not expect to face gender discrimination in the workplace, over 60% do so yet only 6% report this"

## 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 discriminationin 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 abound 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 group thinking that prevails with the homogeneity of current leaders. Having more women in leadership positions as well as people from different backgrounds, with different perspectives and experiences, and different lifestyles (not just to reach a number or target), will increase the richness of the workforce. This will help provide a more holistic, rounded care and a better understanding of our patients.

Medicine is a profession where there is no shortage of women, and the environment must be more amenable to them. Women 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

***Acknowledgments:***
***Sarah McLoughlin for her help with survey distribution.***





# 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[1].

**The Royal College of Surgeons of England works to engage women surgeons and 5 of the 36 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 260 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.

**Anu 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 easy camaraderie between other members of the group making it an enjoyable experience overall."*

http://www.kingsfund.org.uk/audio-video/women-and-medical-leadership-infographics

# The Other Side:

## Doctors as Patients

**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 agonizing journey from a healthy, sporty (she is a cyclist and triathlete) professional woman to a cancer patient.

**Blog link - http://liz.oriordan.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 the worst. Most women do. I am the doctor nobody wants to see, and my clinic waiting room is full of fear. Luckily for me, and for most of my patients, those lumps are often harmless.**

### No Learning Curve

In March 2015 I found another lump. Like before, it was just a cyst. A new lump appeared in June, and this time, I was not worried. I waited a month before chatting to my mum, and she said I should get it checked out – just in case. The mammogram was normal. The radiologist then asked me if I wanted to see the ultrasound scan.

I said yes. I turned my head to look, and in that split second, I knew. It was cancer. I was young. I would need chemotherapy. I knew all the side effects of all the treatments, and all the risks of recurrence, metastases and death. Normally, when I break bad news, I do it in baby steps, only giving the patient the information they need or want at that time, and often done over a series of appointments. Not for me.

### Waiting Game

My results were rushed through in three days, and I had MRI and CT scans within the week. There are few benefits to being a doctor, but I was very glad of this one. The two days I spent waiting to get the provisional results were some of the worst of my life. I am still not sure how I got through my clinics and my operating list.

On the way to see the surgeon, I told my husband something a patient had once said: "You know that it's bad news if the specialist nurse is in the room." My patient had come for a biopsy result that confirmed her second skin recurrence, and before I could speak, she said "It's cancer, isn't it?" She knew because the nurse was in the room with me, unlike a previous normal biopsy result when I was on my own. We were called in to see the consultant by the breast care nurse.

### It's not really happening

I was told that I would be having chemotherapy first, followed by a mastectomy and then radiotherapy. The chemo would start in a week. From the moment I had the cancer diagnosis confirmed, I went into self-preservation mode. I was floating above myself looking down on the consultation. It wasn't real. I was trying to protect myself from the cruel reality of having my 'own' disease, being looked after by a close friend and colleague who had trained me, in a hospital where I had worked as a registrar, and where my husband works as a consultant surgeon and had been a Medical Director and interim Chief Executive. I was not a 'normal' patient by any means, and was anxious about whether that would change things.

### Learning to become a patient

Chemotherapy is the one area of breast cancer that I know the least about. I give patients a brief overview of the side effects, and then pass them on to the Oncology team, who look after them until they come back to my care. Now I was about to experience it first-hand.





I have been blogging about what it was like, and for those of you who want to, you can read it here – (http://liz.oriordan.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's right, you get a free underarm and leg wax and a Hollywood (or is it a Brazilian, I never get 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 10-20% chance that your hair won't grow back after chemo.

### "Sticks and stones…

...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 deal with. I have been cajoled into 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," or "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, no cancer 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 make the surreal 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 neutropaenic 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 have 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.

I have treated colleagues myself and know that it can be awkward and embarrassing when asking personal questions and exposing them for an examination, and I know that I have not always done it well. But please, please try to forget who they are, and treat them like any other patient. Things get missed and details get forgotten when you don't. For example, I was not written up for DVT prophylaxis or given TED stockings, which could have had serious consequences.

### Life will never be the same

I don't know what the future holds with regards my work. A lot of my patients work part-time during chemo, and return to full time work during radiotherapy. But I can't. Until I have finished treatment, I cannot mentally cope with treating women with breast cancer, and it would not be ethical or safe, even more so because of my blog and tweets. Whatever happens in the future, cancer will change how I treat patients forever.

### 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 what 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**

# 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 Specialty 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 Prefect; 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**

**When we hear "eating disorders," most of us visualise a teenaged girl, 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 when younger and recovered partially or fully, relapsing later in life. Others were subclinical and able to control their symptoms until midlife. A very small number develop eating disorders for the first time as adults.**

Whatever the pathway, health care professionals need to understand the depth and breadth of these problems in our patients, our peers, and our own profession, as we all share the cultural risk factors contributing to the increase of eating disorders in the 21st century.

### Myth 1. Eating disorders primarily affect young white women.

Body image preoccupation, weight concerns, and eating disorders go hand in hand with aging, and affect women in every developmental stage and demographic group.

Research of multi-ethnic pre- and peri-menopausal women (aged 42-55 years) finds disordered eating common and equally frequent in Black, Hispanic, and Caucasian women. However, due to the misconceptions about who is at risk for eating disorders, non-white women are much less likely to be identified and referred for treatment.

### Myth 2. Once a woman exits adolescence, her risk to develop an eating disorder is minimal.

The peak risk periods for developing an eating disorder are 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? However, in reality I just felt miserable all the time. I thought this only happened to teenagers – not people like me who are 43 years old. Even the doctor said you are too old to be bulimic, or am I?"
– 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 once more at risk. The 30s and 40s come with decisions about marriage, relationships, pregnancy, fertility issues, parenting, and career. Midlife stressors such as multiple role changes, menopause, divorce, loss, and health and mortality add to the normal complications of an ageing body, as wrinkles appear, hair thins or greys, and sexual energy wanes. From youth through midlife to old age, western culture mandates that women control their bodies and "maintain their girlish figure." Now, 75% of women aged 25-45 report eating behaviours or symptoms consistent with eating disorders.

### 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, starting with one category of symptoms and moving to another. Years of starvation may lead to binging and purging. Obsessive exercise may substitute for other symptoms like self-induced vomiting but medical professionals are apt to overlook this purging technique.

### Myth 5. Anorexia Nervosa is the most serious eating disorder.

All eating disorders have serious side effects and mortality risks. Although the low weight of anorexia makes us readily consider malnutrition, an average or high weight body suffering with an eating disorder may be at equal risk due to chronic and chaotic nutritional intake.

The problem is less to do with the specific diagnosis but more the frequency, intensity, and duration of the symptoms and other contributing factors including substance abuse, severe mood and anxiety disorders, and trauma. For example, alcohol abuse increases the risk of death due to medical issues or suicide.

### 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. Dieting 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. Many have very serious longstanding eating disorders despite a weight that is at, or above average, as chronic calorie 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.

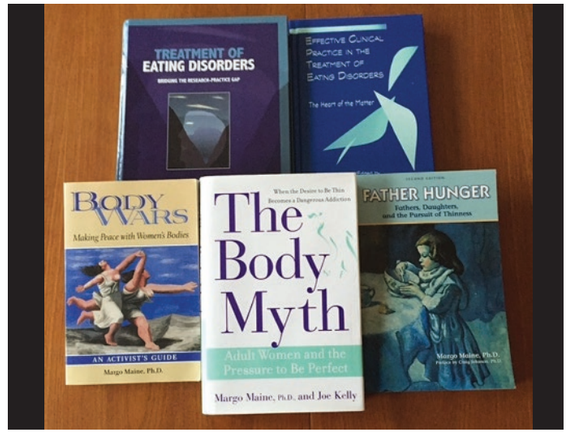
**Myth 10. These are chronic illnesses with little chance for recovery.**

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. Most women are embarrassed and fear being judged if they admit to an eating disorder – they "should know better." This creates enormous barriers to seeking help. The tendency for medical providers to overlook eating disorders and to focus more on the benefits of weight loss due to the increased rate of obesity also creates a professional barrier.

Incorporated into medical assessments, the following questions could launch a productive discussion of the role of food and weight concerns in a woman's life.

- Has your weight fluctuated during your adult years?
- Are you trying to "manage" your weight?
- If so, how?
- What did you eat yesterday?
- How much do you think or worry about weight, shape, and food?

Once a woman is diagnosed, the next barrier is access to care.




She may not have local specialised services available, or she may not be able to take time away from her many roles if she needs more than outpatient care. Women tend to carry the weight of multiple responsibilities for their families, raising children, working, taking care of extended family members, and being active in their communities. Making time for themselves is not an easy task.

For those adult women who come into treatment, most will find relief from the loneliness and isolation of their eating disorder and will gradually begin to make peace with their bodies and with food.

Recovery is a slow process. It also is not a black and white condition – all better or deeply entrenched in the eating disorder. Unlike recovery from substance abuse, the woman cannot just abstain. Instead, day in and day out, she has to deal with food, weight, eating, body image and a culture full of negative and confusing messages about all of these.

Medical professionals play a vital role when they tune into women's eating and body image concerns, instill hope, provide support, and collaborate with other providers, especially the primary psychotherapist, to set reasonable goals and make treatment decisions together.

The take home message is that all medical personnel need to be attuned to the possibility of eating disorders in their adult patients. 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.**

**DISPELLING MYTHS**

**Despite the ban on mobile phone usage in hospitals, no death has been caused by their use & for the phones to interfere in Critical Care, they must be very, very close – median distance of just 3cm**





# IN Conversation:

## INTERVIEW WITH ANITA ASIIMWE

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 our 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 in Scotland. When I returned I was employed by the Ministry of Health assuming different roles. 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 UN Aid who have in-country officers. They were very key partners to us and we would see globally what is being recommended.

As at the end of last year, over 94% of those who needed treatment with anti-retrovirals received it and over 98% of pregnant mothers who need anti-retroviral medication are receiving it. I remember vividly in 2002 we had only four main hospitals in this country offering anti-retroviral therapy. Now we have more than 500 facilities. For us that was very key – you want people to be adherent, you want to cut out all the barriers. People used to believe that you could contract HIV via shaking hands or by hugging. We have drastically improved the general population's understanding of the basics of HIV and reduced stigma and discrimination in our society and encouraged relatives to immediately take care of orphans.

**What is 'Living Positively?'**

It is encouraging people with HIV to speak out. They come out and say 'I have HIV, I've had it for ten years, I've known I've had it for 10 years and my life goes on much the same. I am taking my pills daily and I'm OK. The difference between me and a person who does not have HIV is I take a pill and they don't take a pill.'

**What roles have you held during your career?**

I have served as Minister of State in charge of Public Health and Primary Health Care. I have served at the international level as a board member of the Global Fund for TB, HIV and malaria. I am the vice chair of the strategy committee overseeing investment for impact for the Global Fund.

**How do you achieve work life balance?**

I must say that it's been tough because I am a mother of four – my children are eight, six and three years of age – my eldest died in a car accident. I achieve work life balance thanks to a husband and a mother who understand, support and carry me. I left my daughter with my mother when she was one year and four months to study in Dundee. I knew when I left that when I get back she wouldn't remember me. I got back when she was two years and four months. She recognised my voice as I used to phone her but she didn't recognise me in person and that hit me real hard. I knew I had to make that sacrifice. Luckily we can afford stay in nannies and other help in the house.

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.*

**DID YOU KNOW?**

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

# WHO REPORT DECEMBER 2015

**Dr Clarissa Fabre**
MWIA representative to WHO

One of our contacts at the WHO, Dr Claudia Garcia-Moreno, was the lead author of a recent paper in the Lancet 'Addressing Violence Against Women: A Call To Action' (http://raisingvoices.org/we-ontent/uploads/2013/02/Calltoaction.16days2014.LancetVAWSeries.pdf).

The paper is an excellent summary of the current situation and emphasises the importance of political leadership and government investment as essential components to reducing violence against women. As doctors we are in an excellent position to approach sympathetic politicians who will raise the issue at the highest level and initiate the formation of an effective action plan. The health sector has a crucial part to play in both the prevention of and response to violence against women and children. For too long we have been uncoordinated and have largely sat on the side-lines.

The WHO launch of the Safe Childbirth Checklist (in which MWIA are participating with a pilot in Nigeria), originally scheduled for October 2015, has been deferred. The checklist was devised by the Harvard School of Public Health and funded by the Bill and Melinda Gates Foundation. The aim is to reduce maternal and perinatal mortality. For more details see http://www.who.int/patientsafety/implementation/checklists/childbirth/en

One of the UN Millennium development goals was to cut maternal mortality by 75% between 1990 and 2015. However, only a 44% reduction has been achieved. Only 10 countries (Belarus, Cambodia, Estonia, Kazakhstan, Lebanon, Mongolia, Poland, Rwanda, Timor-Leste, and Turkey) managed to achieve the target.

Two in three maternal deaths now occur in Sub-Saharan Africa, and this is where the major improvements are needed to achieve the new Sustainable Development Goal of reducing maternal mortality. An effective Safe Childbirth Checklist would be a simple and very useful tool to help achieve this.

Twenty experts convened by the Harvard Global Health Institute and the London School of Hygiene and Tropical Medicine published a report in the Lancet recommending that the WHO should be stripped of its role in declaring disease outbreaks to be an international emergency. This follows its catastrophic failure to warn the world of the dangers of Ebola in West Africa last year. The report calls for far greater accountability and transparency within global health institutions. Although there is strong criticism of the WHO, the focus of the report is on shoring up its strengths while farming out crucial decisions potentially influenced by political considerations. When to declare that an epidemic is an international emergency is one of those areas.

# 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 or just let off some steam.

Whether it is attending a "First5" group monthly or having an informal coffee and catch up, it is important to maintain the links with other new GPs in your area. Additionally, you might pick up some good ideas of what might be working well at another surgery and take them back to improve your own.

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 for as long and 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 the 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 conveyor 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!





# The Wall of Wisdom

## TIPS FOR DEALING WITH AN ANGRY PATIENT

Listen. Don't interrupt. Let the patient finish. Angry patients are often like fireworks and will fizzle out after they have had their say.

Helen Goodyear

*Acknowledge their anger calmly.*
*"I can see you are feeling angry/ upset..."*

Alex Murray

Let them speak. Give them enough time and listen. Their grievances are real to them.

R Greenhalgh

Take a breath. Take your time. Try to connect with their underlying need and where the anger is coming from.

Bitty Muller

Remember that the real reason they are angry may have nothing to do with you. Don't take it personally.

Dr Hannah Bonnet, (@mh_evans)

Ask how they think you could help them.

Nandita DeSouza

*Don't be afraid to say you are sorry.*

Alex Murray

What patients want more than anything else is to be heard, their problem acknowledged and for you to make them feel better. Do not get drawn into the 'Doom loop.' Arguing back and forth will only intensify the anger.

Dr Farah Jameel

Don't take it home with you. Use the 3:1 positive: negative - think of 3 positive ways you handled the situation.

Lucy Morse

Take the patient into a separate room where there are no interruptions.

Anon

Stay calm. Avoid confrontation. Apologise if it's due. State your case calmly. Always be honest & polite.

Melanie D

Let them speak and listen without interruptions.

Charlotte Gath

Stay calm; speak quietly.

Sarah Matthews

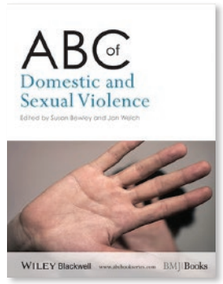
If you cannot defuse the situation, call for help &/or leave the room

Sue Overal

# Book Review:

## ABC of Domestic and Sexual Violence

**Edited by Susan Bewley and Jan Welch**




**The statistics for domestic abuse are a stark reminder that this is everybody's problem: 31% of women and 18% of men experience lifetime partner abuse; 21% of women and 3% of men are sexually assaulted in their lifetime. As doctors, we have a key role to play but we still receive little training about how to do this.**

The ABC of Domestic and Sexual Violence is a comprehensive, practical and accessible guide for health professionals. The chapters cover many aspects of domestic violence and are specialty specific from dentistry to women's health. The many presentations of domestic violence are discussed with safe ways to enquire about it, and what may need to be done on a practical level. Sources of referral and support, completing documentation and information regarding legal proceedings are also presented. The case studies help to portray the reality of this problem.

There are also chapters on vulnerable groups. The chapter 'Children' is important in light of recent high profile cases. The chapter on 'Elder Abuse' is also timely and reminds us that older people are also at risk from family, neighbours and acquaintances. In 'Perpetrators' there is excellent advice on how to approach abusers. We are reminded that, while few come into contact with the criminal justice system, many will present to their GP. These can be difficult consultations and the book provides many helpful suggestions to deal with these. There is also an overview of female genital mutilation, sexual assault of men and boys and the violation of professional boundaries with signposting to additional information and resources.

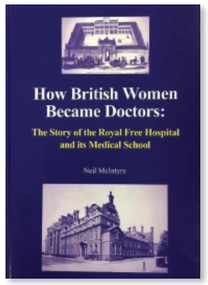
The final two chapters about developing care pathways and the implementation of better services are very positive. An appendix with national support services, charities, campaigning and self-help groups with website addresses is a great resource for busy clinicians who may be unaware of these organisations.

Whilst reading and working on this review, I left the ABC of Domestic and Sexual Violence in a place where anyone coming in to my living room could see it. Without fail, every guest I had picked it up, flicked 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: Dr Rebecca Say, Doctoral Research Fellow, Newcastle University**

## 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 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 1998 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 former 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: Joan Trowell**



# Succession Planning

## The Sequel

**Dr Catherine Harkin, GP, Scotland**

**Illustration by Laura Coppolaro**


*Dr Iona Brock*

**Iona sank gratefully into her chair** and tapped the mouse to awaken the computer from its lunchtime slumber. She was just scanning down the list of names for afternoon surgery – mmm.....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, er, informally. Encourage Maggie to wind down. Make her feel the place is in safe hands."

"Why don't you ask her?"

"Be better coming from you. Woman to woman and all that. See what Abbie says, won't you, and feed back to me?"

The afternoon was so busy that it wasn't until they had slammed the door thankfully behind the last patient that Iona had time to corner Dr Newland. After the requisite chit-chat about patients seen and tests ordered, she managed to pluck up courage to ask the dreaded question.

"A vacancy?" said Abbie, looking puzzled. "Here?"

"Er, yes," answered Iona, feeling treacherous, "might you be interested?"

Abbie laughed. "You've got to be joking. General practice is such a mess, it's far too busy and anyway I've got a job 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 with streaks of grey in her once-lustrous hair and dark bags under her eyes. She suddenly realised that it was a long time since anyone had told her she looked too young to be a doctor. It was time she took herself in hand. She thanked the locum and handed over the cheque, and made her way to Iain's consulting-room and tapped gently on the door.

She had a feeling that "You've got to be joking" was not the response he had been hoping for.

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