

# MEDICAL WOMAN

VOLUME 34: ISSUE 2  
AUTUMN/WINTER 2015



**WHAT  
KIND OF  
PATIENT  
WOULD  
YOU BE?**

**10 Steps  
to Success...  
THE LILANI WAY**

**Special Report:  
GMC & RCS  
IN NUMB3R5**

**KAREN HOUPPERT  
BREAKS THE CURSE**

[www.medicalwomensfederation.org.uk](http://www.medicalwomensfederation.org.uk)

# Contents

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the Medical Women's Federation**

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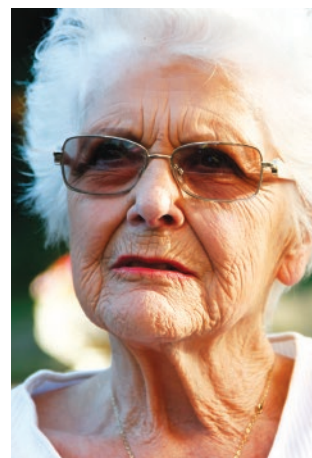
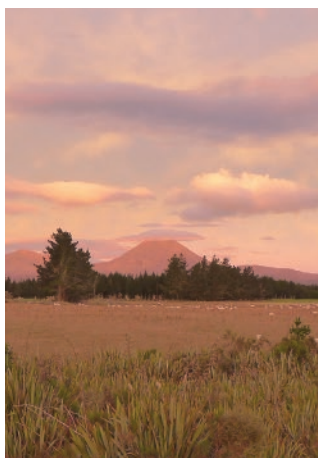
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This issue's cover Rebecca Southall,  
photographed by Paresh Solanki  
[www.lifeView.media](http://www.lifeView.media)



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# Contributors

AUTUMN 2015



Professor Karen Houppert

## Professor Karen Houppert

Taboo Topics, page 22

### A medical woman you admire/respect:

My GP Mari Blackburn, who despite her time pressures, is never rushed & always spends time to ask if I am exercising, getting enough sleep, & generally touching base. In the US, with the pressure insurance companies place on doctors to see as many patients as possible, she bucks a trend.

### Five favourite things in life:

- Cats and kittens
- Glastonbury festival
  - Cheese
  - Books
  - Summer



Mrs Pinky Lilani

## Mrs Pinky Lilani

Women of the Future, page 6

### A medical woman you admire/respect:

Miss Fiona O'Sullivan, Ophthalmologist – she is so approachable, happy to chat & does not make you feel she needs to see the next patient immediately!

### Five favourite things in life:

- Eating out with my family & entertaining at home
- Receiving hand written notes
- Reflexology
- Seeing a matinee film during a working day
- A cake with lots of custard



Professor Neena Modi

## Professor Neena Modi

Women at the Top, page 8

### A medical woman you admire/respect:

Professor Allyson Pollock

### Five favourite things in life:

- Watching and reading science-fiction
- Mountain trekking in remote locations around the world with my family
- My mother's cooking
  - Dancing
- Thinking time in bed on Sunday mornings, with my cats beside me, & a strong cup of tea made by my husband



Dr Eva Shirreffs

## Dr Eva Shirreffs

Medical Memoirs, page 20

### A medical woman you admire/respect:

Cicely Saunders

### Five favourite things in life:

- Gardens
- Good wine
- Good food
- Beautiful things
- Talking to people



Ms Sarah McLoughlin

## Ms Sarah McLoughlin

MWF Communications & Administration Officer

### A medical woman you admire/respect:

All the fantastic medical women I'm lucky enough to work alongside at MWF

### Five favourite things in life:

- Being surrounded by my family
  - Laughing with my friends
- Going to see live music and theatre
  - Sipping wine in the South of France
  - A nice, long lie in!

## Dr Binita Kane

Career Focus, page 10

### A medical woman you admire/respect:

Clare Marx – the 1st female president of the Royal College of Surgeons, England

### Five favourite things in life:

- My Family
- Laughter
- Fun
- Music
- A nice cup of tea



Dr Binita Kane

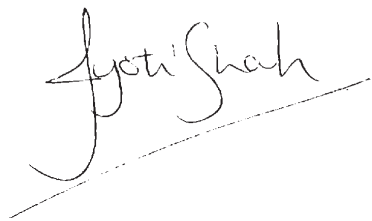
# Editor's Letter




I start my term as Editor-in-Chief of Medical Woman buzzing with ideas, enthusiasm and motivation. My handbag essential, my ideas book, is with me at all times, even by the bedside!

However, as I combine my passions for medicine and journalism, I can't help but reflect on the parallels between the two professions. An article in this issue by the GMC and another from the Royal College of Surgeons of England address the subject of medical women in numbers – we all know that the numbers of women at entry level in medicine at least equals that of men. But, alas, the attrition with experience as so few reach the top. Is journalism any different? As with many industries, at entry level there is little gender difference but there is a paucity of women in the upper echelons of the national papers in this country. Perhaps it is the same across the pond? When Time magazine appointed its first female Editor-in-Chief in 2013 – the first time since its inception in 1923 – it was huge news. Medicine is not unique in having a problem with gender disparity or trying to address it.

I couldn't start without thanking our previous editor, Sarah Khan, for the amazing work that she has done. It is a challenge to follow in her footsteps, but I am extremely proud to lead this project with a new team. If you have any ideas or comments, or would like to work with the team, please contact me.

A handwritten signature of Jyoti Shah in black ink.

Jyoti Shah, Editor-in-Chief

Contact me:  
missjshah@gmail.com  
@missjyotishah 



## JOIN US! JOIN US! JOIN US!

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

Become a member at: [www.medicalwomensfederation.org.uk](http://www.medicalwomensfederation.org.uk)

### WHAT YOU GET FOR YOUR MEMBERSHIP FEES:

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

**GRANTS, PRIZES AND BURSARIES** – for both Students and Junior Doctors.

**SUPPORT WITH AWARDS** – we are a nominating body for ACCEA and give support with individual applications from women. We also nominate Medical Women for the Women in the City Award and the Woman of Achievement Award.

**NETWORKING OPPORTUNITIES** – we hold small networking events in our local groups and hold 2 national conferences a year.

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



## Background to MWF

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

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

### The MWF aims to:

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

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

### Achievements:

MWF has campaigned for many years for:

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

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

**Join MWF to boost your  
CV, confidence and career  
through to retirement!**  
[medicalwomensfederation  
.org.uk/about-us/join-us](http://medicalwomensfederation.org.uk/about-us/join-us)

# NEWS & EVENTS

## Swansea Medical Student Evening May 2015

### Carol Sullivan, Wales Chair

Leah Gray (medical student rep) and I ran a very well received evening meeting for the Swansea medical students (all graduate entry) at the end of May entitled 'The Realities of being a Female Doctor'. The objective was to dispel myths about medical careers for women, training whilst being a mother, LTFT training, work – life balance etc.

30 students attended and there were eight 10 minute talks. Melanie Jones (MWF member) started with an overview of LTFT training, with her previous Deanery experience. The others were:

- O&G new consultant, FT with 2 children
- GP partner, two teenage children and elderly parents (the sandwich generation)
- Consultant Histopathologist, with a few changes in career path, LTFT just returned from maternity leave
- Adult respiratory/research consultant, FT with 2 small children
- Several paediatric trainees with children, working as FT, 80% and 60% LTFT, one who has worked her entire training career as 60% LTFT and has nearly finished at last!

I finished by outlining a career and life without children just to address the balance a little.

The message was clear – women are a very resourceful bunch, with varied experiences not only within medicine but extra-curricular activities, even including 'best in show pigs'! Several consultants had taken time to work overseas in both medical and non-medical jobs, despite being advised that it would be detrimental to their career. All were convinced that these were positive experiences and helped their CVs and careers.

Other consistencies were that if you have children you need a supportive partner, it's easier if they are not medical, and you need a network of friends. It is also important to get the right child care that works for you. It is possible to do your whole training as LTFT but it takes a very long time, and it is possible to work full time with children.

We were very fortunate, that in addition to Melanie, several other MWF members came, including Sally Davies, who travelled from Cardiff and Hazel Martin from North Wales! Informal discussions over refreshments helped forge the importance of the MWF network for doctors of the future, and we were grateful for all the support we received.

## My Time as a MWF Student Representative

### Jenny Hong



I had the privilege of representing the MWF at Leicester Medical School during much of my time as a student. Whilst championing women's rights and the MWF, I was promptly labelled as "that feminist" by my colleagues. Upon reflection, it took me many years to adjust to the negatively perceived label.

Of the many lessons I learned as a MWF student rep, this was the most striking – people, men and women, don't think women's rights are an issue in the 21st century, particularly for women doctors. That the majority of medical students in the UK are women is true. However, many do not recognise that this figure does not reflect in the number of higher level positions and in academia. Another lesson is that those who see these inequalities keep it to themselves.

Many students worry about the logistical challenges of fitting life in. Many also

feel burdened by the pressure of having to fulfil the expected role as a married, fertile woman in the most crucial point in their career building. Whatever the issue, people stay silent and simply hope for the best.

As the MWF student rep, I have helped to raise awareness of issues surrounding women in work and created a welcoming platform for students and doctors in the region to open up about their concerns. The students and junior doctors who attended the events we organised have told us how enjoyable and helpful these events were. I have also created ties between the well-known initiative Athena Swan, which I hope will bring solidarity to believers of gender equality at Leicester Medical School and the greater Leicester area.

Additionally, my role as the MWF student rep helped me to develop the feminist ideas I held since I was young. My understanding of feminism and what it means to be a working woman in this century have matured tremendously and the reason that an organisation like MWF still needs to exist could not be clearer. With all our efforts, I believe we will see a day when women in work don't decide on a career path simply because it is 'easier for a woman' but on the basis of their merits and desires.

I would like to thank MWF for this unique opportunity to represent the organisation. I would also like to give special thanks to the senior members in Leicester and Nottingham who have supported me over these years. They have not only helped me fulfil my role as a student representative but also mentored me in my personal time of need. I hope that I will be able to contribute to this great organisation as a doctor as I begin my training.



# Stepping Up, Speaking Out;

## EMPOWERING WOMEN DOCTORS AND THEIR PATIENTS

**Friday May 15th 2015, Manchester**

**Dr Judy Booth**, *Speciality Doctor in Palliative Medicine at Wheatfields Hospice in Leeds*

This year's Spring Conference was well attended by delegates including many medical students and junior doctors, from all regions and represented a wide range of specialties.



### Stepping Up – Women in positions of leadership

Dr Shelley Ross, Secretary General of the MWIA, gave us a brief overview of the history and aims of the International Association. MWIA has links with WHO and the UN and the current triennial theme is for the prevention and elimination of domestic and sexual violence.

The 'Question Time' featured a panel of four medical women in leadership positions: Prof Jacky Hayden CBE (Dean of Post Graduate Medical Studies Health Education North West), Prof Ann Garden MBE (Dean of Lancaster Medical School), Prof Cathy Urquhart (Manchester Metropolitan University) and Dr Sally Davies, MWF President. Discussion centred around why there are so few women in leadership positions and what we can do about it, based on their individual experiences.

Women tend to suffer from 'imposter syndrome,' where they believe that they can't do something well enough and so they don't push themselves forward. For the same reasons women doctors do not apply for awards.

The value of mentors, particularly at times of transition, was discussed. Why not choose a male mentor!

The best and worst aspects of a leadership role were discussed. The panel members felt that women gain the skills needed for leadership roles, without knowing it from, for example, negotiating with toddlers and the organising of the family. It is never too soon to start and the students present were advised to look for leadership opportunities whilst still at medical school. The overall message was that we will not move on if we keep doing things as we have always done. Women are becoming the majority in the medical workforce and therefore leaders need to be representative of those they are leading.

### Speaking Out – Social media

The various forms of social media are now widely accessible and doctors need to be aware of how to use it to their advantage. Dr Anne Marie Cunningham spoke about 'the peaks and pitfalls of speaking up in the age of social media'. She presented us with some cautionary tales, but also the positive aspects

of connecting with other people in this way. The example of #hellomynameis, the twitter campaign started by Dr Kate Granger, is legendary and a fantastic example of how social media can be helpful. Many of the conference delegates were tweeting @medicalwomenuk#MWFCnf15!

### Speaking Out – Raising concerns

Dr Kim Holt discussed 'How to support whistleblowers and create an open culture.' She has personal experience of the potential consequences of raising concerns about patient safety and as a result of this is working to change the culture within the NHS so that whistleblowers are supported and protected ([www.patientsfirst.org.uk](http://www.patientsfirst.org.uk)). Doctors who raise concerns may still face hostility and bullying from colleagues and managers and have no protection in law. Even in the worst cases where they lose their job, the Employment Tribunal may only award compensation and not reinstatement. Meanwhile, the patient safety issues remain unaddressed. Evidence has been presented to the Parliamentary Health Select committee and a review by Sir Robert Francis concluded that staff are deterred from raising concerns due to fear of the consequences which may include vexatious referrals to the GMC.

### Speaking Out – Taboo subjects

The Dame Hilda Rose Memorial lecture about female genital mutilation (FGM) was delivered by Dr Joanne Topping. Approximately 54,000 women in the UK are believed to have had, or are at risk of FGM. It is done for traditional and cultural reasons and often arranged by mothers and grandmothers who see it as beneficial in securing good marriages for the girls. Although now illegal in this country, most cases remain unidentified. She discussed the different forms that FGM may take and the short term and long term complications that may follow. She provided the audience with some advice on how to identify cases by asking the right questions, bearing in mind that the girls may not see themselves as different. It is important to do this to manage the potential long term health problems

and to identify other family members who may be at risk. If children under 18 years of age or vulnerable adults present, a safeguarding referral should be done. Affected women in this country will need ongoing support for many years and the psychological impact is greater in the UK than in the country of origin because it is less common amongst peer groups.

### Empowering

The workshops provided smaller groups an opportunity for discussion and participation with an expert resource for guidance. Topics at this meeting were Advancing Women in Leadership: Overcoming the barriers, Domestic Violence, Introduction to Resilience, Mentoring for Excellence and Good Medical Practice in the Digital Age – GMC guidance. Key messages from each group were summarized to the whole audience.

The winner of the abstract presentations was Harriet Cant, a medical student from Brighton, who presented her work looking at the healthcare needs and uptake of services amongst homeless women.

During the breaks we had the chance to look at the posters which echoed the theme of the conference. The winning poster was 'Dr Fairfield: Forgotten for being female?' by Emily Garrett, a student at UCL.

Finally, the Katherine Branson Medical Student Essay Prize winners, Sara Ebbinghaus and Nicola Kelly, read out their essays.

The social programme began with an informal supper the night before the conference for those staying overnight and this was a chance to meet up with friends and welcome new ones.

### After dinner speech –

#### 'Bare Reality' May 17th 2015

**by Dr Caroline Sheldrick, Ophthalmologist**

After a delicious dinner we were treated to a talk by Laura Dodsworth, creator of the book *Bare Reality* depicting photographs of 100 women's breasts and their stories!

Women from all walks of life participated in the project. They were aged 19-101 years, sizes AAA to K, and their careers ranged from Buddhist Nuns to burlesque dancers. These women bravely shared their photos alongside honest, courageous, powerful and humorous stories about their breasts and their lives. Laura created *Bare Reality* because of her fascination in the dichotomy between women's personal lives and how they are depicted in the media. In her talk she shared some of the poignant personal stories about the people in the pictures. She feels that this project "explored what it means to be a woman."

# The Life Foundation



The Life Foundation is a charitable organization that works in Romania helping disabled babies, children and adults living in institutional environments. We organise annual specialist placements of two weeks duration for a variety of healthcare professionals and trainees. This provides skilled multidisciplinary team input for both the children and the adults we care for.



**T**he primary aim of these teams is to work together to identify issues, plan and commence care plans or therapeutic programs, and then train the Romanian care assistants to continue this work. Our aim, wherever possible is to empower the carers who have no formal training and give them access to the education, skills and resources they may need.

Volunteer placements can be emotionally challenging but incredibly rewarding experiences for students and professionals alike. Much of the Romanian medical and therapeutic practice is several years behind that in the UK and there are limits on what can be achieved in just two weeks. Volunteers report a great sense of achievement by the end of their trip and, their many successes, however small, result in volunteers choosing to return year after year.

As a medic myself, I have always found it astounding to see conditions that would have been easily treated in the UK become severe and debilitating. Our medical students and doctors have been able to advise on individual health care as well as on the health of the population of adults in general – resulting in worming and antibiotic treatment. This summer we ran a health clinic seeing over seventy adults to make sure any health care they may need is accessed, and any concerns addressed where possible.

We have had a wide range of specialists involved from plastic surgeons to neuro-disability consultants who have all played a key role in making improvements to individual's lives. Medical students have the opportunity to develop their existing skills and design projects, and we encourage their innovative ideas and ability to think outside the box. This has contributed much to the care of the people they have worked with. We hope to widen the amount of research we undertake within health care and institutions in Romania in future.

Moving forward, we will continue to need medical students and doctors who have an interest in doing something new, challenging and extremely rewarding. You must have a desire to help make a real and lasting change to care practices overseas and the ability to work well within a multidisciplinary team of students and health care professionals.

We look forward to hearing from those of you who may be interested in contributing to our amazing work.



# Women of the Future

**Pinky Lilani** CBE is founder and chair of a number of awards, each attempting to recognize, support, connect and inspire women. When she moved to Britain from Calcutta, she could not cook – an unusual finding in Asian women. Now, not only can she cook, she advises British manufacturers of Indian supermarket meals, and has published a bestselling cookbook, *Spice Magic*. She was awarded her OBE in 2007 but has just been recognized for her ongoing wok in the 2015 Queen's birthday honours list with a CBE.



## Here are my top 10 tips for success:

1. DREAM
2. Integrity, never compromise on your core values
3. Hard work
4. Collaboration
5. Good Networks
6. Be kind. Do not expect to get anything back and you will get so much more than you could ever imagine
7. Be creative, don't be like everyone else
8. Work out what you stand for; what is your brand? People very quickly work out if they trust you and want to be part of your world
9. Talk to somebody you don't know every day – my best ideas have come from others!
10. NEVER GIVE UP ON YOUR DREAMS

my guests would not get indigestion... I decided to concentrate on my other passion – People.

The two awards I have set up [The Asian Women of Achievement Awards (AWA) & The Women of the Future Awards] are all about recognising, profiling and helping women. William James once said the greatest human craving is the craving to be appreciated. Appreciation, I have discovered, can make all the difference in the success trajectory.

The AWA was created to break down the stereotypes enveloping Asian women, and show that Asian women did much more than fry onion bhajis.

Starting new programmes is never easy – the chicken and egg situation – people don't want to support you until you have a track record – but how do you get a track record without support?

Fortunately for me, Cherie Blair (our then Prime Minister's wife) believed in me and became our patron. Wearing a salwar kameez at our first event, she gave it all the publicity we needed.

Cherie is one of the most inspirational women I have met and has changed the landscape for so many of us in spite of all the challenges she has faced. Her walkabouts during the Awards dinner are legendary. One year, when smoking was still allowed indoors, she came across a candidate smoking a cigarette and told her that it was not good for her health. The girl told her that she would give up smoking if Cherie came to her gastro pub – Cherie turned up there the following week with her husband!

I came to the UK 37 years ago when I met my husband. We married just 3 weeks later. He did no due diligence whatsoever and instead of having a wife who could cook a good Tarka Daal, he had one who did not know how to cook at all!

I was not the typical Indian wife – when people asked if I walked 2 steps behind my husband, I always said that I walked 10 steps behind him, so that he did not know what I was up to!

In my DNA is a love of food and a great curiosity about the stories of people. After I had mastered the art of cooking so that





The girl has since given up smoking.

The Women of the Future awards is based on my belief that recognising women less than 35 years of age would help them in their careers and they would then be role models and an inspiration for the pipeline of talent.

Of course, there were sceptics, and I am glad that I ignored them and followed my heart. Today we have built a community of phenomenal women (and men) who are not only proud of their achievement but incredibly committed to helping others coming behind. They are all sending the elevator down again.

Madeline Albright once painted a grim picture of a world that had so many women not moving it forward and warned that there was a special place in hell for women who do not help other women.

Empowering women is my mission and I feel blessed that so many people share my vision. Through our collaborative endeavours we have been able to help women dream, follow their passion, find their voice, and be themselves. However, at the heart of all we do is to harness the profound human capacity for cooperative connections. I hope our message reaches deep into the human soul and gives hope – each of us can play a part in making the world a better place

In the ultimate analysis I try to live by my mantra: “You have not lived a perfect day, unless you have done something for someone who can never repay you!”



## MEDICAL WOMEN'S FEDERATION Autumn Conference 2015 **BUILDING RESILIENT LEADERS**

**The largest  
body of women  
doctors in the UK  
looks forward to  
meeting you!**

6th November 2015 – Friends House, 173 Euston Road, London, NW1 2BJ

### Speakers:

**Prof Amanda Howe**

Vice Chair RCGP & President Elect of WONCA

**Vijaya Nath, Assistant Director**

Leadership Development, Kings Fund

**Niall Dickson**

Chief Executive and Registrar of GMC

### **A year in the life**

### **of a Royal College President**

Dr Suzy Lishman, President of Royal College of Pathologists

### **Careers interview**

Dr Dora Black, Honorary Consultant Child and Adolescent Psychiatrist at Traumatic Stress Clinic, London

**Why not submit an Abstract? Deadline – 2nd October 2015**

**Still want more? How about a social programme excellent for networking?!**

Registration details available at

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Email: [admin@btconnect.com](mailto:admin@btconnect.com) Tel: 0207 387 7765



# WOMEN AT THE TOP

## Professor Neena Modi

Professor of Neonatal Medicine at Imperial College & President, Royal College of Paediatrics & Child Health

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



### Professor Neena Modi

was born in South Africa and grew up around the world, going to school in the United States, the UK, Africa and India. She was lucky enough to get a

place at the University of Edinburgh Medical School where she found the cold very difficult! She met her husband after graduating even though he was also a University of Edinburgh medical student. They have two children; a daughter who read physics at Oxford and is now training to be an architect, and a son, who read medicine at Cambridge and is now a junior doctor.

Professor Modi has a very varied working life. She leads a great multidisciplinary neonatal research group of clinicians and non-clinicians, students and staff. Her team has a broad portfolio of research aimed at improving perinatal care and understanding early life trajectories that impact upon wellbeing. She is also part of a clinical team that has responsibility for a large tertiary neonatal service. Her many professional commitments include chairing the British Medical Journal ethics committee, and the presidencies of the Academic Paediatrics Association of Great Britain and Ireland, the Neonatal Society, and most recently, the Royal College of Paediatrics and Child Health.

She admits that it is a privilege to work in the National Health Service. She has travelled widely and there is no country in the world that provides such a fair, cost-effective, and equitable service. She wants it to retain its magnificent founding principles and go from strength to strength. She would also like to help strengthen the children's science and research base and grow a new generation of intellectually curious and innovative paediatricians and clinician scientists. After all, the health of our children determines the health of our nation.

**Name:** Neena Modi

**Approximate age:** Old enough to have had a lot of wonderful experiences; young enough to be looking forward to many more

**Lives:** In London, but my husband and I have recently also acquired a farmhouse in Umbria

**Medical School:** University of Edinburgh

**Speciality:** Neonatal Medicine

**Place currently works:** Imperial College London and Chelsea and Westminster Hospital

**First Ambition:** In the society in which I grew up, boys, not girls, rode bicycles, wore trousers, read comic books, and became doctors. So, of course, those were the things I was determined I would do.

**Other Career Related Interests/Roles:** Strengthening the research and evaluation skills of clinical trainees has been a particular goal, as has increasing high quality research that benefits infants, children and young people. These groups remain under-represented in discovery science, and research, whether in the clinical, health services or policy domains.

**Challenges along the way:** Three principal challenges: first, the faint-hearted, the naysayers and the second guessers; second, sustaining a research group and helping promising young scientists develop their careers. There is great insecurity in research funding and the country loses many talented individuals because of the lack of strategic support to research groups; third, the enormous threats facing the NHS.

**Rewards of your role(s):** I am very privileged to have a fascinating career with varied roles, involving clinical medicine, research, teaching, and professional leadership. The rewards are seeing the babies I cared for grow up and do well, and watching my research group develop their careers and flourish.

**Inspirations/influences:** Politicians often get bad press; yet the greatest influence on my professional life – other than my father – has been the realization that the magnificent National Health Service that has served this country so well for over six decades, and been a global beacon of social justice, was created through political vision and will (and a good dollop of pragmatism). The doctors of the day opposed its creation, but I'm glad that the profession is staunchly supportive today.

**Quotas for senior positions for women in healthcare – yes or no?** I've swiveled on this one over the years. In principle, I'm against quotas and believe ability wins through. However, there is a place for measures to ensure women are not disadvantaged as sadly it sometimes takes a real push, such as the excellent Athena-Swan awards, for large institutions to sit up and take notice. I also believe we would have been better advocating for family rights, instead of accepting the premise that childcare is a women's issue – it isn't, it's a parental issue.

### ADVICE

**Do's:** Know yourself

**Don'ts:** Don't castigate yourself over mistakes – we all make them

**How to get there:** Follow your muse



# IN Conversation:

## INTERVIEW WITH DR MICHELLE TEMPEST

Partner at Candestic, Management Consultancy, Bespoke for Health and Social Care. @DrMTempest

### ■ What did you do before your current job?

I worked as a psychiatrist for 12 years, specialising in liaison psychiatry, and became an accredited cognitive analytical therapist. I also taught medical ethics and law at Cambridge University for over a decade.

### ■ What led you to leave clinical medicine?

It was a really slow cross taper of career. I started working as a management consultant when I had annual leave as a junior doctor. That slowly progressed into working two very different career paths, part time, for a number of years. When I was a locum consultant it became apparent that I had to make a choice.

### ■ What skills, if any, do you use from clinical training in your job?

I use my clinical training every day – learning and knowledge is never lost. I would never want to trade in my clinical years (other than maybe the night shifts!). Because I work for a specialist health and social care management consultancy, clinical knowledge and care pathway is imperative. In fact, I believe more medical professionals need to get involved in the management of their own profession.

### ■ Have you done further training or gained qualifications since leaving clinical medicine?

I have done enough exams in my life! However, I have had to learn plenty of other skills (and fast) to change careers; there is no escape from sheer hard work and extra hours. In the same vein as being a junior doctor, the best training is to get on with the job and deliver high quality results. To make an analogy, I had to become bilingual in the languages of medicine and business. Having both languages helps cut straight to the core of the issue and not get bogged down in waffle.

### ■ What attracts other industries to recruit doctors?

What's not to like about recruiting doctors? Doctors know how to work hard, take on responsibility, and are used to dealing with challenging situations. If anything, I would say that it's the NHS as an employer who undervalues and underappreciates the goodwill asset it has in its healthcare workforce.

### ■ What did you think of the career advice you received during medical school/after qualification?

In my day at medical school there was not much career advice – it was all about doing exams and specialist training. Working clinically with long hours there was little time for personal reflection and most doctors stayed in medicine or academia – there were few people to ask advice from. But now doctors have their eyes opened to the world and, if they are inquisitive, there are no limits.

### ■ What should people think about when moving to a non-clinical or new career?

#### Top Three Tips:

(i) **Financial risk:** jobs outside the NHS are not like having a substantive post, and this comes with financial risk and losing the NHS pension.

(ii) **Missing patients:** there is nothing like having that doctor-patient relationship. It's a privilege that you miss.

(iii) **Staying true to your roots:** in a world outside healthcare, not everyone puts patients first. It's a responsibility to ensure that the medical ethic, innate in medical professionals, is spread to other professions... even banking, if that is where you choose to go!

## MEDICAL ETHICS & MORALS

In this new section, Medical Woman will open a discussion about a moral or ethical issue from clinical practice.

Please send your comments or thoughts to  
[admin.mwf@btconnect.com](mailto:admin.mwf@btconnect.com)

This issue's debate is:

***"Is it fair for a female doctor to be called by her first name when her male colleague is addressed by his title and surname?"***

# Women Doctors in Numb3r5...

**W**hen Professor Thomas argued that the increased number of women doctors could deprive patients of continuity of care in a *Daily Mail* article last year ('Why having so many women doctors is hurting the NHS,' Jan 2014), I wondered what his views were on the current shift working. Isn't that lack of continuity of care – even at consultant level within hospitals?

Ask any patient attending their GP's surgery what their biggest complaint is and they will report that it is not seeing the same doctor on any two occasions – in fact not even seeing the doctor with whom they are registered! That is lack of continuity of care, and frankly nothing to do with the gender of the clinician. Headlines such as "Women docs weakening medicine" propagate fear but do not reflect reality.

As greater numbers of women in the profession break down barriers, it is clear there is huge disparity between the genders within the senior echelons and it is the disparity at the top that is the real problem.

In the first article below, **Clare Barton**, Assistant Director of Specialist and GP Register applications at the General Medical Council, provides an update on the overall picture with regards the numbers of women within the profession.

In the second article, **Clare Wynn-Mackenzie**, Careers Support Services Manager at the Royal College of Surgeons of England, informs readers how the numbers of female consultant surgeons has risen over 10% for the first time.

**Jyoti Shah, Editor-in-Chief**

## THE CHANGING PICTURE OF WOMEN WORKING IN UK MEDICINE

**Clare Barton, Assistant Director of Specialist and GP Register applications at the General Medical Council**

The GMC was launched more than 150 years ago in 1858 to help distinguish between qualified and unqualified doctors. Bristol born Elizabeth Blackwell was the first woman to have her name entered on the register in 1859 and now nearly 120,000 females have followed in her footsteps.

For a long time the register remained the same, with few notable changes, until the 1950s when doctors from South East Asia started to come to work in the UK and the amount of female doctors started to rise.

By looking at the data that makes up the register we are able to see that not only are the number of doctors on the register higher than ever at more than 266,000, but the face of the medical profession has changed significantly.

Each year has seen a gradual increase in the number of qualified female doctors practising in the UK. There are now more than 118,000 women on the medical register – a 16% increase on the figure from 20 years ago. And this once male dominated profession is now heading towards equal numbers of men and women – already female doctors account for 44% of all registered doctors. In addition, recent figures from UK medical schools show that half of their students are female.

Although women continue to remain underrepresented overall on the specialist register – with men outnumbering women by two thirds – more women than ever are achieving specialist qualifications and breaking into traditionally male areas such as surgery and emergency medicine.

Yet, the most popular choice of speciality for female doctors for the last twenty years remains anaesthetics with more than 3,200 female doctors currently holding qualifications in this field. But psychiatry has now overtaken paediatrics to move into second place followed by general internal medicine.

Women also now account for 51% of doctors on the GP register – a figure that has crept up by 6% since the introduction of the GP register in 2009. The number of all registered doctors aged 50 years and older has increased by 27% from 2010 to 2014 whereas the numbers of male doctors in the same category has increased by 10% for the same period.

By looking at these figures we can paint a picture of the medical workforce today and although it is difficult to predict what the future may hold for the profession, this data does give us some clues to help inform future decision making. What we can be certain of is that women doctors continue to make an ever increasing contribution to healthcare in the UK.

Figures from the medical register are published annually by the GMC as part of its report, 'The state of medical education and practice report.' The reports from 2011 to 2014 are available at <http://www.gmc-uk.org/publications/25452.asp> and the 2015 report is due to be published in the Autumn.

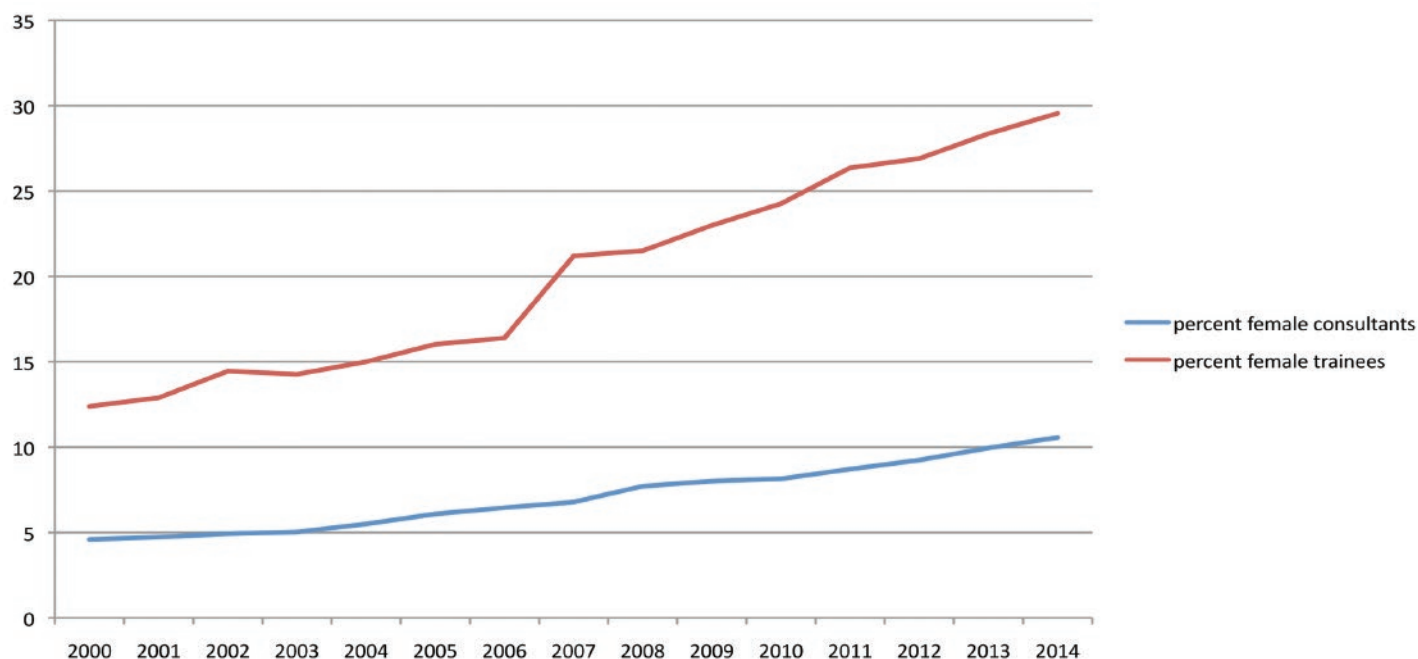
## WOMEN IN SURGERY

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

For the first time, the proportion of consultant surgeons who are women has reached 10%\*. As more women reach senior positions, there are more role models to encourage juniors to pursue this career, opening the possibility of a career in surgery to all those with potential.

Of the ten surgical specialties, paediatric surgery has the highest proportion of women consultants (26.11%, 47) and general surgery has the highest number of women consultants (293, 13.87%). This is closely followed by Trauma and Orthopaedics (T&O) (118, 5.25%). Despite the large number of women consultants, T&O has the lowest proportion of women consultants (5.25%). Vascular surgery has the lowest number of women consultants at only 7 (9.46%), followed by neurosurgery with 19 women consultants (7.2%). Low numbers in vascular





surgery are possibly due to the recent split from general surgery – many surgeons working in vascular surgery are still recorded as general surgeons.

Within the training grades, defined as the 'registrars group' by the Health and Social Care Information Centre, the pattern is similar. Paediatric surgery has the highest proportion of women with 47.32% (97). The lowest is vascular with only 6 female trainees (18.75%), followed by T&O (21.29%, 447). Again, the highest number of women is in general surgery (742, 32.57%). Oral & Maxillofacial Surgery has 76 trainees (34.7%). The data excludes vascular surgery whose training programme was separated from general surgery in 2013.

The proportions of women at both consultant and trainee levels are increasing steadily and at a similar rate. There remains, however, a large gap between the two lines on the chart above, indicating attrition from training grades to consultant posts.

Women in Surgery (WinS) is an initiative run by the Royal College of Surgeons of England to encourage, enable and inspire women to fulfil their surgical ambitions. WinS works to address this attrition, as well as to attract more women into surgery. The organisation provides a range of events to encourage students and trainees to meet role models and also provides practical support through prizes and advice services. There are also senior women's activities, which are aimed at supporting women's career development once they have reached a senior level. There is less structure at this part of the career path than in the training grades, with no clear, established paths to follow. With this work, WinS aims to support women in their careers and help them become role models for future generations of surgical leaders.

	2000	2001	2002	2003	2004	2005	2006	2007
Consultants %	4.59	4.73	4.92	5.03	5.5	6.08	6.45	6.78
Trainees %	12.39	12.89	14.45	14.27	15	16.02	16.39	21.2

	2008	2009	2010	2011	2012	2013	2014
Consultants %	7.71	8.01	8.14	8.71	9.24	9.95	10.56
Trainees %	21.5	22.99	2.26	26.36	26.9	28.36	29.55

*\*All data is published by the Health and Social Care Information Centre <http://www.hscic.gov.uk/> in the Medical and Dental Workforce Census. Data is published in April for the previous September.*

### DID YOU KNOW?

There is a 32% increase in blink rate for women on the OCP compared to those who do not take the pill

### Dates for your Diary:

**2nd October:** Abstract deadline for MWF Autumn Conference

**23-24th October:** BMJ Careers Fair, Business Design Centre, Islington

**October:** Elective Bursary applications begin – date to be confirmed – please check the MWF website for details

**6th November:** MWF Autumn Conference: 'Building Resilient leaders,' Friends House, London

**November:** Dorothy Ward Travelling Scholarship Prize begins – date to be confirmed – please check the MWF website

**December:** Katherine Branson Student Essay Competition begins – date to be confirmed – please check the MWF website

# Career Focus

**Dr Binita Kane** – Consultant Respiratory Physician, University Hospital of South Manchester



**D**r Binita Kane is a newly appointed Consultant Respiratory Physician at University Hospital of South Manchester. She has a role that is split 60:40 between direct clinical care and clinical leadership. She graduated from the University of Manchester and has undertaken all of her training in the North West, except for a year's sabbatical in Perth, Australia. She undertook a PhD in Airways Inflammation with the University of Manchester, which she completed in 2008 before starting as a Specialist Registrar

in Respiratory Medicine. She was recruited onto the Medical Leadership Programme by Health Education North West in 2013 and is currently working towards a Masters in Healthcare Leadership. She works within an academic department providing tertiary services for patients with Severe Asthma. Her non-clinical roles include acting as the Strategic Lead for the North West Severe Asthma Service and leading the development of integrated respiratory services in South Manchester. She is a married mother of two young daughters.

In March 2015 I started as a consultant respiratory physician at University Hospital of South Manchester (UHSM) with a job that involves both clinical work and leadership responsibilities.

As a new consultant, this was an unusual and unprecedented mix in my trust, with leadership positions of this kind largely devolved to more senior clinicians. Although there are no official training tracks that involve clinical leadership as there are for academia, the tide may be turning. The medical leadership movement over the last four years has been immense and is high on the agenda for NHS England in the wake of the Francis and Keogh Reports. Organisations such as the NHS Leadership Academy and Faculty of Medical Leadership and Management (FMLM) have successfully established themselves at a startling rate. Leadership schemes have sprung up across the country and elements of the Medical Leadership Competency Framework are being embedded in medical school curricula and junior doctor training. The concept that 'management' positions should be taken up by those in the last decade of the career and learnt 'on the job', is being challenged and replaced by a recognition that medical leadership is a skill that requires training and nurturing.

## How did I get here?

Looking back I have always been interested in clinical leadership, though perhaps didn't realise it at the time. As a junior doctor I took on roles like Mess President and Associate Royal College Tutor. I had particularly good organisational skills, which combined with my pathological inability to say 'no' meant

that I was never without a 'project' to do. During my PhD programme 2005-2008, I took the opportunity to set up and run the 'Respiratory Research Forum', a monthly meeting which developed my skills in relationship-building and networking. In 2008 in my first year as a SpR, I began to (unknowingly) show an interest in quality improvement. I simply noticed that some things in my everyday practice could be done more efficiently and safely, I decided to try and change them. I initiated and completed some projects around acute service provision that involved co-ordinating a number of specialties and working with senior leaders. In 2010, a consultant colleague expressed a wish to create a network of specialists in the North West who had an interest in severe asthma. I saw this as a fantastic opportunity and offered to establish the group. This started off very much as an administrative role; organising venues, speakers and co-ordinating multi-disciplinary teams from ten different acute Trusts to attend. As time went on, I was devolved more and more responsibility. By the time I was nearing the completion of training, I was effectively leading the group, which was now firmly established as the North West Severe Asthma Network (NWSAN) and respected nationally. When severe asthma was announced as a condition that would be specialist commissioned in 2013, NWSAN became a steering group to develop a workable model for the North West. I led a process of discussion, debate, consultation and conflict resolution for over 12 months until we reached a consensus on a regional model, my neutral position as a SpR being a great advantage. We influenced a change in the National Service Specification to include a more networked approach as a direct consequence.

In 2014, I was one of a few trainees in the North West appointed onto the Medical Leadership Programme by Health Education North West. This involved undertaking a Master's Degree in Healthcare Leadership via the NHS leadership academy (The Elizabeth Garret Anderson Programme) which was fully integrated into training, with up to 50% of my time being devoted to leadership activities. As part of this I was also privileged to have a bespoke programme of leadership training delivered by the King's Fund and got to shadow several inspiring leaders, including the National Clinical Director for my Specialty, Chief Executives, and the DOH advisor for specialist commissioning in asthma and Medical Directors.

My leadership journey also took me to Parliament where I represented one of my Professors to discuss the National COPD and Asthma Strategy. In addition to my work in asthma, I took up the position of SpR representative on the National Oxygen Guidelines Committee and since then, established a working group across the Manchester Academic Health Sciences Centre (MAHSC) to promote the safe use of oxygen in hospitals.

Undertaking the Medical Leadership Programme was a life changing event for me. I began to notice a fundamental difference in my thinking, interactions with people in daily life and in my view of patient experience. I was working as a junior



doctor but starting to think like a healthcare leader with a greater understanding of navigating complex systems. I have made connections with people from all corners of the NHS. I have developed a deep insight into myself and the impact I have on those around me. I have gained the confidence to raise concerns and directly challenge the status quo. The rate of change in me was quite alarming at times.

I obtained my Certificate of Completion of Training (CCT) in February 2015 and was keen to take on a role that had a leadership component. I am lucky that UHSM believe strongly in the medical leadership model and created a joint role with dedicated programmed activities (PAs) for clinical leadership. I now have the opportunity to implement the North West Severe Asthma Service Model that I helped create as a SpR as well as other projects such as developing integrated respiratory services in Manchester, which is very exciting. I am keen to share what I have learned and am actively involved in developing clinical leadership skills in junior doctors.

## Work Life Balance

I have two young children aged 3 and 5 years. My training was a mixture of less-than full time and full time work. I returned to full-time working two years ago to finish my training, but also because some excellent job opportunities had arisen. This was a difficult decision and I had to employ a nanny. It led to many challenges; watching my baby develop a strong bond with another woman was difficult at times, doing medical night shifts with small children in the house was exhausting and working 14 days straight without seeing the children left me fraught with guilt. The additional burden of a Master's degree and applying for consultant jobs was incredibly taxing.

However, I had a goal and a vision and kept this at the forefront; I was doing this for my family to secure their future and I believe passionately in being a strong role model for my daughters. I managed by strictly keeping work time to when the children were asleep and ensuring that academia would not impact on our weekends as a family. I made every effort to make sure any time with the children was of good quality and I am fortunate to have had fantastic support from my husband.

Now that I have achieved my goal of becoming a consultant, life has settled down. I have been able to negotiate a job plan that suits my childcare needs and I am able to work a full-time job in four days. This means that I now have precious additional time with the children, which I treasure.

## Challenges of a mixed clinical: leadership role

For anybody considering taking on a mixed clinical and leadership role, there are some challenges that must be considered. Firstly, this almost invariably means that it is not possible to lead a clinical service. PAs for direct clinical care, once one has considered supporting professional activity (SPA) time and administration, is limited. For example, I currently undertake 2 clinics, attend an MDT and do 1 ward round a week. Whilst I am involved in the wider strategic development of the service, the day-to-day decisions about patient care, procedure lists and team discussions are done by my colleagues. It is important to consider whether this would be fulfilling having spent years training to be a clinician. This was a concern for me, but I have found that I gained enormous fulfilment from leading change that impacts

patients in a different way. Whilst not as instantly gratifying, involvement in transformation that improves long-term quality of care is just as rewarding for me.

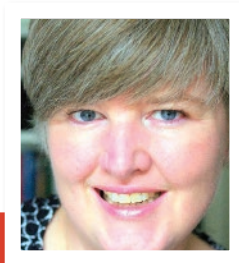
There can also be a stigma attached to such leadership roles due to the historical perception of those involved in management turning to the 'dark side.' I am very keen to change this outdated perception, promote the difference between leadership and 'management' and develop better working relationships between clinical and non-clinical staff. However, one needs to be resilient enough to take on any negativity, particularly from clinical colleagues.

The obvious major challenge is leading change in an organisation as complex as the NHS. The wheels of change are slow, the constant flux of staff is frustrating and you need rather large wellies to wade through the swathes of red tape. This is something that drives me to succeed rather than holds me back and such a disposition is crucial for this role.

## Top tips for anyone considering leadership as a career

1. It is never too early to develop your skills. Even if you are very junior, look locally for short courses or events focussed on clinical leadership. These will be valuable life skills whatever your long-term career.
2. Try to leave a footprint in any role you undertake by making a positive change. Start small; this can often lead to bigger things
3. Shadow some leaders. Members of Trust executive boards are usually happy to have trainees shadowing them for a day.
4. If you have a serious interest, a structured course via Health Education England, NHS Leadership Academy or the Medical Directors Clinical Fellow Scheme might be for you. Contact current Leadership Fellows and find out more.
5. Join the Faculty of Medical Leadership and Management (FMLM). This is an excellent resource for anyone interested in leadership.
6. Make use of social media. Twitter is a fantastic tool for networking and connecting with leaders around country, keeping abreast of current affairs in leadership and a resource base for articles.

# Twitterview



MWF @medicalwomenuk with:

Dr Anne-Marie Cunningham, @amcunningham, GP in Wales

**Q: @medicalwomenuk**

What is your medical background?

**A: @amcunningham**

I'm a Belfast-trained GP who has worked at @cardiffuni for 13 years - in #meded - and at Gelligaer practice

**Q: @medicalwomenuk**

Who/what has been your biggest inspiration?

**A: @amcunningham**

my parents - committed to social justice, believe in the power of communities, and do the right thing

**Q: @medicalwomenuk**

What has been your greatest achievement?

**A: @amcunningham**

my greatest achievement is a series of micro-achievements; having students, peers and patients who trust me

**Q: @medicalwomenuk**

Which part of your job do you most enjoy?

**A: @amcunningham**

the moments of true connection/understanding through interaction with others - mostly face to face - sometimes online

**Q: @medicalwomenuk**

How do you juggle your many roles?

**A: @amcunningham**

with the support of a great network of colleagues who understand the tensions involved. Thank you!

**Q: @medicalwomenuk**

What motivates you?

**A: @amcunningham**

working to achieve a just & fair society through developing health professionals and healthcare systems

**Q: @medicalwomenuk**

How do you motivate & engage with your students?

**A: @amcunningham**

sharing insights I have gained from my own practice and hopefully modelling patient-centeredness

**Q: @medicalwomenuk**

How can we use social media to engage with the public?

**A: @amcunningham**

think about objectives; we should go where the communities are already and we should empower those we meet. There are many publics - and many of those who we really need to listen to - the most deprived are not on Twitter. But all of our engagement should start by listening and asking questions. Be social, don't broadcast

**Q: @medicalwomenuk**

When did you join Twitter and how often do you check it?

**A: @amcunningham**

I joined Twitter in 2008 and I check it a few times a day when free i.e. not with patient/colleague/family

**Q: @medicalwomenuk**

Do you suggest women medics use Twitter as a networking tool?

**A: @amcunningham**

I certainly do! Follow topics and people. Say hello! Engage in discussions. Share what is important to you!

**Q: @medicalwomenuk**

What would you say to people who say they do not have the time for Twitter?

**A: @amcunningham**

I'd want to learn from them how they manage to stay up to date and develop wide networks. If they don't make time for those activities and don't think it's important then yes, stay away from Twitter!

**Q: @medicalwomenuk**

Name someone you love to follow on Twitter and why?

**A: @amcunningham**

@trishgreenhalgh - she had just joined a few months when she started #womenhealthcareacademics. She is open, shares her learning and frustrations, honest, generous and supportive!

**Q: @medicalwomenuk**

How do you balance the personal and professional side of Twitter?

**A: @amcunningham**

personal/professional balance is not the issue. What I share here is public. I remember that with everything so I only share what I am happy (personally or professionally) should be in the public domain.

**Q: @medicalwomenuk**

What are the possible pitfalls of using these channels?

**A: @amcunningham**

misunderstandings can happen - so assume the best of those you meet and use emoticons :) no fights!

**Q: @medicalwomenuk**

Are we better at communicating now or worse? Have we lost our voices?

**A: @amcunningham**

I think we always have to be true to our values. This is how we find our voice...and we're getting better

**Q: @medicalwomenuk**

What's next after twitter for social media?

**A: @amcunningham**

there are new social media services coming out every week but don't worry about them. You need community :)

**Q: @medicalwomenuk**

You seemed to really enjoy #MWFCConf15 What's the appeal of MWF for you?

**A: @amcunningham**

#medwomen is all about bright, committed women supporting each other. The conference was a real pleasure!

**Q: @medicalwomenuk**

What advice would you give to graduate just starting FY?

**A: @amcunningham**

follow #tipsfornewdocs. You will never regret time spent listening to patients and find time for yourself!

**Q: @medicalwomenuk**

Finally - What advice would you give to women looking to have an academic career?

**A: @amcunningham**

1. Find a mentor 2. Find several mentors! 3. Don't exhaust yourself 4. Stay true to your values!



# TOPTIPS *for* THE FEMALE DOCTORPRENEUR

By Dr. Lafina Diamandis, Founder of Property Investing for Doctors @medwomeninbiz

Business skills, medical innovation, and entrepreneurship are not subjects currently on the UK medical training curriculum. For those interested in this exciting field, here are some simple steps to help you innovate and become more creative.

## 1 'GET IN THE GAME'

Learn about medical innovation & entrepreneurship by meeting people already in the field. You can join or start clubs & societies (e.g. the Society of Physician Entrepreneurs (SOPE) or Doctorpreneurs.com), read books and articles, taking short courses (e.g. at edX or Enterprise Nation), attend conferences & events, or learn by doing. If you don't have an innovative idea yet, help someone with their idea, which is an invaluable way to 'learn the ropes'. Internships, observerships or postgraduate medical fellowships in diverse healthcare business settings allow 1st hand experience of the industry.

## 2 BRAIN TRAINING: EMPATHISE & PROBLEM SOLVE

The ability to truly empathise with someone's needs, pains, and desires, coupled with problem-solving is a powerful skill, particularly in social entrepreneurship. Always think of your patient/client/target market first, & what value you can bring to them; if the problem is big enough & the solution viable, success will follow!

## 3 CARRY A LITTLE BOOK OF BIG IDEAS!

Each time you come across a problem in your everyday practice, view it as an opportunity to do something that benefits patients or society. Carry an 'ideas book' to record these 'problem opportunities' & brainstorm solutions. This helps to develop a practical, solution-orientated approach and exercises your entrepreneurial mind-set muscles – with practice you will start to see potential 'opportunities' everywhere!

## 4 NETWORK: YOUR NETWORK IS YOUR NET WORTH!

Networking is vital to meet business partners, collaborators, mentors and potential investors. The more diverse your network, the better the chance of finding the right person for advice, help or support. To network effectively get some business cards printed. Don't worry about pretentious titles or not having a company name. This creates a professional impression & facilitates exchange of details.

## 5 BE HUMBLE AND WILLING TO LEARN

Most medical professionals will be accustomed to a level of respect or admiration from their immediate network or community. Leave your ego at the door & understand that your former achievements may not earn you instant kudos or impress others – no matter how many publications or letters after your name! The most important qualities you can hold are humility, determination, a willingness to learn & share your medical experience where relevant.

## 6 NEGATIVE FEEDBACK AND FAILURE ARE GIFTS!

It is easy to fall in love with one's ideas at the beginning & as a result, become oversensitive to failure or criticism. Discuss your ideas with as many people as possible (the more diverse the background the better) & consider negative feedback (or constructive criticism) as a gift & a great opportunity to improve or reject your idea before going too far with it. Many successful entrepreneurs have several failed ventures before striking gold. We learn more when we fail than when we succeed. Think of failure and mistakes as 'life's tuition fees' and a natural progression towards success.

## 7 IT TAKES TEAMWORK TO MAKE THE DREAM WORK!

Many young entrepreneurs starting out alone quickly become overwhelmed with the many aspects of running a business. This is natural because it is impossible & not much fun to do everything yourself. Think about **who** you need to help you early on & find them. This is where the time you have spent expanding your network really pays off!

## 8 CASH FLOW IS KING!

If your business idea is viable then you will need to think about cash flow. Write a business plan, seek the advice of an accountant, & ask other entrepreneurs how they look after their finances. If this is an area you don't enjoy, ensure that you understand the basics & find someone to manage this side of the business. This is particularly important if you have employees & contractors to pay, or if your own income is derived from the business revenue.

## 9 FIND A MENTOR OR ROLE MODEL

Have a/several mentors whom you can turn to for advice & support in your entrepreneurial venture. This is invaluable – particularly when times get tough & you need encouragement or the benefit of their experience. If you don't have a potential mentor within your immediate network, find one online or at networking events. Some great resources are LinkedIn & www.founderdating.com where you can connect with entrepreneurs, founders & advisers.

## 10 RESILIENCE

Compared to Medicine, the world of healthcare entrepreneurship & innovation can be unpredictable, unstable & even disappointing. Building a business from scratch is hard work & there will be many challenges along the way. However, enjoy the journey. You will develop skills such as patience, humility, self-belief & true resilience en route.

# Remote & Rural

**Gabrielle Deehan**, gap year Medical Student, St Andrews

Gabrielle Deehan is a medical student, taking time out from her studies to explore healthcare delivery across the developed world. She has recently visited Australia and New Zealand.



One of the many delightful things about Australia and New Zealand is the fresh produce: much of the country's soil is rich and fertile. I wholeheartedly embraced educating myself about the rural areas I visited by indulging in the local offerings including, of course, the cheeses and wines. It was amazing to go grocery shopping and find that the majority of the fresh food for sale originated in the country I was in. After a few weeks, I even found myself turning my nose up at imported fruit! Most of this food was produced in rural areas, and agriculture provides vital employment in many of the places I visited. To try to understand this, and some of the stranger injuries I saw in local practice, I toured an abattoir in Tasmania – a fascinating experience and an education in just how important buying local produce is to supporting local employment. I sampled some great food including haangi (food cooked underground in the traditional Maori way), dived for my own scallops in northern New Zealand, and visited a dairy where I sampled milk fresh from a cow and some of the delicious cheese that it produces. In King Island, a small Tasmanian island, partway between Tasmania and the mainland, I visited a BYOF restaurant, where you Bring Your Own Food. The restaurant is an old boat shed overlooking the water, owned by a local artist and decorated accordingly. The restaurant was unstaffed (patrons were expected to do their own washing up and re-set the tables) and the owner relied on an honesty box for the nominal barbeque rental fee and payment for any of the wonderful paintings which could be removed by

the buyer from the walls of the building. It is a testament to the goodness and creativity of the King Island community that such a wacky system works so well.

In addition to community spirit and creativity, I found that the local industry is a major contributing factor to the overall happiness and health of each rural place where I have been. In places where unemployment is endemic, and many people cannot afford to move away, the community spirit prevalent in other rural places is lost. One such mining village struggled for several years without a permanent doctor and I was fortunate enough to visit shortly after a permanent doctor arrived. He was the star attraction, and patients who had grown tired of the stream of locums and the lack of continuity in care in the community came to him with problems that really should have been seen to years before. The notes he inherited were, for the most part, inadequate and required much time to tidy and update. Fortunately for the town, this doctor was kind, patient and very knowledgeable. Indeed, every other patient told me how happy the town was to have him. Unfortunately for the new doctor, after years of decline, there wasn't much happening in the area, with few opportunities to make friends. The omnipresent issue of confidentiality means that doctors new to rural practice may feel isolated, particularly those without families to support them.

Many of the places I visited were charming, with rich cultures, local crafting and food industries, plentiful employment in diverse activities, and a local sense of belonging. However, many did not. Without this rural charm, how does a remote place attract – and keep – a passionate, dedicated and happy physician?

Mental wellbeing of both staff and patients in isolated areas is important and challenging. As part of my trip, I shadowed many different professionals, including a morning with a community health nurse. This was in a lovely area with beautifully kempt houses and residents. However, at the end of the morning, we pulled up to an abandoned house, knocked at a door with a hole where the handle had once been and were greeted by a scruffy looking man with half his teeth missing. Paul was in his early forties and had suffered with mental health problems since his late teens, which put to rest a promising career taking over his family's bakery business. I was told that he had been one of the town's champion athletes, excelled in the local school and was well known and loved by all. Such an image contrasted starkly with the worn and malnourished man who stood before me. He lived in the house he had grown up in and had been left to him by his parents; I learned that Paul was doing well, following a couple of uncontrolled years in which his delusions had led him to pull





down internal walls and disconnect power lines. The community health nurse recently had the great idea to provide him with meals on wheels, which was going very well and, despite appearances, the man I met was charming, articulate and intelligent, with great insight into his illness. As the nurse pointed out, he was the ideal candidate for an assisted living home, with little supervision and a lot of structure. Unfortunately, such services don't exist in remote communities and Paul loved his home and would not consider moving.

The most significant aspect of my year has been realizing that just as different cultures across the world have wildly differing beliefs about health and expectations of healthcare, so too, do individuals. It might not be feasible for an entire healthcare system to deliver affordable options entirely tailored to each individual patient, but healthcare workers can listen to, interpret and advocate for individual patients. I am sure that my experiences this year will be of enormous value to me in understanding and rationalizing my experiences, both next year as a clinical medical student and as the NHS evolves over my lifetime.

**I am ever grateful to the R&A Foundation for their generous funding, as administered by the University of St Andrews, for my travels. If you would like to read more, I have been blogging about my adventures at [randascholar.wp.st-andrews.ac.uk](http://randascholar.wp.st-andrews.ac.uk).**





# WORKING IN NEPAL:

## Speaking the Language of Public Health

**Dr Sangeeta Rana**, Specialty Registrar in Public Health, London

Last January, with the inspiring but intimidating vision of Hillary Clinton in my mind, I set off for Kathmandu to serve as a “Special Technical Assistant” to the Nepal Health Research Council (NHRC). As a Fulbright-Clinton Fellow, I had the opportunity to live and work in Nepal, contributing to the public sector, learning with and from new colleagues, and gaining hands-on public health experience in a new and challenging environment. The first Fulbright-Clinton Fellowships were awarded worldwide in 2012 and my colleague and I were the first to go to Nepal last year. A core aspect of the fellowship is that fellows are placed in areas of need for host governments; in the case of Nepal, a key need was identified in Public Health, which led to my placement.

On my first day at the office, I arrived at a beautifully carved wooden door, leading to three levels of offices surrounding a circular central stairway. I was warmly welcomed by the NHRC team, and quickly began to learn the appropriate (Nepali) greetings for my colleagues, including the gendered and ranked titles of each member of staff. My colleagues wore formal uniforms in identical colour schemes, which included white shirts and blue trousers, or the option of Nepali kurtas or saris for women. The Council staff, made up of research, administrative and management officers, are civil service employees. I started to learn the timings and patterns of tea breaks and the appropriate times and occasions to serve tea to visitors. I also tried, unsuccessfully, to change my morning coffee habit to a morning plate of rice, lentils, and vegetables at the Ministry canteen. I did, however, succeed in getting used to the best tea and snacks that I have ever had delivered through my office window.

The NHRC is linked to the Government of Nepal Ministry of Health and Population in Kathmandu. It is statutorily responsible for a huge list of national public health functions ranging from ethical regulation of research to ensuring that national policy is evidence-based. The area that I worked in was promoting evidence-informed policy-making. However, we all pitched in when extra help was needed around the NHRC, to train others, undertake research projects, or practically anything else that came up! We shared public health evidence to support developing national health policies and plans, for example the 5-year plan for the health sector, and the national non-communicable diseases action plan. Promoting a sound evidence base for these plans made for eventful, interesting and varied days. My team and I could be found briefing policy-makers, organising consultation events, or jumping on a scooter to catch a colleague across town to talk through the latest research in Nepal. When we saw a gap in communication between policy-makers and researchers, we set



up workshops in Nepal and abroad to connect, discuss, and bridge the gaps.

In many ways, the challenges I faced in my work in Nepal were the same that I face as a Public Health Registrar in London. Limited resources for prevention and health, an uncertain political climate, debates around local versus national control of planning and resources, stark inequalities in health by socio-economic status, gender, ethnicity – I could go on. Of course, in Nepal the barriers can seem as high and as difficult to climb as Everest, and the resources grossly inadequate in comparison.

In one rural community in the hills, hours from Kathmandu, I visited a small government primary health care centre (PHCC). It provided basic services for the surrounding poor communities. Patients with more complex needs, like obstetric emergencies, had to travel long distances, often on terrible roads, for further care. There was only one doctor in the PHCC and it was her first job out of medical school. Imagine working in a community with diverse health needs but with such limited resources as an FY1 doctor? The community benefitted from an army of volunteer health workers, who like their colleagues across Nepal, were essential in promoting women’s and children’s health.

This is just one example of the many health system challenges in Nepal, before the devastating impact of the recent earthquakes. Added to this there are the challenges of Nepal’s long history and complicated role of foreign aid for health, and a decade long civil war. I often felt overwhelmed and confused. What does it take to improve health, and what does it mean to do no harm? When resources are so constrained, uninformed health policies can feel like harm.





On a practical level, when I started at the NHRC, navigating language and professional cultures was a challenge. Learning to follow and participate in meetings run in formal Nepali language and style was exhilarating to achieve, but a struggle! For the first time I noticed that I was the only woman in the room. But, this rapidly became the norm.

“Who’s her father? Which Rana is her father? Or husband?” I got used to these conversations in my year in Nepal, much as I got used to explaining to my friends and colleagues at home, that actually, the public policy fellowship that brought me to Nepal was honouring **Hillary Clinton** and her work, **not** her husband’s. These simple conversations were an introduction of sorts to the surprising importance of gender in my understanding and experience of working in public health and policy.

In contrast, public health is one of the most gender-balanced specialities in the UK, and I now realise how much I take that for granted. Working within a national government service, and particularly national decision-making forums, gender imbalance is the norm in most nations, including the UK. As UN Women pointed out recently, only 17% of ministerial posts worldwide were held by women as of 2014.

Learning to work effectively with these challenges gave me invaluable skills in public health, and in my approach to life; I learned to communicate and present more directly and confidently, to navigate new cultural norms, and to apply my existing public health skills to new problems. Even more importantly, I was forced to step outside of my comfort zone, to appreciate parallels and differences in public health practice around the world. I learnt to deal more effectively, and with more enthusiasm, to overwhelming frustrations and barriers; to keep the enjoyment and purpose at the front of my mind and to be persistent. Even at key opportunity points, change is slow.

The female friends and mentors I met in Nepal showed me how to be a confident and effective female professional, regardless of where I am working. My colleagues were, and are, incredibly inspiring, and I hope to keep these relationships and learn from them for the rest of my life. I hope, one day, to return to Nepal.

With the recent earthquakes, the NHRC, and Nepal, feel closer to my heart and mind than ever. I hope I can continue to support and learn from the inspiring health professionals, volunteers, and communities in Nepal, men and women, slowly rebuilding the health system.

*Note: Please consider supporting the organisations below, who have been on the ground, working in the relief and rebuilding efforts since the April and May earthquakes that struck Nepal.*

ANMF: <http://americanepalmedicalfoundation.com/>

BNMT: <http://www.britainnepalmedicaltrust.org.uk/>





# MEDICAL MEMOIRS



**Dr Eva Shirreffs**, Retired GP, Barrow upon Soar

*By Miss Jyoti Shah*

A combination of talent, hard work, and a sprinkling of luck have shaped the career of a General Practitioner, who has lived life to the full. Dr. Eva Shirreffs, now 93 and a great grandmother, is strong, fearless, and even with her walking stick she exudes a certain grace to her movements.

**E**va is the daughter of Dr. Gray, who was a well-liked popular village GP (after whom Gray Court in Barrow is named) and Louise, his French wife. Eva's older sister, Marie excelled in languages and was a French teacher, but Eva grew up pouring over the anatomy books on her father's bookshelves. She has fond memories of her childhood and recalls helping her father stick labels on medicine bottles to give to patients in his surgery. She knew from the age of 8 that she would follow in her father's footsteps.

Eva trained during the war at Aberdeen University, which was regarded as one of the best universities at the time. Medical school then was tough she describes, and there were no summer holidays. Her year started with 120 students and only 12 girls; less than half the year finally qualified.

"We went on many ward rounds with consultants and the course was clinically orientated. It was important to learn about patients and show that you were genuinely interested in them," she reminisced.

Eva met the man of her dreams, James, at University and soon after they married having two children. As he joined the Armed Forces, they had to spend around eighteen months apart – like so many others during the time of the Second World War.

As part of her medical training, Eva was initially drawn to plastic surgery. But she fell into dermatology instead. She had heard through the grapevine that if she applied for a VD and dermatology house job at Aberdeen Hospital (she wanted a teaching hospital job) she would definitely get it! And she did.

Eva was fascinated by the enormity of dermatology as a specialty. The art of diagnosis appealed to her more than the actual treatment. She admits that her passion for medicine was not so much that she wanted to just help people, but that she was intrigued with medical diagnoses.

Despite few women at medical school and in the profession in general, Eva did not really think about the gender differences although "female students were a target for sexual innuendoes." She recalls an example of a lecturer asking one of her female





colleagues ‘What is the obvious external difference between men and women?’ The female student replied by saying the penis. ‘What about the larynx?’ he continued. ‘Lecturers tried to embarrass you, but you ignored them. Standing really close to you in ward rounds and backing you into a corner was another such nuisance.’

After her house jobs, Eva returned to work as a GP in Leicestershire, initially working with her father and later her husband. She managed her career and family by getting up very early and putting in the hours. She also enlisted the help of a nursemaid.

Eva endured many of the odd call outs that GPs have to deal with in the profession. These included one young girl who had stomach ache after eating green apples; a woman who could not get her dog off the bed and a man upon whom a wall had fallen. ‘His rib cage was caved in and he was obviously dead. I did not know what to do next!’ she exclaims. ‘You got to know the patients and their families in those days and the GP was pivotal to village life.’ It is so different now she reflects.

One day Eva received a phone call from the dermatology consultant at Leicester Royal Hospital, and she has never looked back. Since then, she successfully combined a GP career with dermatology until she retired in 1997.

Throughout her career, one of the major political issues she faced was the creation of the NHS, which she did not vote for because she just didn’t believe in it. Patients used to contribute 4p a week to a doctors’ club as a form of insurance, and this would cover medical costs.

Although against it originally she concedes that the NHS was the best health system in Europe. Eva takes a deep breath: ‘not anymore. I am horrified by the NHS now. Who is responsible for the tragic mess that it is now in?’ We speculate; we reminisce; we despair!

We lighten the mood. She describes her funniest encounter while doing a scrotal biopsy. ‘Just a small prick,’ she said to the patient as she approached with a needle and syringe. She lifted the



drape and to her utter embarrassment she faced the smallest male organ that she had ever seen!

Since retiring, her interest in medicine has continued, and she is well informed with the latest medical advances and news. Her secret to longevity is healthy salads (her favourite food), a glass of wine, especially one with bubbles in it, and gardening. Of her career: ‘I just loved it’ she reflects.

Photos courtesy of Paresch Solanki: [www.lifeView.media](http://www.lifeView.media)

## DISPELLING MYTHS...

**Cracking knuckles (thought to be due to imploding gas bubbles in the synovial fluid) does not cause arthritis**

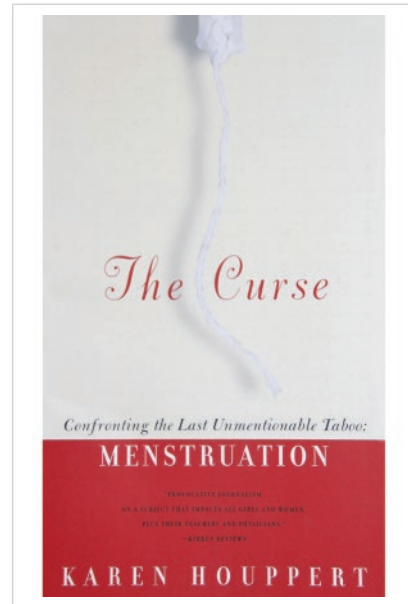
# Menstruation

**Professor Karen Houppert**

School of Global Journalism and Communication, Morgan State University, Baltimore, USA



**P**rofessor Karen Houppert is a US-based journalist, author of *The Curse: Confronting the Last Unmentionable Taboo, Menstruation* and founder of the blog, *MenstrualMoments.com*. Her reporting has appeared in a wide variety of publications, including *The Washington Post Magazine*, *The New York Times*, *Newsday*, *The Nation*, *Salon*, *Slate*, *Mother Jones*, *The Village Voice*, *The Baltimore Sun*, *Glamour*, *Self*, *Fitness*, etc. A former staff writer for *The Village Voice*, Professor Houppert has won several awards for her coverage of gender politics, including a National Women's Political Caucus Award and a 2003 Newswomen's Club of New York Front Page Award. She lives in Baltimore, and is writing about the criminal justice system, race, poverty, education, politics—and their unholy mix here and in the nation at large.



In my extended family, like all families, we have stories that come up regularly at gatherings—stories of foibles and faux pas, comeuppances and coup de graces that are told so many times they acquire folkloric status quality across the generations. One of those stories gets told only among the women as we do the dishes after dinner, play solitaire, sip a nightcap.

The extended family was having a dinner at a restaurant with my

twentysomething brother-in-law and his twentysomething fiancée. She wore white pants. When she stood up to go to the salad bar, my seven-year-old niece noticed a big spot on her pants, “You’ve got something on your bum!” she said in her loud voice. “Hey, what is that? I think you sat on something. You’ve got a lot of red on your bum.”

Mothers and aunts and grandmothers hushed the child. “But she’s got something on her bum!” the girl insisted, at a volume that drew the entire restaurant into the observation.

“No, she doesn’t. It’s fine,” the women lied as the embarrassed fiancée rushed off to the bathroom, followed by a sister-in-law who gave her a v-neck sweater to tie around her waist and hide the blood stain.

Meanwhile, the remaining women at the table, in unspoken agreement, pretended for the men’s sake that nothing had happened, lied to the child and said she imagined its redness and maybe the fiancée had just sat in a bit of chocolate and “now let’s talk about something nice,” and behaved as if nothing had happened when the mortified fiancée finally rejoined the party.

Years have passed since this day – the “child” is a thirtysomething mother herself and the “fiancée” married, had kids and divorced my brother-in-law and moved far away – but we still laugh about that day and the child’s emperor-has-no clothes cry.

And the ways in which we were complicit in denying the child’s reality in order to spare everyone embarrassment.

It makes you think.

The curse. Wrong time of the month. Monthlies. Monthly troubles. Calendar days. Cycling. On the rag. The nuisance. The plague. Poorly times. Tides in. Red letter day. Riding the red



“In my extended family, like all families, we have stories that come up regularly at gatherings – stories of foibles and faux pas, comeuppances and coup de graces that are told so many times they acquire folkloric status quality across the generations.”

tide. Lady in the red dress. My red-headed aunt from red-bank. Raining down south. Aunt Flo is visiting. Communists in the summer house. Package of troubles. Period. The moon. Cramps. Under the weather. Weeping womb. Those days. Girl things.

When I was writing my 1999 book, *The Curse: Confronting the Last Unmentionable Taboo: Menstruation*, I began collecting euphemisms for menstruation that I encountered in conversation and literature. I strung a partial list together in a collage for the book's endpapers because I thought the terms were revealing. They were revealing the same way that anthropologists suggest that the hundreds of words Eskimos have for snow are revealing.

But with a twist.

When people say, “Eskimos have 100 different words for snow,” they are suggesting that societies evolve – linguistically and otherwise – to accommodate and reflect the things that vitally affect their lives. This is certainly true of menstruation for women; once a month we spend some time considering, at the very least, the mechanics of this regular event. But the slew of terms we've developed are also a code, designed for concealment, to hide the fact that we're bleeding.

Think about the lengths we'll go to make sure no one at the office or restaurant or party knows we're menstruating. Do we brazenly carry a tampon from our office cubicle to the bathroom? (No. We tuck it in our sleeve or bring our purse along for the walk down the hall to the toilet.) Do we pop two ibuprofens at the restaurant and when our father-in-law worries that we've got a migraine do we correct him, explaining that we've got cramps, or do we just nod our heads in a little white lie? At a party, when we discover we've forgotten to bring a tampon, do we casually stride up to a group and ask if anyone's got a spare (as we might bum a cigarette) or do we discreetly whisper in the ear of the few women we know best to see if they can help us out, hoping no one hears or deciphers what we're up to?

In 2015, we like to concur with that old Virginia Slims cigarette ad, “you've come a long way, baby.” But the culture of concealment on this topic endures. Why is that?

As recently as January 2015, menstruation made it into the headlines – at least the sports page headlines – when British tennis player Heather Watson mentioned that it was a “girl thing” to explain why she wasn't in top form and lost at the Australian Open. I counted at least 104 articles on the topic, ranging from the BBC to blogs – and then I just stopped counting. Commentators – myself included, since I get calls from reporters every time the topic of periods leaks into the press; not a lot of talking heads vying for the title of Expert when it comes to periods, apparently, and my 1999 book comes up when reporters google menstruation – tended to fall into two camps. Some, like Marie Claire writer Suzannah Ramsdale

called it “really brave” while others called it a “cringe-worthy” moment. Few asked why this made news at all.

Women bleed once a month; why do we hide it?

I was particularly struck by a quote from tennis player Tara Moore in *The Telegraph*: “At Wimbledon we have to wear white, so it's quite a big deal. Especially because male players don't understand that we have another element to deal with. [Bleeding on your uniform] is something you feel quite worried about. If something like that happens, it's mortifying – it's a nightmare.”

A “nightmare?” Really? Why is it that we have to keep our periods a secret and it is “mortifying” to let anyone know we're menstruating? I get that it is a drag to ruin your panties and skirt with a blood stain, but “mortifying?”

Reading that, I was suddenly back in the restaurant with my seven-year-old niece denying a reality of women's lives just to keep the peace at the dinner table. The truth is that the culture of concealment surrounding menstruation prevents needed oversight of the sanitary protection industry (we need to know the ingredients of these things we stick inside of us); prevents necessary research on menstruation (large-scale, reliable scientific studies are so slim no one really knows how or if periods affect athletic performance, medication use, sex drive, self-image); prevents young girls from naturally accepting the changes in their bodies as no-big-deal signs of healthy growth. We don't even know what we really think about our periods because our relationship with our cycles are so tangled in myths and taboos about the topic that we can't tease out our natural feelings from culturally-imposed notions about menstruation.

Sometimes I wonder what a mini-menstrual revolution would look like. What would happen if women everywhere stopped playing the game and were out-loud and proud about their periods? What if we refused to protect the men in the world from our sometimes messy reality, declining to keep it under wraps?

After all, we are all complicit in the culture of concealment – even me, author of a book on the topic, when my seven-year-old niece needed confirmation that what she saw with her own eyes was so. Why deny the truth of our bodies – and lives?

### TOP TIP

Prevent your necklace from getting tangled by threading one end of it through a drinking straw until it comes out at the other end. Then redo the clasp – a perfect traveling tip



# WHO REPORT GENEVA: MAY 2015

**Dr Clarissa Fabre –**

GP East Sussex and former MWF president

I am very pleased to report that MWIA now has a comprehensive collaborative work plan with WHO for 2014-2016. We have established fruitful relationships with staff in relevant departments at the WHO. Progress on the work plan will be reviewed by the WHO Executive Board once every three years.

MWIA's priorities remain the Safe Childbirth Checklist (SCC) and our handbook on Domestic and Sexual Violence. Dr Rosemary Ogu from MWIA has led a pilot of the Checklist in various centres in Nigeria. WHO will officially launch the SCC in October in Mexico. MWIA plan to send a representative.

With regard to sexual violence, WHO has recently published a Clinical Handbook. Dr Claudia Garcia-Moreno, WHO lead on the subject, is very keen to receive feedback from MWIA on the handbook, especially its relevance and usefulness in different parts of the world. If you are interested, see <http://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/>. Our handbook will be written from a different perspective, taking account of experiences of our members in many different countries.

A highlight of the World Health Assembly is always Dr Margaret Chan, the Director-General of WHO. She emphasised the importance of responding more effectively in the future to emergencies such as Ebola. A single new programme will be created, designed for speed and flexibility, with key partners such as the UN, experienced emergency coordinators, and rapid response teams. A large contingency fund will be established. The Sustainable Development Goals will be finalised in September. At present there are 17 goals and 169 targets. The health goal is number 3, which will cover among other areas non-communicable diseases and universal health coverage.

Angela Merkel was this year's guest speaker and spoke of the Ebola 'catastrophe' and the world's slow response, the problem of anti-microbial resistance and the need for everyone to work together. As she said, the WHO is the only organisation that has true legitimacy at an international level.

## Advice to a new medical student...

**Miss Amy Woods, Medical Student**

1. Don't worry if you are not the smartest one in your class. Even if you were the smartest student at your school/previous degree, you may not be now, and that's ok! You don't have to be top of the class to become a good doctor!

2. Make friends. Make all the friends you can. From your 1st day, and especially at Fresher's week, make friends with everyone you meet. Over time, your group of close friends will get smaller, but you will have lots of potential study buddies and friendly faces whilst you are on placement.

3. Make 'non-medical' friends. You will be surprised how quickly you lose the ability to hold a conversation that does not revolve around medicine. It can be all consuming. The reality is that you need a break from medicine to keep you sane. So, make time for those friends from before medicine and from other courses – it will help you in the long run.

4. Don't be embarrassed. When you feel like there is too much to learn and you have no idea what is going on, but it looks like everyone else does – they are as overwhelmed as you are. Give yourself time to work out which method of learning is best for you. Don't be embarrassed to do things differently. If you need to use a colouring book to help you learn anatomy, then do!

5. Be confident. Confident enough to say you don't know; confident enough to ask questions. Confident enough to put yourself forward for any opportunity that is offered to you, even if it seems scary – the practice will make you better!

6. Finally, enjoy it! Medicine can be a challenge. However, you have worked hard to get this far, so make sure you relish the experience and have lots of fun along the way. You will spend your years at medical school studying with close friends, meeting amazing new people, and at the end you become a doctor! All in all, it is not as hard as you think it will be!

# The Wall of Wisdom

This issue's question was:

## "HOW TO DEAL WITH A BAD DAY AT WORK?"

"First I accept that I am having a bad day & then I concentrate on understanding my emotions - am I stressed, angry, fearful or spacing out? I accept & regulate these emotions so that they don't affect my work. I take 5 minutes of 'me time', make a cup of tea & slowly have it, relaxing in the process. Then I identify the trigger. Sometimes, talking to a colleague or loved one helps. My advice: take a step back & go with the flow. If you can, do something about it; otherwise reassure yourself it's just another day."

Dr Preeti Shukla, GP, Blackburn

"Make tea or play solitaire (quicker than Sudoku) to clear the head. If you can't leave then that's the patient who needs you most"

Dr Tushar Vince, (@tushar\_vince)

*"Get on your bicycle!"*

Dr Hannah Bonnet, (@mh\_evans)

"I head to the beach with my lovely little doggy & hurl out my frustration & stress in the form of Frisbee throwing! I also drink copious amounts of tea whilst at work & large glasses of alcohol based beverages on a Friday night to celebrate that another week is over!

Oh, & a nice facial never comes in wrong."

Dr Danielle Robinson, GP, Newcastle

"Go out for even a 5 minute walk. A change of scenery always helps to put things into perspective."

Dr Pooja Arora, (@Pooja\_Arora1)

"Play your favourite music very loudly in the car and go via the gym to run away from all your frustrations before arriving home."

Anonymous

"Do your best & it's surprising how quickly a bad day passes. Alternatively, there is always chocolate!"

Dr Sally Davies, (@sallydavies27)

"Depending on the reason, speak to a friend or partner; stop & take a break for few minutes; recharge with coffee/chocolate/cake."

Dr Farah Jameel, (@DrFJameel)

"The answer depends on how bad a day it was. Ideally it would be pounding the pavements, a nice meal or a debrief/ rant with friends. Worst case scenario may involve vodka & Chaka Khan - the preferred method of character Bridget Jones. One thing's for sure though, laughter is clearly the best medicine & at times if you didn't laugh, you would cry!"

Dr Siobhan Wild, GP ST1, Swansea

*"Pour myself a glass or two of wine!"*

Dr Georgina Elston

"Have someone or a group of people you trust & can talk honestly with. They don't have to be your peers - I have a group of fellow consultants in different specialties & some senior nurses. Have an 'out' - something else that is not medicine related - read a book, run, sing, bake or play with your children."

Dr Sarah Pearson, (@Sarah\_Peas)



# The Other Side:

## Doctors as Patients

**Dr. Wendy Oakley**, a Consultant Obstetrician and Gynaecologist reflects on her experience of being a patient after a few moments of inattention leading to a serious injury abroad. Her candid description is a reminder to us all that it is hard to distinguish between doctor and patient as we inhabit our doctor roles all the time. Whilst we can leave our white coats at work, we cannot as easily remove our identities as physicians. It seems that no amount of doctoring prepares you to be a patient who is scared, vulnerable and exhausted.

**T**here is a heatwave in the Bordeaux region of France and the chilled wine I was drinking several hours earlier is a distant memory. My husband and daughter are ahead of me on their tandem and the tree cabin where we are due to stay is in sight.

However, the front wheel of my bike slips and as the bike swerves in one direction, my foot and I fall in another. I am terrified to move and wonder if I am delirious with pain when a fire truck arrives to take me to hospital. The fireman reassures me in French that it may just be a sprain but cannot give me any analgesia – he is just a fireman! Every jolt of the truck jars my leg and I know something awful has happened.

### The break

I am taken to the ‘trauma centre’ of a small general hospital, far away from Bordeaux. I am relieved to see only a break in my left fibula on my X-ray. That is easy to mend, isn’t it? I’ll only need 4 weeks in plaster and a couple of months off work, won’t I? The emergency doctor, in perfect English, points out the tibial fractures and the dislocated ankle that I have missed. High on morphine, we chat about the differences in our working lives while I wait for my ankle to be reduced and immobilized. He tells me of the need for definitive surgery, and I ask if he trusts the orthopaedic surgeon – he reassures me he would let him operate on his wife. I phone an orthopaedic colleague in UK who tells me the proposed management sounds reasonable.

### The environment

The hospital is full and I am parked overnight in the maternity unit. The irony



of this, as an obstetrician, is not lost on me. I am given a “new mother” pack with basic essentials like a toothbrush and am well looked after – they even wash my hair. But, I cannot sleep. I am lost and alone in a foreign country. I want to go home.

The next morning I meet the orthopaedic consultant who communicates with me more as a doctor than a patient and tells me about my simple ankle fracture. It just needs a screw into the medial malleolus and he will do this over the next few days. I struggle with the discussions in French and my request for an interpreter is refused. One kind nurse, the first of many who will stick in my memory, returns after the ward round to explain more slowly in French. Attempts to arrange repatriation home are unsuccessful, and I accept that surgery will be done in France. However it will not take place until after the weekend.

I am moved to a 2-bedded room on the orthopaedic ward but my neighbour does not speak with me for the whole 6 days I am there. Further isolation. My

sanity is saved by regular short visits from my family (they have a 3 hour round trip), and by the text conversations that I have with a group of medical friends in the UK. I am blissfully unaware that they have agreed that the best way they can support me from a distance is to each text me prolifically.

I worry about everything, particularly the potential for drug error as my infusions have no patient identifiers and are labelled by room and bed number. I worry about the absence of an ID band. I am relieved when one appears just as I am moved onto the theatre trolley. The ODP is the only other English speaker I will meet – a temporary respite from thinking in French. The ability to speak in English is a bigger comfort than I realized at the time.

### The operation

After surgery I learn that the operation went well – 6-8 weeks in plaster and 3-4 months before I can go back to work. I still can’t sleep uninterrupted. The high temperature with no air conditioning and the smell of 2 unbathed bodies reliant on bedpans overwhelms my family. Although desperate to see them, I discourage their visits.

I develop blisters on my hands from shuffling around the bed. After more than two decades of asking post-operative patients if they are passing wind, I realize the indignity of intestinal reawakening, and the lack of privacy offered by a curtain. I am desperate for some privacy. Forty-eight hours after surgery, the consultant refuses to allow me out of bed for at least a further 24 hours – something else that I had taken for granted my whole life. I lose all control and sob



“After more than two decades of asking post-operative patients if they are passing wind, I realize the indignity of intestinal reawakening, and the lack of privacy offered by a curtain.”

hysterically. Finally, the senior nurse returns with two colleagues to secretly deposit me behind the bathroom door.

Lying in bed, there is little else to do but look down at my foot. I become increasingly concerned by the 45 degree external rotation. The doctor and nurses are happy with its appearance and simply re-plaster it. The pain is excruciating. I cannot concentrate and I am desperate to sleep. I self-medicate and swallow the antihistamine and paracetamol containing propriety cold medicine from my travel kit. When a nurse gives me the first bag of IV paracetamol in 24 hours shortly afterwards, the overdose risk is one I am prepared to take! I finally manage 5 hours sleep.

### Falling again

Almost 7 days after the accident I am finally allowed out of bed for the first time – but I am so unstable that I am offered a zimmer frame. How did it come to this? That night in the toilet I stumble and lie on the floor. I cannot get up. The indignity of it all overwhelms me but 2 days later I am finally home after weeks spent battling with our travel insurance company.

### Coming home

Friends have arranged a fracture clinic appointment in my own hospital the next morning. I admit that I am still in significant pain. X-rays are arranged. The radiographer immediately sees what the entire team in France has missed – there is still a major problem. My ankle remains dislocated. Furthermore, the original injury was extremely complex and the screws inserted in France have achieved nothing other than damage the joint cavity further.

I am immediately admitted and more surgery is scheduled. I am constantly thinking of work and I calculate that I am unlikely to return before the end of the year. I am devastated by the first mention of possible permanent joint damage, but relieved that there is an explanation for

my pain. For the first time since the accident I feel safe.

Colleagues and friends visit and I laugh, for the first time in weeks, when the nurse in charge tidies my bed before the most senior consultant in my department arrives. A terrified FY1 clerks me and I cannot believe that I am intimidating in my current state. After surgery, the physiotherapist successfully teaches me to use crutches and armed with a bath seat, perch stools, wheelchair and 8 different medicines, I am finally discharged home.

The first weekend at home passes in a blur of exhaustion. I cannot quite believe how debilitated I am, and how tiring every activity is. A few days later, I am unable to hop to the toilet quickly enough. I think I have C. diff but my GP explains this off as a side effect of Lansoprazole. How quickly a perfectly fit and healthy person can be reduced to this state!

### The recovery

I give in to the temptation to google – reading blogs from fellow broken ankle sufferers across the Atlantic brings home how fortunate we are to have the NHS. Despite my many worries, paying the hospital bills is not one of them. My self-employed neighbour explains that she would not be able to pay her mortgage if she did not work for three months. Once again, I appreciate the NHS and my sick pay.

Three months later my plaster comes off, and my new automatic car gives me back a welcome degree of independence. I start swimming and have regular physiotherapy. I notice aspects of my own hospital from my new perspective as a patient. This includes the introduction of a new car park charging system, which is a particular challenge for the elderly and those unable to stand in a long queue.

As my physical recovery continues, I re-establish links with work. I complete as much online CPD as possible and I start to attend departmental meetings on my crutches. I am keen to return

to clinical work as soon as possible and a provisional start date in January is arranged. However, my walking progress is slow and I am advised to wait until after my next orthopaedic review before deciding for sure.

Between Christmas and New Year I accept that my leg is getting stiffer and more painful. I chide myself for not exercising enough. At my next appointment, the orthopaedic surgeon tells me that the damaged ligaments in my leg have not healed, the bones have separated, and my ankle joint has subluxed again. The options are limited to a further repair or arthrodesis. As I process the implications of this latest setback, and realize that my journey as a patient is not over, I think about what I have learned already:

1. *How life can alter in a few seconds.*
2. *How disabling and disempowering pain and lack of sleep can be, and how this is compounded by an inability to speak the required language fluently.*
3. *How excellent nursing care can never compensate for poor medical care.*
4. *How let down I feel by a professional who spoke to me daily in France as a fellow medic, but who did not recognize the seriousness of my injury and didn't admit that its repair was beyond his ability.*
5. *How I would like an apology and explanation of why things went wrong in France.*
6. *How drug side effects can be more unpleasant than the problem they are supposed to be treating.*

I still repeatedly ask myself why I didn't just discharge myself from the hospital in France and let my husband drive me home, or even just to the nearest French major city.

On the positive side, it is 2 years since the accident and I am back to work and leading a busy life. My accident and chronic pain have changed me profoundly as a doctor. We are still only human.

# ALL CHANGE!

## Menopause in Medicine

Dr. Hannah Short, GPST2, West Suffolk

In July 2013, at the age of 35, I entered premature surgical menopause. The preceding years were blighted by endometriosis and, latterly, pre-menstrual dysphoric disorder. My quality of life (QoL) had deteriorated to such a degree that the decision to have my womb and ovaries removed seemed to be the only option I had to reclaim my physical and mental health.

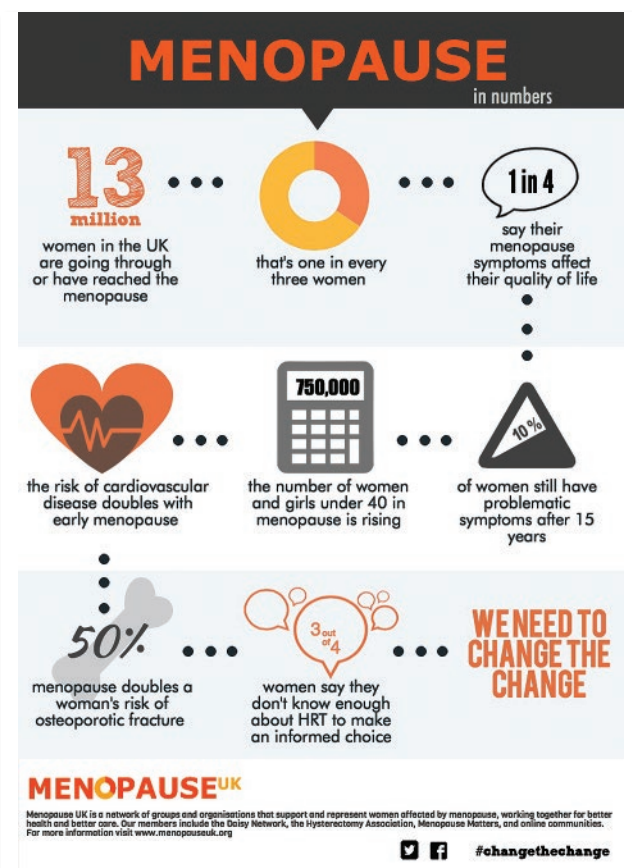
Two years on I don't regret this decision – the operation has undoubtedly been a lifesaver – but my eyes have been opened. Post-reproductive healthcare, and knowledge of this area within the medical community, is woefully inadequate. I say this as both patient and physician.

Surgical menopause has been a shock. I was not prepared, although I had tried very hard to be. Prior to my procedure, I thoroughly researched the subject in the medical literature, online forums and had frank, detailed discussions with my gynaecologist. I knew I was in excellent hands for my after-care and, whilst anticipating a few teething problems, I was confident that all would be well. Despite my medical qualifications, I naively believed that once my ovaries were gone, hormonal fluctuations would be over – I was a blank canvas. As soon as I worked out how much oestrogen I needed I would be up and running.

Immediately following my hysterectomy and bilateral oophorectomy I awaited my first hot flush. It never came. Severe nausea, headaches, constipation, urethral pain and palpitations, however, did. I had not considered that I would not absorb my prescribed hormone replacement therapy (HRT), but that is exactly what happened. I had not banked on the fact that it would take me 15 months to feel vaguely “normal” or that, during that time, I would need to take six months off work. I experienced bone-crushing fatigue and brain-fog that was so debilitating that I felt unable to make safe clinical decisions. I wondered if I would ever be able to return to work.

Thankfully with trial and persistence, some luck and a great deal of help from my ever-patient consultant, I am now in a much better place. However, I shudder to think how things would have been had I not been a doctor, not ensured I was referred to an expert in the field, and not known that I could question the textbooks. Even with my medical knowledge and strong personal drive I struggled to access up-to-date information to explain what was happening to me and to learn how to help myself.

In March this year, the #ChangeTheChange campaign was launched as part of NHS Change Day 2015. Inspired by personal experience, Natasha North – a fellow health professional in early surgical menopause – and I joined forces to tackle the system head on. Our aim is to raise awareness of post-reproductive health issues and encourage the NHS to recognise menopausal health as a priority and not an afterthought. With an average age of 43 years, women encompass 77% of the NHS workforce. The NHS cannot afford complacency. Surgical menopause may be at the extreme end of the spectrum but one in four women going through



natural menopause say their symptoms severely impact their QoL. This is notwithstanding the thousands of women who are affected by Primary Ovarian Insufficiency and radical cancer therapies. Misinformation and outdated ideas surrounding post-reproductive health remain widespread. Sadly, the suffering is very real.

Speaking out on this issue has meant that I have unavoidably waived my medical anonymity. This has, and continues to be, challenging. I chose to leave a private Facebook support group – a lifeline in the early days after surgery – when I became viewed as more doctor than patient. My inbox was inundated with medical queries and I was tagged in endless posts. For a time, it had been my refuge – the one place I felt I could be open and honest, without my professional hat on – but this inevitably ceased. It was no one's fault. Patients desperately need support and advice in this area but it is not easy to find.

I recently spoke at the Daisy Network Annual Conference, a charity set up to support young women in premature menopause. I was there to give the patient perspective as a medical professional. My consultant was in the audience and I found it a difficult balance – tempering the good care I have had from him with the often-harsh reality of my situation.

Last week I attended the British Menopause Society Conference dinner, and found myself on the same dance-floor as my gynaecologist. He is never anything short of professional but I feel exposed. I wonder how seriously others take me. Being a patient in my area of special interest, how am I viewed? Am I an equal?

For the moment, I'll continue to swallow my pride. I believe it's a price worth paying.

If you had told me five years ago that I would spend a vast proportion of my time talking and writing about menopause I would have laughed. Hardly glamorous or groundbreaking and what is there to say? Well, as it turns out, quite a lot. And I'm on a mission to get my fellow medical colleagues to listen.

<http://changeday.nhs.uk/campaigns/changethechange/>

# Succession Planning

## Introducing Iona's partners...

Dr Catherine Harkin, GP, Scotland

Illustration by Laura Coppolaro



### The meeting should have started twenty minutes ago...

Iona wished she hadn't bothered to wolf down her salad so quickly, and wondered why the deli always had to put raw onions in everything, especially when she didn't have time to pick them out. Now she was going to end up burping pungently through afternoon surgery. Iain was riffling through the minutes impatiently and drumming his fingers on the table.

"Any idea where she's got to?" he said with a sigh. "We can't hold on much longer, I think we should just start..."

At that moment the door opened, and the ample figure of the senior partner, Dr Margaret Comfort, bustled through it.

"Sorry, dears, got held up at Crumbleford Lodge again. Do you know, that new manager turns out to be Mrs Wildebeest's stepdaughter, you remember she used to live in Milesaway Road, had that really bad abscess on her – anyway we had a lovely catch-up and she said to pass on her regards – oh, have you started?"

"No," said Iain through gritted teeth. "We were waiting for you. You're supposed to be chairing, remember?"

"Am I, dear?" said Maggie, "Oh well, we'd best get going then. Does anybody mind if I make some tea first?"

Iona thought that Iain might actually explode. It had seemed like a good idea to take on a keen young partner, and Dr Iain Sharpe was certainly keen. Fresh out of training, newly married and full of good ideas, he was determined to drag the

practice into the twenty-first century, if not the twenty-second. One major obstacle lay in his path, and it was at that moment, handing him a cup of tea and a ginger biscuit. So, a certain recurring theme had begun to crop up in their recent partners' meetings, which could have been summed up simply as: when is the old girl going to retire?

"Item 1," said Maggie, "Succession planning. I thought we talked about this last month?"

"We did," said Iain, going red, "But we just wondered about your, er, plans..."

"Plans? I don't have any plans, dear. Apart from holidays, I thought we'd probably go to the Isle of Wight again. We had a lovely time last year, and..."

Iain sighed heavily and crossed his legs, and a tinnily electronic version of "The Power of Love" manifested itself. His wife was still sufficiently infatuated that she bought him novelty socks, and he was still sufficiently infatuated that he actually wore them. Iona quenched her desire to giggle by glancing through the practice accounts, which were certainly nothing to laugh about.

"I think we probably need to consolidate rather than plan any major changes" she said carefully, knowing that Iain was desperate for Maggie to leave but that she had no intention of going. Iona was fond of her, although had to admit that she seemed to be becoming a little forgetful.

"Definitely, dear" said Maggie with a pleased smile. "Now, item 3..."



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