Mrs Ann Maxwell
Dr Kim Holt

Dr Rebecca Viney
Dr Susan Kersley
Dr Hannah Gaston

Your five favourite things:
• My three grandchildren
• Walking on the cliffs in Cornwall
• Painting abstract pictures
• Yoga
• Sunshine

Dr Hannah Gaston
A medical woman you admire or respect:
Elizabeth Garrett Anderson who pioneered medical training for women, courageously & effectively. Also because she founded (with others) the Royal Free Medical School, where I trained.
Your five favourite things:
• Babies (especially my newest seven-month old grandson)
• Children (my three older grandchildren & my own grown-up children)
• Reading (anything, anywhere & everywhere)
• Sewing
• Sitting at the seaside

Ann Maxwell
A medical woman you admire or respect:
Professor Helen Cross, The Prince of Wales’ Chair of Childhood Epilepsy for her commitment to childhood epilepsy, her determination to improve outcomes & her relentless & abounding energy that enables her to give so much.
Your five favourite things:
• My husband & three sons
• My home in Scotland & in France
• Entertaining friends & family
• Seeing the world through travel
• I have an absolute passion for fashion

Dr Hannah Aldean
A medical woman you admire or respect:
My mother, who was a specialist nurse in the NHS for many, many years, who managed work, six children, several moves around the country & a surgeon as a husband!
Your five favourite things:
• Chokpeas (I couldn’t really start this list with red wine)
• Lie-ins (sadly a rarity)
• Etymology (especially of the English language)
• Scary movies (it’s a love/hate thing!)
• Football (if only the United team of 1998 would come back…)

Karen Webster
A medical woman you admire or respect:
My line manager, Fiona, who demonstrated extraordinary team management skills in supporting us in our frenetic caseloads. As a result, I have always tried to demonstrate a similar approach to my teams. I believe we are too often quick to criticise but don’t praise or acknowledge good practice readily enough.
Your five favourite things:
• Family & friends
• Chocolate
• Wine (to be shared with the family & friends)
• Exercise (to combat the effects of the chocolate & wine!) & better for having her – a role model to watch as she ascends.

Dr Karen Morton
A medical woman you admire or respect:
Dame Carol Black. She got into medicine via a third class history degree. Her ethos of the importance of work, & her changing of the ‘Sick note’ into a ‘Fitness to work note’ fits well with my own view on life.
Your five favourite things:
• Being outdoors, preferably on my bike or hitting a golf ball
• Chocolate
• Live music of all sorts
• My work
• Sunshine

Dr Kim Holt
A medical woman you admire or respect:
Dr Francesca Silman & Nadia Masood, both of Justice for Health, for their campaigning against the imposition of the junior doctor contract
Your five favourite things:
• Spending time with my children & grandson
• Theatre – especially in London (last amazing experience was Jesus Christ superstar in Regent’s Park Open Air Theatre)
• Love yoga
• Walking on a beach or in the hills

Dr Karen Morton
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.

JOIN US! JOIN US! JOIN US!

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

WHAT YOU GET FOR YOUR MEMBERSHIP FEES:

MWF has to offer.

SUPPORT WITH AWARDS

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

NETWORKING OPPORTUNITIES

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

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

WHAT YOU GET FOR YOUR MEMBERSHIP FEES:

MWF

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.

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Editor’s Letter

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

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

There is a buzz in the air in the MWF office as well, as we approach our centenary celebrations in Spring 2017. I hope that you will join us in marking the centenary and celebrate in Spring 2017. I hope that you will join us in marking the centenary and inspirational medical women of our time who have cut the proverbial umbilical cord with medicine and achieved their dreams with parallel careers, on their terms. The names read like a who’s who: internationally renowned suspense thriller writer, Tess Gerritsen; Channel 4’s Embarrassing Bodies media media; Dawn Harper; Editor-in-Chief of one of the world’s oldest general medical journals – the BMJ – Fiona Godlee; Scotland’s Chief Medical Officer Catherine Calderwood, and style advice from fashion icon Amanda Wakeley. I am very excited about this issue and if you have lost that va-va-voom, then this should definitely re-ignite your passion.

I hope to encourage some of these colleagues to become members and to come to a conference to truly get together.

Meet the Team

Dr Farah Jameel
Dr Henrietta Bowden-Jones
Dr Clare Gerada
Dr Olwen Williams
Dr Heidi Mounsey
Professor Parveen Kumar
Dr Eleanor Checkley, MWF Yorkshire Representative
Dr Sarah McLoughlin
Dr Jyoti Shah, Editor-in-Chief

Contact me: missjshah@gmail.com @missjyotishah

Jyoti Shah, Editor-in-Chief

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 doctors 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
c• 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 Deansaries.

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

Swansea ‘Training as a Doctor with a Family’ Event, June 2016

Dr Carol Sullivan, MWF Wales Chair

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

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

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

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

Airedale Medical Women’s Federation Super Club, March 2016

Dr Eleanor Checkley, MWF Yorkshire Representative

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

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

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

We organised a convivial senior medical women’s dinner at a local restaurant in Skipton, on 9th March so home very quickly, and many colleagues have been really supportive.

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

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

DATES FOR YOUR DIARY

October 2016

MWF Elective Bursary opens
11th November 2016
MWF Autumn Conference: ‘Women Doctors: Equity or Equality?’ at The Light, London
November 2016
Dorothy Ward International Travelling Fellowship opens
December 2016
Katherine Branson Student Essay Prize opens
10th – 13th May 2017
MWF Centenary Celebrations: ‘100 Years of Medical Women: The Past, Present and Future’
that night I had no idea what we were about to embark on; a
he was just four months old. As we rushed him into hospital
Myoclonic Epilepsy in infancy. Muir had his first seizure when
years for our cause.
'punch way above our weight' and our reach is wide, having
one part-time employee. Although we are a small charity, we
Chairman, supported by fourteen trustees. I am the Trust's
families who often struggle to cope. My husband is the Trust's
care 24/7, including personal care.
The work of the Trust has always followed our experience of
raising Muir, providing services we discovered were lacking, but
always finding a funding partner to continue that service once the
need had been established. Our own lack of sleep whilst watching
over Muir meant that we began by distributing potentially
lifesaving epilepsy alarms that alert a parent or carer to a child's
seizure during the night. The use of an epilepsy alarm reduces
the risk of Sudden Unexplained Death in Epilepsy (SUDEP)
and misunderstood but severe epilepsy syndrome is now at the
forefront of epilepsy research because of the cohort group the
Trust we decided to establish the UK's first dedicated genetic
diagnostic service for childhood epilepsy based at Yorkhill
Children's Hospital in Glasgow. The service initially focused on
Dravet Syndrome and the results took just 40 days. Today, it tests
for a panel of epilepsy genes. Over 500 children and young adults
in the UK have now received a confirmed genetic diagnosis of
Dravet Syndrome and world class research has been published
by our MMT funded Fellow, Andreas Brunklaus, on the serious
quality of life issues in Dravet Syndrome. A much unknown
and misunderstood but severe epilepsy syndrome is now at the
forefront of epilepsy research because of the cohort group the
service has created.
More recently the MMT has formed a partnership with
Edinburgh University College of Medicine and Veterinary
Studies to establish the Muir Maxwell Epilepsy Centre (MMEC), a collaborative research centre focused on finding
and addressing causes, cures and the serious quality of life issues
in epilepsy. As part of the University's world class Neurosciences
Service, the head of MMEC, paediatric epilepsy consultant
and epidemiologist, Dr Richard Chin, together with his team,
is leading the way on collaborative research across a variety of
neurological conditions also affecting children, including Autism
and Fragile X Syndrome.
All of these essential services are now established and thriving
and families across the world are benefitting from improved
diagnosis enabling earlier intervention, more effective treatment
and a better prognosis in epilepsy for our children.
They say that an effective charity will eventually make itself
redundant – in our dreams that would be our aim.

Muir Maxwell Trust by Mrs Ann Maxwell

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

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

I am mother to three sons. Our middle son Muir is profoundly affected by Dravet Syndrome originally diagnosed as Severe Myoclonic Epilepsy in infancy. Muir had his first seizure when he was just four months old. As we rushed him into hospital that night I had no idea what we were about to embark on; a journey that would alter the course of our lives forever and that Muir would grow up severely learning disabled, with speech and language difficulties and a prognosis for a short life. Muir will never live independently. He will never work or marry. He requires care 24/7, including personal care.
The work of the Trust has always followed our experience of raising Muir, providing services we discovered were lacking, but always finding a funding partner to continue that service once the need had been established. Our own lack of sleep whilst watching over Muir meant that we began by distributing potentially lifesaving epilepsy alarms that alert a parent or carer to a child's seizure during the night. The use of an epilepsy alarm reduces the risk of Sudden Unexplained Death in Epilepsy (SUDEP) and provides peace of mind, as well as restoring long-lost sleep for families. In the course of ten years, the Trust has distributed approximately 5000 epilepsy alarms at an equivalent retail cost of over £2m.

Other funds raised have provided seed capital for many world class services under the Muir Maxwell Trust banner. The Neville Medical Centre at Young Epilepsy, Surrey, has a diagnostic unit named after the Trust and accommodates state of the art video telemetry funded by us. We also made a significant contribution to the video telemetry service in the new Neurosciences and Neurosurgery Koala Ward at Great Ormond Street Children's Hospital (GOSH) in London, as well as many other paediatric epilepsy centres of excellence across the UK.
The early days also saw MMT launch ketogenic diet clinics in Scotland and fund the arrival of specialist nurses and dieticians in GOSH and Young Epilepsy. The ketogenic diet service has now been pioneered by another charity, Matthew's Friends, and the ongoing funding of specialists has been absorbed by the NHS.
In 2005, Muir's consultant suspected a mutation in the SCN1A gene causing Dravet Syndrome. We agreed to send his DNA to Australia at a cost to the NHS of £2000 and two long years later the diagnosis was confirmed. As a consequence, through the Trust we decided to establish the UK's first dedicated genetic diagnostic service for childhood epilepsy based at Yorkhill Children's Hospital in Glasgow. The service initially focused on Dravet Syndrome and the results took just 40 days. Today, it tests for a panel of epilepsy genes. Over 500 children and young adults in the UK have now received a confirmed genetic diagnosis of Dravet Syndrome and world class research has been published by our MMT funded Fellow, Andreas Brunklaus, on the serious quality of life issues in Dravet Syndrome. A much unknown and misunderstood but severe epilepsy syndrome is now at the forefront of epilepsy research because of the cohort group the service has created.

More recently the MMT has formed a partnership with Edinburgh University College of Medicine and Veterinary Studies to establish the Muir Maxwell Epilepsy Centre (MMEC), a collaborative research centre focused on finding and addressing causes, cures and the serious quality of life issues in epilepsy. As part of the University's world class Neurosciences Service, the head of MMEC, paediatric epilepsy consultant and epidemiologist, Dr Richard Chin, together with his team, is leading the way on collaborative research across a variety of neurological conditions also affecting children, including Autism and Fragile X Syndrome.

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

They say that an effective charity will eventually make itself redundant – in our dreams that would be our aim.
June 19th this year was a normal surgical working weekend for me. I was the house officer running ragged between various surgical specialties, reviewing poorly patients and executing the jobs generated by the weekend ward round. Little did I know that this day would change my perceptions of the health system, our patients and how I would practice clinical medicine in future.

On this particular day I was asked to review a patient who was clinically unstable but without a working diagnosis. Could she have a pulmonary embolism? The patient had a normal CXR, was tachycardic, hypoxic, and had an altered mental state. I discussed this with my seniors, and took blood from her for d-dimers.

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

The following day the microbiologist called me to notify me that the patient was a previously unknown and newly diagnosed case of HIV. My heart sank as this news was being delivered; with my ungloved hand, I tried to re-sheath the needle that had been used. I had to take some time out from work as not only was I feeling constantly nauseated and dizzy from the PEP, but I had been dreary and demotivated to carry out my duties as a doctor. I was also very angry: at her for the risk she posed to me; at my seniors for not supporting me and not indulging my grief; at the system, that had failed me; but mostly at myself for doing what I did. I learnt that we are expected to ‘put up and shut up’. No-one should complain about their exhaustion or discuss the pressures we work under.

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

In spite of taking PEP (an ordeal in itself), I tried to carry on with my daily work and life in a normal fashion. But, I was amazed by the lack of support amongst my fellow colleagues. Everyone kept telling me that only 1 in 300 people are at risk from HIV after a needlestick injury, and therefore I had nothing to worry about. ‘Just carry on; you’ll be fine,’ was a common platitude. But only I knew how hard it was to carry on as though nothing had happened. What if I got HIV? What would happen to my relationship? What about my career? So many questions.

But no answers and very little sleep. There was an expectation for me to carry on with my normal duties without any pastoral support when on anti-rtrovirals, which are notoriously for a high side effect profile. Worst of all was living in fear that I could have contracted HIV in the workplace which would alter my future not only within medicine but within my personal life, too.

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

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

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

While on maternity leave, and grateful for a son who slept a great deal, Tess revisited her childhood passion and began writing. She was instantly rewarded with a first place win in a literary competition. Her book was published soon after. Eight more romantic ‘official’ novels followed before Tess switched gears to write medical thrillers. Her books have repeatedly hit the New York Times best-seller lists and she has written an original screenplay that was made into a film. Her books have been translated into thirty-five languages.

Now a successful, best-selling author, she has a reputation for chilling details, intrigue, edge-of-your-seat, heart-pounding suspense with menacing tension, all richly entwined with careful and meticulous research, cerebral knowledge of medicine and the human psyche; written clearly and effectively. Tess gets into the mind of a killer and under the skin of the reader. Her plots are gripping, her characters compelling, her suspense provocative, and her writing reflects her background in science. Her books are chilling, yet absorbing. Her prose is rich in detail and her dialogue is crisp and engaging.

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

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

“Maura is very close to me. She was supposed to be a
secondary character, but I didn’t have a good vision of who
she was. So, I transplanted myself into her: she went to my
medical school; she drinks my wine; she drives my car; she
plays the piano – she is me. She is logical and scientific.”
The concept of two strong, intelligent, courageous colleagues who have grown to be close friends has proved to be
a successful recipe for Tess. “I try to keep their lives always
evolving – just like real life, and this keeps them fresh. I follow
their stories, and their evolution keeps them interesting. As
long as they are still struggling, there is still a story to tell,”
says Tess.

Tess loves having complete control of her day and being a
multitude of people – an astronaut or an archaeologist. For
her, the best part of being an author is the research where she
learns “such cool and wonderful things.” This is evident in
the masterpieces that she creates, but she is under no illusion about
how hard it is to break into the industry, especially for medics.

“Being a doctor is a hindrance to writing because we learn to
be so objective, but writing fiction requires you to go with
your emotions. It requires you to throw away the objectivity
and just become completely subjective. Scientific writing is
also in the passive voice. As doctors, we say ‘an incision was
made’, whereas in fiction we say ‘he cut the skin’. So, doctors
becoming a novelist have to unlearn a lot of things.”

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

Her advice to medics considering a move into writing is:
- Read a lot
- Stay curious and keep asking ‘what if?’
- Go outside and get some sunshine
- Travel a lot – get a fresh perspective
- Indulge your hobbies in feeding your curiosity
- Hear the voices of your characters
- Let your characters evolve and change
- Learn to develop a protective shell
- Just keep writing...

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

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

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

It is hard to imagine that my parents waved off their only
daughter, alone, to go to a place they could never have dreamed of
and no people they had never met.

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

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

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

Then we come to the arrogance of medicine. It may be that it
is defensiveness, but arrogance seems a more appropriate term to
me. When a medical registrar with a stethoscope slung across his
shoulders emerged from the CCU and told my mother, (who left
me. When a medical registrar with a stethoscope slung across his
shoulders emerged from the CCU and told my mother, (who left
medical school at the age of 14 years), “your husband has a dysrhythmia”
(I say that genuinely as I have been victim to the ‘imposter
syndrome’ all my life) of being head girl, and learning that
I was therefore expected to apply for the school travel
scholarship. Not knowing where to go, my biology teacher
suggested that I go to Tanzania to work in Mwanza with
Dr Richard Evans, an obstetrician.

It is hard to imagine that my parents waved off their only
daughter, alone, to go to a place they could never have dreamed of
and no people they had never met.

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

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

But back then, I have felt frustrated by the increasing regulations;
the prescriptive nature of tones of printed pathways where most
pages are left blank or the enormous waste inherent in policies
aimed at preventing a rare occurrence. Examples would be too
numerous to mention and may seem trivial but include TED
stockings for the timely procedure in healthy and active women;
MRSA screening for caesarean sections; camera covers for a quick
in and out hysteroscopy; I could go on. In my opinion, regulation
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Medical Woman | Autumn 2016 www.medicalwomensfederation.org.uk

Beyond Medicine

Business

Dr Karen Morton
MA MRCP FRCOG
Consultant Obstetrician and Gynaecologist
Royal Surrey County Hospital, Guildford
Founder Dr Morton’s – the medical helpline©

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

My father died.

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

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

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

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

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

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

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

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

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

Dr Sonia Swart
Northampton General Hospital NHS Trust

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

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

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

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

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

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

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

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

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

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

It is notable that many CEOs come through various forms of graduate training schemes and many shape their careers with short spells working in parts of the NHS, which is often overseen and facilitated. Not so for Sonia who recognises that her managerial experience is less than many of her colleagues. Sonia cared for her patients as a doctor and how, as a medical doctor, she now cares about the patients and the staff. For her, the best preparation was watching different people in the role and being an active MD. At a time when CEO turnover was high, it is important to note that the best organisations have stable leadership. "More doctors should become CEOs as they understand services, are naturally inquisitive and have good training in scientific methodology," she explains.

Beyond Medicine

Dr Fiona Godlee

The BMJ, Tavistock Square, London

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

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

After her SHO years, she began a general medical registrar rotation at Whittington Hospital and completed her fellowship of the Royal College of Physicians. It was at this stage that Fiona started thinking about her sub-specialty interest but instead spotted an opportunity to work as a medical scientist at the BMJ. "I suddenly found myself doing something that I really enjoyed," she says.

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

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

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

With a CV that is peppered with extensive experience in the editorial field, Fiona has held many key roles. As Editorial Director for Medicine from 2000 - 2002, she helped establish BioMedCentral, an online open access publisher. She is on numerous advisory and executive boards, which include Alltrials, a project advocating that clinical research adopts the principles of open research and that all trials should be listed and shared as open data, and the Peer Review Congress. Another initiative Fiona is involved in is the International Forum for Quality and Safety in Healthcare, which is now in its 21st year. This biannual meeting is jointly organised by the Institute for Healthcare Improvement and BMJ, with the ambition to improve healthcare and outcomes for patients. Other enterprises include Evidence Live, Preventing Overdiagnosis, and the cross-professional, international initiative, the Climate and Health Council, an organisation that recognises the urgent need to address climate change to protect health and
amongst patients admitted to NHS hospitals during the weekend, safety of paroxetine in adolescents. She has also taken a firm against US dietary guidelines, the efficacy of Tamiflu, and the of controversy. Under her direction, the BMJ has crusaded is reported. A firm believer in transparency, Fiona is not afraid her precious home audience.

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...something that appeals to the readership and presenting it in a cogent way. She loves "creating debate."

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

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

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

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

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

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

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

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

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balanced life. They realised that what they dreamt of doing was within their grasp. I shared my own experiences, if relevant, but no longer assumed that my way is the only way because, instead, I was a catalyst for people to make changes in their lives.

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

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

Coaching tips for female medics

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

Avoid the following:

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

Finally, my BMJ/Career Focus articles evolved into books and audiobooks, personal development books for doctors, self-help books and novels.

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

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

By Jenny Rogers and Arti Maini

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

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

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

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

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

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

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

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

Reviewer: Ms Beryl De Souza

The first speaker, Dr Christine Goodall, experienced so much violence in the course of her practice that complicates medicine – the draining of energy, insight and resources being called into play in “professional” and “patient” roles.

There were lots of prizes and the Katherine Branson Essay prize winners were Miss Helena Fawdry and Miss Karthika Velasamy. Over lunch, seven medical students and doctors presented poster abstracts on various topics and the Elizabeth Garrett Anderson Poster Prize was awarded to Alison Howe for ‘Together We Can End Female Genital Mutilation’.

The joint winners for the Elizabeth Garrett Anderson Oral Presentation went to Dr Jacqueline Andrews for her wonderful talk and poster ‘The Leeds Female Leaders Network- Partnership Working in Action’ and Dr Yesim Karapinar for her engaging presentation on ‘The Treatment Room: Prepared Procedure specific “Trays”.

The next speaker, Ann Maxwell, shared her personal story of setting up the Muir Maxwell Trust (MMT), named after her son Nairt, who had his first seizure at the age of four months leaving him profoundly disabled. Muir is 19 years old and has had his first seizure at the age of four months leaving him profoundly disabled. Mrs. Maxwell stressed the clinical need for improved epilepsy management and highlighted the simple truths that complicate medicine – the draining of energy, insight and resources being called into play in “professional” and “patient” roles.

Dr Philippa Whitford, a Locum Consultant Breast Surgeon, and as of 2015, MSP for Central Ayrshire, was told in her third year of medical school ‘nobody wants to be a breast surgeon’. She said, ‘For the first four hours I thought they were just winding me up’, she said. Naturally, she became a surgeon. Dr Whittard spoke about getting the female voice into politics, and talked the audience through her fascinating career treating breast cancer in Gaza, arriving to the UK in 1991 and returning to Gaza in 2016, an awe-inspiring story. She gave an eloquent testimony detailing the impact of politics on the survival of women with one of the most common cancers.

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MWF DINNER
13th May 2016, Edinburgh

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

In true MWF style, the dinner was another opportunity for members, their spouses and guests, to enjoy each other’s company, establish new connections and catch up with old friends. The Fabre family were certainly the winners in terms of numbers – Clarissa’s husband, daughter and son-in-law all came to the dinner. We were honoured that so many of the Scottish in-law all came to the dinner. We were Clarissa’s husband, daughter and son-in-law – the winners in terms of numbers – and friends. The Fabre family were certainly new connections and catch up with old friends. The tunes also reflected the local description of being belly flopped in farmyard squabble!

Many thanks to all the organisers of the wonderful dinner and entertainment, and a special mention for Jyoti’s long suffering husband (Paresh), our MWF patients, choosing to “eat black forest gateau and die.” Another highlight was our two Welsh officers, Sally and Olwen, letting their hair down in a rendition of shrieking Welsh goats – apparently the uninitiated in high culture; to the uninitiated in Welsh, like me, easily mistaken for a farmyard squabble!

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

After returning to surgical practice, I eventually took the opportunity to continue on my journey in the wider healthcare system, and I applied for a specialist role in healthcare consulting. In my current role at McKinsey, I have the privilege of working with some of the most interesting people from around the world on some of the most important challenges in healthcare, and that is what now drives me. It is a role in which you work alongside organisations to explore both the difficulties and the opportunities that lie within our complex health systems; defining the challenge ahead, learning from local and global examples of excellence, developing solutions and implementing change.

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

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

Beyond Medicine...

Management Consultant

Dr Hannah Aldelan

Making God laugh. So here it is, my life plan at age 15, in no particular order:

- Move to France
- Have 7 children
- Become a surgeon

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

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

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

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

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

Media Medic

Dr Dawn Harper
MBBS MRCP DCH DFFP

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

Educated at the prestigious Bath High School, where she enjoyed and excelled in languages as well as science, Dawn trained at Charter Cross and Westminster Medical School. After completing her hospital training and becoming a member of the Royal College of Physicians, she chose to become a GP. As the only female partner in her practice, she naturally started to see the majority of patients with women’s health issues and obtained a Diploma of Child Health and a Diploma of the Faculty of Family Planning. It was after she responded to a query from a magazine journalist that the seeds of her media career were sown. She has since become a household name. She still continues to work as a part-time GP in Gloucestershire as her media career has gone from strength to strength over the years. She now also presents an accompanying series, Embarrassing Bodies: Live from the Clinic, which was first aired in summer 2011 and featured Dawn giving live consultations to patients in the comfort of their homes using Skype, a technology that she believes many GPs could use in their daily work.

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

As though clinical practice, public speaking, and regular television and radio shows are not enough to fill Dawn’s working day, she has written a series of books under the banner of Dr Dawn’s Health Guides on subjects that include heart health, digestive health, diabetes and many others. A wonderfully warm, kind, friendly and hugely energetic and passionate person, Dawn is well placed to advise medical women about how to become a media medic.

Jyoti Shah

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

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

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

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

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

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

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

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

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

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

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

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

TOP TIP
Hold a steam iron above a dent in the carpet (from say, heavy furniture) and
steam onto the dent – the carpet fibres should spring back very quickly.
Mind you don’t touch the carpet!
Mentor

Dr Rebecca Viney
Rebecca Viney Associates, London

How I became a champion of mentoring

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

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

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

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

Dr Bitty Muller, one of my mentors, once described a woman’s career as being less of a ladder and more of a garden. We recurrently meet at the garden, nurturit and then climb back on the ladder. This has been my experience and I have loved it.

When I left my first GP partnership in 1995 I realised that locus and GP salaries had no contract, expansion, no CPD and were invisible. This seemed a senseless waste of the workforce. Within three months I found 400 of these doctors, just in north east Thames. In the months that followed I became the second chairman of GP non-principals in the NHS.

I have set up a not-for-profit company, Rebecca Viney Associates, to pay those who run coaching, mentoring or training courses over a minimum of 3-4 days. Look for a structured course run by a faculty that combines an expert coach, who has trained in coaching and mentoring over a minimum of 3-4 days. Look for a structured course run by a faculty that combines an expert coach, who has trained in coaching and mentoring over a minimum of 3-4 days. Look for a structured course run by a faculty that combines an expert coach, who has trained in coaching and mentoring over a minimum of 3-4 days. Look for a structured course run by a faculty that combines an expert coach, who has trained in coaching and mentoring over a minimum of 3-4 days. Look for a structured course run by a faculty that combines an expert coach, who has trained in coaching and mentoring over a minimum of 3-4 days. Look for a structured course run by a faculty that combines an expert coach, who has trained in coaching and mentoring over a minimum of 3-4 days. Look for a structured course run by a faculty that combines an expert coach, who has trained in coaching and mentoring over a minimum of 3-4 days. Look for a structured course run by a faculty that combines an expert coach, who has trained in coaching and mentoring over a minimum of 3-4 days. Look for a structured course run by a faculty that combines an expert coach, who has trained in coaching and mentoring over a minimum of 3-4 days. Look for a structured course run by a faculty that combines an expert coach, who has trained in coaching and mentoring over a minimum of 3-4 days. Look for a structured course run by a faculty that combines an expert coach, who has trained in coaching and mentoring over a minimum of 3-4 days. Look for a structured course run by a faculty that combines an expert coach, who has trained in coaching and mentoring over a minimum of 3-4 days.

In 2002-2006 I led the Flexible Career Scheme in London which was devised and launched to retain the workforce. Over 400 GPs joined and it helped people at all stages of their career to have flexibility, a portfolio career, and to feel valued.

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

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

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

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

I now have two passions. Firstly, to embed the coaching and mentoring approach throughout the NHS including primary care, secondary care and the communities that they serve. Secondly, I plan to harness doctors and other healthcare workers in their last five years in the ‘expert’ stage of their career, to consider using their expertise, knowledge and innovation in different settings and contexts after they retire from the NHS.

I would like this cohort of professionals to continue to learn and to do things that they feel passionate about. This is an opportunity to do things that they never imagined they could do and to achieve the best work-life balance.

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

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

What is mentoring?

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

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

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

What is it not?

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

Why is it important?

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

How do you become a mentor?

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

Where can you get a good course?

I commission providers to roll out coaching and mentoring courses over a minimum of 5-4 days. Look for a structured course run by a faculty that combines an expert coach, who has trained thousands of doctors, working alongside a doctor who is an educationalist and coach. This combination is powerful. It takes two to two to get the mind-set change and a further day to embed the approach after practice on real clients. Institute of Leadership and Management accredited courses are preferable.

What makes a good mentor?

This requires a combination of core skills and qualities.

Core skills

• Active listening – the ability to engage with and respond to what the client is saying. Listen to what is being said and manage distractions.

• Observation – the client will at times display much of what they are thinking or feeling using their body language. The mentor should notice this, especially when there is a mismatch between what is being said and the non-verbal cues that are being displayed.

• Questioning – the ability to use questions to help the client to develop their thinking and to explore the issue/topic in depth.

• Challenge – the mentor must be able to challenge the client’s thinking either through questioning or through observation and comment.

• Feedback – providing specific and constructive feedback is a necessary part of helping a client to develop.

• Reflection – the mentor needs to practice reflection and to foster a reflective perspective in their client.

Mentor Qualities:

• A high level of self-awareness is essential so that a mentor is aware of their own reactions and weaknesses in order to manage the impact of these on the mentor – client relationship. It is one of the reasons that supervision is essential.

• A genuine interest in others and a passion for helping them to develop, as the focus of the discussion will be on the client’s issue work this.

• An open and approachable style that the client feels that they can trust the mentor and feel safe to say what they really think. Creating that rapport is central to successful mentoring.

• Humility. An excellent mentor will never consider that they have learnt everything and will always be looking for new challenges for themselves. They will foster a relationship of equals with their clients.

• Integrity. The client should feel that they can believe in and trust the mentor and that there has to be a degree of transparency with no hidden agenda.

• There should be an explicit commitment to confidentiality. Coaching and mentoring are part of the same continuum. The objective of both is to facilitate the client so that they are able to develop personally and professionally.

What does a quality mentoring service look like?

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

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

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

Where do I find a mentor?

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

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

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

Some definitions:

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

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

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

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

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

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

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

Blocking – this prevents someone from following you.

1. Customise your profile

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

2. Privacy settings

Remember that everything you post is public! Twitter is great for debate and discussion but you are speaking to an audience. Remember that everything you post is public! Twitter is great

3. Use your 140 characters wisely

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

4. Keywords

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

5. Lists

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

6. Frequency

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

7. Hashtags ($)

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

8. Stay “on brand”

You might be really excited about that delicious lasagne you’ve cooked for dinner; not so for your followers. Only tweet what’s relevant to your audience.

9. Schedule your tweets

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

10. Get to know your fellow tweeters

Twitter is a great way to meet other medics. Dive in and engage with other tweeters, start a conversation or join in the debate. It’s called ‘social’ media for a reason.

11. Repeat yourself

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

12. Engage followers

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

13. Images

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

14. Direct Message (DM)

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

15. Beresponsive

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

16. Retweets

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

17. Tweet etiquette

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

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

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

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

1. Build your wardrobe around pieces that you wear all of the time. Don’t force a look that isn’t really you.

2. Get rid of things that you never wear – they just take up space in your wardrobe and it becomes difficult to create quick looks in the morning. As a rule, if you haven’t worn it in the last year, then you probably never will.

3. Whatever you wear, you must be comfortable.

4. Try using a single outfit in many ways – put a jumper over a dress to use it like a skirt.

5. Try to buy the best quality that you can afford.

6. Different colours give off different impressions:

Black – makes you look thinner and gives an air of authority

Grey – this colour exudes sophistication and confidence

Navy – calm, control and loyalty

Purple – another sophisticated look and one that epitomises wealth and luxury

7. Wear a silk blouse or silk scarf with a suit to soften the look and feel good all day.

8. Avoid anything too low cut or too tight when choosing a top.

9. Use accessories to bring your outfit to life – a belt, brooch, or simple jewellery. A good watch is an investment as it is an expensive bag.

10. What size heel? The answer is simple – one that you will feel comfortable in for the working day. A medium heel will lengthen your legs and so you will walk better.
Ruth Bensusan-Butt, known as Ben, was born in Surrey in 1877 and was one of five children. On learning that as second daughter she would be expected to care for her parents, she enrolled at Sydenham High School for Girls and was the first student there to sit exams.

As the first woman doctor in the town, it was not easy. She visited every doctor and left her card but only got two replies. There is a lovely story of a doctor’s wife recounting how her husband was shocked that Ben saw male patients. Ben’s reply was typical: ‘If your husband gives up his women patients, I will give up my men.’ She notes in her diary that she only had two patients and they were just curious.

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

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

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

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

Ben was a founder member of MWF and founded the Colchester branch and was President of the Colchester Medical Society (the second oldest in England) in 1934. She retired at the age of 77 years, continuing a few appointments and her many donations for the garden of the house where she brought up her family and which was responsible for workhouses and ‘boarded out’ children.

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

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In 1916, whilst playing croquet, her left foot started to drag, the start of a stroke. She recovered sufficiently to return to work, but died after breaking her femur. Her ashes were scattered in the garden of the house where she brought up her family and which was responsible for workhouses and ‘boarded out’ children.

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

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

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

She set up practice in a number of venues before finally, in 1915, moving to The Minories, a large house in the centre of the town. As the first woman doctor in the town, it was not easy. She visited every doctor and left her card but only got two replies. There is a lovely story of a doctor’s wife recounting how her husband was shocked that Ben saw male patients. Ben’s reply was typical: ‘If your husband gives up his women patients, I will give up my men.’ She notes in her diary that she only had two patients and they were just curious.

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

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

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She set up practice in a number of venues before finally, in 1915, moving to The Minories, a large house in the centre of the town. As the first woman doctor in the town, it was not easy. She visited every doctor and left her card but only got two replies. There is a lovely story of a doctor’s wife recounting how her husband was shocked that Ben saw male patients. Ben’s reply was typical: ‘If your husband gives up his women patients, I will give up my men.’ She notes in her diary that she only had two patients and they were just curious.

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

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

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

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

Ben was instrumental, with her partner Dr Gwyneth Hugh-Jones, in setting up the Colchester Maternity Hospital. She attended home births, started ante-natal clinics and referred those with normal pregnancies to their GPs.
As the UK Coordinator for the Medical Women's International Association (MWIA), I was delighted to attend the Central Asia Regional Congress in Kolkata (formerly known as Calcutta) in December 2015. The conference was organised by the Association of Medical Women in India (AMWI) and I was graciously invited by Dr Usha Saraiya, whom I previously met at the North East European Congress in Copenhagen in September 2014.

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

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

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

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

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

The Mission Hospital is keen to receive any donations of money, or equipment specific to obstetrics and gynaecology.
A year or so ago, I began to have increasing difficulty in my right eye. This was more noticeable with my mono-vision contact lenses, where I used my right eye for distance, than with the varifocals I used in the evenings. I knew that I needed more light and more contrast than my juniors, but attributed this to my age. At my annual contact lens check that year, the optometrist seemed to take a long time over the refraction and studied my right eye intently with her ophthalmoscope. Then she dropped the bombshell. There was a lens opacity – an early cataract – in my right eye.

On my way home, an internal dialogue developed fast and furiously: I CAN’T have! Patients have cataracts, not me. I’m finished. I mustn’t let anyone know. I won’t be able to operate now. Why? Why me? Why my dominant eye, etc. I was 51 years old; not diabetic; there was no family history; there was no trauma to my eye. I told no-one for the first few months, but came to realise that a minor change in my prescription would make a difference to my ability to perform.

It was an effort, after months of silence, to start telling those who needed to know. Although I was advised to stop performing intraocular surgery I continued to work. Knowing that it would soon be “my turn” made advising patients about cataract surgery and talking through them more difficult. I was not a teaching consultant and the opacity had increased and the vision in my right eye had deteriorated. It was therefore a huge relief to be offered private care for free. I grappled with this decision as well, as I had always been very happy with NHS care.

I opted to have surgery under a local anaesthetic block, but felt a complete wimp for not being up for the much newer, topical procedure, where only drops are used. I felt a little better when a friend told me that she would have a general anaesthetic, but I had the impression she was fairly young and fit. I felt it was rather different for me as my future employability was at stake.

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

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

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

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

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

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

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

By day six after my operation, I was much more comfortable and able to catch up on patient information. A nurse, who I knew anyway, was back in the swing of a busy clinic and in contrast, my colleagues were often more cavalier in their advice.

The importance of touch
I am not really a touchy-feely person, but the hand shake from my surgeon when he saw me just before surgery, and the way my eye was held – reassuringly – by the anaesthetist, were immensely comforting at a worrying time. After this I have tried especially to do the same for my patients.

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

The worst were those who added to the burden by saying things like “the other eye will go, you’ll need a laser capsulotomy and so on”. I knew all of this. But at that time I was thinking about the operation, which was worrying enough. One colleague made me call the College to find out whether they would sanction my operating afterwards. I would have had it done for it if you were another consultant colleague suggested I might have to. Nevertheless, I discovered the hard way, that recovery was not quite as instantaneous as some of my colleagues made out and that rehabilitation for “young and fit” patient could be harder than for the average over seventy year old cataract sufferer. Like any other operation, this one can also have risks and inconveniences and does not restore complete normality.

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

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

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

Hannah Gaston DM FRCOphthal surgeon
Dr Hannah Gaston is a retired Consultant Ophthalmologist who trained mainly in Hampshire. She is married with four grown up children. Dr Gaston wrote this previously unpublished article many years ago when she was an ophthalmology associate specialist. The article is an account of her experience as a clinician having surgery in her own specialty. Writing the article, as stated by many others who share similar experiences of being a medical patient, helped her to get this episode out of her head and therefore to move on.
In 2012, Patients First co-organised a conference on whistleblowing hosted at BMA House – a watershed moment in the campaigning journey of Patients First(1). Patients First is a network of campaigners, who came together in December 2011 to raise awareness about the failures of the health service and to protect those who spoke up about poor care. Personally, I gave evidence to the Mid Staffs inquiry team on the challenges of speaking up, and Patients First provided data to Blueprint for Free Speech, who examined the evidence of our concerns about the failures of whistleblowing legislation, as well as to the Health Select Committee(2-3). The Blueprint report confirmed what many of us felt: that the Public Interest Disclosure Act (PIDA) does not actually protect a whistleblower from retaliation before it occurs, even though it was created by Parliament to protect whistleblowers from detrimental treatment, victimisation or dismissal from employers as a result of whistleblowing. This is no longer in doubt and was acknowledged in the conference in BMA House.

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

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

During my absence, Peter Connelly was seen by a locum consultant paediatrician, Dr Al-Zayyat, who was inexperienced in the field of paediatrics, and raising concerns session 2014-2015. Published 21 January 2015.

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

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

When we spoke at the BMA whistleblowing event we hoped that the union would align behind the campaigners for a change in legislation, so that the current ‘under protection’ of whistleblowers would be remedied. Sadly, despite the Chair of Council agreeing that the law fails to protect whistleblowers, the BMA have since remained silent. Patients First has campaigned the department had seemingly lost its humanity. The hospital had tried to hide the health failings as part of the serious case review(4).

In the aftermath of Peter Connelly’s death, I commented that the department had seemingly lost its humanity. The hospital did not seem to care about standards of patient care, but those in authority were ruthless against anyone who had either made a mistake or tried to speak the truth to senior managers. I began to think that I was mad in raising these issues. But, I am now sure. There were also some very real questions about whether Great Ormond Street Hospital had tried to hide the health failings as part of the serious case review(4).

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

My personal campaign has been to raise awareness in the workplace about the impact of bullying on teams, and the associated negative outcome for patients. This was acknowledged by Sir Robert Francis in the Freedom to Speak Up review(5). Although statements have been made, such as that by the Secretary of State regarding a zero tolerance of bullying, they need to be followed through with tough penalties for those who subject staff to humiliation and suffering(6). What can we do? Backing the Patients First campaign and lobbying unions and politicians to bring about effective change is a good start.

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Dr Kim Holt
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Women at work

THE BALANCING ACT

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

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

STANDING

• Stand tall. This will instantly make you look younger!
• Keep your shoulders back and relaxed
• Pull in your abdomen
• Keep your feet apart at hip distance
• Think of your head over your shoulders; your hips over your knees and ankles

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

DESK WORK

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

TIP:
• Do not dangle your legs or cross them
• Adjust the chair so your hips and knees are at 90 degrees of flexion
• Rest your feet flat on the floor
• Keep your elbows at your sides and keep your forearms resting on the desk
• Don’t reach for the mouse
• Keep the top of your screen at eye level and slightly tilted up so you only need to move your eyes to view the screen
• Keep your head straight
• Sit about 10in away from the screen and face it directly – no twisting

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

KILLER HEELS

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

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

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

HAND BAG

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

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

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

MOBILE PHONES

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

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

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

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

PREGNANCY & BREASTFEEDING

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

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

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

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

The Handbag Diet:

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The Handbag Diet:
WHO REPORT - JUNE 2016

Dr Clarissa Fabre – MWIA representative to WHO

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

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

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

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

At one of the fringe events on Women and Leadership, we heard Dr Margaret Munghera, a psychiatrist from Uganda and a former president of the WMA, give outstanding talks about setting up Hope after Rape with eleven other women doctors in 1994. Encouraged at the time by Dr Shelley Ross to form a women doctors’ organisation in Uganda, Dr Munghera said that universal primary education has made a huge difference in her country, but that the challenge is keeping girls in school as early marriage and unemployment is both one of the causes and consequences of conflict, and is an urgent global crisis. Conflict poses a huge burden on women and has a major impact on the future psychological and physical well-being of children. It is important that education is available for children in conflict situations. We saw a very moving montage showing the effects of attacks on health workers and health facilities.

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

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

After qualifying from Trinity College, Dublin, she met and married Dr Thomas Bewley and they moved to England to return to England after the war.

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

In her private life, family, friends and music were of the greatest advantage both as role models and for career connections, and supportive colleagues were some of her most fulfilling years. Her strongest point, and the waiting was not making her any easier to deal with. So Iona’s heart sank as she surveyed the array of Portakabins, fences, diggers and other industrial-looking objects that now occupied the space where the car park used to be. A tiny sign that said ‘Temporary Car Park’ pointed them towards the back of the hospital where Iona joined the queue of cars, buses, taxis and the occasional bicycle that was slowly snaking its way past the main door, hoping against hope that they might still be able to crawl forward.

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

"Is it all right?" said a distant voice anxiously. "Of course she’s all right", snapped her mother’s non-dulcet tones. "Sorry to disturb you, love, but you’re causing an obstruction," said the attendant, gesturing to the stationary bus behind Iona’s car. "Of course she’s all right", snapped her mother’s non-dulcet tones. "Iona’s Wake up!"

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

"Sorry to disturb you, love, but you’re causing an obstruction," said the attendant, gesturing to the stationary bus behind Iona’s car. "I’ll show you where to park; then you can help your mum." The minutes on the car clock ticked relentlessly towards the appointed moment. But as she turned her car into the hospital grounds, a new obstacle presented itself.

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

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

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

“At this rate were not going to make it, Mum,” said Iona. “Why don’t you just hop out and go along to out-patients and I’ll come and find you once I’ve parked!” Iona was aware even as the words passed her lips that this proposal included a number of events that were unlikely in the extreme, such as her mother hopping anywhere and herself finding either the out-patient entrance, her mother within the hospital, or a parking space during visiting hours. But Professor Forth-Bridges was already out of the vehicle and heading for the main door. Iona turned on the radio. Soothing music filled the interior of the car, as the queue continued to crawl forward.

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

“Is it all right?” said a distant voice anxiously. "Of course she’s all right", snapped her mother’s non-dulcet tones. "Iona’s Wake up!"

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

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

OF MEDICAL WOMEN:
THE PAST, PRESENT AND FUTURE

A SERIES OF CELEBRATORY EVENTS TAKING PLACE ACROSS LONDON

Wednesday 10th - Saturday 13th May 2017

CENTENARY EVENTS:

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

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

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

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

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

REGISTRATION OPENS FROM SEPTEMBER 2016

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SOCIAL EVENTS:

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

OTHER EVENTS:

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

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