

Royal College of Psychiatrists

Psychiatry-East

The Eastern Division e-Newsletter



Editorial

Long last spring and summer has sprung upon us and the weather Gods are smiling!

Spring is synonymous with new lease of life and fresh ideas. It is a poignant time to reflect on our experiences, challenges and triumphs and embark on new goals and aspirations. Whilst we all have our profession as a common denominator yet, what makes us all unique is the different and diverse paths we have navigated in our professional and personal lives. In this edition, our colleagues share their experiences in their working and private lives taught by the best institute; University of Life!

As a customary we have the chair, Dr Raof giving his update on the developments in the Division. Another regular feature is an overview and the highlights of the successful Eastern Division spring conference put together by Dr Crozier. Dr Magon, shares with us the mentoring scheme in his Trust that guides to shape the experience of doctors positively.

Additionally, we have Dr Khaja, revealing his journey of doing locums as a staff grade before plunging back into higher training. On the other end of the spectrum, we have Dr Canagasabey shed some light on the challenges and rewards of doing locums post retirement. Dr Jha & Nehety share their personal gratifying experience of helping victims in the aftermath of an earthquake in Nepal.

Meghan Markle, now HRH Duchess of Sussex, as an eleven year old girl brought about a shift by ensuring that the media

portray and depict women at par with men. Here, Dr Jha continues on her quest for gender parity and urges everyone to contribute to make this a reality in the NHS; "every little helps".

Last but not the least by any measure, is my favourite, a write up by Dr Sarma, a woman of substance (no gender bias here!) on her experience of being on the other side of the table as a patient and battling cancer. Her determination and resilience to overcome her illness will inspire many.

As always, our continuous effort is to ensure the newsletter meets your expectations and we would love to hear suggestions for improvement from you. A big thank you to all our contributors and readers.

Enjoy the 'official' British summer, a time to "make hay, oops I meant, Vitamin D while the sun shines!" Happy reading!



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Dr Indermeet Sawhney, Editor, Psychiatry East



Chair's Column

By Dr Abdul Raof

Hi Colleagues,

NHS is celebrating 70th birthday this summer.

Despite uncertainties related to Brexit the summer has started with some good news!

We already heard about the 20 billion birthday present for the NHS announced by the Prime Minister. Our College and other partner organisations have managed to keep mental health at the top of political and news agenda over the last year and I really hope that mental health services would get a fair share of these potential new resources. As we welcome the new investment, our president Prof Wendy Burn has urged the government to spell out plans for social care and training which are outside the NHS England budget.

We also heard recently about [the lifting of tier two visa caps for doctors and nurses](#) which will come into effect from 6th July 2018. As our registrar Dr Adrian James has pointed out, overseas doctors have made significant contributions to mental health services over many years.

I was pleased to hear that College's recruitment campaigns are probably beginning to show a positive impact and [more young doctors are taking up psychiatry at Core Training level](#). However, recruitment into higher training posts remains challenging, may be the shortage we experienced at Core Trainee level over the last few years is feeding through and the tide will turn soon!

As you might have heard we are having another medical school in our region. [Anglia Ruskin Medical School, Chelmsford, Essex](#) is scheduled to admit 100 students this October. I am delighted that the new medical school is committed to promote mental health and community based specialties and have been proactive in seeking input from our psychiatrist colleagues in curriculum development and recruitment.

As we focus on recruitment, we cannot afford to forget about the importance of retention and the need to support our colleagues who are at the beginning of their consultant career. Our next ['Startwell' event](#) aimed at newly appointed consultants and senior trainees approaching CCT is on 11th October 2018. Please spread the word and encourage our young colleagues to attend.

I am very grateful to our patient/carer representatives for their input to the division activities. As some of you may know our patient representative, Ms Kate King is

actively involved in supporting College's input into review of the Mental Health Act.

Thanks to all the colleagues who have made some very helpful suggestions during our spring conference on how we can make division activities more relevant to our members, associates and trainees. I would be really grateful for further ideas and suggestions especially on any future events or activities you would like to propose or be involved. Please email me (a.raoof@nhs.net)

Finally, congratulations to all the new Fellows from the region who received the fellowship from the president on 14th June at the College.



Dr Abdul Raof, Chair, Eastern Division

Mentoring for Doctors

By Dr Rakesh Magon

Mentoring is a process whereby an experienced, highly regarded, empathic person (the mentor), guides another individual (the mentee) in the development and re-examination of their own ideas, learning, and personal and professional development (1). Mentoring is a non-judgmental and non-directive developmental process that provides a safe and confidential space to reflect, increase self-awareness and a rewarding experience for both the mentor and the mentee. Other benefits of mentoring include greater productivity and improved staff wellbeing and retention.

Mentoring should be available to all doctors, at any stage of their career. It helps in achieving a doctor's full potential and applies to doctors throughout their career pathway. The General Medical Council (2) suggests that all doctors should 'be willing to take on a mentoring role for more junior doctors and other healthcare professionals'. The Royal College of Psychiatrists supports the view that mentoring is central to developing and supporting doctors and underpins many aspects of medical leadership. More information can be found via the link:

<https://www.rcpsych.ac.uk/workinpsychiatry/mentoringandcoaching.aspx>

Hertfordshire Partnership University NHS Foundation Trust (HPFT) has been successfully running a mentoring scheme available to all doctors and has, for a number of years, held Mentoring Training for the doctors. The Trust has built a database of mentors who can be approached by those wishing to avail themselves of additional support. Our mentors receive support and our offered opportunities to attend refresher training on a regular basis to help them continue with their development as a mentor.

NHS Improvement has recognised mentoring as one of the eight high impact actions to improve the working environment for junior doctors (3). HPFT has worked with Health Education East of England (HEEoE) and recently implemented a Peer Mentoring Scheme. Through this scheme a peer mentor is assigned to Foundation Year doctors. This adds a further layer of support to junior doctors, some of whom are in their first year of rotation in psychiatry. Further mentoring training sessions have been arranged to increase the number of peer mentors in the scheme and extend peer mentoring to all grades of trainees.

Feedback from the scheme to date has been good. Mentees have found the scheme supportive and helpful.

Mentors have stated that it has been a rewarding experience.

The Royal College of Psychiatrist's document – 'Setting up a Mentoring Scheme', gives advice and tips on setting up a mentoring scheme. HEEoE also provides a detailed guidance for setting up a mentoring scheme and has created a package of template documents that can be used and adapted in your own scheme including application forms, mentor person specification, feedback forms, and reflection proforma and mentoring agreements. These can all be downloaded from the link: https://heeo.e.hee.nhs.uk/setting_up_a_scheme

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1. The Standing Committee on Postgraduate Medical and Dental Education, 'Supporting doctors and dentists at work: an inquiry into mentoring'. London (1998).
2. The General Medical Council, '*Leadership and Management for all Doctors*'. January, 2012.
3. NHS Improvement, 'Eight high impact actions to improve the working environment for Junior Doctors'. October, 2017.



Dr Rakesh Magon
Consultant Psychiatrist and Mentoring lead for HPFT and Eastern Division Royal College of Psychiatrists

Back to training!

By Dr Jaleel Khaja

The kaleidoscope of postgraduate medical training was shaken in 2007 and as the pieces settled I found myself coming to terms with an unsuccessful bid to secure a higher specialist trainee post. Soon afterwards and still in somewhat a disgruntled state of mind I went on to do locum work with the intention that I will do it just as a short stint and in that time I will actively seek to re-join training. It did not exactly pan out like that. Although I was quite motivated to get a training post there were not many to go round, not least because the College did not go back to 'uncoupled training' until as late as 2010. Then there was an additional constraint of limited geography I had to remain confined to because of my family. In the end it was almost 9 years that I had worked as a locum SAS doctor before I eventually got back into training.

Working as a locum affords a great flexibility which, if you have a young family, makes a big difference. For example, you can plan your work more easily around school holidays. Secondly, locum work can provide an opportunity for gaining broader experience. Thirdly, it can be argued, one's subsequent career choices are more likely to be better informed. Lastly, an additional incentive is that it is financially rewarding.

However, despite all the advantages I realised that working as a speciality doctor and as a locum did not provide enough scope for career progression. It was particularly disheartening to see some excellent speciality doctors not being able to fulfil their great visions and aspirations because of the lack of leverage needed to muster necessary resources and support. I felt that, on the other hand, consultants enjoyed a bit more sway and were more likely to get an attentive ear. Finally, I got the sense, and it might resonate with some specialty doctors, that there is a small minority of consultants whose style of working could be more collaborative, and I came to realise that perhaps the best way to overcome this was to become a consultant yourself and do things differently. In my own case all the above reasons accumulated over time, eventually outweighing the advantages of continuing as a career middle grade doctor, and indeed providing a much needed impetus to re-join training which I did in 2016. I had cleared my MRCPsych exams in the autumn of 2006, however, despite this I toyed with the idea of applying through the CESR route to save time. I soon realised that it was by no means an easier option. If anything, the process involved was quite cumbersome.

Getting into higher training was not a simple switch over either. Instead, I had to work on my CV to improve my chances of success with the application. Although I had been a 'basic psychiatric trainee' until early 2007 I had to put in some more work to measure up to the requirements set out by the College in its core trainee

curriculum (1). My suggestion to my speciality doctor colleagues wanting to become higher trainees is to go through the curriculum at the very outset to help identify the domains that need improving.

The speciality training provides a more straightforward pathway and I feel as a trainee one has more support and protected time available to ensure a better balance between service-focused work and training and educational activities. I agree that some experienced speciality doctors may, as higher trainees, need a bit of adjusting to the idea of having to be assessed in the basics such as history taking, mental state examination etc for the purpose of Workplace Based Assessments. I myself do not find it off-putting despite having had over thirteen years of experience in psychiatry prior to joining the training.

I am currently an ST5 in Psychiatry of Intellectual Disability and I am learning a great deal every day, contrary to the oft-voiced reservation that the training was not going to add much to the clinical know-how I had gained as a speciality doctor. Besides, the training is more geared towards helping develop other important skills — managerial, leadership etc. The trainees are encouraged to pro-actively seek such opportunities and indeed have many courses (2) available to them. I would end on the note that it has so far been a very exciting experience for me and it has been nothing but refreshing to see my tutors, TPDs, and supervisors take interest in and provide direction for my personal and professional development. I just wish I had got back into training sooner.

1. https://www.rcpsych.ac.uk/pdf/Core_Psychiatry_Curriculum_April_2018.pdf
2. <https://eoeleadership.hee.nhs.uk/>



Dr Jaleel Khaja, ST5, Intellectual Disability
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My travails as a Locum Consultant Psychiatrist

By Dr Anton Canagesabey

I retired after being a substantive NHS Consultant Psychiatrist in Intellectual Disability in 2014, after 22 years of service as a Consultant. I enjoy my clinical work, it helps to keep me mentally stimulated, physically more active and some extra money doesn't hurt, so I decided to do some ad hoc part time locum Consultant jobs in the NHS.

Post retirement I have done locum jobs in different NHS Trusts. It was interesting to see how different NHS Trusts' clinical services are set up. I have seen some interesting complex cases that continued to sharpen my clinical skills, enjoyed driving around the countryside and experienced travelling like a man without a car, using the 'Transport For London' services and by foot to reach the inner city patients in their residences or in the day centres.

The first locum work I did was mainly to get registered with a Locum Agency and receive their continued free on-line training and free Appraisals to continue with my GMC registration. In all these locums I worked part time, initially I worked 3 days a week but on realising that in 3 days I am expected to carry a fulltime Consultant work load, I opted to work 4 days a week.

More often the Electronic Health Record systems in different NHS Trusts were different, which was a challenge to get accustomed to. In one NHS Trust, I worked as a locum covering two different community jobs. Interestingly the two Community Learning Disability Teams (CLDTs) within the same Trust had two different Electronic Health Record (EHR) systems. Well we know how to make things simple in the NHS!! On a positive note by the end of the job I was certainly more tech savvy!

While working as a locum away from home finding a suitable, affordable accommodation was a challenge. I had a taster of the hospital accommodation which to me was a health and safety hazard and the less said about it the better. After staying for a couple of days I moved out to stay in a local hotel for a month which was not cheap! At times I questioned my sanity for working under this set up post retirement. Working in one NHS Trust for years was much easier.

In one NHS Trust an even bigger challenge was getting a decent office space to work from. When I went to work, I had to search around to find a place to do the work. Some days I was lucky to find a desk but some tables had no desk top computer screens and I had to stoop over my lap top. Ergonomic factors in the working

environment seemed a distant call and I ended up time to time with a neck and back pain. As a Consultant Psychiatrist carrying an active case load of around 200 patients I had to flutter about and hot desk in the manner said. Is it under valuing the Consultant Psychiatrist or was I old fashioned and was struggling to adapt to the modern ways of NHS working, I will let the reader decide.

In most of the NHS Trusts the medical secretaries (in some places they are not even called that) now have non-medical line managers. However, the clinical supervision is imparted by the Consultant Psychiatrist on a day to day basis, so the medical secretaries end up working for two masters. Sometimes Medical secretaries are asked to cover non clinical administration work by their non-medical line managers, at times at the cost of clinical work being delayed. Another manifestation of the new ways of working in the NHS! In this set up, it is important to remember that locums who are new to a particular NHS Trust will need more secretarial support than the substantive staff.

In some NHS Trusts Clinical meetings appeared to have become more multi agency than clinically necessary and appeared never ending! I felt that our cash strapped NHS could do with some efficient way of working to cut down on our waiting lists!

In the good old days, the single point of referrals was to the Consultant Psychiatrist and they with their medical secretaries' support attended to these referrals which usually took a couple of minutes to allocate. Now under the garb of single point referral meetings, very lengthy multidisciplinary meetings have become the norm with referral allocation taking the precious time of so many senior professionals. As a locum consultant being the "new kid on the block" attempts are made by some of the team members to pass on more of the clinical work on to you.

Over all, during my time as a locum I came across some excellent clinicians and supportive colleagues. Putting in more support for the locums can pay dividends and helps the NHS Trust get the worth of their "pound of flesh" and also make the Locum's travails a pleasant and enriching travel through the various NHS Trusts.

Dr Anton Canagesabey MB.BS, FRCPsych

PTSD work in Nepal: Our experience

By Dr Arun Jha and Rajesh Nehete



Nepal was struck with a major earthquake on 25th April 2015 killing nearly 9,000 people and injuring 18000. We went to Nepal in June 2015 to do a feasibility study of revised Narrative Exposure therapy (NET-R) (1), in which we had both received training.

NET-R is aimed to help trauma survivors 'emotionally process' their traumatic experiences in order to diminish PTSD symptoms. It works by encouraging the individual to tell their trauma story and by relieving the past traumatic sceneries within an imaginative exposure design. In NET, the patient repeatedly talks about the traumatic event in detail while re-experiencing the emotions, cognitions, physiology, behavioural, and sensory elements associated with this event. In conjunction the patient also narrates positive life experiences. With the guiding and directive help of the therapist, the patient constructs a narration of his or her life, from birth to present, whilst focusing on the details of the traumatic experiences. Participants are encouraged to relive emotions while reporting the events. This process allows the majority of persons to recognize that the fear they are experiencing is as a result of past experiences and that it's activation is nothing but a memory. This intervention is designed to help the cognitive processing and habituation of

emotional responses to the trauma. They thus lose the emotional response to the recollection of the traumatic events, which consequently leads to a remission of PTSD symptoms. At the same time, they gain access to "lost" past memories and develop a sense of coherence, control, and integration.

We decided to screen two villages near Kathmandu affected by earthquake. The locals were still scared of aftershocks, however we managed to identify 15 mental health nurses, psychologists and social workers as local volunteers. After two day of intensive training in trauma counselling, grief and PTSD for the volunteers we travelled to the villages of Khoicha and Farsidol. We supported and supervised the volunteers in carrying out NET-R and the experience was very positive (2).

All adults (aged 18 and above) were initially screened, using the Nepalese version of 4-item Primary Care PTSD Screen (PC-PTSD) by a pair of interviewers through door-to-door visit. All screen-positive survivors were offered four individual sessions of NET-R, each session lasting 60–90 min; the first three sessions were delivered daily, while the last session was given after a gap of 1–2 days.

Encouraged by our previous experience, we wanted to do

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more for the Nepal earthquake survivors. We were aware that individual NET-R was not a viable option for mass trauma survivors in a low-income country like Nepal. We explored and discovered that Control-focused Behavioural treatment (CFBT) was developed in Turkey as a group therapy for PTSD following natural disasters (3). This is as an intervention to facilitate natural recovery processes by restoring sense of control over anxiety, fear, or distress. It's underlying principle is to reduce helplessness responses by encouraging behaviors that are likely to enhance sense of control over stressor events and life in general.

We went to Nepal again in March 2016 to do PTSD trial. All 30 volunteers who were graduates from department of Psychology in Kathmandu received two day trauma focused training. Two-session group control-focused behavioral treatment was imparted two weeks apart to patients who screened positive for PTSD.

Altogether, 333 survivors were surveyed (130 in July 2015 and 203 in March 2016) with PCL-5 as the screening instrument, using the cut off score of 38 or more for diagnosing PTSD. A PTSD prevalence of 33% was noted in 2015 and 28.5% in 2016. This drop of 4.5% prevalence in the intervening 8 months suggests a significant number of survivors are still suffering from PTSD. Most participants were female, aged 40 or above, married and poorly educated. Compared to individual NET-R, a group-based Control-Focused Behavioural Treatment (CFBT) was found more acceptable and affordable.

Both of us had a great experience of working with local volunteers and earthquake survivors. We also managed to write and publish a self-help CFBT manual in Nepalese language for future use.

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1. Zang Y, Hunt N, Cox T. A randomised controlled pilot study: The effectiveness of narrative exposure therapy with adult survivors of the Sichuan Earthquake. *BMC Psychiatry*. 2013;13:41
2. Jha A & Shakya S. Rational for conducting PTSD research and challenges of recruiting and training volunteers to screen and treat PTSD among the Nepal 2015 earthquake survivors. *J Nepal Med Assoc* 2015;53(199):202-7
3. Basoglu M, Salcioglu E. *A Mental Healthcare Model for Mass Trauma Survivors: Control-Focused Behavioral Treatment of Earthquake, War and Torture Trauma*. Cambridge, UK: Cambridge University Press; 2011.

Dr Arun Jha and Dr Rajesh Nehete

Consultant Psychiatrists

Hertfordshire Partnership University Foundation Trust

Towards Gender Parity at a faster speed: can we do it in the NHS?

By Dr Tulka Jha

“Each time a woman stands up for herself, without knowing it, possibly without claiming it, she stands up for all women”- *Maya Angelou*

With this in mind, I nominated myself for the chair position for our trust's (Hertfordshire) Staff Women's Network and was elected In January 2018. It has been a steep learning curve in the understanding of what is expected from the network. The main principle of promoting gender equality remains the aim but the challenge is in how this will come about? The difficulties have been the struggle to engage people-“too busy”, “too political”, “fears of being seen as a trouble-maker”, “why isn't there a men's network?”, “what's the point, nothing will change?” etc. The barrier that bothers me the most is motivating other women to commit their time and energies to the network. As I say this, I realise that I am laying the blame on women instead of considering the value that organisational culture places on the Women's network. There is no protected or remunerated time allocated for this purpose.

On the other hand, it's important to not throw the baby out with the bathwater. I have been heartened by the glimpses of a movement of courage, support, compassion and hope in the stories of colleagues, service users and network members.

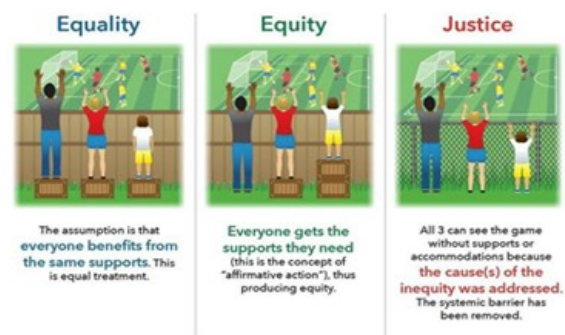
The fact that the NHS workforce is made up of 77% women and 23% men came as a surprise to both me and my colleagues. The discovery that only 36% of CEOs and 24% medical directors are female really brought the issue of gender inequality to light (1).

There is a drive for trust boards to achieve gender parity (NHS women on board 50:50 by 2020) (2). We are 2 years ahead of accomplishing this goal at HPFT but our work for gender parity has just begun.

There has been ample research showing that a greater diversity and inclusion (not just gender inclusion) improves quality of care, recruitment and retention, wellbeing of staff and most of all performance of the organisation overall (3). So why are we not moving fast enough towards this goal? Perhaps identification of the goal is the starting point and this cannot be achieved with large blind spots that make the status quo a comfortable place from where inequalities cannot be seen or understood. The first task may be to make a compelling case for gender diversity.

“There is nothing more unfair than treating unequal people equally” -Thomas Jefferson

Nobody working in the NHS is exempt from the common issues of limited resources, increasing demand, poor recruitment and retention, lack of joined up care for our service users and difficult work –life balance for staff, all leading to low morale and a spiralling of the vicious cycle.



We often hear the rhetoric of innovation, working smarter not harder etc. and I wonder whether better gender parity can turn the rhetoric into reality? What if the innovation of the decade is sitting in the minds of women that make 77% of the NHS workforce but have not had the opportunity to progress up the career ladder? Research shows that women are better at governance and prevent groupthink leading to well-balanced decision making (4).

Recruitment and retention issues can be better resolved through improved gender parity. IBM increased productivity by 30% by introducing flexible working (5) BT saves £3 million per year on recruitment by retaining 98% of its women returners (6).

An organisation with a small gender pay gap, good gender split in senior positions, a range of flexible working options and most importantly a culture of parity of esteem for men, women and non-binary employees is likely to attract larger cohorts of prospective employees. It will in turn improve retention with a better balance and representation of views, policies and culture.

This leads me to consider the topic of work-life balance. For too long this has been attributed to a female issue. A good work-life balance, however, should be seen as a public health initiative in prevention of poor child health, reduction of substance misuse in both men and women and of improved mental and physical health of

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all families. This will have a strong impact on the economic positions of families, communities, cities and countries. Do we not wish as women and men for more flexibility to fit work to into our lives rather than the other way round?

The challenge for our women's network is about developing the best forums to engage, involve and increase participation in changing the organisational culture. My predecessors have done some important work in setting up Schwartz rounds, role models and mentoring schemes for women and participating in our Trust's Big Listen event. We aim to build on this work by incorporating new and exciting insights about the complexity of poor gender parity. Intersectionality (7) is one such pain point that organisations need to tackle head-on. It is the concept that identities that are multi-layered and intersect in varying and complex configurations and degrees to impact upon us. For example, a black woman may experience both racism and sexism. We need to consider the co-constitution of gender at all times. Women have differences in class, race, nationality, sexual preference, ability/disability and queer and transgender challenges.

I believe that for meaningful change to occur, we need to address internal factors (increasing confidence and assertiveness within female workforce) but more importantly address external systemic factors involving organisational culture. Individual women within the organisation may have good self-esteem and confidence but this does not change structural aspects of discrimination related to class and race against women. A democratic engagement of insiders in positions of power within the organisation is likely to speed up the quest towards gender equality (8).

Remedial actions focussing solely upon fixing women are shown to not work. For example, confidence building, resilience and assertiveness training can be counter-productive and insulting to the female workforce. Women need to feel that they have an equal stake in the success of their organisation and they are able to mould and shape the organisation which largely depends upon their so called natural ability to care for and nurture the world. If women are bearing the burden of this emotional labour, they deserve to be paid equally in money and value.

With this in mind, we are open to ideas from anyone who wishes to join this journey of justice and joy.



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What doesn't kill you makes you stronger!!

By Tanushree Sarma

It's been two years since I was diagnosed with cancer, and it feels like a lifetime ago. It all started with a visit to an ENT surgeon because I thought I had a hearing problem. Turns out it was impacted wax, but while he was examining me, he asked me how long I'd had the neck lump for - something that neither me nor anyone else had ever noticed before. It must've been fate, as this particular ENT surgeon was a head and neck cancer specialist, and to his trained eye, my neck lump looked suspicious. He requested a biopsy and marked it urgent, and at that time I thought it was just professional courtesy, and did not think anything major would come of it.

A week later, I got a call from the ENT consultant. The moment I got the call, I knew something was wrong. He asked me if I could come and see him that day, at the end of his evening clinic and bring my husband with me. Those eight hours of waiting to see him, were probably the worst time in my entire cancer journey. When we finally got to see the surgeon, he was extremely positive when breaking bad news - and I have to admit, over the course of my treatment, I have learnt a thing or two about being positive about approaches to treatment to patients and to instil hope. The first thing he said was - yes I had cancer, but I was going to live a long and healthy life. I needed to hear that, whether it was true or not. It put me in a positive frame of mind, and I knew I would be able to beat it. I was diagnosed with Papillary carcinoma of the thyroid Grade 5 and I underwent a thyroidectomy.

Soon after my surgery I realised that my voice had been affected, and when they started giving me liquid and food, I was choking and couldn't ingest anything. I was very scared and realised that my worst fear of vocal cord palsy had actually happened. With the help of a speech therapist at the hospital, I was able to position my neck while swallowing, such that I could tilt my head and close off my right side and swallow without choking. I was given various exercises to do during the day, and continued to do them, and my swallowing came back to normal gradually. I was able to eat solids and also sip liquids without choking. I did not have a voice though. Soon after the surgery, my voice was croaky. A couple of hours later, my voice was completely gone and I could only communicate by writing down. I was discharged home after a few days, as I was physically well.

This was one of the hardest times, as I wasn't able to communicate with my young children. When I was discussing the complications of surgery with my surgeon, I had joked with him to spare my vocal cords,

as it was my bread and butter, being a Psychiatrist. But my voice was so much more than my bread and butter! It was my identity and defined my personality. In a group, if I did really want to say something, everyone would have to stop talking and focus very hard on reading my lips !

Luckily I managed to see a speech therapist every week, who gave me loads of exercises. She would do the exercises and I would have to copy - but unlike her, I wasn't able to create sounds. However, it was working slowly, as my whisper was getting stronger and could be heard and I could make some noises occasionally. I religiously exercised my vocal cords for hours, several times a day and slowly they gained strength and my voice started coming back very gradually over a period of a few months. I still can't do high notes when singing anymore, but I was never going to be Adele anyway!

Unfortunately, since my cancer had invaded other parts of my body tissue, I now needed radio iodine treatment. This was scheduled for a few months after my surgery. I had to be on an iodine free diet for three weeks prior to the treatment, which meant I couldn't eat anything outside and had to cook everything from scratch. I was only allowed certain vegetables and certain pulses - it was a very restrictive diet, but it did make me lose weight!

The treatment itself entailed me ingesting a dose of radioactive iodine in the form of a pill. This was the easy part, the hard part was having to remain in a closed room in the oncology ward with no human contact for four days! The room was small, and every time I needed food, they would phone me so that I locked myself in the bathroom before they put food through the door. The staff didn't have to enter my room, they would just put the food in through a hole at the door. I felt like I was in a high security prison! This was of course to protect the staff from radiation, and I was very radioactive according to the Geiger counter used to measure me.

I spent my days of isolation reading books, staring out of a tiny window and watching James Norton in "Grantchester" on the iPad. Any books I read or clothes I used were all binned. The room where I resided was fumigated and temporary flooring removed.

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By Tanushree Sarma

I was discharged from hospital after few days and as I was radioactive I couldn't be in close contact with people over five minutes. I had to be away from my children for three weeks, as it was feared that radiation could damage their reproductive system.

Time passed very slowly and I felt miserable and missed my family terribly and finally I was back home reunited with my children.

I am thankful for my struggle because without it I would not have stumbled across my strength. It worked in my favour to remain positive, and I had positive and supportive people all around me. I feel stronger, both physically and mentally now. I have completed a marathon and raised over £4000 for cancer research last year, and continue to give back in any way possible.



*Dr Tanushree Sarma, Consultant Psychiatrist
Essex Partnership University NHS Foundation Trust*

Eastern Division Spring Conference 2018 'New Services, New Treatments' Conference Report, By Dr Anna Crozier



“As per previous conferences, it did not disappoint! It was extremely well attended and informative”

On Thursday 17th May we had our Eastern Division Spring Conference at The Wellcome Genome Campus in Cambridge. The topic was 'New Services, New Treatments' with the focus on Perinatal Psychiatry. As per previous conferences, it did not disappoint! It was well attended and informative.

Dr Raof, Chair of the Eastern Division opened the Conference with some introductory remarks.

Then the day started with a talk from Dr Jan Falkowski, General Adult Consultant and Treasurer of the Royal College. He talked about the recruitment crisis in Psychiatry but also noted that this was not new and how incentives such as the Mental Health Act officer status were introduced in the past to tackle the issue. He spoke about the need to address morale within the medical profession. Today less than 50% of FY2 doctors go straight into specialist training. A discussion followed about funding and the impact of austerity on the NHS.

The next session was delivered by Professor Alex O'Neill-Kerr, Medical Director in Northamptonshire. He talked about various rTMS applications in Psychiatry and how it is not just for treatment resistant depression. He presented evidence for it reducing cravings in cocaine addiction and treating primary nocturnal enuresis. He explained how the treatment delivery is inexpensive as it can be given by a trained technician. The results are so good as to be life changing in some cases. He argued it should be considered early, particularly for adolescents and not just reserved for treatment resistance.

Just before lunch, Dr Liz McDonald, Chair of the Faculty of Perinatal Psychiatry and Chair of the London Perinatal Mental Health Network gave the Keynote address. She talked about the Perinatal Frame of Mind and how it applies to all women of child bearing potential including adolescents. She emphasised the importance of getting details when a woman reports a history of postnatal depression as the severity may be under reported. She stressed the need to treat even residual symptoms because they are a cause of poor social functioning. She



Dr Jan Falkowski, Treasurer, Royal College of Psychiatrists

Eastern Division Spring Conference 2018 'New Services, New Treatments' Conference Report, By Dr Anna Crozier

also spoke about the mental health of fathers. She highlighted the Perinatal Psychiatry Bursary project – funding for enhanced training in Perinatal Psychiatry for other Psychiatrists. Above all she urged us to support women and instil hope!

After lunch, the fourth session was delivered by Dr Regi Alexander, Consultant in Intellectual Disability and Co-Chair of the RCPsych International Congress. He talked about the common co-existing developmental disabilities around the central triad of impairments in patients with ASD. He spoke about the interface with forensic service for this cohort of patients. People with ASD have a similar prevalence or less in forensic community samples but the nature of their crimes can draw media attention as they



Dr Regi Alexander, Consultant Psychiatrist, Intellectual Disability, HPFT and Co-Chair, RCPsych International Congress

can be perceived as un-understandable. He talked about cognitive empathy versus emotional empathy and how this differentiates people with psychopathic personalities from those with ASD. He finished by talking about some autism screening tools.

This session was followed by five minute poster presentations from those selected in various categories (students, FY doctors, general and multi-disciplinary) with one minute quick fire questions. During the breaks, delegates had the opportunity to view the posters on display. Poster presentations covered subjects ranging from falls, EUPD and polypharmacy, physical examinations on admission, medical student reflections and end of life care in Dementia.

The last session was on Preconception Advice delivered by Dr Maddalena Miele, Consultant and Clinical Lead of the Perinatal service at St Mary's Hospital, London. She placed particular emphasis on the need to address inter-generational dysfunctional parenting. Without help, history will predict destiny despite good intentions. Pathogenic parenting leads to insecure attachments and negative internal object relations. This in turn leads to subsequent dysfunctional adult relationships, poor choice of spouse and harmful parenting styles.

If you have never attended this Conference, I would thoroughly recommend it and encourage you to bring a poster. The atmosphere is friendly and supportive. As well as high quality speakers and poster presentations, the venue is very good, easily accessible and just off the M11 with plenty of parking. The lunch is excellent, which is always a bonus. It is also a great opportunity to showcase your Specialty, network, spark interest in our junior colleagues and encourage them to 'Choose Psychiatry'.



Breakout area for delegates, Wellcome Genome Campus Conference Centre

Royal College of Psychiatrists

Thursday 11th October 2018

Eastern Division StartWell Event

Hughes Hall, Cambridge



StartWell is a Consultant led initiative for Psychiatrists in their first five years as a Consultant or Locum Consultant

StartWell focusses on 6 elements to support Psychiatrists in their first consultant role with the intention to establish good habits for their careers



3 CPD points
(subject to peer group approval)

**For further information and to register please visit: <http://bit.ly/2c4BOUe>
or contact: moinul.mannan@rcpsych.ac.uk Tel: 0203 701 2590**

Royal College of Psychiatrists

Thursday 29th November 2018
Eastern Division Autumn Conference
'The Ageing Brain'
Wellcome Genome Campus, Cambridge



FREE Entry for Foundation Year and Medical Students through 'Enhancing Foundation Experience in Psychiatry' initiative of HEEoE School of Psychiatry



Lectures on various topics including a keynote presentation, poster exhibitions, prizes and networking sessions

6 CPD points
(subject to peer group approval)

**For further information and to register please visit: <http://bit.ly/2c4B0Ue>
or contact: moinul.mannan@rcpsych.ac.uk Tel: 0203 701 2590**

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The Royal College of Psychiatrists is the professional body responsible for education and training, and setting and raising standards in psychiatry.

The Eastern Division is made up of members from Essex, Hertfordshire, Cambridgeshire, Bedfordshire, Norfolk and Suffolk.

We'd like to thank all members for their contributions towards Eastern Division activities throughout the year.

Eastern Division Medical Student Essay Prize Autumn

The Eastern Division has established this prize in order to raise the profile of the Division and to encourage medical students to pursue further study and professional training in Psychiatry.

Prize: £200

Eligibility: All medical students training in Medical Schools located within the Eastern Division.

Where Presented: Eastern Division Autumn Conference, 29th Nov 2018 at the Wellcome Genome Campus, Cambridge

Regulations:

1. Eligible students are invited to submit an original essay of up to 5000 words on any aspect of psychiatry. The essay should be illustrated by a clinical example from medical or psychiatric practice relevant to mental health and should discuss how the student's training and awareness has been influenced as a result. The essay should demonstrate an understanding of the Mental Health issues pertinent to the clinical problem and should include a discussion of the effects and consequences of the condition for the individual, their family and the wider healthcare system.
2. The essay should be supported by a review of relevant literature and should be the candidate's own work.
3. The Eastern Division Executive Committee will appoint three examiners to judge the entries. Criteria for judging merit will include: clarity of expression, understanding of the literature and evidence, cogency of argument and the overall ability to convey enthusiasm and originality. The Division reserves the right not to award the prize if no entry reaching the agreed minimum standard is received.

Closing date: Friday 9th November 2018

Submissions should be made to:

Moinul Mannan

Eastern Division Coordinator

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Deadline for next edition

Submit your articles for Winter 2018 edition by 9th Nov 2018 at psychiatry.east@rcpsych.ac.uk

Royal College of Psychiatrists - Eastern Division E-Newsletter

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The opinions expressed in this newsletter are those of individual authors and do not necessarily represent the views of the Royal College of Psychiatrists