

Everyone reacts to a diagnosis of MS differently, and Hempling dealt with it philosophically. But he adds, “An immediate reaction was to look at somebody else who has had it for 10 years and wonder what I was going to be like in 10 years compared with them. Fortunately I have not

progressed in the same way as virtually any of them. I mean I have had problems ... but I can't say I let it bother me.”

I'm amazed at people's different responses to health issues. As a journalist, I suspected I had MS for a good couple of years before I was diagnosed 13 years ago. Yet,

despite his medical background, Hempling managed to have no suspicion that he had MS until he was 50. With hindsight, he thinks it likely that his first symptoms were back in 1971.

As for talking about multiple sclerosis, Hempling is used to mentioning it every time he is

introduced in court: “I say ‘I am telling you because I may sound a bit slurred, and if I do it is not because I have gone out for a quick one.’ I always reckon that my reputation is worth more than secrecy.”

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The world of a person with depression can be shrouded in despair, forcing retreats from humanity, so for someone with a disabling depressive illness to pick medicine as a career, with all its emotional and physical demands, is an unusual move. And of all the possible specialties, to select psychiatry, where communication is of the essence, is even more remarkable. And then finally to branch out into grief and bereavement work seems a truly astounding career choice for someone who suffers from profound depression.

But when Cambridge history and law graduate and former lorry driver, journalist, teacher, and carpet salesman Mike Shooter, now president of the Royal College of Psychiatrists, decided to study medicine, his family thought at last his career was set for calmer waters.

He was in his mid-20s when he struggled for the science qualifications he needed, fought for a place at medical school, and found himself back as a student at Cambridge. But just as he was about to qualify, he was overwhelmed by a major bout of depression, the first and worst of the depressive episodes that have dogged his life. “I got thunderously depressed, but I thought it was more to do with my ability to do medicine. I was thoroughly dejected about my performance. I knew I was a failure—that I had let everyone down.”

The episode that launched him into depression was seeing

Depression

Mike Shooter, president of the Royal College of Psychiatrists, has suffered bouts of depression throughout his career. Helen Crane, a journalist who has been hospitalised with severe depression three times, spoke to him about how being a patient has helped him be a better doctor



MARK THOMAS/

A bout of depression left Mike Shooter on the brink of committing suicide

a doctor comfort and support a dying man: “I thought, ‘I can't do this, I can't get that close to someone in distress and survive.’

The next day a message came down from the same patient that he wanted to talk to me. It terrified me ... by the time I went to see him, he had died, and I knew I had failed him.”

Soon after, he found himself as an outpatient at a local psychiatric hospital being treated for a depression that led to the brink of suicide and kept him away from medicine for a year, but introduced him to psychiatry at its best.

His regular sessions with a psychiatrist gradually helped him fight his way back from the quicksand of depression with the loving care of his wife, Mary, a probationary teacher,

who supported him both emotionally and financially. “My immediate family was very supportive, but I think my wider family wondered if it was just Mike making another strange career move again. I moped around at home. I was totally exhausted physically and mentally. I lost all interest in family life or in any kind of activity. I was just in a black limbo.

Shooter had good old-fashioned psychotherapy, which he describes as “a godsend.” Drugs also played a major part in his recovery.

“The pills probably helped biochemically. The pills also helped in that, for me, they represented the fact that this was an illness and it wasn't my fault. I was already feeling guilty—I felt so many people

had put themselves out to give me a second chance, and I had blown it.”

He decided to carry on with his medical training and to specialise in psychiatry, providing

psychiatric support for a team looking after gravely ill youngsters.

He started to read about grief and bereavement and to run workshops for other members of staff: “Before you know where you are, you are considered some sort of expert. It is very satisfying and, in a strange way, very hopeful. You can give people an enormous amount of hope, not necessarily false hope by saying that someone is not going to die, but that ‘We can give you a better death, we can help you.’”

Over the years he has come to recognise the point at which he has to quit the struggle and take time off: “I have a better idea now of when things are going wrong. I start feeling I am a failure, I start working harder to prove that I am not, and then I get tired and the sleep pattern goes all over the place, and I start drinking heavily and not eating properly, so I get into a spiralling pattern of disorganised activity.”

He has developed his own form of cognitive behaviour therapy, which he uses regularly, particularly when he is on the verge of sliding from self criticism into depression: “It is always about failure—I have to challenge the

assumptions I make. And for me, this way of dealing with it is extremely beneficial.”

He has had to learn to become particularly self aware in his work with grief and bereavement: “I think there are times when I am feeling so miserable in myself that it is extremely difficult to help other people who are facing those problems. Then I have to take a step back, I have to say, ‘This is too much for me to do right now.’ Doing grief work, you have to give of yourself, and there are times when I can’t do that.”

He feels his personal experience of mental illness has helped his understanding as a psychiatrist.

“I think it has helped knowing what it feels like from inside. I don’t foist it on them, but if I feel it is constructive to say to them, ‘I think I have had an experience like yours—for me it felt like this, I wonder if it is the same for you?’

“That gives them the room to say, ‘Yes, you know exactly what I am talking about.’ In that case we are closer together, or they can say, ‘It was different for me,’ and then straight away I know more about them.

“Because I have been depressed myself, I have to be aware that the way I feel may be very different from the way they feel, but I do think it has given me a kind of empathy for what it might be like for them.”

Helen Crane, freelance journalist
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Diabetes

Derbyshire general practitioner Stuart Bootle has had diabetes for 20 years. He speaks to Paul Smith, who also has type 1 diabetes

Stuart Bootle’s diabetes was effectively diagnosed by a veterinary nurse. He was a medical student in 1983. He laughs as he tells the story, because the vet nurse in question was his girlfriend, Nancy, who used a urine strip intended for her animal patients. He was suitably grateful, and she eventually became his wife.

“I’d been feeling terrible and was drinking loads. I was living with four other medical students at the time, and I suppose I felt that it was just part of the student lifestyle. None of us had been taught much about diabetes, so when Nancy did the test and I had glycosuria, I think that was the first indication it might be diabetes.”

As luck would have it, he was sent, as part of his training, to Manchester Royal Infirmary to work in the endocrinology department: “There was a discussion about diabetes, and at the end I put up my hand and told them I thought I may have it. My blood sugars were actually dangerously high—I had a measurement of about 50 mmol/l.”

Now 42 years old, Stuart Bootle’s experiences as an NHS patient have influenced

his NHS career. Today he runs a primary care diabetes service in Whaley Bridge, Derbyshire, he’s had input into the national service framework for diabetes, and he helps other professionals improve diabetes treatment.

Like me, he is one of the few people with diabetes to have read the diabetes national service framework from cover to cover. It is easy to describe him as an expert patient—that new breed of “NHS consumer” now central to the Department of Health’s conception of how those with chronic disease should take on greater responsibility for their own care. However, the fact he is a doctor specialising in diabetes with first hand experience of patients with poor self care—and the long term complications ranging from kidney disease to increased risk of heart disease—does not mean he’s a perfect patient.

As a diabetic for the past 12 years, I could disapprove. I’ve drunk myself stupid at university, I’ve smoked, and I’ve vegetated. I’ve binged, and I’ve forgotten to take my insulin and still gone out wining and dining because I didn’t want to turn down a night out.

However much I understand the risks—and even fear them—and however much it frustrates

healthcare professionals, I, like many people with diabetes, rarely put my condition first in my lifestyle.

Bootle suffered his first hypoglycaemic episode only days after his diabetes was diagnosed—seduced by the pub down the road from the hospital and frustrated by the boredom of being a patient. All he remembers after drinking two beers is waking up back on the ward he had left a few hours earlier and “sweating like a pig.”

“I don’t always look after myself all the time. Even GPs are human. I do drink, but I don’t smoke. It comes down to personal risk management, and, like everyone, I want a balance in my life. I know that sounds very rational. The truth is I am scared about the long term, I’m scared of going blind or having my legs chopped off. But you have to focus and manage those risks like any other.”

His practice is a success—with patients achieving reductions in their blood sugar, blood pressure, and serum cholesterol results, and low DNA (“Did not attend”) rates. To those who attribute his success to having diabetes, he says: “The idea that you only understand a condition by having it yourself is a myth. You don’t need to suffer a heart attack to treat a heart attack victim. It’s the same with diabetes. The secret is to listen.”

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QUICK FACTS

For more information on: Depression United Kingdom

■ Royal College of Psychiatrists (for information booklets, etc).
Tel: 020 7235 2351.
Website: www.rcpsych.ac.uk
■ MIND. Tel: 020 8519 2122. Mindinfoline: 08457 660 163. Website: www.mind.org.uk
■ Mental Health

Foundation. Website: www.mentalhealth.org.uk
■ Depression Alliance. Tel: 020 7633 0557. Website: www.depressionalliance.org
United States
■ American Psychiatric Association. Website: www.psych.org
■ National Mental Health Association. Website: www.nmha.org
■ National Foundation for

Depressive Illness. Website: www.depression.org
For more information on: Diabetes
■ American Diabetes Association. Website: www.diabetes.org
■ Diabetes UK. Website: www.diabetes.org.uk
■ Association of British Clinical Diabetologists. Website: www.diabetologists-abcd.org.uk

For more information on: Multiple sclerosis
■ The Multiple Sclerosis Society of Great Britain. Tel: 020 8438 0700. Helpline: 0808 800 8000. Email: info@mssociety.org.uk. Website: www.mssociety.org.uk
■ National Multiple Sclerosis Society, 733 Third Avenue, New York, NY 10017. Website:

www.nmss.org
■ Multiple Sclerosis International Federation. Website: msif.org
■ American Academy of Neurology. Website: www.ann.com
■ International Multiple Sclerosis Support Foundation. Website: www.nsnews.org