DSN Chair Report AGM 2014
by Dr Angelika Luehrs

DSN started in 1996 as a small, informal self-help group for doctors with mental health concerns, and registered as a charity in 2004.

DSN has three main functions:

1. Peer support via the email forum, Doctors’ Support Line (DSL) and support groups.
2. Raising awareness of mental health problems amongst doctors to reduce the associated stigma.
3. To help improve the working conditions of doctors, support them in looking after their mental health, improve the support available for doctors, and encourage doctors to look after their mental health while asking for help as early as possible.

Following the last AGM there have been some changes to the committee:

Helen has joined the committee.

Howard, who has been our treasurer for many years, has decided to take a step back. We are therefore looking for a volunteer who would be interested in the treasurer role and would benefit from Howard’s support during this year.

Ajay has taken on the role as secretary and DSN would like to thank him very much for his fantastic work.

Clive has taken over some of the DSL work and has done great work in looking into its organisation and recruiting volunteers. We continue to look for somebody to support DSL.

Our team of newsletter editors with Rob as Executive Editor and Louise as Senior Editor continues to work extremely well. The quarterly newsletters (now the 125th edition) are now of high quality thanks to the excellent contributions from you, our membership.

Fiona, our previous chair has remained on the committee and has continued to be a much appreciated source of knowledge and advice.
Summary of DSN activities over the last year:

DSN feels that our presence at relevant conferences is important to raise both awareness of the problems doctors with mental health problems can encounter and, of DSN as an organisation. I would like to thank Matilda and Louise for all their hard work in coordinating the DSN stands at various conferences, as well as all of the other members who have helped.

Conferences attended by DSN:

- De-stigmatising Healthcare for Healthcare Professionals, February 2014
- PHP 5 Years Event, May 2014: DSN was a member of the original National PHP Stakeholder Advisory Group. It was great to see the success of this service after five years.
- UKAPH, June 2014
- AMA – CMA – BMA ICPH Conference, September 2014: the DSN stigma survey was presented as a poster (also exhibited at our AGM & the BMJ Careers fair).
- GMC Consultation Event on Indicative Sanctions Guidance, September 2014
- BMJ Careers Fair, October 2014

Stigma Survey: DSN conducted a survey amongst members looking into the impact of stigma on doctors with mental illness. The results (poster published by Louise Freeman and Rob Sykes) demonstrate the effects of stigma on doctors with mental health problems.

Our BMJ adverts continue and are very effective in increasing website ‘hits’.

The DSN website remains, thanks to Rob’s on-going hard work, at a very high standard. We have started to publish the minutes of the committee meetings in the newsletter to increase transparency about DSN. In future we also aim to publish costs for DSN activities such as conferences to show members how we spend their donations.

DSN Facebook Group

DSN is on Facebook and we plan to advertise via this medium. DSN would like to emphasise that the Facebook group is not a closed group and that it is not possible to verify peoples’ profiles to tell who they are.

There has been a variety of other activities by individual members to raise awareness, reduce stigma and support doctors, such as writing articles in the BMJ, medical student training, and involvement in training programmes such as Health for Healthcare Practitioners and liaising with third parties.

The DSN Support groups continue at present in London, York, the North East, the North West, Southampton, the Midlands, Scotland and Wales with relevant contact details on the website and in the newsletter. The attendance at groups tends to fluctuate. We encourage and support members who would like to start a new group at anytime.

DSN Support Forum

The email forum continues to be lively and well used. It is a confidential forum and allows doctors to express themselves freely without the fear of implications for their professional life. An anonymised forum
Editorial: continued... By Dr Angelika Luehrs

would protect both forum users and committee members against this. DSN needs to ensure that this remains possible. Therefore, we now aim for the email forum to be fully anonymised. This has been controversial and we appreciate that this might be a difficult decision for some and appear like a ‘step backwards’. Therefore we will send a reminder to individual members who are on the forum to please ensure that they are anonymised. Should members not be anonymised by the New Year we will unfortunately have to remove them from the forum in order to keep the forum going.

Finances

There has been a change from subscriptions to donations, with our main income via member donations. DSN decided to stop asking members for annual subscriptions as this had created delays in processing membership applications. The removal of the need for payment verification prior to joining the forum has also made the new member registration process easier. This excellent work by Alison and Sally has optimised the registration process.

Dr Oliver Quantick has run the London Virgin Marathon in aid of DSN and we would like to thank him very much for his support and fundraising.

Overall, the financial situation of DSN is not as good as it has been.

The most pressing aspect of this situation is DSL. DSL has been a unique and essential aspect of support provided for many years. The costs of running it are however substantial. DSN: with our current income and expenditure, we will not be able to fund DSL for much longer. We have ensured that DSL is secure for the coming year and a dedicated account covers the running costs for two years. A decision needs to be made as to what happens after that. We would also like our members to consider other means of peer support we could provide such as one to one email support or mentoring. Therefore, DSN asked members at the AGM whether they would vote to keep DSL going in the current climate, and we would be very grateful if members could participate in the forthcoming online survey.

Plans for the next year:

DSN will continue to provide support for doctors and ensure that this is provided in the best possible way. We will continue to campaign to raise awareness, emphasise openness and reduce stigma wherever we see a possibility to get involved. The coming year will be financially challenging and one of the most important decisions to be made will be about the future of DSL. DSN aims to be fully transparent with how the money donated is being used. We aim to up-date members not only about our activities but also about the costs incurred, for example, in maintaining a conference presence.

DSN will involve members as much as possible in decision making about our activities. We will therefore survey members about their wishes and what they feel DSN should provide.

Dr Angelika Luehrs
DSN Committee Minutes 27th July 2014 via Skype

Financial update
DSL’s current financial position is significantly worse, with no effect on DSN income from the recent appeal in the newsletter or changing from subscriptions to donations.

Action:
- From now on, all major DSN expenditures need to be approved by the committee
- Show of hands at AGM regarding DSL future.
- Online DSN member survey on the future of DSL—see advert on this page.

Updates from Local Groups
Northwest of England: efforts are being made to set up a local group here.
Scotland meetings: new members have joined the group

E-mail forum
Reminder of need to have anonymous email for support forum to be placed in the next issue of the newsletter.

Newsletter
The next issue is due December 2014 with a focus on the annual conference.

Publicity & Networking
GMC consultation event (guidance used by MPTS)
23.09.14- members to be urged to contribute to the online consultation.

Conference Update
Feedback from ICPH: LF and AH presented posters. Discussion re broadening DSN appeal to international using the Facebook group.

Action:
RS to pursue advertising through Facebook

AGM/Annual Conference
Publicity discussed - PHP website advert, flyer sent to speakers to distribute among their contacts.

AOB
HA was happy to act as Treasurer for another year. Volunteer new treasurer needed to work with Howard and learn the role.

Next committee meeting:
AGM - Saturday October 11th 2014

Doctors’ Support Network & Doctors’ Support Line
ONLINE SURVEY

Please take a few minutes to give us your views on the future of DSN & DSL.

Just click on the link below:

[DSN & DSL ONLINE SURVEY]
DSN AGM Minutes 10th October 2014

Human Rights Action Centre, London

Present:
Committee: Louise Freeman, Roberta Hewitt, Alison Holt, Matilda McLoughlin, Ajay Mirakhur, Robert Sykes
Members & Associate Members: 4
Apologies (committee): Howard Allmark, Fiona Donnelly, Angelika Luehrs, Sally Mason, Helen Plowman

The minutes of the 2013 DSN AGM were approved as an accurate record of the meeting.

Chair’s Report: see page 1 of this newsletter
Treasurer’s Report: click link

Election of Officers, Committee and Trustees
Angelika Luehrs: re-elected unopposed as chair
Louise Freeman: re-elected unopposed as vice chair
Ajay Mirakhur: re-elected unopposed as secretary
Howard Allmark: re-elected unopposed as treasurer
No new members joined the committee.
The DSN Trustees remained the same.

Any Other Competent Business:
The Future of the Doctors Support Line
DSL is regarded by many members as a vital strand of what DSN offers, but it is not currently financially sustainable. Therefore it was important to have a discussion about whether the membership as a whole considers it to be worth holding on to and, if so, how it could be made financially viable.

Many members see one to one support from a volunteer who is mentally in a better place than they are as being an important service to continue. However, there was the question of whether full use is being made of this resource. Recent data indicated as little as one call to the helpline per week or even one in a month. Conversely, the times when someone wishes to call the helpline may not be the times when it is open.

Another issue is that many of the members who run the Support Line are of retirement age, with a need to train new members. This is difficult due to the geographical location and high costs (estimated at £250 per volunteer). It is also difficult to identify an outside body that would provide safe and effective training. Roberta Hewitt had attempted to organise a training event in 2009, but was unable to get funding for it. Also, training is not limited to what volunteers receive prior to taking their first telephone call, it also encompasses supervision, and consideration needs to be given to how this would be organised. Other telephone support services such as the Samaritans have in-house support for their staff. New volunteers would also need to be insured, resulting in additional costs.
One possible solution would be to use Skype as the infrastructure for DSL, given that Skype calls (with the exception of Skype telephone calls) are free. It was suggested that anonymity could be preserved by locking the video facility out of use and having callers login with a standard anonymous ID. Limitations of Skype include that not everyone will have the Internet bandwidth to use Skype and some members may also find it difficult to talk into a computer. Other suggestions that were put forward included one-to-one e-mail support and an economical mobile phone SIM only deal. It should be emphasised that the committee’s position on this matter is not fixed and we are open to reasonable challenge on this issue.

**The Need for Anonymity across Both DSL and the Support Forum**

Many members have found it difficult to accept the need for anonymity both with DSL and with the e-mail forum. The committee’s position was explained: according to the GMC *Duties of a Doctor*, there is an obligation to report a doctor where fitness to practise is compromised and those duties apply whether we are at work or not. However, in DSN we are functioning as peers rather than as clinicians. In the hypothetical (and tragic) event that a DSN member committed suicide, if fellow DSN members knew who s/he was and knew s/he was suicidal and did not take action to preserve life, they would be liable to censure by the GMC. The legal advice obtained by DSN in relation to this matter indicated that (unless a reasoned discussion can be had with the GMC) fellow members can only be responsible for acting to preserve life if they know who the actively suicidal member is. They cannot act if that person’s identity is anonymised; it would not be feasible to decrypt an anonymised ID, identify what part of the country they are in, and get help to them in a short space of time. It was pointed out that when members are expressing suicidal ideas on the forum or DSL, thoughts are not the same as actions and members may be using the calm, confidential environment provided to ventilate difficult emotions. For these reasons, it is imperative that ALL users of the support forum have an anonymous ID.

**Action:**

- Investigate further the possibilities of Skype and economical mobile-phone deals for DSL
- All forum users who are not using anonymised IDs will be e-mailed shortly, and we regret to say that if they are not anonymised we will have no choice but to remove them from the support forum.
DSN attended the recent International Conference on Physician Health (ICPH) in London en masse! ICPH is a collaboration between the American Medical Association, the Canadian Medical Association and the British Medical Association and is held biannually with the venue rotating around the three host associations.

DSN sponsored a stand and spoke to many interested delegates from around the world. Several attendees were particularly interested in how DSN works as they are considering setting up a similar support network at home.

**Reflections on ICPH**

**Alison Holt** 15 years ago I believed that doctors could not get ill, that I could not be ill. I was forcefully disabused of this notion. But when recovered I had to go back into the world where unwell doctors were an anathema, if they were acknowledged at all. In the intervening years I have become involved in supporting others, through DSN and elsewhere, and a lot of what I do is awareness raising- popping up at conferences and training events to make the case that doctors get ill and that getting help is difficult. And audiences range from hostile, through dismissive, to accepting and interested. But always is the need to explain, to justify what I am saying, to "make a case".

The most enjoyable thing for me about the International Conference on Physician Health was spending three days surrounded by people who already "get it" – who understand that there is a problem and are actively involved in trying to solve it – be that through policy, education, service provision or research. Refreshing, re-energising, inspiring, interesting and affirming. Not often you can say that after three days of study leave!
Louise Freeman I was interested that there were frequent references at ICPH to the needs of sick doctors for advocates. Janet Ballard states elsewhere in this edition that occupational health practitioners cannot be advocates due to their responsibilities towards doctors and employers. So who should be the advocate for the sick doctor? Doctors providing specialist services to sick doctors would seem to be the obvious candidates for this role. I wondered if physician health practice in North America differs from that in the UK given that the Canadian and US doctors seemed very comfortable with this concept.

Sarah It was a real privilege to attend the ICPH and help man the DSN stand. As a relatively new member of DSN, it was lovely to meet people face-to-face and to support each other in person. While manning the DSN stand, we met people from all over the world, explaining the set-up of DSN and sharing experiences. Support networks for doctors have been set up in many countries, but often with a “top-down” structure, rather than providing peer support (like DSN does). It was also a privilege to be able to attend the plenary sessions and seminars throughout the conference.

Is a Career in Medicine Suitable for Women?
A highlight for me was attending a talk given by Dr Clare Gerada, entitled, “Is a career in medicine suitable for women?” The talk was structured around data from the Practitioner Health Programme (PHP). Over the past five years, PHP has seen a surge in young doctors (aged 25–35 years) consulting the service; the majority of whom are women, with a peak age of 29–30 years. Several postulations were given for this:
1. Characteristics of “good doctors” (e.g. perfectionism and altruism) make us more vulnerable to mental health problems.
2. The NHS is a toxic, barbaric environment within which to work, with a culture of bullying and blame.
3. As a trainee, there is very little stability: we cannot guarantee where we will work, what our next placement will be, and where we will live. The lack of a “firm structure” at work also means that we may be working with different people each week, leading to further instability.
4. Young female doctors look around at their peers - many of whom by the age of 28–30 years have a stable career, a partner, and children. It is hard to ignore the “biological clock” ticking away … this creates tension between progressing through training and wanting to settle down to start a family.
5. We are exhausted from working erratic shift patterns, which disrupt continuity, reduces resilience and causes exhaustion.

The good news is that once women access the service provided by PHP, they do remarkably well. The majority are back to full functioning after five or six sessions of cognitive behavioural therapy and have an increased awareness of how to avoid a relapse. But fundamentally, the working environment needs to be reviewed to make it less “toxic”; to provide more continuity and stability (e.g. by restoring firm structure); which, in turn, will lead to increased resilience and reduce disruption to everyday life.

Reference:
Over recent months I have repeated the phrase ‘pull your own oxygen mask down first’, not I hasten to add because I am now moonlighting as an airline stewardess, but because it’s a phrase I use when talking to doctors about how to stay mentally and physically healthy in these troubled times within the NHS.

**Doctors not immune to mental illness**

Doctors are not immune to mental illness; in fact, doctors have high rates of depression and anxiety, and female doctors in particular have significantly higher suicide rates than the general population. Since 2008, I have run a confidential NHS service for doctors with mental health and addiction problems. Our experience at the Practitioner Health Programme is that, by and large, most doctors have months of distress and disability until they present as unwell after a work or home crisis. Many doctors who come to our service often talk about the shame associated with not ‘coping’ or becoming unwell, and of their fear that disclosure of their mental illness would lead to ‘career suicide’. They worry about confidentiality and about being referred to the regulator if they admit to having a mental illness.

**The NHS is depressed**

There are other deep-rooted problems. I have written recently that if the NHS were a patient, it would be depressed and in need of psychological treatment. The NHS is troubled for many reasons, but predominantly due to increasing workload and decreasing support systems. Also, constant reorganisation is creating a culture of fear: fear of exposure, fear of being shamed, named and blamed. This working environment is undermining the development of resilience. In recent years, a culture of increasing blame, bullying, and retribution has developed in medicine.

The General Medical Council estimates that one in eight doctors in training has suffered bullying. Constant reorganisations destabilise relationships, and coupled with early retirements and the moving of older and more established doctors, this removes the continuity and corporate memory that builds resilience in institutions. Paradoxically, shorter working hours may also be a contributory factor. Working time rules mean doctors work shifts, which further fractures the relationships between staff and patients that provide support and feedback to build resilience for trainees. Changes to working hours also erode continuity of care, which is valued by healthcare workers and patients alike.

**Super-human doctors**

The relationship between doctors and patients rests on the unconscious assumption that patients embody illness and, in contrast, doctors stand for health and immortality; if doctors are ill, they ‘have only themselves to blame’. When consulted in an independent survey to evaluate the need for a confidential, stand-alone mental
health service for doctors, the public admitted to regarding doctors and dentists as ‘super-human’ rather than ‘normal people’. On further reflection they were aware of, and empathetic towards, the health impacts of such a stressful job. So … maybe we need to admit to our vulnerability more often … perhaps we do only have ourselves to blame ….

Health professionals rightly have a strong sense of vocation to ‘help people’, but sometimes it is done to divert the helper from their own psychic pain and vulnerability, and leads to the denigration of their own needs. This means that when unwell, rather than seeking help or taking time out from the work space, doctors merely work harder, in the assumption that this will ‘make things better’.

Not surprisingly, this approach rarely helps, and a study has shown that when doctors finally allow themselves to take time off for ill health, they tend to be off work for longer periods because they consult so late.

Look after ourselves first

The General Medical Council exhorts us to ‘make our patients our first concern’. So does this run counter to the advice that I gave at the start? I don’t think so. Putting patients first means recognizing where we cannot deliver care to the standard that our patients warrant – for example, when we are exhausted or suffering from physical or mental illness. This isn’t to promote taking sick leave for any minor problem – but just being mindful of our own health needs and how they might impact on the patients we treat.

The GMC advises that doctors should be ‘alive to mental health problems, depression, and alcohol and drug dependence [in colleagues]’ and should ‘act without delay if you have good reason to believe that you or a colleague may be putting patients at risk.’ In most circumstances, this means advising that they take time out, removing themselves from the workplace and seeking appropriate help.

The good news is that it is still unusual for doctors to become mentally unwell, and most pass through training with few problems. Predictors of good psychological wellbeing are the same in doctors as in the rest of society: stable relationships and a high level of support from family members. Doctors tend to have many of these positive protective factors, being highly educated and having good friendship networks. However, we must not be complacent.

Doctors are an important and expensive resource for society, and loss of this workforce due to avoidable ill health is a waste to the health service, a loss to patients, a stress on colleagues, and a disruption to individual careers. Avoidable causes of ill health in the system that doctors work must be dealt with, and doctors must have timely access to confidential help.

Pull down your own oxygen mask first

Perhaps it is time to be honest with our patients and accept that a good and safe doctor means replacing the exclusive and somewhat over idealised medical role that dictates we serve patients come rain or shine. Instead, we should adopt a more mature role that extends to self-care and putting the needs of doctors alongside the demands of patients – indeed, pulling one’s own oxygen mask down first is better for doctors and better for the patients they serve.
Occupational Health—How We Can Help Doctors
By Dr Janet Ballard

Janet has been an occupational health physician for seventeen years working mainly within the NHS. Janet is Clinical Lead for the Health at Work team for the West London Mental Health NHS Trust.

What Occupational Health CAN do
As an occupational health physician (OHP) for seventeen years, working mainly within the NHS, I have seen doctors at all stages of their careers in my clinic. My role includes providing support and advice during sickness absence or periods of stress, signposting to other services (I am fortunate to work in London and have resources such as the Practitioner Health Programme and MedNet, as well as organisations such as Doctors’ Support Network), advising on return to work plans or adjustments, and advising employers about disability law.

What Occupational Health CAN’T do
As an OHP, I can only advise a manager regarding adjustments to work, I cannot make him or her follow my advice. Occupational health does not usually provide clinical care (you should have a GP, and possibly a specialist, for this) although departments may offer interventions such as physiotherapy or counselling. As the OHP, I cannot be your advocate as I have a responsibility to advise your employer, as well as to you; I am required to give an impartial, professional opinion.

Doctors as patients
It is increasingly acknowledged that doctors don’t make good patients and may need ‘permission’ to be unwell, particularly for mental health issues. A relationship of trust between the doctor and the OHP is important in allowing the doctor to be the patient, and to accept help.

NHS appointments for mental health problems often take too long, but dedicated services for doctors are able to respond in a timely fashion (e.g., the Practitioner Health Programme). This type of service is being replicated across the country, but slowly.

I try to start a conversation with the doctor about return to work plans once their recovery is underway, as this supports the expectation of recovery. A plan to address work-related problems needs to be discussed. Occupational health is also best placed to flag when disability should be considered. A doctor may need to have a renegotiated job plan to return to work, such as reduced commitment, to allow for disability.

Confidentiality – who needs to know what?
Occupational health consultations must be confidential, unless overridden by mandatory
Occupational Health—How We Can Help Doctors contd

disclosure requirements such as safeguarding of children. Information provided to others should not include confidential information. There is no need nor obligation for occupational health to disclose an employee’s diagnosis or personal circumstances to anyone – just to advise what the employee can or cannot do.

All communication is disclosable to the individual (under Data Protection law). You should be shown the letter for your employer, for your agreement to send, and to allow correction of any factual errors.

Key relationships for OHPs exist with Medical Directors and Human Resources Directors, as well as clinical and training programme directors. There may be tensions for the OHP as the Medical Director and Human Resources Directors are usually also the professional manager and line manager, respectively. Despite this, occupational health must keep staff medical details confidential. No-one in the employing organisation has right of access to the OH files; this is supported by statutory and case law. Disclosure of confidential information is strictly controlled, and does not allow for the Medical Director to demand to know. But, you should remember that the GMC has the same rights as a court of law, and can require disclosure of all of your medical files.

Finally
Where tensions do exist, these must be challenged because the best outcome for all – the doctor, the employer, the patients and the OHP – is for you to be well and at work.

Meanwhile, organisations like the Doctors’ Support Network are invaluable to doctors coping with health and employment problems, by providing emotional and practical support, but also by demonstrating that the doctor is not alone. A doctor not in work is in a very isolated and lonely place.

Adjustments to support return to work
A successful return to work may require temporary adjustments, such as reduction of workload, responsibilities and/or out of hours working, usually time limited over four to six weeks. Longer term adjustments may need to be considered for the doctor with ongoing health problems. Occupational health
Experiencing and Exploring Mindfulness

By Dr Elwyn Perry

How I became interested in Mindfulness

I’ve always been interested in the working of the mind, and over the years I have attended many courses to learn techniques to help control the mind, so that it doesn’t control you. Twenty years ago I trained to teach cognitive behavioural therapy (CBT) courses to help others learn about their minds and how to control them. Three years ago, I took a course in mindfulness and began to use it as part of my practice. Recently, I also started to meditate regularly as a way to help regulate my energy levels. I now find myself calmer, more resilient, and more assertive than before – able to handle crises better and recover from distressing events faster.

Where does Mindfulness come from?

Clinical mindfulness was initially used in the States, developed by Jon Kabat-Zinn as mindfulness-based stress reduction (MBSR). Mindfulness-based cognitive therapy (MBCT) is a form of mindfulness developed by Dr. Mark Williams and John Teesdale. It has proven to be very successful at relapse prevention for people who have suffered at least three episodes of depression. More recently, MBCT has been adapted to treat anxiety and help with eating disorders.

What is Mindfulness?

Mindfulness is becoming aware of your thoughts, emotions and bodily sensations. I used to think that I was my thoughts and my emotions, and that I couldn’t do anything about them. Now I have learnt that I am bigger than my thoughts and emotions. I can change my behaviour because I don’t have to act out what they were telling me to do.

How does Mindfulness differ from CBT?

CBT challenges those same thoughts, it helps you to look at them and replace false negative ones with true thoughts, often much more positive, with an accompanying change in emotions and sensations in the body.

What part does Meditation play?

Simply, meditation is time taken to sit and observe our thoughts – to go within. If you have spiritual beliefs you might also use meditation as a time to connect with energies outside the body and to drawn
Experiencing and Exploring Mindfulness continued

on their positivity and power.

How does Mindfulness work?
Mindfulness teaches techniques to develop self-awareness by allowing thoughts, emotions and the sensations that they produce to be there; understanding that if you breathe into them, allow them to be there and don’t fight them, they will actually dissipate and pass. The breath is really important— it can be used in so many ways- to reduce adrenaline, to increase awareness of our bodily state, to help ground us when caught up in strong emotions, and to keep us alive!

Mindfulness is not for everyone
It is important to remember that it takes time to become proficient in mindfulness techniques and that not everyone will find it useful. Dr. Mark Williams recommends an 8 week programme to build up the techniques.

I am now an associate trainer with an organisation called ‘Mind at Work’ and am planning to run more courses, particularly for the caring professionals, combining CBT and mindfulness techniques to give them tools to be calmer, happier and more in control of their minds.

Would YOU to get involved with running DSN?

There are a variety of tasks needed to maintain DSN including:

- Membership administration
- Minute taking
- Article writing for the newsletter
- Website contributions
- And much more!

We can offer opportunities to acquire new skills, attend national level meetings regarding doctors’ health and generally enhance your professional CV while helping to improve the experience of doctors who suffer mental health problems.

TREASURER NEEDED

We are currently looking for a volunteer treasurer—there is the valuable opportunity to shadow Howard our current treasurer this year before he retires.

Please email info@dsn.org.uk if you are interested in joining the committee.
Cracking up, Cracking on

By Bobby Baker

Firstly - I’m an artist. You may know about my work from an exhibition of my drawings at the Wellcome Collection in 2009 – Bobby Baker’s Diary Drawings: Mental Illness and Me 1997-2008. This exhibition continues to tour in several formats and is also a book - which was chosen as MIND Book of the Year in 2011. I’m proudest of all to describe myself as an ‘expert by experience’ of mental health issues and a survivor of mental illness, and the mental health system!

Diagnostic Overshadowing

In 1996 I saw a psychiatrist who gave me the first of many diagnoses - ‘borderline personality disorder’. Over the next 11 years I received many more diagnoses: mood disorder, eating disorder, anxiety disorder, depressive disorder… I am very critical of the diagnostic framework, especially the notion of ‘personality disorder’. In my eleven years as part of the mental health system, I had forty-one short psychiatric admissions - a fact regarded by my friends in ‘the system’ as a considerable achievement whilst continuing to work! One of the most problematic issues I faced on this journey through the ‘mental health system’ was ‘diagnostic overshadowing’.

Whenever I mentioned any physical symptoms, I was asked “But how do you feel? You’re very stressed” - so it was a battle to get treatment for a variety of physical problems, including late diagnosis of breast cancer, osteoarthritis, dental, and gynaecological issues. It’s important to point out that I led a double life, with my artistic career continuing and thriving throughout this period.

Creative industries as a Resource

So, I know a fair amount about mental health. But I know more about the art world, including the publicly funded arts, which has its own hierarchy, economy, set of issues and systemic flaws – admittedly relatively minor compared to those faced by the NHS – but the creative industries are a resource which deserves to be understood and respected. I am the artistic director of Daily Life Ltd, and our work challenges the well-intentioned trend of the ‘wellbeing agenda’ that strives towards the homogenous delivery of the arts for health with the talent, individuality and potential of participants underestimated and overlooked so that there is a risk that the movement for arts and health is no more than modern day ‘basket weaving’ in another guise.

Bobby then took us on a short illustrated tour of her work:

Having trained in painting at St Martins Art School, and as a young woman in the early 1970s, I couldn’t express my ideas in contemporary art forms such as painting or theatre.
Cracking up, Cracking on continued

I had this sudden and exciting idea – to start making art out of cake. It was so absurd, so rebellious, so interesting in its newness. My first artwork out of cake was a baseball boot:

From the age of twenty-three, I made a firm decision to make artworks based on my own experience. I still needed to make the work even if no one other than myself was interested – in part as a way of processing my own reflections on life, clarifying my ethics and political opinions.

Bobby then explained that when she started her journey through the mental health system in 1997 and that she chose to make regular diary drawings documenting various aspects of her experience. Out of the 711 drawings made over 11 years, she selected 158 to form the Diary Drawings exhibition.

Daily Life Drawings—link to Bobby’s website

It’s not me that’s mad but the world

What I finally realised was that it’s not me that is mad – but the world. My response – through my recovery and how I’ve made my life so richly worth living now – is to focus on what I value. I’ve become an expert on how mad the world is. And I haven’t been depressed, or truly sad, or mad, for over eight years now. Mental illness is commonly seen as a deficit and weakness. I want to show otherwise that people with personal experience have much to contribute and teach, that society has much to learn from us.

Daily Life Ltd has recently had an exhibition ‘The Expert View’ at Dalston Square in London until 16th December 2014. The work featured the Diary Drawings as well as art made by mental health users and professionals in workshops delivered by Daily Life Ltd.
Clown Improvisation—Helping You to Care Without Burning Out

By Dr David Wheeler

What is the clown?

Shakespeare in Twelfth Night comments paradoxically “this fellow’s wise enough to play the fool”, which refers to the court jester who can tell the truth about things. This archetypal clown lives in the moment, is emotionally expressive, vulnerable and naïve, an imaginative storyteller, but one who knows what is real and what is fantasy. Our modern clown is also influenced by the philosophy of Carl Rogers: “Being trustworthy does not demand that I be rigidly consistent but that I be dependably real”. You can trust what a clown expresses emotionally; he/she is not trying to hide behind a social mask. The clown also shows awareness of what is going on around, and is sensitive to whoever and whatever else is there. Like the court jester of old, the clown will hold up a mirror to the world and challenge the accepted norm.

The Risks of Empathy

In the past, when I have talked about my experience of clowning I have referred to empathic communication ... and if you combine this with caring ... you end up with compassion, which has become the buzz word in the NHS! But this combination appears to lead to a double bind. The very act of involving myself in the patient’s emotional world threatens to overwhelm me, leading to defensive reactions, which block my ability to respond creatively. The result? Emotional exhaustion + cynicism + ineffectiveness = burnout.

Clowning is an antidote to burnout

The clown can express and play with emerging emotions in a way that we suppress in our daily job. This ability to play in a clown workshop frees us from being drowned by our emotions and can be a powerful antidote to burnout. The thoughts and emotions don’t stick needlessly.

What happens in a Clowning Workshop?

In a clowning workshop, we start with warm-up exercises and progressively move into improvisation on stage with no script or agenda. By being receptive to what is there we allow stories to emerge. We can relate this to consultations with patients and their frequently bizarre stories. On stage it is as much
Clown Improvisation—helping you to care without burning out continued

about relationships as it is about the story being told. The clowns connect not only with each other but also with the audience (who are other participants).

In 2012, I organised a one-day clown improvisation workshop for the Greenwich GP Trainers. The trainers highlighted:

- the power of simple actions (less is more)
- the value of slowness or stillness to allow one to take in what is happening
- the importance of eye-contact, of being responsive
- awareness of our physical presence and how it influences others
- to connect with one’s own emotions, notice them and be outside of them
- sitting with a problem or an emotion without trying to solve it
- letting go and not pre-judging a situation.
- an alternative way of being with others
- reflection in action as well as reflection on action
- being authentic and empathic

All of these benefits were felt to relate to both consultations with a patient and interactions between learners and teachers.

“*Our emotions work subversively under the conversation we are having. It is important that we are aware of them; in clowning we show them, whereas in everyday life we usually suppress or try to hide them*.”

- For information and booking on our next one-day introductory workshop go to www.clowndoctor.co.uk and for other courses and info: www.nosetonose.info.

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**Would YOU to get involved with running DSN?**

There are a variety of tasks needed to maintain DSN including:

- Membership administration
- Article writing for the newsletter
- Website contributions
- And much more!

We can offer opportunities to acquire new skills, attend national level meetings regarding doctors’ health and generally enhance your professional CV while helping to improve the experience of doctors who suffer mental health problems.

**TREASURER NEEDED**

We are currently looking for a volunteer treasurer—there is the valuable opportunity to shadow Howard our current treasurer this year before he retires.

Please email info@dsn.org.uk if you are interested in joining the committee.
Useful Resources

Sources Of Support

GENERAL:

Doctors.net.uk
www.doctors.net.uk
UKs largest and most active on-line medical community. Contains _the couch_ providing emotional and professional support through on-line discussion forum and peer-to-peer support

BMA Counselling Service
Tel: 08459 200169
24-hour support with immediate access to trained counsellors.

Support4Doctors
www.support4doctors.org
Website run by the RMBF – aims to put doctors and their families in touch with a range of organisations who can help. Covers: Work & career; Money & finance;
Health & well-being; Family & home

BMA Doctors for Doctors
www.bma.org.uk (click on doctors health & well-being)
Web based resource pack intended as a self-help tool to aid doctors in accessing appropriate help for any difficulties in which they may find themselves. Also contact with doctor-advisers through BMA Counselling service. For BMA members only.

The Sick Doctors Trust
Tel: 0870 444 5163
www.sick-doctors-trust.co.uk
Undertake to provide early intervention and treatment for doctors suffering from addiction to alcohol or other drugs, thus protecting patients while offering hope, recovery and rehabilitation to affected colleagues and their families.

The British Doctors and Dentists Group
Tel: 0870 444 5163.
Monthly group meetings for doctors recovering from chemical dependency.

Independent Career Assessment
www.medicalforum.com

HOPE for Disabled Doctors
www.hope4medics.co.uk
Help in obtaining professional equality for those with a disability or chronic illness.

SPECIFIC GROUPS:

Medical Womens Federation
www.medicalwomensfederation.org.uk
Aims to advance the personal and professional development of women in medicine, to change discriminatory attitudes and practices and to work on behalf of patients.

Psychiatrists Support Service
http://www.rcpsych.ac.uk/member/psychiatristssupportservice.aspx

A confidential telephone advice line for all members of the Royal College of Psychiatrists covering all subjects including health, career and problems at work
Telephone 020 7245 0412
psychiatristssupportservice@rcpsych.ac.uk

Anaesthetists
Tel: 020 7631 1650
www.aagbi.org
An alternative contact for anaesthetists seeking help

NON-MEDICAL

Mind Tel: 0845 766 0163
www.mind.org.uk
The leading mental health charity in England and Wales. Work to create a better life for everyone with experience of mental distress

Samaritans
Tel: 08457 90 90 90
www.samaritans.org.uk

Financial Help

BMA Charities Tel: 020 7387 4499
Including the Cameron Fund
Royal Medical Benevolent Fund
Tel: 020 8540 9194 www.rmbf.org
The Royal Medical Foundation
01372 821011
www.royalmedicalfoundation.org
How to save money on your professional subscriptions while unemployed / on long-term sick leave / working reduced hours

General Medical Council (GMC)

If your total gross income (from all sources) is below a set threshold for the relevant year, you can apply for a 50% discount on the annual GMC retention fee - see link below:

GMC lower incomes

British Medical Association (BMA)

The BMA offers a salary link scheme to allow members with limited professional income to pay a reduced subscription fee - see link below:

BMA subscription rates

Defence organisations (MDU, MDDUS & MPS)

The Medical Defence Union, the Medical and Dental Defence Union of Scotland and the Medical Protection Society all offer deferred membership for members who are having a career break. This is offered at no cost but each organisation has slightly different rules on what they are able to offer.

Colleges

All of the medical colleges should consider an application to their treasurer for either deferred membership or a reduced subscription rate due to straightened financial circumstances of whatever cause. It is worth addressing this as early as possible as fee reductions are unlikely to be applied retrospectively.

Tax allowances for professional subscriptions

Professional subscriptions are allowable against tax if you are still working as a doctor. Unless you normally receive a significant untaxed (and taxable) income from other sources such as cremation form fees, it is likely that you will profit overall from declaring your professional fees against tax. If you wish to claim professional subscriptions against tax, you will need to provide the Inland Revenue with the relevant details via a Self Assessment tax return.

The advice on this page is offered in good faith but it is the reader’s responsibility to assess whether it is appropriate to follow the advice in their own situation. Neither the Doctors Support Network or the author can be held responsible for any consequences of following this advice.

If You have received this newsletter via email, simply click the logo. If you have received a paper copy, then please visit Facebook, sign in, and search for us.
Some ideas of where to start with your own CPD:

**Journal reading**

Obvious, but where most of us begin if only to reduce the mountain of unread journals awaiting our return to work.

**Internal teaching sessions**

For employed doctors: If feeling well enough, it is possible to ask if you may attend relevant formal teaching sessions at your place of work.

**External paid for courses**

For employed doctors: If your medical advisers agree that you are well enough to undertake some CPD while on long term sick leave, then it may be worth asking your employer if they will consider funding relevant course fees.

**Deanery**

Your local deanery may offer a variety of learning opportunities for doctors within the region. If you are on long-term sick leave from an NHS post, you are likely to be able to access some valuable learning sessions for free or at reasonable cost.

**BMA library**

The BMA has a full medical library service for members with access to books and journals. Books are posted out to you by the library and returned at your expense. It is also possible to request copies of journal articles.

**Information Technology (IT) training**

If you are not working and in receipt of a government benefit such as Jobseekers Allowance (JSA) or Employment Support Allowance (ESA) you should be able to access relevant IT training without cost. There are many different providers, each with their own specific funding criteria in this field. One example of the type of IT training available is the European Computer Driving Licence ECDL, which is widely recognised by the NHS as a badge of proficiency in the use of Microsoft Office. The ECDL qualification counts as 40 hours of CPD and, depending on the provider, may often be followed online at home. Your local Jobcentre Plus may be able to provide you with suggestions of appropriate local IT training providers.

**BMA library services**

FREE for BMA members

**FREE for MPS members**

**Colleges**

**E-learning** : Your college may offer free e-learning modules via their website. N.B. The Royal College of General Practice has some excellent free (for anyone) modules including the e-learning session for the Health for Healthcare Practitioners course.

**Courses & conferences** : Colleges may offer a reduced rate for retired members and it is worth asking if you could be treated as retired for the purpose of paying conference fees if you are on a career break due to ill health.

**Medical Protection Society**

The MPS offers an excellent series of risk management workshops which are free to members including those with deferred (free) membership.

**Tax allowances for CPD expenses**

If you are still employed or working as a doctor in some capacity, expenses incurred for CPD events may be allowable against tax. You will need to inform the Inland Revenue of your claim for adjustment of your tax allowance.

**MPS courses and workshops**

FREE for MPS members
DSN is a thriving community of doctors with mental health problems. We offer a range of services from regional support meetings and social events to the more involved such as our flagship service the doctors support line (DSL) - doctors for doctors and entirely confidential. We would love to offer this for free but due to running costs and lack of funds, that would not be sustainable. Free online support can always be reached via our website.

PO BOX 360, STEVENAGE, HERTS, SG1 9AS

WEB: www.dsn.org.uk (login: members@dsn.org / password: bluesky)
DOCTORS SUPPORT LINE: 0844 395 3010 4p/min

SUPPORT MEETINGS

London & SE  Support meeting are at Sally’s house in Ealing, West London. Contact membership@dsn.org.uk
York  Please contact Rosemary on either 01142305537 or lethem@doctors.org.uk for details
North West  Regular support meetings or day trips run on an ad-hoc basis. Please contact astrid@dsn.org.uk to attend.
North East  First Monday of the month (except BH) at 18.00 near Haymarket in Newcastle. Contact Louise@ffzzz.plus.com
South  Take place in Southampton; please call Helen on 07811 360 880 or email hj.plowman@googlemail.com
Midlands  Please contact either Ruth at ruth@dsn.org.uk or Joy at joykdz@yahoo.co.uk
Scotland  Often take place at Malcolm’s flat; contact malcolmh@doctors.org.uk
Wales  Take place in Cardiff; contact Clive at wales@dsn.org.uk

IF YOU ARE INTERESTED IN SETTING UP A SUPPORT GROUP IN YOUR OWN AREA, OR YOU WOULD LIKE TO ATTEND ANY OF THE EXISTING MEETINGS PLEASE CONTACT US AS ABOVE

THE DSN COMMITTEE

The committee has changed slightly for 2013, with Fiona stepping down as chair at the 2012 AGM.

We would particularly like to thank the volunteers of the Doctors’ Support Line, who are not mentioned here.

The committee is now as follows:

Angelika: Chair
Louise: Vice Chair & Senior Editor
Howard: Treasurer
Ajay: Secretary
Sally: Membership Secretary
Rob: Editor-in-Chief
Fiona: GMC Liaison
Matilda: Conference co-ordinator
Alison: Committee Member
Helen: Committee Member

Clive: DSN Wales
Malcolm: DSN Scotland

Other regular volunteers:
Declan: Forums
Richard: Fundraising
Tanya: DSL

We are on Facebook! Come and join us and show your support...
THE DOCTORS SUPPORT NET-

WWW.DSN.ORG.UK
Contact us at info@dsn.org.uk

Campaigning to reduce the stigma of mental illness
Liaising with the GMC, NCAS and PHP
Expert advice to those undergoing GMC procedures on health grounds
Anonymous email forum
Social outings and support meetings
The Confidential Doctors Support Helpline (see below)

Support Line: 0844 395 3010
Mon, Tues: 8pm - 11pm / Wed, Thurs, Fri: 8pm - 10pm / Sunday: 4pm - 10pm