

# THE REGISTRAR

The Psychiatric Trainees' Committee magazine  
October 2020



# Contents

Editor's introduction	3
PTC officers' update	5
COVID-19 challenges faced by BAME psychiatry and IMG trainees	7
Is love really all you need for psychiatric administration?	9
My pathway into psychiatry and the creation of the PsychStart mentoring scheme	11
Psychiatric training – looking back	14
Interview with Professor Subodh Dave about his charity bike ride for Doctors in Distress	17

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## The Psychiatric Trainees' Committee

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# Editor's introduction



**Dr Ahmed Hankir,  
Editor of *The Registrar*,  
Academic Clinical Fellow in general  
adult psychiatry at the South London  
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 [@ahmedhankir](https://twitter.com/ahmedhankir) – 'The Wounded Healer'

Hello and welcome everybody to the October 2020 issue of *The Registrar*. I sincerely hope that you are all well.

Firstly, I really want to say a huge thank you to the Psychiatric Trainees' Committee (PTC) Officers who recently selected me, following a rigorous interview process, to serve a second term as editor of your magazine. I understand that the competition was fierce and rightfully so. In my opinion, it is no exaggeration to state that *The Registrar* is the best magazine for psychiatric trainees on the planet. It is such an enormous honour for me to occupy this position within the PTC once again and I pledge to live up to (and hopefully even exceed) your magazine's global reputation and expectations, and to continue amplifying the voices of psychiatric trainees throughout the UK and indeed beyond.

It is with a heavy heart that we bid farewell to Dr Ross Runciman whose tenure as Chair of the PTC has come to an end. Dr Runciman presided as Chair during the peak of the pandemic and his composure, earnestness, tenacity, empathy, wisdom, leadership and assiduity helped us tremendously to navigate uncharted territory and to progress with our training with minimal disruption. On a personal note, I can't thank Dr Runciman enough for the support he has given me and for his friendship. Anyone who has ever sat down with Ross will attest to how dignified you feel in his presence and how uplifting his smile is no matter how melancholic you are feeling. You will be missed Ross, and we wish you the very best with your career and life in general.

Since our last issue, life has been very eventful. COVID-19 continues to rage on and the Black Lives Matter movement has thrust racism and racial inequality to the forefront of public consciousness. The psychiatric profession is no exception when it comes to racial inequality; we know that people from Black, Asian and Minority Ethnic (BAME) backgrounds are disproportionately detained under the Mental Health Act and that we trainees from BAME backgrounds feel like we 'must work harder' than our non-BAME counterparts. The College is not oblivious to this and two Presidential Leads for Race Equality, Dr Lade Smith and Dr Raj Mohan, have been appointed to address this pernicious issue. Please watch this space for developments on that front.

With this loud noise continuously humming in the background, we have all been working assiduously to provide high-quality care to our patients with mental health difficulties. Many of us have also been busy preparing for the dreaded ARCP, so it's understandable if you have been feeling a bit overwhelmed – I know I have! It is important to recognise when you

are approaching your threshold and to take the necessary measures to address this, which include reaching out to your support network and speaking to your clinical and educational supervisors. This is the perfect opportunity to segue to the article published in this issue about Professor Subodh Dave's herculean 800-mile bike journey to increase awareness of mental health difficulties in medics and raise funds for the mental health charity Doctors in Distress.

The content of this issue of *The Registrar* will, I am sure, be highly beneficial for your personal and professional development. Professor Anuj Kapilashrami and Professor Kamaldeep Bhui published a paper in the British Journal of Psychiatry in August 2020 entitled 'Mental health and COVID-19: is the virus racist?' In this article, the authors alluded to the over-representation of healthcare workers from BAME backgrounds who tragically died subsequent to contracting COVID-19. This topic will be delved into in our article by International Medical Graduate (IMG) Representative to the PTC Dr Saadia Alvi, who highlights the implications for IMG and BAME trainees.

I think many, if not most, trainees will agree that administrative work and service provision consumes copious amounts of our time. In his engaging and entertaining article that permeates with wisdom and wit, Professor Steve Moffic, 2016 recipient of the Administrative Psychiatry Award from the American Psychiatric Association and the American Association of Psychiatrist Administrators, asks: 'Is love is all we need for psychiatric administration?'

Since being handed the baton to be editor of your magazine, I really wanted to provide insights into the human elements of the psychiatric trainee workforce. That is to say, what drives us, what our values and world views are, what obstacles did we have to overcome to get to where we are now and what are our career aspirations? To this end, I am absolutely delighted to include

an article from Dr Tom Hewson, the 2019 Royal College of Psychiatrists Foundation Doctor of the Year Award Winner, as part of our 'Profile Series'. I have never met Dr Hewson in person, however I still have a profound connection with him just by following him on social media, exchanging messages and reading his scintillating article signposting his #choosepsychiatry journey.

I am fortunate to be currently co-editing a textbook on Christianity and psychiatry with professors of psychiatry at Harvard Medical School, Duke University and the Medical College of Wisconsin in the United States, which our publisher Springer aims to release in 2021. Dr Christopher Cook FRCPsych, Professor of Spirituality, Theology & Health, and Director of the Centre for Spirituality, Theology & Health, at Durham University, was a chapter contributor for our textbook. Dr Cook very kindly accepted my invitation to write a piece for *The Registrar* about his psychiatric training and how and why he developed an interest in spirituality and religiosity and mental health. This might shatter my masculine bravado, but I did experience a crescendo of emotion reading Dr Cook's mind-blowing, soul-stirring, consciousness-raising and breath-taking article which is emotive and erudite in equal measure.

Well, that'll be all from me for now. As always, we welcome submissions from you for consideration for publication for future issues of *The Registrar*. In the meantime, with the ongoing uncertainty and changes regarding COVID-19, please do take good care of yourselves. Protect your minds and hearts, engage in self-care, relax whenever you can and do whatever you have to do to unwind, restore that work-life balance and salvage your sanity.

Best wishes,

**Ahmed**

# PTC officers' update



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Firstly, and most importantly, we hope that you are well. Secondly, we would like to welcome any new trainees to the College and anyone who is reading *The Registrar* for the first time.

As the newly elected Officers of the Psychiatric Trainees' Committee (PTC), we would like to say thank you. Firstly, to Dr Ross Runciman for leading the PTC in what has been a truly difficult year for trainees. We would also like to say thank you to *you* for continuing to work so hard and with such flexibility. We appreciate that these are uncertain and challenging times for everybody, and that training has undergone a number of changes during this time. We want to thank you for your adaptation to ARCPs, recruitment and the digitalisation of the exams, changes that have been made in a fraction of the time they would normally take.

Engagement is always a priority and we want to ensure that the voices of psychiatry trainees are heard throughout the RCPsych. We continue to work tirelessly to do this and

are grateful for your thoughts, concerns and suggestions. There are many ways to contact us if you do wish to get in touch (see the end of this introduction to learn how).

We are currently working on our plan for the next year focusing on the themes of engagement, wellbeing, and the trainee workforce. Due to current circumstances, our Breaking Barriers conference is likely to be held virtually. Although this means that face-to-face networking won't be possible, we are excited that the conference will be more accessible to trainees from all four nations and that we will get to 'meet' many of you at the conference. This is also a fantastic opportunity for you, as trainees, to showcase the fantastic work that you are doing. Details are still being finalised and as soon as these are confirmed, we will share them with you. We are continuing to advocate for our current projects to be completed. This includes projects related to mentoring, parental leave, staying well, International Medical Graduates (IMGs), the trainee social media platform and cost of training.

As always, our editor Dr Ahmed Hankir has put together a fantastic group of articles in this issue of *The Registrar* with psychiatry trainees and training at the heart of it. We have all been affected by COVID-19, however this has had an excessive impact on our BAME colleagues. In response to the pressing issue of the high and disproportionate numbers of deaths of BAME healthcare staff due to COVID-19, the College has produced timely guidance on risk mitigation for urgent implementation across all mental health care organisations in the UK. We would like to thank Dr Saadia Alvi, the PTC IMG representative, for all her hard work on this project and her fantastic article in this issue.

While the COVID-19 pandemic continues, it's important not to overlook other issues. The events of the last few months have heightened awareness of both racial inequality and systemic racism. The College is working hard to address these key issues, and in response to this have announced the appointment of two race equality leads, Dr Lade Smith and Dr Raj Mohan, to develop a

race equality action plan. We hope that the conversations that follow will encourage us all to think about how we can change things for the better.

Professor Subodh Dave's incredible cycle ride for Doctors in Distress reminds us that there is a possibility that when we are busy caring for patients, especially in such uncertain times, that our own mental health can be neglected. We would like to encourage you to think about your needs, be kind to yourself, make time for yourself and if you need help or support, reach out to those around you. The Psychiatrists' Support Service (PSS) is one such option, providing free, rapid, high-quality peer support by telephone.

Thank you once again and please continue to keep in touch. As always, you can do this via your local representatives or through Facebook, Twitter or by emailing us at [ptcsupport@rcpsych.ac.uk](mailto:ptcsupport@rcpsych.ac.uk). We really appreciate hearing from you and receiving your feedback. Stay safe and stay well.

Best wishes,

## Luke, Shevonne and Rosemary

The PTC Officers

# COVID-19 challenges faced by BAME psychiatry and IMG trainees

– Dr Saadia Alvi



**Dr Saadia Alvi is an ST5 Higher Trainee in General Adult Psychiatry at Rotherham, Doncaster and South Yorkshire NHS Foundation Trust. Dr Alvi is also the International Medical Graduate Representative of the Psychiatric Trainees' Committee.**

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The COVID-19 pandemic has impacted every part of the healthcare system, but particularly frontline staff. There is emerging evidence from multiple audits and empirical research that Black, Asian and Minority Ethnicity (BAME) health care workers (HCWs) are at greater risk of contracting COVID-19 infection<sup>1</sup>. Not only this, but HCWs from BAME backgrounds who are infected by coronavirus have worse outcomes

in terms of mortality as compared with their white counterparts<sup>1</sup>. A report published by Health Services Journal on the 22 April 2020 states that 94% of COVID-19 related deaths in doctors and dentists were individuals from a BAME background<sup>1</sup>. This figure is all the more disconcerting as individuals from BAME backgrounds constitute approximately 45% of the medical and dental workforce<sup>1</sup>. It is therefore unsurprising that anxiety is widespread amongst BAME members of the healthcare workforce; a substantial proportion of which are International Medical Graduate (IMG) trainees.

Trainees are frontline workers in each speciality of medicine and make the backbone of the medical workforce. As enumerated above, COVID-19 has not only impacted the physical health of BAME and IMG trainees, it has also had a profound effect on their psychological and social wellbeing.

Specific challenges faced by trainees from a BAME background include:

- Lack of Personal Protective Equipment (PPE)<sup>2,3</sup>.
- Discrimination around FIT testing for PPE, e.g. due to beard, veils or turbans<sup>4</sup>.
- Increased likelihood of working out of hours, covering Section 12 duties and to be allocated to inpatient wards. Moreover, BAME HCWs are less likely to complain if they are put on rotas which may be unsafe for them<sup>5</sup>.

- COVID-19 testing for trainees in this group (and their families) has been an issue<sup>6</sup>.
- Some of the issues were addressed to a certain degree however plenty of work still needs to be done. With the extent of the second wave of coronavirus unknown, resolving these issues is even more pressing:
- A robust and sensitive [risk assessment tool](#) has been created by RCPsych. Many royal colleges have also developed their own. The utilisation and effectiveness of these tools will need to be repeatedly evaluated.
- The redeployment of BAME trainees to general hospitals and to high risk areas has resulted in adverse outcomes as described above. This needs to be addressed as a matter of urgency especially given a second wave is highly likely.
- It is imperative to put measures into place to mitigate against high-risk areas and high-risk procedures like seclusion and restraint, ECT, and chest compressions as part of cardiopulmonary resuscitation (CPR) and other aerosol-generating procedures.
- All staff should be FIT-tested and if someone fails FIT-testing, the risks should be reviewed, and they should be assessed for alternative PPE such as respirators or hoods.
- Sensitive conversations about cultural factors and PPE must be facilitated between trainees and their supervisors and managers.
- Managers are responsible for ensuring that necessary provisions are put in place, i.e. they can make arrangements to minimise exposure to COVID-19 by authorising remote working whenever possible.
- COVID-19 testing should be prioritised for BAME/IMG members of staff and their families, given their increased risk of mortality.

- All educational bodies and royal colleges have an obligation to prepare physicians for competent independent practice. The royal colleges and educational bodies of all four nations of the UK must continue to deliver up-to-date guidance through webinars and on their respective websites. They must also make reasonable adjustments and allowances for any disruption to training due to COVID-19.
- Many, if not all, IMGs had to bear the extortionate burden of NHS surcharge which at times could be financially challenging. This has been reviewed following a continued campaign from private organisations.

To conclude, the medical profession has an ethical obligation to support the workforce during the pandemic. They must be cognizant of the concerns that BAME HCWs have, particularly about their increased risk of mortality from COVID-19. It is vital that everyone plays a part, from trainees to regulatory bodies such as the royal colleges, the General Medical Council and Health Education England.

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# Is love really all you need for psychiatric administration?

- Dr H. Steven Moffic, M.D.



**Dr Moffic is a retired tenured Professor of Psychiatry at the Medical College of Wisconsin, USA. Not only a recipient of the Administrative Psychiatry Award from the American Psychiatric Association (APA) and the American Association of Psychiatrist Administrators (AAPA), he has also received the one-time Hero of Public Psychiatry Award from the APA's Assembly.**

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"There's nothing you can do that can't be done.

Nothing you can sing that can't be sung

Nothing you can say, but you can learn how to play the game

It's easy . . .

All you need is love..."

- *All You Need Is Love* by The Beatles

Is it really that easy to become a successful psychiatric administrator? Though they surely weren't thinking about that, The Beatles may have been saying so by singing about the utopian ideal in their 1967 Summer of Love performance for Our World, representing Great Britain for the first global television link.

Nevertheless, it was a clear message conveying that love is everything, and to be sure that everybody got that message, they repeated the line "all you need is love" over 20 times to end the song. Then, again, their intragroup love diminished and they broke up not too long afterward.

Whenever love is mentioned in psychiatry, it's often about the problems that passionate romantic love can cause. Therapists falling in romantic love with a patient is a countertransference problem in the least, and a major ethical transgression if acted upon. The more common romantic love of patients for therapists is part of transference, needing to be managed, interpreted, and worked through. Staff falling in love with each other can upset the overall team dynamic. Sometimes, love in psychiatry is mentioned in regard to narcissism and self-love.

These were the main topics that seemed to be covered in the over 24 million entries on Google when I looked up "psychiatry and love" in 2016. I didn't see anything about love in administrative psychiatry, though.

Why was I looking up psychiatry and love in 2016? Well, I had just heard the news that I was to receive the highest administrative psychiatry award, intermittently given by the American Psychiatric Association. The year 2016 was also the time when psychiatrist administrators were getting a worse and worse rap because the

burnout of colleagues was reaching epidemic proportions. It seemed that the system was the major factor in the burning-out process, and people running these systems were usually psychiatrist administrators!

That problem made me wonder: If I was a good administrator, which the award was apparently conveying, why was I? So, I asked three former colleagues and staff what they had seen in my administration. Here are the responses, verbatim, from three different systems that I led:

“He cared. We all knew he cared about us no matter where we were on the organizational chart. He would listen not only to us but to the patients we worked with. He brought a large staff together. We were a close-knit family. Many of us have stayed in touch 35 years later. I mainly learned from watching and observing him with his patients, our staff and his family”.

“In my opinion, a large part of the success of his clinics reflected the combination of his consultative leadership style, his clinical expertise, and his genuine caring and concern for staff and patients: rare gifts among academic psychiatrists.”

“What makes a good one? They understand and care about individual patients, of course, not just processing code numbers. They do the same for therapists working for them, too, both guiding and forgiving mistakes (and sometimes critical).”

In reading those statements, a few words stood out for me: “his family”, “his genuine caring and concern for staff and patients” and “forgiving mistakes (and sometimes critical)”. My light bulb then went on. This sounded similar to how a good-enough parent treats their children. This is a different kind of love, a caring and compassionate love. That gave me the focus for my award lecture.

Of course, parental love should never be completely unconditional. There should be changing realistic expectations. Monitoring your children’s work is essential. Parents can be taken advantage of. All apply to administration, too.

There are also differences. Administrators may not automatically love their colleagues and staff. However, if one comes to this field with feelings of compassion and caring for all concerned in patient care, love can evolve. To do so, a leader can look for the strengths and successes that any given staff member possesses, rather than mainly focusing on weaknesses and problems.

If administrators could love their staff, is that an antidote to the worrisome rise of physician burnout in the United States and other countries? I think so. Because no matter the financial constrictions on resources and care, if the whole team feels they are loved and ‘in this together’, that can go a long way from the disengagement that is the major systemic cause of burnout.

And the results you are likely to get? If you don’t believe me, here are the words of Avedis Donabedian, M.D., known as the ‘father of quality improvement’ in medicine, who apparently said this on his deathbed:

“Ultimately, the secret of quality is love. You have to love your patient, you have to love your profession, you have to love your God. If you have love, you can then work backward to monitor and improve the system.”

In conclusion, then, it is not so easy. Love is not all you need in psychiatric administration, but it can go a long way. It helps for the administrator to not only be loved back by colleagues and staff, but at home and from friends. For me, most crucial was my muse and wife of 52 plus years, Rusti, who had the passion and warmth to always keep my fires burning and, even, at times to douse those fires a bit when my Don Quixote impossible dreams got too unrealistic. There are also role models and mentors.

For book learners, there is a voluminous literature. There are education seminars for residents/trainees and continuing education for practicing psychiatrists. But you won’t find much, if anything, about caring love in administrative psychiatry there. For that, you’ll have to look into your hearts.

# My pathway into psychiatry and the creation of the PsychStart mentoring scheme

- Dr Tom Hewson



Dr Tom Hewson is an Academic Clinical Fellow in general adult psychiatry at Pennine Care NHS Foundation Trust. In 2019, he received the accolade of 'Foundation Doctor of the Year' in that year's RCPsych Awards. Among his particular interests are forensic psychiatry and innovative methods of supporting medical students and trainees - exemplified by his cofounding of [PsychStart](#), a mentoring scheme for medical students.

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## Medical school and early experiences of psychiatry

My first experience of psychiatry was in my second year at Nottingham Medical School during an optional 'Introduction to Psychiatry' module. I recall being fascinated by the complexity and variety of mental illness, whilst also acknowledging that as a second-year student I was only 'scratching the surface'. At the same time, I felt inspired by the truly holistic and bio-psycho-social approach to patient care taught and demonstrated by my supervisors; amongst all of the pre-clinical lectures, this reminded me of why I chose a career in medicine in the first place - to treat patients, not simply diseases!

Throughout my other placements, I realised that my strengths were related to history taking, listening to the patient, and arriving at the diagnosis. I preferred hearing patients' stories

and understanding the impact of their illness more than I ever enjoyed watching complex surgery, performing practical procedures, or reading textbooks... I was never the one to fight to 'scrub in' or for a seat in the library! My passion for psychiatry was then re-enforced during the fourth-year psychiatry module and, again, during my clinical elective in forensic psychiatry in Melbourne, Australia. I entered foundation training knowing that my skills and interests aligned with psychiatry and that I would #choosepsychiatry two years from then.

"Mentoring is a brain to pick, an ear to listen, and a push in the right direction."

- John C. Crosby

Throughout medical school, I found myself gravitating more towards particular doctors, teachers and supervisors than others. I couldn't always explain this, but often it was for several



reasons – feeling inspired by their approach to patient care, feeling comfortable around them and being able to talk openly, or simply thinking, “I want to be like them”. Occasionally, I thought to myself, “I wish this person would be my supervisor” or, “I wish they would show me how they developed these skills that I admire”.

At the end of a psychiatry teaching session in my fourth year of studies, I boldly approached the tutor and said, “I’m really interested in psychiatry, will you help me start preparing early for the specialty?” Little did I know, that this person would then go on to become my mentor. Over the next few weeks, we discussed training pathways, extra-curricular psychiatry projects, audit opportunities, and plans for my clinical elective.

Over the next few months, we then discussed exam preparation, my strengths and weaknesses, and arranged additional clinical shadowing. This all felt very different to my previous interactions with clinical and educational supervisors...

I felt more empowered because the content of our discussions was centred around my needs, interests, and development and not around any set curriculum or completing supervisory paperwork. Feeling able to discuss anything and everything with this person made me feel very supported and valued, very informed about my career choice, and very thankful that I had developed the confidence to approach her initially.

Reflecting on how useful I had found my interactions with this mentor inspired an idea... why not make mentoring accessible for all medical students that want to do psychiatry?

## **PsychStart: Encouraging and inspiring the next generation of psychiatrists**

I discussed this idea with my mentor. In true mentorship fashion, she supported and encouraged me, whilst also challenging me to think about the limitations and practicalities of a mentorship scheme. I realised that I could not establish a mentorship scheme alone... I sought the support of the University Undergraduate Psychiatry Society and University staff, whilst my mentor introduced me to her networks and local healthcare leaders that would really help to drive the project forward. Again, this highlighted another benefit of mentorship – socialisation into the profession.

Very quickly, the project grew wings and PsychStart was developed: a mentorship scheme for medical students interested in psychiatry. This scheme pairs medical students with local specialist registrars and consultant psychiatrists who are trained to act as mentors. The mentor-mentee matching process is bespoke, taking account of factors such as sub-specialty interests, geographical locations of students and mentors, and interests in medical education, quality improvement, research and leadership.

Since its inception, PsychStart has supported over 120 medical students to develop their interest in psychiatry. PsychStart has also expanded and has been established at three other medical schools throughout the country. Achievements by mentees on the programme have been numerous and wide-ranging, including the establishment of new medical school societies, as well as various research projects, conference presentations and national prizes.

## What have I learnt from the PsychStart scheme and my mentorship experiences?

- 1 Many students/trainees desire mentorship but do not access this for several reasons – students often state that they were previously unaware of the benefits of mentorship and/or lacked the confidence to approach mentors prior to joining the scheme.
- 2 Mentoring can improve productivity and broaden exposure to a specialty – many students on the PsychStart scheme have completed additional extra-curricular activities with their mentors and arranged shadowing opportunities in sub-specialties that are less established within the medical school curriculum.
- 3 Mentoring can support career decision-making – as one student stated: “My mentor has helped me to feel like my decision to do psychiatry is well-informed”. From a personal perspective, it has also helped me to integrate into the profession and establish networks that improved my confidence entering into psychiatry.
- 4 Mentoring is very different from clinical and educational supervision – as the title implies, clinical and educational supervision focuses on clinical and educational performance, whereas the focus of mentoring interactions is dictated by the individual mentee and their

specific interests, needs, and ambitions. Mentoring is also often more longitudinal in nature, allowing for greater development of rapport over time.

- 5 Mentoring is a two-way street – mentoring may benefit mentors in addition to mentees. This was recently highlighted in a post by Dr Pallab Majumder<sup>1</sup>, a mentor on the PsychStart scheme: “A mentoring experience can be a breath of fresh air for the mentors. It is formative not only for the mentee, but also for the mentor”. He explains that time spent mentoring can generate new thoughts, perspectives and ideas that are conceived jointly in the mentoring space and which may improve the productivity of both parties.

### Final words...

I would urge anybody with an interest in mentorship to approach potential mentors, and similarly to offer to mentor junior colleagues. I strongly believe that this offers potential for innovation in medical education, improving the support available to juniors and nurturing the talents of the future.

### References

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# Psychiatric training – looking back

– Professor Christopher Cook FRCPsych



**Christopher C.H. Cook is Professor of Spirituality, Theology and Health, and Director of the Centre for Spirituality, Theology and Health, at Durham University. He is a Fellow of the Royal College of Psychiatrists, with research doctorates in medicine and theology. Ordained as an Anglican priest in 2001, he is an Honorary Chaplain for Tees, Esk and Wear Valleys NHS Foundation Trust. His books include Spirituality, Theology and Mental Health (2013), Spirituality and Narrative in Psychiatric Practice: Stories of Mind and Soul, (edited with Powell & Sims, 2016), Hearing Voices, Demonic and Divine (2018), and Christians Hearing Voices (2020).**

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I was one of a whole generation of medical students inspired by psychiatry when I was at St George's University of London Medical School in the 1970s. Under the leadership of Arthur Crisp, with opportunities for 'experience of everything' from long stay wards at Springfield Teaching Hospital to the therapeutic community at Atkinson Morley Hospital, the department gave students a vision of an exciting and forward-looking medical speciality. When I applied for a post on the rotational training scheme after I had completed my house jobs, my former teachers asked me why I wanted to do psychiatry. My answer (which sadly didn't impress them enough to offer me the job) was a mixture of my vocational desire to help relieve mental suffering and a scientific excitement about the possibilities for research. Those twin concerns have stayed with me over the 40 years since, even though I ended up in a job which I could never have imagined all that time ago, and my research vision is much more interdisciplinary now than it was back then.

My postgraduate experience, as a junior trainee, was on the rotational training scheme based at Guy's Hospital – then under the auspices of the United Medical & Dental Schools of Guy's and St Thomas's. With Jim Watson as Head of Department, Guy's was also an exciting place to be in the 1980s. Only later did I realise how important the personal qualities of the Head of Department are in creating a supportive, friendly and motivating research and teaching environment. I was very fortunate as a student and trainee to have such good role models. At Guy's I experienced acute psychiatry at the sharp end. I was taught by some of the leading

psychiatrists of the time, and I found a sub-specialty – addiction psychiatry – which became my academic home for over two decades. I took my first steps on the research ladder – albeit disappointingly with my paper in *The Lancet* being about ‘a trial that failed’<sup>1</sup>, rather than one that worked! (A good lesson, however, in how to rescue a publication from disaster.) I learned that psychotherapy (in those days a much broader training experience, less dominated by CBT) is a part of the basic fabric of doing any kind of psychiatry well. Relationships with patients matter and have to be worked at and reflected upon.

Despite all of these advantages, it was only much later that I realised that some of the most important things that I was learning were not part of the MRCPsych curriculum, and were taking place outside of the hospitals and clinics where I worked. During my first five years of working in psychiatry I became a father (twice) and Ruth, my wife, died after an illness lasting almost two years<sup>2</sup>.

During the months of her illness we found that our Christian faith was the main thing that carried us through, albeit not to the happy outcome that we both hoped for. In the months after Ruth’s death, my psychotherapy training and my faith wrestled with one another in an attempt to find some kind of integrated understanding of what had happened. Was the faith that had helped me to cope with my wife’s illness and death just wish fulfilment? Did I believe just because it provided me with comfort during distress? Had there really been no-one there to hear the prayers that now seemed so painfully unanswered?

Real though these questions were, I decided that I wanted to believe anyway. Just because I wanted to believe, it didn’t mean that there were no good reasons for believing. I had good reasons, both rational and emotional. In any case, Christian faith is about

encountering God in the suffering of Christ – and experiencing suffering as a sharing in his suffering – it is not about avoiding suffering.

Although I never discussed them with my patients, these events transformed my view of psychiatry. I went on to undertake most of my higher psychiatric training (what would now be specialist registrar training) at University College London in a research post. My scientific work – in psychiatric genetics – was very biological, but my clinical encounters were not. Psychiatry is about how we attend to mental suffering. How we cope with our own suffering changes the way that we respond to the suffering of others. It is not something that we can or should keep in a separate compartment somewhere, well out of the way of clinical practice. Suffering people are not objects for the psychiatrist to study merely with academic or professional interest. They are people with whom the good psychiatrist has an authentic relationship with. If the psychiatrist is not in touch with his or her own experience of suffering, how can he or she relate honestly to that of their patients?

I came to see that psychiatry requires not only empathy, but a spiritual awareness of the human condition. By this I categorically do not mean that psychiatry should be a platform for proselytising or forcing religion upon others. In fact, that seems to me to be exactly the opposite of what I came to see as important. Spirituality, impossible as it is to define in any completely satisfactory way, is concerned with all of those things that are most important to us as human beings. (I say this with all due respect to those who see themselves as neither spiritual nor religious, and I recognise that some do not like the word “spirituality”, preferring to use a different vocabulary.) It is about our relationships with ourselves, with others and with a transcendent order (however we choose to understand it). It is about the things that matter most; it is about finding meaning. For

much of my clinical career, this was most often about helping people who struggle with their own destructive desires to drink or use drugs in their quest to find a way out of that inner division of the self. However, it is also about facing the certainty of our own mortality, and that of our patients. It is about how we make sense of our life experiences, the voices we hear, the beliefs that we find ourselves holding true (even when we are not sure why), the loves and fears that find a way inside us.

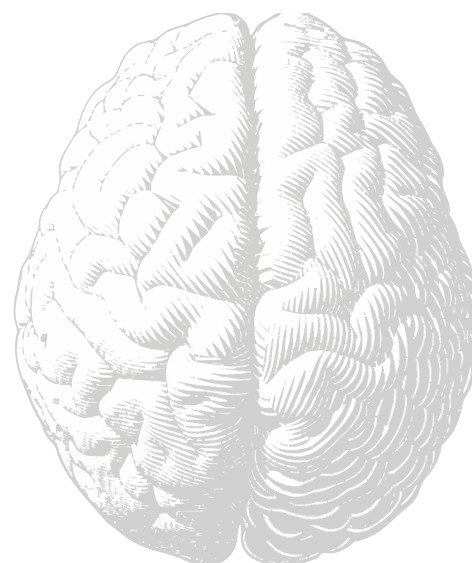
Eventually, all of these preoccupations led to my ordination as a priest within the Church of England, a PhD in theology, and my present post as Professor of Spirituality, Theology & Health at Durham University. As I get closer to retirement, I feel that I am really just beginning to explore what it is to be human, and the mystery of how we help one another in dealing with the suffering that is inherent in the human condition.

I sometimes wish I had done things differently, but my training in psychiatry gave me unique insights into people's lives and I do not regret any of that. I do regret that our speciality was (and to a lesser extent still is) seen by many as the province of atheism and agnosticism. Patients want to feel safe to talk about their illnesses in the context of their spirituality and faith. Person-centred clinical practice is concerned with giving compassionate attention to things that matter to our patients including, when they wish us to do so, their spirituality or religious faith<sup>3</sup>.

Ironically, I have learned a lot about this from my atheist friend and colleague from the good old St George's days, now also a professor of psychiatry, Rob Poole. He and I disagree on many things, but we do agree that boundaries are important<sup>4</sup>. Learning to navigate well the boundaries of specialist expertise, of our personal and professional lives, and the sacred and the secular are vital to good psychiatry.

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# Interview with Professor Subodh Dave about his charity bike ride for Doctors in Distress

–Dr Shevonne Matheiken

Professor Subodh Dave is a consultant psychiatrist and deputy director of undergraduate medical education at Derbyshire Healthcare NHS Foundation Trust. He was recently granted Professorship at University of Bolton, and will be working to promote integrated mental health care. He is the chair of the Association of University Teachers of Psychiatry (AUTP) and was awarded the Trainer of the Year at 2017's RCPsych Awards.

**New Vice Chair for the Psychiatric Trainees' Committee** Dr Shevonne Matheiken picked his brain on his epic 900-mile bike ride to raise awareness and funds for mental health difficulties in medics.

**SM:** Thank you so much for accepting my invitation for a virtual interview for *The Registrar*. I was so inspired by your 900-mile epic bike ride from Land's End in England to John O'Groats in Scotland (LeJog) which you accomplished in 10 days to raise awareness about doctors' mental health. You also managed to raise £6,000 for the mental health charity Doctors in Distress. So, I will start by asking what inspired you to do this?

**SD:** Equality and inclusion are major driving principles for me in my work as a psychiatrist and as an educator over the last 15 years. My work to address the differential attainment that Black, Asian and Minority Ethnic (BAME) doctors and IMGs face in their MRCPsych exam performance and the broadening access



Professor Subodh Dave

work that I do with state school students who want to get into medicine reflects this. Inclusion really suffers when there is mental illness involved, and most of us are familiar with diagnostic overshadowing that our patients often face in acute hospitals. Sometimes we forget that doctors are part of the 1 in 4 statistic – if anything they are, in a way, more vulnerable to stress, burnout and mental illness so I wanted to do my bit to get the message out there that there is no 'us and them' when it comes to mental illness in medics.

**SM:** Regarding broadening access to medical school, I have seen some highly thought-provoking Twitter threads about this. Were you alluding to the socio-economic divide and disparity in opportunities?



Professor Dave braved the elements and cycled through rain and storms but there was a rainbow at the end!

**SD:** Yes, exactly. A quick statistic would be that only 7% of secondary school students are in private education yet they constitute nearly 30% of medical school entrants. Moreover, 50% of state schools have never sent a single student to medical school and many are concerned that they never will.

**SM:** And I guess these conversations about mental health are also important to start right at the beginning of their medical careers too?

**SD:** Indeed. And that is exactly what we facilitate in the Dr1in4 programme for medical students that has had overwhelmingly positive feedback. The role of lived experience in educating is so important in this regard. We have trained over 50 patient experience educators now who offer teaching beyond what happens in the structured clinical setting, i.e. if we are teaching about schizophrenia, it would be the consultant and a patient co-delivering the session, with the patient providing a Q&A session as well as a narrative of their experience.

**SM:** As an IMG, I am unfamiliar with the details of how medical schools are set up in the UK. Is what you have described the default for undergraduate psychiatry teaching in this country? Because it sounds amazing to me!

**SD:** No, it's not the default but I hope that someday soon it will be. When we set up a group at the RCPsych to look at person-centred care, we had doctors with lived experience on that scoping group panel offering their 'dual expertise' which can be very powerful in terms of impact on policy and practice.

**SM:** What do you think about the approaches to 'mistakes' in our profession and its relation to doctors' well-being and burnout? Maybe you could share more about the setbacks you have personally experienced and the fall you had on your bike journey? Are there any parallels?

**SD:** Yes, we want an ideal world without any medical errors, but the reality is that mistakes will happen – some due to incompetence (where performance measures are needed) but often mistakes happen due to stress, or a systemic issue that somehow pins

the blame on an individual (which needs support measures). But there is usually a conflation between the two and the route to addressing these two ideally shouldn't be the same. Compassion needs to be a vital part in the whole process.

About the fall... Well, I do have a competitive streak like many of my fellow doctors and that can sometimes act as a barrier to seeking help early. I had struggled with my cleats from day 1 and my team members sensed it too but were hesitant to say anything and I didn't want to slow my team down. This thought of not wanting to let the team down also stops you from seeking help early in

medicine. In my case, both my team and I hesitated to have the conversation about my cleats until it was forced upon us when I had the fall and broke my bike!

I think the metaphor for us medics is pretty clear – we tend to delay seeking help for mental health issues. Partly this is because we feel that seeking help somehow endorses the notion of “not being good enough” and partly it's fear of not wishing to burden our teammates. But delay is often tragic. We know that the evidence is clear that outcomes are very good with early help-seeking. Substance misuse in doctors is a good example.



The power of the online community: Professor Dave shared both the ups and the downs of his journey with his Twitter network

**SM:** We talked about mistakes... What are your views on 'failure', given that a good majority of doctors have Type A personalities with perfectionist traits?

**SD:** I think it's about how we internalise failure. When we had to call off one day of the ride due to Storm Francis, I kept calling it 'LeJog minus one' in my head. I felt I was being untrue to myself for many days. But when I saw the support and affirmations from many colleagues including Wendy Burn, (our former President) supporting the sensible decision, it helped me re-frame the 'failure'.

**SM:** Going back to the cause, I remember the tragic death of a doctor that had led to his brother starting the charity Doctors in Distress. I guess one can never imagine the impact of the suicide of someone close to you. The death of a patient due to suicide is also extremely difficult to deal with as a trainee, and I'm guessing harder as a consultant when you are the senior person?

**SD:** Doctors in Distress is about awareness of one end of the spectrum, i.e. doctors with serious mental illness. But it's also about providing peer support at the early end of the spectrum. Communities are important, given the increasing isolation due to specialisations and medics often working in silos in some ways. I have unfortunately witnessed the impact of suicide of a colleague, and that is maybe less talked about than the death of a patient, but both require a lot of support.

**SM:** Talking about communities, and seeing that you are quite active on Twitter, what are your thoughts on the role of virtual communities in our work as psychiatrists?

**SD:** Twitter for me, is definitely a force for good overall. Twitter can be a good place to make your voice heard but we also need to remember that those voices may not necessarily be representative. The digital boom in the COVID-19 phase has been a boon for many, offering convenient access to specialists from the comfort of their home but it is important that we don't end up excluding people who are not part of that virtual platform. We have been proactive in supporting some of our expert patient educators who have embraced virtual online training, but we have also supported those who don't wish to or are unable to offer online inputs to students.

**SM:** It feels like we have covered lots of important things, and here's wishing for more conversations, easy ones and difficult ones – for our patients and for our own wellbeing. I hope our readers enjoy these insights as much as I enjoyed sharing this conversation. Thank you once again Professor Dave.

**If you are affected by any of the issues discussed in this article, we urge you to reach out to many support networks available including the RCPsych Psychiatrists Support Service (PSS) or your GP. Email [pss@rcpsych.ac.uk](mailto:pss@rcpsych.ac.uk) or call the dedicated PSS helpline on 020 7245 0412.**

