RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

theRegistrar

Magazine of the
Psychiatric Trainees' Committee

Spring 2023

the wellbeing issue

How our patients, environments, minds, relationships and choices impact on our wellbeing: Interviews with fellow trainees and other key thinkers

Your PTC officers:

Dr Chris Walsh, PTC Chair

Dr Gemma Buston, PTC Vice-Chair

Dr John Moore, PTC Secretary

An introduction from the officers

The term 'wellbeing' can mean many different things to different people, so in this issue of *The Registrar,* we've decided to consider it from a few different angles.

Hello and thank you for taking the time to read *The Registrar,* a magazine put together by psychiatry trainees, for psychiatry trainees.

We know that trainees are tired and burnt out, and we want you to know that we – the PTC – are here for you. That's why our latest issue is focused on wellbeing. We want you to continue to #choosepsychiatry and hope that these articles help you to reflect on the positives of the career, and the great work we can do, even when facing adversity, when we put our minds together and look out for one another.

We would like to apologise for the delay in releasing this issue. We are unfortunately currently without an official editor, so we have called upon psychiatrists across the country to help us by sharing their wonderful knowledge and expertise.

We hope we've included something of interest for everyone, whether that be learning from our colleagues who have bravely shared their lived experiences of mental illness and neurodiversity, or reflecting on the wise words of our esteemed psychiatrists, Dr Chloe Beale and Dr Jo O'Reilly, on how to ensure we keep patients at the heart of what we do without drowning in the complex systems in which we work.

Simon Fleming, TEDx and NHS speaker, gives perspective on striving to make meaningful changes to healthcare systems while recognising your limits, our wonderful trainees share their local wellbeing initiatives (which can perhaps offer some QI project inspiration!) and our chief examiner Dr Hall has provided an update on the likely return of the face-to-face CASC. Finally, our chair, Dr Chris Walsh, has summarised some upcoming national initiatives, to help us prepare and keep calm in an ever-changing system.

In line with this issue, wellbeing is a core part of the PTC's strategy for the year, along with inclusion and engagement of trainees across the UK.

We hope you will be able to come and meet us and your fellow trainees at our annual PTC conference in May 2023, (which we are so excited to announce will be in Wales). There, we will again be focusing on wellbeing, inclusion, and psychiatry beyond the prescription pad.

If you have any feedback on this issue, or just want to know how you can get involved with the PTC, please get in touch. You can contact us at ptcsupport@rcpsych.ac.uk, or Tweet us at @rcpsychTrainees.

You can also find out more about the PTC using the following links: meettheptc.com | ptcandyou.com | ptc-strategy.com.

– Chris, Gemma and John

Disclaimer: The opinions expressed in this magazine are those of individual authors and do not officially represent the views of the Royal College of Psychiatrists.

Be the next editor of theRegistrar

We are looking for someone to take on the role of editor of the PTC's magazine, *The Registrar.* This is an opportunity to communicate about ideas and topics close to trainees' hearts as well as sourcing other writers, interviewees and images. With the support of RCPsych staff, you will produce three issues of our trainee-led magazine per year.

If you are interested, we would love to hear from you.
Find more about this role on the College website.

Cardiff

Trainees' conference

Save the date for the Trainees' Conference 2023 – Psychiatry Beyond Prescription – taking place in **Cardiff** on **11–12 May**.

See the College website to register interest and find out more.

Contents

Dr Chris Walsh , PTC Chair

Come together

Dr Chris Walsh, PTC chair, shares his thoughts on the current pressures on doctors and urges you, his fellow trainees, to group together to define the problems and have a voice in the conversation.

Four in 10 doctors plan to leave the NHS within the next five years, citing working conditions and pay as the main reasons, according to a survey by the British Medical Association published in December.

Personally, I would be fibbing if I said the thought of leaving had never crossed my mind. It can feel like we're in this unfortunate position and we know that there is only so long we can continue to tread water. Despite this, many of us don't resign, retrain or find another career – we keep going. At first I wondered – is it because of a sense of duty, purpose or service? I think it's more than that. Even when the proverbial is hitting the fan, we feel part of something and get the chance to make positive change every single day – big or small for patients, for staff, for ourselves.

But the anxiety and cumulative negative charge has to go somewhere. We might find ourselves watching reassuring YouTube videos and podcasts on Moral Injury and Burnout, having a pint of ice cream, drinking wine, purchasing a random basket of useless nonsense from Amazon or watching TV to escape (sometimes sleeping less because of it) among various other maladaptive coping strategies. Anecdotally, in this current role as PTC chair, I find trainees talking about anxiety over the constant uncertainty – their next on-call, ARCP or exam outcome.

But there is another cluster of mature defences that can be our sword and shield: identification, affiliation, humour and altruism.

The coming together of people with a common interest is the prosocial element that forms the backbone of fellowships, clubs, societies, sports teams among many others.

As trainees, we need to do the same. We need to come together, locally and nationally, as a group of like-minded individuals. The perfect place to start is the PTC; there will never be a time when the PTC won't want to engage with other trainees and listen to their concerns. So, I mean it when I say: please feel free to contact us. Seriously.

Positive shifts that are happening around us. We have exciting new ways to train in terms of run-through training for CAMHS and ID, an updated curriculum for each higher training subspecialty and core training, and a new way of capturing this in our portfolios in the form of PSPDPs.

The College is listening to trainees who have spoken about equality, diversity and inclusivity. RCPsych's President, Dr Adrian James, and Chief Executive Paul Rees, have created an action plan where they have committed to deliver a host of outcomes, some of which I've been involved with myself, such as the College's 2022 survey into the experiences of LGBTQ+ psychiatrists in the workplace.

Many of us, myself included, have sat the CASC and written papers online, thanks to RCPsych having been one of the royal medical colleges to have acted with decisiveness and speed during the pandemic so that exams could take place allowing trainees to progress without significant disruption.

We welcome the positive shifts, but there also remain unresolved issues. These include the disparities in the training experience across the different regions of the UK affecting factors like being able to take study leave and having access to non-RCPsych training courses for exams and psychotherapy competency-related resources.

Trainees are also concerned about the MSRA for core training, and the self-assessment 'dropdown box' assessment form for higher training both lacking the 'space' or consideration of who the applicant may be 'as a person'. (Most people seem to agree that this is the foundation of what 'makes or breaks' one as a psychiatrist.)

There are concerns about the plans to redistribute training posts over time in-keeping with the needs of the populations we serve. And of course, there are the wider concerns that we all have about the ongoing privatisation of the NHS, the future of our careers, our pensions and our tolerance of the demands of the job declining.

Our first challenge is to identity the problems and define them – we must talk to the people who we know will listen and help us, and keep the dialogue going even when things become difficult. Our second challenge is to ensure trainees are consistently able to have a voice in these key issues.

The PTC's 40–50 reps who meet quarterly and are in regular contact, must strive to make decisions and give feedback on behalf of the thousands of psychiatry trainees in the UK in a way that accurately represents them. So, I encourage you all to engage with the PTC to help make a difference.

Have we lost the 'P' in biopsychosocial?

How psychiatric care has drifted away from psychological thinking: a snippet from an interview with Dr Jo O'Reilly, chair of RCPsych's Executive Committee of Medical Psychotherapy (ECMP), conducted by Dr Alina Braicu, dual ST including Medical Psychotherapy, and Dr Daniela Borges, CT and PTC rep to the ECMP.

Dr Jo O'Reilly, chair of RCPsych's Executive Committee of Medical Psychotherapy

Dr Borges: Dr O'Reilly, you've mentioned how there is a concern in the Medical Psychotherapy Faculty, as well as among other members in the College, that psychiatry seems to be moving away from psychological thinking, and away from using case formulation as the basis of care. I wonder if you could tell us a bit more about this?

Dr O'Reilly: Yes, of course. There is essentially a concern that we've abandoned the 'psychological', and psychiatrists are starting to be seen predominantly as diagnosticians or prescribers.

We've noticed a tendency to go straight to diagnosis, rather than holistic case formulations – which involves thinking carefully about patient's biological, psychological and social factors so you can really understand them – as the basis for care planning.

Dr Braicu: Can you offer some examples of where you and your colleagues have seen this move away from psychological thinking within the profession?

Dr O'Reilly: We've noticed this shift in several areas. For one, I've personally observed it in my own work as a consultant – psychological thinking seems to have really faded away as part of the normal discussion of someone's presentation. We take this early history information so we know something about the disrupted attachments, or the early losses, or the boundary violations that an individual may have had, but we aren't putting this all together in a useful way.

We therefore can often miss opportunities to understand why this person has broken down at this point. Making sense of this could even offer important insights into the patient's treatment and their relationships with the care team. Do they have difficulty trusting the team, for example, and why and when might they relapse?

We've also noticed this shift in psychiatric training. Concepts such as containment, countertransference, or team dynamics – all these sorts of things that help us understand the practice of psychiatry – seem to have faded away from the conversation.

Even in College events and conferences, there is a noticeable prevalence of biological over psychological/psychotherapeutic content. Yet many of the advances in psychiatric care in recent years have been in evidence-based psychological interventions led by psychiatrists such as Aaron Beck and Stirling Morey with regards to CBT in the UK and Otto Kernberg with Transference-Focussed Psychotherapy. We should be celebrating these contributions and firmly owning them within psychiatry.

Dr Braicu: I have reflected similarly, for example, when working with individuals who require treatment for addiction. I felt really frustrated when taking histories where almost all had PTSD, depression and/or a history of trauma which I had to acknowledge to be able to see past the physical aspects of the detox process, and the basis of this is the full history.

I have hope in medical students, however. Where I work in Birmingham, they are exposed to reflective groups, formulation sessions and Balint groups, and they learn to use these in practice.

Dr O'Reilly: I'm very pleased to hear that because when we practise with the psychological in mind, it doesn't just better our understanding of our patients – it also makes the work we do more interesting and enriching.

Dr Borges: I wonder if both psychiatrists and trainees tend to assume psychological thinking and formulation are more complex than they really are.

Dr O'Reilly: Yes, I think this is largely the case. People think these ideas are quite complicated, but drawing together vulnerabilities in patients and where these have arisen from isn't as difficult as it might seem.
And formulations simply allow us to explore why a person might be presenting in a certain way. They're beneficial as they're a working model that you can create with input from your patients and their families, and you can even adapt your formulation in light of new information. But you're constantly trying to think within this framework, as opposed to, "I'm here to diagnose a condition and prescribe a treatment." -->

Continued:

Have we lost the 'P' in biopsychosocial?

Dr Alina Braicu

--> There's a really good paper on formulation written between us, the Medical Psychotherapy Faculty, and the General Adult Psychiatry Faculty. I'd recommend this to anyone wanting to learn more.

Dr Borges: It sometimes seems there is a divide between psychiatrists who are 'doctors' and psychiatrists who 'think psychologically'. Would you say this a limitation of the use of formulations, and other care models based on psychological thinking?

Dr O'Reilly: There's always been this kind of divide and I think it's a bit of a false dichotomy, as both ways of understanding the brain can work together.

In a very simplistic analogy, we know when we're angry, our levels of cortisol, adrenaline and noradrenaline are raised. That's the biological process of the emotional state, but that isn't why we're angry. It might be why we're experiencing some of the physical symptoms of anger, but we would have been triggered by something relational or some frustration in the outside world, or some limitation in ourselves. Therefore, the anger will have a relational, psychological, and social origin.

You could hypothetically make somebody less angry by reducing their hormone levels, but it doesn't solve the factors that are causing the anger.

So, I think it's quite interesting that in psychiatry – which is primarily about difficulties with emotions, thoughts, feelings, and beliefs – we can favour biological ways of understanding our patients rather than the factors which may underlie the difficulties.

Dr Borges: We know that the faculty of medical psychotherapy has a project regarding the biopsychosocial model. Can you tell us a bit more about this?

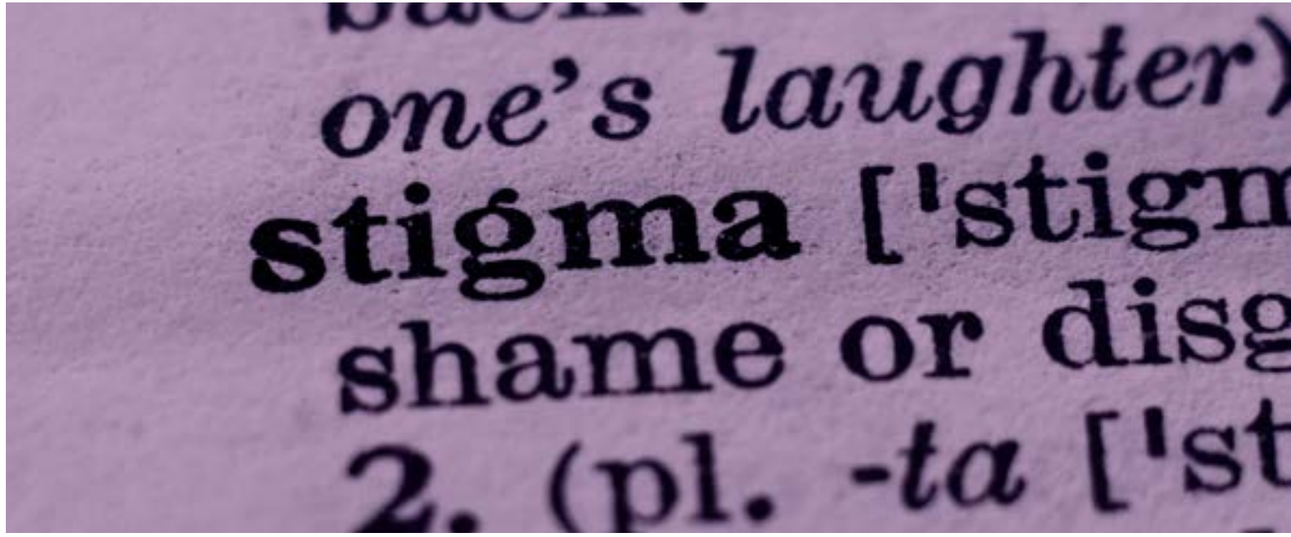
Dr O'Reilly: As a faculty, we've developed the 'Campaign for Parity for Psychological Thinking Within Psychiatry'.

We also wrote a paper on the need for the College to promote psychological thinking within the biopsychosocial model and presented it to RCPsych Council in October., It went very well and received a lot of support from psychiatrists, service users, carers, and other members of the College. Ways of carrying forward action are currently being considered by the College.

Dr Braicu and Dr Borges:
Dr O'Reilly, thank you so much for talking with us today. We are hoping that psychiatrists and healthcare professionals in general, will think more of the "P" within the biopsychosocial model from now on.

The Psychiatric Trainees' Committee supports the Executive Committee of Medical Psychotherapy on the 'Campaign for Parity for Psychological Thinking Within Psychiatry' and we will share information with our colleagues who want to find more about it.

Dr Daniela Borges



An ironic problem for a psychiatrist

As a CAMHS ST6 trainee with depression and autism, Dr Scott Deschain talks about how fear of stigma caused him to delay seeking support.

My name is an anagram of "Chattiness Doc". Most of my friends and colleagues would agree that it suits me and my outward persona – cheerful, friendly and empathetic. So, it's been interesting to see how those same people respond when I tell them I'm also depressed and autistic.

These factors have had a huge impact on me and my career. In the last few years for example, I've taken two years out of training to undergo treatment for depression. But perhaps what has had an even bigger impact has been the stigma I've felt – both the internalised stigma from myself, and the perceived stigma from others. The fear of this stigma held me back from getting help for a long time.

My career as a psychiatrist was well under way before I really came to terms with my depression. Throughout my whole life I would distract myself with new friendships, new relationships, new cities. I didn't seek any more concrete help than an inadequate dose of an SSRI.

After graduation, I actively felt under pressure to avoid questioning my mental health with boastful stories of resilience and 100-hour weeks being the norm. Talking about it in supervision felt like dicing with consequences that felt inappropriate, unhelpful or punitive. I feared my supervisors and peers wouldn't trust my clinical judgement.

By the time I accepted I needed effective treatment, depression had left me unsure whether I really was at all empathetic or capable of building positive relationships; I was utterly lacking confidence in what I had thought were my greatest strengths in psychiatry.

Deciding whether to disclose your mental health to others is deeply personal and, while we like to believe we are good at discussing the stigma around mental health in respect of our patients, we are still behind when it comes to ourselves.

When I first entered treatment (with huge thanks to the Practitioner Health Programme, which I would recommend to any struggling doctor, particularly a psychiatrist), I decided I had to tell my supervisor, given how incapable I felt of taking an objective view of my performance. I've told every supervisor since and, on the whole, I've been fortunate, with only one consultant handling it with anything other than respect and well-pitched support.

It's been genuinely reassuring when seniors have chosen to share their experiences in response, and this has helped to normalise my own. I've done my best to pass this on and share my history with other colleagues when I've felt it would be helpful. My hope is that this may alleviate their own sense of fear and reassure them that seeking support earlier in their careers might benefit, rather than hinder, their own wellbeing.

What's happening with wellbeing where you are?

Dr Sangbarta Chattopadhyay explores trainee-led well-being projects that have developed innovative ways for trainees to connect, support and mentor each other across the UK.

We, the PTC, are keen to focus on tangible well-being initiatives that can make a real difference. But what do these initiatives look like? Do they always have to be as formal as therapy sessions or seminars?

Here, our trainee peers talk about their local trainee-led initiatives, and demonstrate how even simple ways of supporting one another can go a long way.

Thames Valley, England

Dr Daniela Almeida Borges:

"In the Thames Valley region, we have set up Trainees4Trainees (T4T), which facilitates peer support groups accessible to doctors in Foundation and Specialty training.

Group-based peer support and reflective practice are interventions known to reduce clinician burnout and optimise wellbeing. In this trainee-led project, we support the creation of 45-minute online group sessions facilitated by two trainees with special training in peer support. Trainees can use these sessions to discuss challenging experiences and think about their emotional responses in a supportive and validating environment.

Our trainee facilitators themselves are supported with a 90-minute group training session and access to regular supervision from a consultant psychiatrist in medical psychotherapy.

Feedback from trainees has been extremely positive, with trainees praising its accessibility (any trainee can join) and its ability to normalise the difficult feelings that doctors experience daily. You can read more about the scheme at: www.tvpsw.com/t4t"

Lancashire and South Cumbria NHS Foundation Trust, England

Dr Heidi Soliman:

"In our trust, we have many well-being activities. We have formally organised social events to connect with diverse cultures, as well as casual dine-outs organised amongst trainees. We have wellbeing walks, football matches, and even relaxing massages!

However, the one thing that stands out for me is having a safe space or, as we call it, our 'venting space' for trainees. It started as a locality-based WhatsApp group so that we could help one another with work issues around the clock.

As time went by, we started to use the group to talk about anything and everything, from difficult situations at work to personal dilemmas. It has become a space where one can simply vent with no expectations other than a willing ear, without fear of judgement. Three years down the line we still come back to that group for anything and everything. It's important to create a safe space and to reach out to people who you think are struggling. We won't always have solutions, but we can just be there for each other."

Northern Ireland

Dr Alex Todd:

"There is nothing like the fear of the unknown. What do I do? How does this work? Am I on the right track? We are all familiar with these questions and the anticipatory anxiety associated with the completion of training.

In Northern Ireland, we have worked to minimise this anxiety with our trainee mentor scheme. Using our 'MentorNet' software, core trainees can be matched with a higher trainee mentor with similar interests. The mentor is then available as a point of contact for advice and support.

The scheme has been invaluable to me and many others, as it allows you to speak with someone who has already walked your path (and to arrange a nice meeting with them over lunch, or a coffee and cake). It has been a great way to get career advice and direction. And a good laugh too!"

Leverndale Hospital in Glasgow, Scotland

Dr Masroor Phulpoto, Dr Jen Lewis and Dr Emma Brown tell us how they set up Leverndale Doctors Wellbeing Committee:

"Post-pandemic, the doctors at Leverndale began to recognise how isolated they were from their peers. Concern for colleagues in the context of stress, burnout, and recent experience of peer mental health issues and suicides sparked formulation of the Leverndale Doctors Wellbeing Committee.

The aim was to create an integrated environment, an inclusive voice and a supplementary layer of support. An additional objective was to welcome international medical graduates and celebrate diversity to facilitate adjustment to a novel culture.

Since the launch in October 2022, numerous initiatives have been developed and we have hosted several successful and well-attended events. These include a 'Bake-off bonanza', a 'potluck dinner party' (sharing foods from around the world), a photography competition, a mindfulness session and a Christmas-themed jumper and quiz event.

These were open to and enjoyed by all grades of doctors and the camaraderie was palpable. Feedback has been overwhelmingly positive. We plan to continue to request suggestions for new initiatives, to access funding and recruit new committee members."

An interview with our Chief Examiner

Trainee Dr Stephanie Ewen speaks with Dr Ian Hall, RCPsych's Chief Examiner, about the future of exams.

Dr Ian Hall, chief examiner

What is the plan for the future format of CASC exams – will they be virtual or face to face? When we put the CASC online, we did so as an emergency measure to allow the CASC to continue running during the pandemic. The College decided to do an Assessment Strategy Review to look at the future of the clinical exam, but also to look out the wider assessment process including Workplace-Based Assessments. The process took over a year and included stakeholder consultations with candidates, trainees who have sat the exams, examiners and educators.

The consultation has shown that most people think that CASC needs to be a face-to-face examination because this is more valid in terms of assessing communication skills, history-taking and performing examinations, particularly physical and cognitive examinations. We acknowledge that some trainees would prefer to have the online format due to travel and accommodation costs. However, the Assessment Strategy Review has made a clear recommendation to the College that CASC should return to a face-to-face format.

There are plans to return to a face-to-face format in the UK from September 2023, and for the introduction of international centres delivering this format in 2024. However this is subject to final GMC approval.

Assuming GMC approval and the CASC returns to a face-to-face format, where will it be held? Before the pandemic, we used to hold CASC at the English Institute of Sport in Sheffield, so, that is the location we're planning for September 2023. We're also looking to reopen our international centre in Singapore.

It has been raised by trainees that consistently holding the CASC in England might not be fair. Would there be any plan to open other venues? I think it's more likely that we will rotate venues. We're aware that it's an expensive exam to take, and that's because it's costly to run. We don't make a significant surplus. In Sheffield, we can get a relatively inexpensive venue to hold the CASC at, which would not be possible in any of the capital cities.

You mentioned that the exams are expensive. Does the College make a profit? Money generated from exams can fluctuate. The College has taken a view for many years that we shouldn't be making excessive surpluses from the exam. So, if we make a surplus greater than 10%, then that money goes back to trainees. A lot of people think online exams are cheaper to run, but they're not. If, later down the line, things change and we find we're saving money, those savings will be passed on.

What reasonable adjustments are available for the CASC? We want to ensure the exam is as fair as possible and that includes making reasonable adjustments for people. For example, some candidates are allocated more reading time or a separate room or additional breaks.

What about the written papers? Will they be returning to an in-person format? We plan on staying with an online format indefinitely because the exams are much more accessible in the UK but also all around the world. But we recognise that there are some disadvantages to sitting the exams online, particularly the completion rates. We've done a lot of work to improve this to make sure that everyone who starts the exam is able to finish it.

What other developments can we expect to see with the written papers? In addition to moving to three diets per year, we want to make sure that the questions reflect current practice. People will be aware that we rewrote the whole neuroscience aspect of the syllabus. We're now looking to include between 30–40% new questions in each paper.

We're piloting 'very short answer questions', and hope to include these in our written papers. We've also started introducing questions on the ICD-11.

What advice would you give to candidates preparing for CASC? It's very different to a theory exam. You need to be able to recall information very quickly, and apply it to a case when you're in an anxiety-provoking situation. I would suggest starting preparations early. For example, in your ordinary practice, try to attend to and present new cases. I also recommend forming study groups. And don't be shy about asking consultants to help with those groups and to do practice stations, especially if they're examiners or interested in medical education.

There is significant differential attainment between UK graduates and IMGs. What does the examinations team do to mitigate this? This is a big concern for us, the General Medical Council and many others. We've done lots to address this, particularly around making the language accessible and straightforward. We've increased reading time for all our written papers and the CASC. We've ensured that our examiners and actors reflect the diversity of the UK population, and we train the examiners on unconscious bias as part of their initial and refresher training.

We believe the rate of International Medical Graduates (IMGs) asking for reasonable adjustments in the exams is less than it should be. So, we really encourage and support IMGs with any difficulties like dyslexia to make sure their difficulties are assessed and declared to the examinations team.

To keep up to date with exam news and developments, see the College's: exams news and updates.

Dr Chloe Beale

Honesty is the best policy

Trainee Dr Fiona Shaw speaks to Dr Chloe Beale about the harmful culture of exclusion criteria, being frank with patients, and looking after ourselves along the way.

Dr Chloe Beale is a consultant liaison psychiatrist at the Homerton Hospital. She has become a well-known advocate for change in psychiatric services, particularly around language and culture, after publishing her article 'Magical Thinking and Moral Injury: Exclusion Culture in Psychiatry' in *BJPsych Bulletin* last year.

Her article was borne from her passion of working in two specific areas of mental health care: suicidality and mental capacity law. While acting as her trust's suicide prevention lead, she became increasingly aware of capacity risk assessments and other concepts being misappropriated to deny access to care. "I'm not the first person to have said it or written about it," she says. But because this was raised by activists and survivors, Dr Beale feels professionals haven't listened.

For her, there are two major issues: firstly, mental health services' structure, culture and language lead to people's exclusion from receiving care. They might be ill, but effectively not 'ill enough'. Secondly, as professionals indoctrinated into this system, we are losing the compassion and humanity that we owe our patients and we are sometimes not honest with ourselves. Instead, we buy into the delusion that exclusion is 'clinically indicated'. This is confronting to realise, but Dr Beale reflects that "nothing ever changes or improves through people being comfortable".

So, how can we help as trainees? Although it may seem a Sisyphean task, Dr Beale believes being open and honest – both with ourselves and with our patients – about the ways services may have let patients down is a start.

Dr Beale says in her article, "Our patients will have more trust in us if we are open about scarcity of resources and restrictions on referrals; if we acknowledge that we cannot provide all we would like to. Instead of pretending that exclusion is clinically appropriate, we must name it."

Dr Beale also notes the importance of being open-minded, reflecting that "the most dangerous thing is when people think they know it all already and don't have space to learn." For clinicians who feel fear or powerlessness to speak up, it can help to recognise how much power we possess compared with patients and carers.

Part of helping our patients is also about helping ourselves. Dr Beale admits that this can feel increasingly difficult in services whose systems might require us to deny patients care. They "expect us to be instruments of harm, without being harmed ourselves," she says." She observes that many clinician-wellbeing initiatives were developed following the pandemic, but that ultimately "no one's looking to change the underlying structures".

For now, maintaining our wellbeing mainly falls to us as individuals. Dr Beale has experienced her own struggles with burnout over the years. She highlights some important ways she likes to look after herself: long-distance running, moving to compressed hours, using a content blocker to limit her access to Twitter and work emails, and being in the presence of cats.

Ultimately, Dr Beale believes clinicians working side by side with, and being honest with, patients will improve services for everyone.

Dr Rebecca Bennett

From the military to mental health

Dr Rebecca Bennett talks about how starting a career in psychiatry has helped her find purpose, pursue her interest in mental health and readjust to civilian life.

On a beach in Mexico in August 2011, I decided that I needed to leave the army. My husband and I had returned from a 7-month tour of Afghanistan during the most kinetic fighting period of the conflict.

I had been in Kandahar, working closely with the US Marines in the field of Psychological Operations at various bases across the region. Although I was an engineer by trade, this exciting area had appealed to me.

My husband was based with the UK Task Force in Helmand. Both jobs were highly stressful, and we often found ourselves on the satellite phone to each other with one of us hiding from missile fire under a desk or in a makeshift bomb shelter.

When we returned to the UK, life felt very different. I took up command of a workshop supporting the Royal Tank Regiment. I had 50 soldiers that reported to me. The scars of 10 years of conflict abroad were evident – many of them were suffering substantially after returning home from war.

> "My hard edges were softened and I valued my time spent on wards"

I made the decision to leave the military after almost nine years of service and go back to university to study medicine. I had a friend from school who was a medical registrar in Birmingham and she made her job sound so exciting.

I struggled with my transition to medical student – my contemporaries were often late for lectures and some would even sleep through them. I recalled the days at the Royal Military Academy and the brutal reprimands for daring to shut eyes during a war studies presentation. The lecture theatre at the Royal Derby Hospital did not know such punishment.

As time progressed, I became more in tune with my new role. I became more empathetic, even towards my fellow students. My hard edges were softened and I valued my time spent on the wards listening to patients and their stories. I knew, given my experiences with my military colleagues, that psychiatry would appeal to me as a career. I enjoyed having the time to consider patients holistically and felt privileged that people would divulge their innermost thoughts.

I found that veterans, like me, often struggled with changing careers. Being in the military is such an all-encompassing profession, retiring from service can often leave individuals bereft, searching for meaning and direction in their lives. But psychiatry has allowed me to flourish and develop areas of special interest within the field, such as sports and exercise, and nutrition.

My military experience prepared me in many ways for my current role, giving me a perspective I feel benefits my patients. Having felt like an outsider at medical school, I can now truly say I have found my calling.

AuDHD, dyslexia and me

Dr Anna Sri offers a trainee's perspective of navigating a medical education and psychiatric career with dyslexia, autism and ADHD.

Since my formal diagnosis of AuDHD (autism and ADHD) last year, I've reflected on the challenges and setbacks throughout my career, medical school and my earliest memories as a child.

I have always felt 'different' and uncomfortable within myself – I knew I didn't naturally fit the stereotypes of what a doctor should look like, or sound like or be like. So, I couldn't be myself.

In my clinical practice, I am open about my diagnosis by wearing a self-identifying badge: "I am Autistic and ADHD; please be patient". I feel it is important to normalise neurodiversity. It would be empowering if my patients and colleagues acknowledged that while my AuDHD and dyslexia mean I face many challenges in my professional and personal life, they also come with many strengths that I can bring my role as a psychiatrist. I hope, in turn, that my patients won't feel shame for having mental health crises and livelihood challenges which require intense support as part of being neurodivergent.

"I have always seen my AuDHD and dyslexic traits as special powers."

Within the last three years, while working at a previous trust at the start of core training, my supervisors told me that I couldn't possibly be autistic or have ADHD because I was being compared with their neurodivergent patients. In their minds, I didn't 'fit' the stereotype, or the diagnosis, of ASD or ADHD as I was a doctor and could manage my life independently – they lacked the understanding that no two neurodiverse individuals are the same, even if they share a diagnosis.

In my experience, the stigma arose amongst the professionals who lacked understanding and awareness of neurodiversity. There is a deprivation of staff training regarding ASD and ADHD. My colleagues hadn't knowingly come across neurodiverse healthcare professionals before, especially neurodiverse doctors. The impression I received from them was that being neurodivergent meant I couldn't be intelligent enough to be a doctor, and they questioned my patients' safety.

During the pandemic, I faced mounting challenges during my training. It is well acknowledged that Covid-19 deeply impacted people's mental health ubiquitously. For neurodivergent individuals who are already living in a narrow window of tolerance between states of hypo/hyperarousal, the pandemic pushed many of us past the threshold.

I shared my suspicions of having ASD and ADHD with the deanery's Professional Support and Wellbeing Service (PSWS) and requested an Occupational Health Referral. My GP referred me to the ASD and ADHD mental health service of my trust. I was told I would have to wait for 5–6 years, while the Occupational Health referral took 3 months to be approved. I felt unsupported when I was told there were no employee referrals for ASD and ADHD assessments.

I was mentally exhausted and my family could see this. We were aware of the urgent need for me to be assessed because there was no acknowledgement of the possibility of neurodiversity unless I was formally diagnosed. I spent a vast amount of money seeking private ASD and ADHD services. Fortunately, I found trustworthy and highly recommended private clinics and, within the space of a year, I was formally diagnosed with AuDHD.

A month ago, my former deanery wrote to inform me that the additional 12-month extension period added to my training time could not be fully classified as mitigating circumstances, and that this was beyond their control. If they had acknowledged this sooner, I would have requested inter-deanery transfer a year earlier, subsequently saving me from burnout and exhaustion.

I have always seen my AuDHD and dyslexic traits as special powers, but it is becoming clear to me that training can take much longer for a neurodivergent psychiatrist than a neurotypical one, consequently placing each neurodivergent psychiatric trainee at risk of persistently being a 'trainee in difficulty'. As a result, the mental distress and high levels of emotional anxiety can be overwhelming and one can live in fear of being removed from the training programme.

In the UK, around 3,000 psychiatrists may be autistic. I worry that there are undiagnosed neurodivergent psychiatric trainees who are silently struggling and not seeking the vital support they require. It is possible that some of those who have stepped out of training, been removed from the training programme, or left psychiatry and the medical career altogether, were potentially undiagnosed neurodiverse psychiatrists. With recognition and support, we could have retained these valuable psychiatrists. Patient care and clinical practice would have greatly benefitted from their lived experiences.

I am proud to be an autistic, ADHD and dyslexic psychiatrist. My traits allow me to observe, process, analyse and gather information in a way that aids my decision-making. On top of this, my tendency to be passionate about my interests allows me to pursue them with dedication. I particularly enjoy expanding, exploring and intercalating my passion for mental health with my other interests, including writing about human rights, geopsychiatry (geopolitical determinants and psychiatry), social justice and gender equity.

In the face of stigma, I chose to become a psychiatrist – not despite my neurodiversity – but because I felt my traits would help me to address the significant mental health inequalities that present as a public health crisis today.

Change is bigger than you or me

New PTC chair Dr Chris Walsh sits down with Mr Simon Fleming – orthopaedic registrar, anti-bullying educator and campaigner, TEDx Talker and speaker at the trainees annual conference in 2022 – to discuss the challenges of striving to make meaningful changes to healthcare systems, recognising your limits, and not overstretching yourself.

Dr Chris Walsh
Well Simon, let's get right into it – there's loads going on at the moment in terms of work pressure, industrial action, as well as concerns about exams and differential attainment. I've been able to see a bit 'behind the scenes' in my new role as RCPsych PTC Chair, as to what our College is doing to fix some of the causes. It's exceptionally hard to know how to address it all, but it feels urgent that we do. From your perspective, how does one bring about changes?

Mr Simon Fleming
Without wanting to sound like a BuzzFeed sound bite, I think the problem is that the clichéd narrative we hear is that "healthcare can't be fixed; it was built this way". If you listen to that you're falling into the same trap I did.

And many people fall into thinking that superficial changes that promise to help us cope better in the moment will be enough: "If I just tweak it, modify it, change it in some way, it'll be better, fairer, more equitable, more inclusive". But, fundamentally, all the power structures and systems are still at a foundational level, designed to maintain the status quo, amplifying some voices over others. The really difficult bit to do on an institutional level is to take a deep breath and say "we recognise that at a systems, foundational and historical level, everything we do and think today is shaped by what has come before us."

There's nothing institutions can do about the past, but they can say: "We can't change that, but we have insight now, and so here is our five-/10-/20-year plan for deconstructing all of these systems that are designed to promote people who look and sound like me [referencing forefathers of these organisations] and not other people."

A nice example of true change like this is exit exams. Exit exams were brought in to replace the previous system, which essentially was nepotism.

These more substantial changes require time. The little tweaks on their own will never work, but of course, that's how the system is designed.

That said, as an individual, you must accept the limitations you're working within. You can say to yourself: "My name's Dr Walsh, and I've got this position for one year. During my tenure, I can achieve X, so I will do everything I can in that time period." Will you be able to solve all the problems that you want to? No. But you can contribute small steps that might one day amount to larger change.

And we see the same in government. "I've got this finite window of time." Because the truth is the work we're talking about is bigger than us. You can't achieve all of it within in your tenure, right? It takes more than one voting cycle.

The challenge is a) recognising that there's better ways of doing things and b) accepting that the work that it will take to really change is bigger than you or me.

Mr Simon Flemming at his TEDx talk 'The era of the bully is over'

Dr Chris Walsh
Yes, it's about collaborative working and making sure that things are accurate, and reaching out for help. It's also a part of GMC requirements to know your limits.

Mr Simon Fleming
The truth is that the expectations of where our limits lie may have started in the early 1900s or even earlier.

My favourite anecdote is about the 'father of residency', William Stewart Halsted, a surgical innovator who developed a residency training programme that, with some modifications, certainly became the model for surgical and medical residency training in North America, and to a lesser extent in the UK. This following may resonate with psychiatrists, considering the work that you do around addiction and maladaptive coping mechanisms.

William had become addicted to cocaine and morphine. He widely published he was able to be the 'perfect registrar,' the 'perfect resident,' through the use of these drugs and he talked quite openly about his view that you can't work more than X number of hours, and be focused and be present and manage and juggle all these other responsibilities without them. This was alongside the fact that he was single, white and extremely rich.

This contributed to a training mentality to "work really hard, work all the time, go the extra mile, it doesn't matter what your hours say, always stay, never leave".

And even to this day, to suggest that there are better ways of doing things gives some people real moral injury because it feels like an attack on their core values – the training they did, the journey they went through, some of the traumatic --> --> experiences they had, which they

Mr Simon Flemming

feel shaped them in a positive way, but probably didn't.

I guess whether you're talking about medical education culture or about a toxic culture of bullying, undermining, harassment stuff, these things require uncomfortable conversations that you can't rush.

Dr Chris Walsh:
Yeah, there are certainly cultural issues in teams that on the shop floor you can really feel – some of these issues exist at a 'grass roots' level.

Mr Simon Fleming:
We're seeing this in the number of foundation doctors who leave. We're seeing it in recruitment and retention. We're seeing it in the rates of burnout, and sadly we're seeing it in the rates of suicide amongst doctors. It can feel like we're just expected to kind of roll with the punches because that's how it is. And it doesn't need to be the case.

Dr Chris Walsh:
It can also be frustrating because sometimes what feels like our basic needs are not met. It can make you feel devalued or even dehumanised. We speak to the people who run the services that we work for with respect as adults, but they can speak back to us in a way that can make us feel like children. You might essentially hear: "No, you can't go to your own wedding because of your rota."

Mr Simon Fleming:
Trainees and SAS grades majoritively run the service on the medical side, right? We just do. And we see that when there are rota gaps and things start to fall apart, and everything gets a bit tense. This means that, yes, you have to stay late, and miss your lunch and take on all the extra shifts. We can end up not eating, drinking, taking breaks, having holidays or taking sick days.

Surely the patient deserves a doctor who is not only well trained but also well rested. On the one hand, this would all be made easier if we were well-staffed and well-funded. But on the other hand, a lot of the stuff we're talking about here is simply about treating people like human beings and with respect, and that's free.

Post-interview reflection:

Dr Chris Walsh:

Despite there being bleak elements to my conversation with Simon, I also came away with a sense of positivity and excitement that everything might just be OK.

I found a clear message, which I think is at the core of his work. Big problems require big solutions. I started to appreciate that cultural change in healthcare is a slow-moving juggernaut, and releasing ourselves from the pressure to find immediate solutions might liberate us from some of the moral injury we are all experiencing, and open us up to a wider perspective.

Looking at the longer game and starting conversations about the intangible cultural issues within our profession (that aren't demonstrated by exam results or statistics), might just be a fantastic way to start. It made me want to put less pressure on myself to fix this massive problematic beach, and instead work through the 'tiny grains of sand', that over time may, ironically, lead to more effective change. It made me want to be more confident and fearless in being honest when I see things that just aren't right in day-to-day conversations, rather than simply taking part in formal initiatives to improve trainees' experiences. I hope that a part of you might have had an internal shift in reading this article in a similar way.