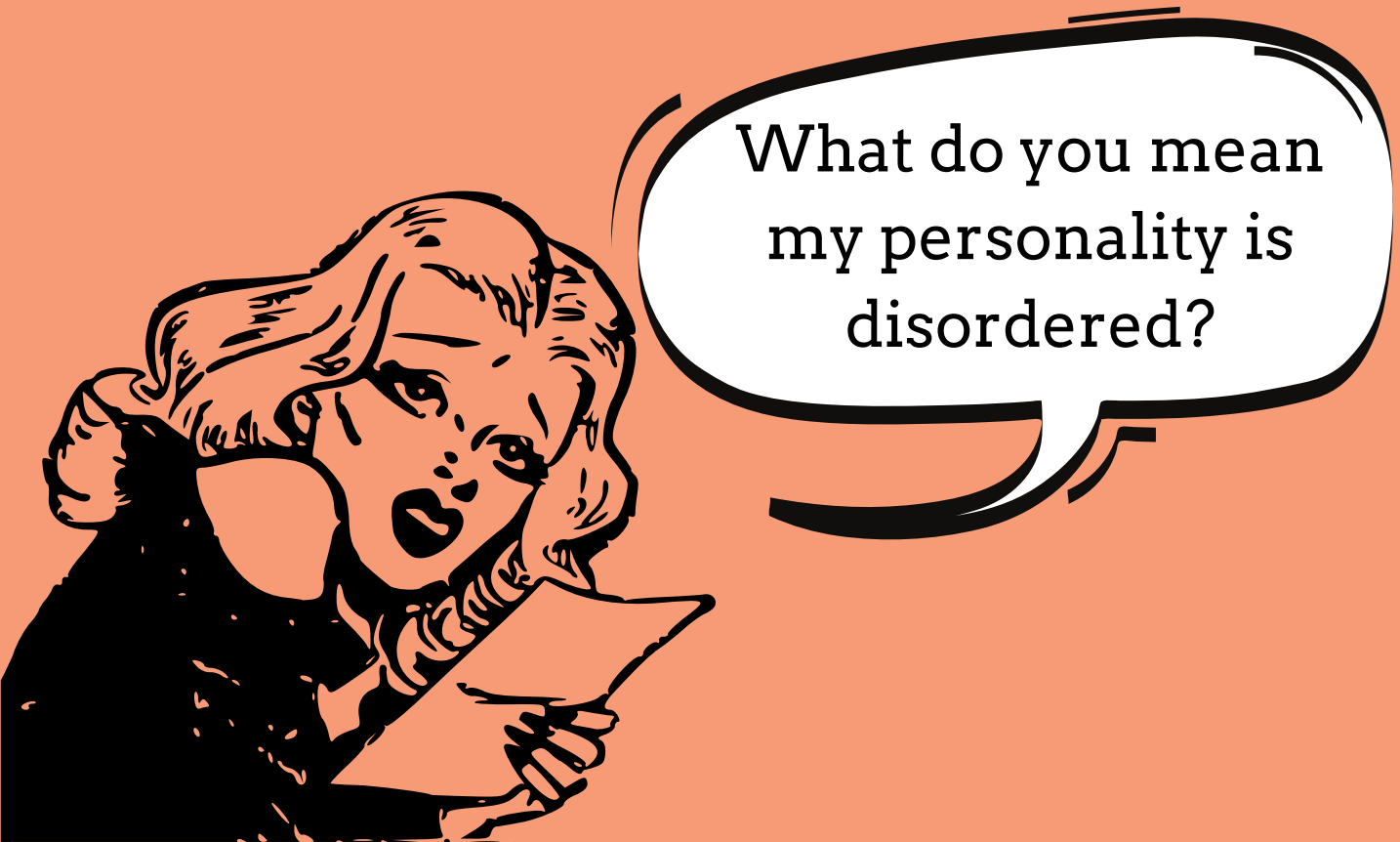
Subjective one-sided analysis
is for everyone!

DEAR GP

Issue 2



DEAR GP...

Issue 2

HOW IT STARTED

Dear GP began on Twitter in 2019. Someone tweeted how their recent clinic letter had stated 'has no hair'. This person questioned the value of this information to her or her GP, both of whom are, of course, fully aware of the hair situation. In the ensuing discussion, people began writing satirical letters to their GPs, describing their mental health professionals in the style of a clinical evaluation. The original poster began her own with 'Thank you for referring me to this meticulously dressed young doctor. He was average build, with hair.'

We decided to turn these letters into a zine and so Dear GP was born! You can still read issue 1 on our website at:

www.deargp.com

Welcome to Dear GP issue two!

Dear GP is a collection of letters written about our encounters with mental health professionals, in the style of a clinical evaluation. These 'clinic letters' are usually written by the professional to the patient's GP and copied in to the patient (if you're lucky). Their function is to provide an assessment of the patient, a working or firm diagnosis, and the treatment plan. Frequently, however, they read as a personal attack on our very beings. Value judgements about a patient are concealed within medical or psychological jargon, insignificant details are recorded without explanation, and inaccuracies, misinterpretations and distortions are abundant.

The letters in this zine ask professionals to re-examine their perceptions and use of language. The Royal College of Psychiatrists official guidance on clinic letters states:

"Consultants need to be mindful and think very carefully about the fact that the patient will be reading the letter and consider how its contents and tone could be interpreted. Language used should be non-judgemental and as objective as possible."

Despite this, the clinic letters we receive often read like a character assassination. It is disconcerting to read about yourself and not recognise the person being described. We hope by turning the tables that we can encourage a shift in language and attitude when it comes to writing these letters.

Indeed, we have heard from professionals that the first issue of Dear GP has made them reconsider the overused tropes and phrases used in clinical writing. We hope issue 2 will continue this discussion, and that those with the responsibility of writing notes will begin to understand the power their words have on our lives.

A NOTE TO PROFESSIONALS READING THIS ZINE...

Please use your distress tolerance skills to manage any uncomfortable feelings that arise from reading these letters. Remember these are only thoughts you are having and nothing to do with systemic problems that need challenging. Focus on your breath and mindfully accept the feelings that arise. Remember, you MUST take responsibility and only be the right amount of distressed in order for us to help you. We've heard making a cup of tea, having a bath and other naive coping strategies are guaranteed to help.

Unfortunately, we can't offer you any support or reassurance as it may encourage dependency.

CONTACT US

We love to hear from people who find our work resonates with them! Email us at:

dearGPletters@gmail.com

FOLLOW US

@dear_gp

@dear_gp

Dear GP

Thank you for referring me to this trainee psychiatrist who I saw in his outpatient clinic at Arse End Community Mental Health Team.

Dr X presented as a very tall and extremely well-kempt gentleman in his mid-30s. He was wearing a dapper waistcoat and jaunty bow-tie, and was carrying a large chip on his shoulder consistent with that of a former public schoolboy bearing up to an unwelcome and unprestigious backwater rotational placement.

Dr X greeted me in reception with a weak handshake and a disdainful gaze. On entering the clinic room, he performed a series of sudden and unexpected movements not dissimilar to a 1990s boy band dance routine. I am unsure if this was an unorthodox attempt to establish rapport or, perhaps more likely, a calculated manoeuvre into the chair closest to the door, in order to ensure a quick escape in the unlikely event of a hammer attack by a depressed woman half his size and stature.

Unfortunately, it was not possible to conduct a full medication review today, due to Dr X's denial of the legitimacy of the NICE Guidelines and his frequent interruptions, in which he regaled stories of his early life experiences, niche academic interests, and his overall sense of disappointment with his current training placement.

Dr X appears to have insight into his condition but remains positive about the future. "All my life, people have told me that I am very odd!" he said brightly, as we concluded the appointment.

I will review Dr X in his clinic in 4/52 to check his privilege and monitor his growing sense of entitlement.

Dear Borough IAPT,

Thank you for referring me to S. I initially interacted with this young lady over the phone at a frequency of once a week across a period of four months. Her phone manner was adequate, but she lacked awareness of how patronising her tone of voice sounded. Her listening skills appeared to be poor, as she would compliment me even when I communicated a negative message, for example “I haven’t completed the assigned modules of my online course”. S. liked to reinforce at all times that I was doing “really well” and particularly liked to commend my understanding of each chapter. The modules were written in basic English. It is my professional opinion that the reading level suits children 10 years and up. I am 35.

Once I completed all of the modules, S. admitted that referring me to the online course had been a mistake and I should have been offered face to face therapy. This did not come as a surprise, as I had in fact requested face to face therapy. This corroborates my concerns about her listening skills. I strongly recommend that every day, she allocates a portion of time to writing about her listening skills, for example 10 minutes. When she is finished, I recommend that she tears the list to pieces and completes a physical action, for example dancing around really wildly to a favourite song. I request that she does this despite it being incompatible with her living arrangements, which I am aware of.

S. subsequently invited me to two face to face meetings, intending to test my recollection of the online course. She favoured a memorising approach, and was indifferent to whether I actually believed what I was repeating. It took approximately five minutes to verify my competency, nevertheless S. thought it prudent to add a third face to face session, the purpose of which was unclear. Throughout our appointments, S. was dressed somewhat unprofessionally, if I was the kind of patient who thinks how you dress reflects on your ability to do your job.

I will be unable to review S. further, as I have now been discharged and referred to a service I must pay for.

A central point of the face-to-face sessions was S.'s recollection of a past relationship with the man who she thought she was going to marry. It may be an effective treatment to imagine the man floating down like a leaf on a stream. Repeated suggestions about the unsuitability of my partner were made. I asked her to imagine herself in front of a judge and jury and whether they would also come to the same conclusion. I also asked her to write on a piece of paper where in her body she could feel that my partner was unsuitable for me and how much she believed this on a scale from 1 to 100.

I believe S. struggles with boundary setting, and is not aware of what is appropriate to discuss with her clients. I have given S. a five-page list of ways for her to make peace with this knowledge, this was developed circa 1995 as can be observed by the fonts and clip-arts used in the document. Suggestions include: using red finger paint, smashing a watermelon, going to myspace dot com, getting on a train to go to the sea and many more. Most of the suggestions are accessible to everyone provided they have money, space, can drive, and own their home so they are able to redecorate it.

I will be unable to review S. further, as I have now been discharged and referred to a service I must pay for. S. delivered the news with a somewhat over-inflated sense of achievement, as my PHQ-9 score fell by a whole entire point while I was in her care, therefore it can now be said that I am only moderately depressed.

Yours sincerely,
S.A.D. (Songs About Drowning)

Dr GP,

I saw Dr. Sheep this afternoon during a routine CPA meeting. She arrived over half an hour late, however seemed unaware of this. I conclude that she is not well oriented to time. She attended with four other clinicians to support her, but to whom she made little reference to throughout the appointment.

She appeared reasonably clean and neatly presented although the appropriateness of her attire brings into question her rational thinking and judgement. When questioned on whether she thought knee-high, high-heel boots and a leather mini skirt were appropriate professional attire she responded defensively. Overall her affect was blunt and aggressive. Speech was spontaneous, although fast paced. Her thoughts were mostly unconnected and seemed to jump spasmodically, without pausing for a response from others. When addressing a direct question to me, Dr Sheep cut me off after only a few seconds angrily professing that my direct answer to her question ‘is not relevant’. Given that I was responding directly to a question she had asked I don’t believe Dr. Sheep to be capable of retaining or understanding straight forward instructions. I suspended the appointment at this point to consult with my colleagues and to allow Dr Sheep to calm down. We re-commenced the appointment after 10 minutes, Dr Sheep appeared objectively calmer. I recommend this course of action should she present in a similar emotional state again. Dr Sheep remained defensive and difficult to communicate with for the rest of the appointment. Medication was discussed briefly, however she appeared willfully resistant to making any changes, prefering to continue with the unsuccessful regime already put in place by a previous consultant. This is a cause for concern: I would like to monitor medication more closely so that we can broach this topic again in our next appointment.

No date was set for a further appointment as Dr Sheep did not feel able to commit to events more than a week in advance. Despite having been in the locum role for more than a year she maintained that she ‘doesn’t want to apply for the permanent job’, continuing to express her wish to leave, without doing so. There are some attachment issues here that should be noted, and followed up on by her treatment team.

Dr Sheep does present some symptoms of mental disturbance, however her main issues appear to be behavioural. I will continue to monitor Dr Sheep by CPA, but recommend a referral to a specialist service for challenging behaviour.

I will meet with Dr Sheep again within 4-10 weeks and will ignore her should she try to communicate with me at any point before that as to not encourage dependance.

Yours Sincerely,

A Human Being

> Her responses were poorly thought and showed an inability to empathise or reflect on the likely consequences of her actions.

Dear Dr W

I met with Ms Blue for a routine review appointment today.

I was particularly struck by her rigid, all or nothing thinking and have suggested that she explore this in therapy. Her responses were poorly thought and showed an inability to empathise or reflect on the likely consequences of her actions.

For example, Ms Blue commented on my piano, which I was given as an engagement present from my ex husband who I subsequently divorced following domestic abuse. Her disproportionate response was that I should dispose of the piano immediately as it meant that I was "clinging on" to my ex husband.

Ms Blue was unable to reflect on the consequences of disposing of the piano on my subsequent ability to play the piano, despite being aware that I play every day.

I discussed her case with the team psychologist, who felt she would be best seen in primary care. I would be grateful if you would refer her to primary mental care services who can then refer back to secondary services. I expect the subsequent cycle of re referrals will only last a few years.

I have not arranged to see her for which my piano is grateful.

Yours sincerely

A. Pianist

Central Integrated Psychological Therapies Team
Outpatients Department
Apparently a ‘World Renowned’ Hospital
London, Somewhere
Direct line: [but no one will answer it]
Email: scream@fuckit.nhs.uk

Date: 01/03/2021

Dear Doctor,

POST-ASSESSMENT CARE PLAN LETTER

I am writing this letter following my meeting with Dr X, as part of their psychodynamic assessment of myself. I was referred to Dr X by Dr Y on 01/11/2019, 18 months prior.

I saw Dr X on 01/02/2021 via Microsoft teams. Dr X is a white female, of average build, who identifies as a woman and who lives in a house with her male partner of 7 years. Dr X works full time as an [insert incorrect job title here].

Dr X was appropriately dressed for the video assessment, wearing a suitably muted blouse, devoid of any loud colours or patterns, with hair tied back and minimal makeup. Because of the nature of the virtual assessment, I could not comment on the appropriateness of her lower body attire.

Dr X demonstrates a significant preoccupation with the belief that I have a ‘Personality Disorder’, a belief not supported by my current presentation, symptomology, or taking into account multiple professional medical opinions sought to challenge this.

The present symptomology can clearly be clinically explained by the presence of Autism Spectrum Disorder and ADHD. Dr X claims that both EUPD and Autism can co-exist. This overvalued ideation of EUPD does not seem to be grounded in reality and does not give evidence as to how I currently meet the criteria for the diagnosis on my records. Dr X seems preoccupied with pathologizing neurodiverse differences and trauma as a 'personality disorder'.

Having explained in the assessment that anxiety is at the core of my struggles, and having recently discovered I am a neurodiverse individual, explaining that I have ASD and ADHD, anxiety is completely absent from Dr X's original assessment letter. Dr X seems confused and has a flat affect and has what appears to be tangential forms of thought. She conflates reports of historical mental health distresses as current, as is evidenced by them claiming I currently struggle with X, Y and Z.

Although Dr X mentions multiple times that they don't focus on labels here, this seems to be out of sync with their thought process of simultaneously referring to a label on my records and not being open to the idea of removing it. This fixed pattern of thought rigidity may be reflective of a deeper underlying stigma that they are unwilling to work on and may become a challenge in future therapeutic environments. It is my experiential opinion that Dr X's need to preserve the EUPD diagnosis is as a defence against some Unconscious Need.

Multiple requests had to be made to correct incorrect information in Dr X's letter regarding my assessment, including incorrect job title, incorrect pronouns and titles which interchanged throughout the letter, and stating that I was suicidal from historical information. This suggests there may be issues with memory and irregular thought patterns in concentration and comprehension as evidenced by their focus on insignificant details, like the gender of my partner, but being unable to get basic facts straight like my job title.

AAs I explained to Dr X, I would like to have a longer-term therapy to focus more on my past trauma and how this has affected my current difficulties, and that previous therapies have been more focused on ‘current difficulties’ [in so far as ignoring any traumatic experiences, acknowledging I am a neurodiverse individual, and putting all onus on me to change by current behaviour to fit societies norms]. Unfortunately, all that could be offered was psychodynamic therapy, and I reluctantly agreed, as 18 months is a long time to wait for help, despite my reservations.

It is my survivor activist opinion that Dr X would benefit from 9-12 months intensive psychotherapy to see how they cope being invalidated and pathologized, and in which they can explore their internal world and make sense of their clinical need to superimpose ‘Personality Disorders’ onto patients within the context of the wider mental health system. Dr X is aware that there are many more months to wait before this service will be provided.

Please do not hesitate to contact me if you have any further enquiries.

Yours sincerely.

L

Exhausted Service User Researcher
Professional Pain in the Arse
Trainee in Navigating the Chaos the is Secondary Care

CC: people you don’t want to read this inaccurate information
CC: more irrelevant people

FIND YOUR DIGNITY IN MENTAL HEALTHCARE PRACTICE

1 HOPE STREET
NEVERWHERE

4/10/2020

Dear Dr Psychiatrist,

This letter is in regard to your recent request for referral by your GP from 10th February 2020 for your psyhiatric review appointment. Please be advised that you are on top of the waiting list and that your appointment is scheduled for **14th October 2020 at 11am.** We prefer to schedule appointments for you and expect you to work around that as we have no sense of the fact that you have a busy schedule too; we simply expect you to be available at any day, any time.

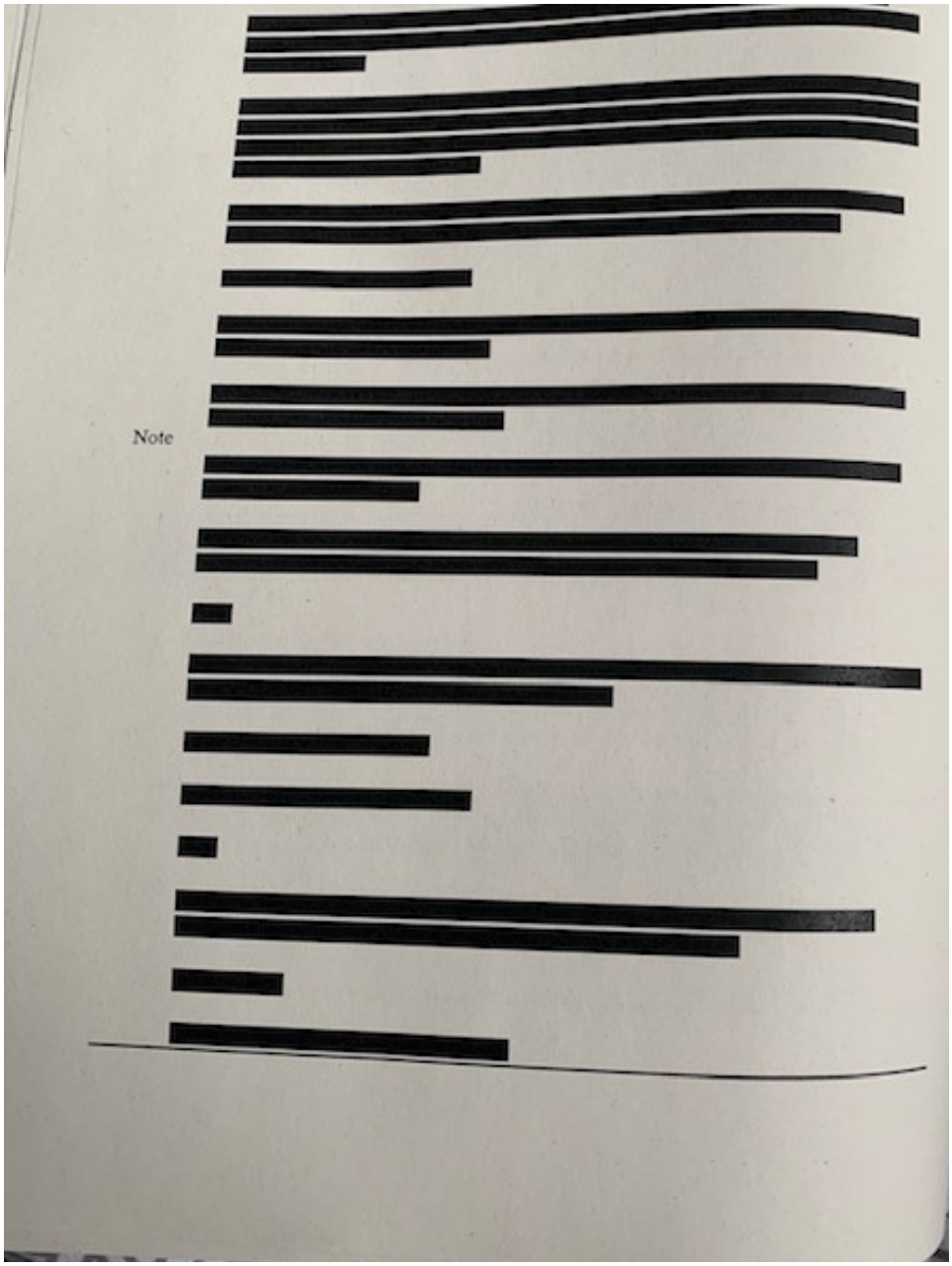
Due to Covid-19 your appointment will take the form of a **TELEPHONE CONSULTATION.** We felt the need to write this in all caps and bold since we're not sure if you can read and we definitely don't want you to show up in person... eeww... crazy people, amirite?

Please be advised that you will receive a call at that specified date and time. Don't call us. We'll call you. After you've waited anxiously for two hours for a call of course, since this is essentially a marshmallow test for basic mental healthcare. Except that you won't get a second marshmallow, nor a follow up appointment in a reasonable amount of time, nor informed of the fact that your appointment is delayed, nor an explanation for the delay. You will however get a quick apology followed by a disinterested 15-minute conversation discussing your medication. Yes, you did have to wait 9 months for that, so worth it! We'll finish our chat by me complimenting you on your ability to remember your own address, the medication must be working!

We look forward to not seeing you in again in another 9-12 months, idk, we might be busy though. If you need an earlier appointment in case you develop side effects or need a change in medication or dosage, well that's tough

Yours truly and sincerely,

A patient Patient



"Thank you for your recent correspondence regarding access to your health records. We have now completed your request. Unfortunately they are all REDACTED because what's written about you is so fckin awful and untrue it will cause you significant harm and make you more Mad"

Dear Jane,

Copy to: Your GP

Jane, I am writing to inform you of your progress during the Covid-19 pandemic. Thank you for continuing to attend your weekly Art Psychotherapy sessions remotely.

Jane, you appear to have a fluctuating grasp of reality. Some weeks you are unaware of the current global crisis and question why I am unable to discuss traumatic events through a computer screen. On other weeks you demonstrate good insight and understanding.

Jane, you told me you experience restricted and incongruent affect. When I gave you a summary of my week and distressing emotions you said you had ‘no thoughts’ after reading it. You previously requested I identify and share emotions with you and insisted I must be experiencing lots of emotions at once even when I told you I wasn’t. Since lock-down, however, you told me you feel ‘overwhelmed’ and I am only allowed to pick one emotion to discuss.

Jane, you found out that prior to starting our work together I had read your history on our Electronic Patient Record System, also known as Google. I reassured you that this is good practice and standard procedure with all professionals on my case load, however, you appeared very distressed and repeatedly exclaimed “But it’s not right!”. I felt this conflicted with your description of yourself as ‘non-judgemental’ and ‘not concerned with right or wrong’ and my professional judgement is that you struggle with unstable self-image.

“I have advised you that if you showed the same level of interest and care you did before Covid, you would probably get more out of our sessions.

Jane, you have tried to split the team by discouraging me from talking to my colleagues Recovery Navigator and CPN. You asked me not to discuss you with colleagues at Mad Covid, citing your over-valued beliefs that therapy is ‘special and sacred’ and therefore ‘must stay only between us’. You told me that you suffer from mild delusions, for example, you believe I must protect your confidentiality.

Jane, you are preoccupied with boundaries. You demonstrated black and white thinking, comparing saying you want to hug someone you can’t even see in person during an unprecedented global emergency, to sexual transference.

Jane, you have refused to engage in discussions about your lack of empathy and understanding since Covid. You are in denial that this might be why I can’t be as open and vulnerable as you want me to be. I have advised you that if you showed the same level of interest and care you did before Covid, you would probably get more out of our sessions.

I am hopeful you will improve now face to face appointments have resumed, however, should the situation continue to deteriorate I will consider medication or referral to another professional.

If you find this letter distressing, please talk to your Recovery Navigator or CPN. However please do not tell them it was because of this letter, because that is about therapy and must stay only between us.

Yours sincerely,

Patient X

Dear GP,

Thank you for the referral of this professional. He was a middle aged, average build, bald male. Throughout our appointment I noticed bizarre behaviours such as dismissing anything that was suggestive of suffering, and instead insisting emotions are inherently manipulative.

Recurrent references to the young-female-?-must-be-PD stereotype were made. I identified this to be a fixed belief as attempts to challenge this were made, to which he would just raise his eyebrows and attempt to make me feel like a piece of fecal matter beneath his shoe. I interpreted this as a diversion technique, suggesting feelings of inadequacy and a low self esteem within himself that he would rather project onto others instead of healthily dealing with. He seemed to enjoy verbalising the term ‘PD’, suggesting a worrying general hyperfixation on this topic. We also attempted to discuss the (multifunctional) rationale for self harm, especially that in young females. He again was inflexible in thought and maintained his argument that self harm in this patient group only functions to inconvenience everyone around the person exhibiting the ‘behaviour’ (coping mechanism).

I would suggest a follow up review for this professional, however, he disclosed having 35 years experience which obviously gives him the obligation to dismiss anyone else’s professional opinion. I have concerns for his risk behaviours. Especially that after 35 years of experience, he still manages to be grossly inept within his communication - highlighting high risk of harm to others.

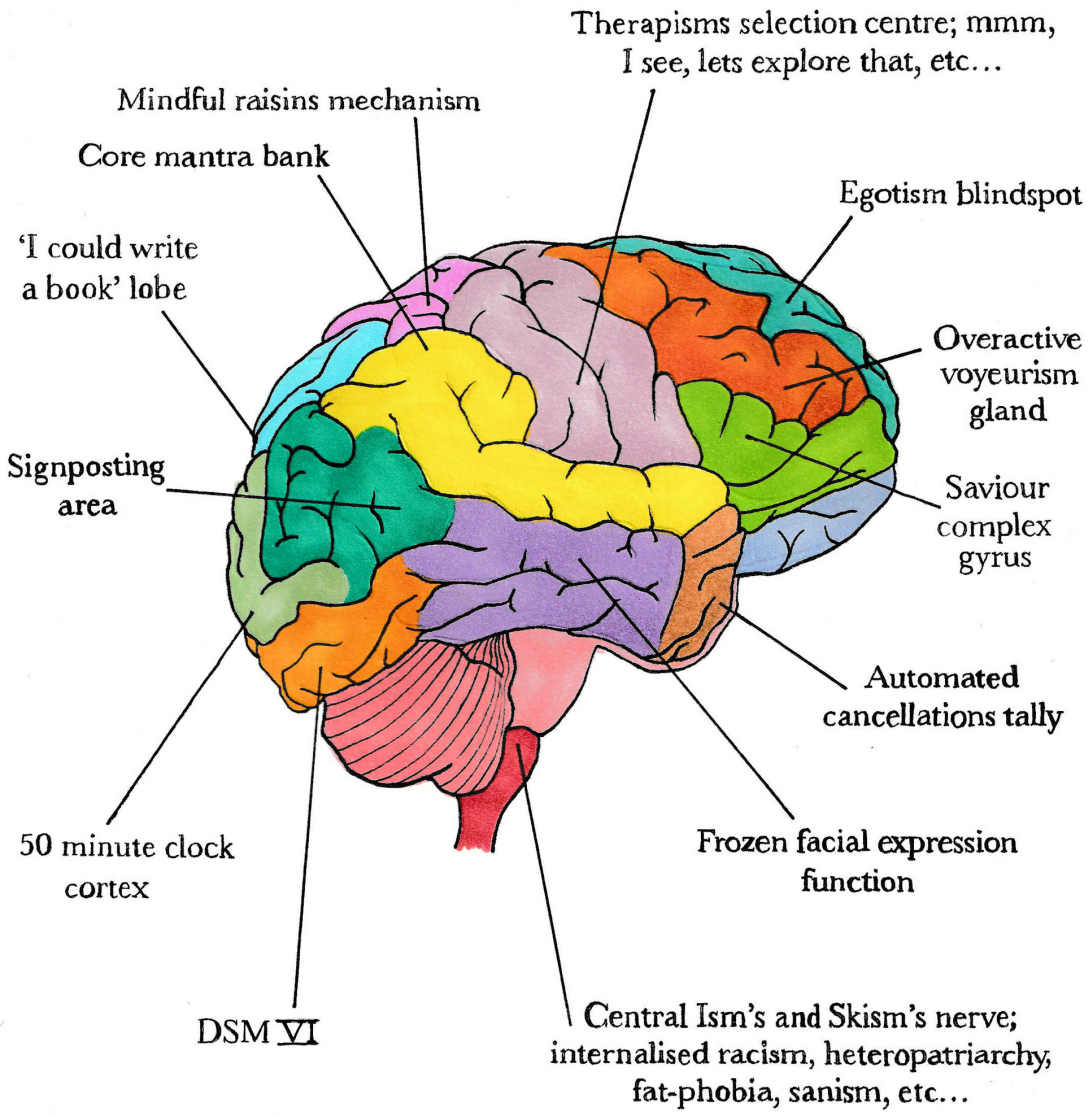
No further input from CMHT required however I have signposted him to The Samaritans helpline should be so need it.

Regards,

An advocate for boycotting this form of psychiatric practice.

Rachel

Atlas of a Therapist's Brain



By Luna Tic

> Ms BS seemed to display an unrealistic sense of self by significantly over inflating her expertise in trauma.

Dear GP

I met Ms BS today. She was reasonably well presented in smart casual attire.

Ms BS seemed to display an unrealistic sense of self by significantly over inflating her expertise in trauma. When questioned further she struggled to give rational to her beliefs.

Of concern was her lack of empathy on seeing someone in distress. She attempted to deflect any emotional connection by listing inadequate “coping” suggestions and seemed extremely uncomfortable.

It’s possible basic human interaction classes could be beneficial but the waiting list is currently closed due to such a high need for said course within the NHS.

I would also suggest you consider referring Ms BS for a memory test. Although she seemed lucid and comprehended our conversation at the time, further contact has shown a significant amount of confusion. She left the office telling me her plans for the near future but during our phone call the next day her plans were totally different and she was unable to accurately recall the previous day’s conversation. She went on to record these inaccurate memories with a level of assurance which brings into question her competency and shows a delusional tendency. This could indicate Pathological Gaslighting Disorder but she will need a further 12 assessments to confirm this diagnosis.

Yours sincerely

Anonymous

Dear GP

Today I met with care coordinator P. She was casually dressed in jeans and trainers. She seemed disoriented and unsure about what was happening. She did not know where she had to be and was indecisive of her next steps. She appeared very disorganised and had not booked a room or remembered that she was meant to be attending my psychiatrist appointment.

Before the psychiatrist appointment, P appeared to disappear and it soon became apparent she was making secretive actions with the psychiatrist. She made no eye contact when I entered the room and was distracted and on her phone throughout the appointment.

P made some abstract comments that only just related to the conversation between me and the psychiatrist. She was keen to please the psychiatrist and back up his treatment plan despite knowing the issues with this way forward, which had been discussed previously. P then showed that she had been trying to rid herself of responsibility and discharge herself from my care with no input from myself. This was overruled by the psychiatrist. She seemed disappointed in this course of action and did not make anymore conversation and avoided eye contact for the rest of the appointment.

At the end of the appointment, P decided to arrange another appointment but was inflexible in this leading to no date being set and no forward treatment plan being set.

I thank you for sending P to see me but I think that going forward there may be no working relationship unless her behaviour becomes more open.

Regards

Jo

Bankside, Bermondsey, Blackheath, Borough, Brixton, Camberwell, Catford, Chinbrook, Clapham, Crystal Palace, Denmark Hill, Deptford, Downham, Dulwich, Elephant and Castle, Grove Park, Gypsy Hill, Herne Hill, Honor Oak, Kennington, Lambeth, Lee, Lewisham, Loughborough Junction, Newington, Nunhead, Oval, Peckham, Rotherhithe, Southend, Southwark, Stockwell, Streatham, Surrey Quays, Hither Green and Walworth

WTF FOUNDATION TRUST
The Address to which my
Psychiatrists copy
Their Letters full
0F L1E5

For the attention of: Another Locum

Dear GP,

I met Miss Y Try for an assessment as per the referral from your colleague 10 months ago. Miss Y Try was confident in demeanour despite her small stature. She took pride in her appearance, wearing high-heels to make herself appear taller and ruffling her fringe to give a busy-but-stylish impression. She spoke at a slightly lower volume than is usual so as not to become startled, but was overall able to articulate herself surprising well.

Miss Y Try presented as an intelligent lady, however she lacks interpersonal skills- shortly after meeting me she referred to us as ‘friends’. Her disappointed reaction when I told her that we could not be friends due to professional boundaries suggests that she is a somewhat of a loner. My response seemed to trigger abandonment issues, as Miss Y Try then became preoccupied with asking for reassurances that I was ‘properly committed’ to our relationship. Despite my verbal assurance, Miss Y Try expressed that ‘my energy’ felt wrong.

> Miss Y Try has very little awareness of her issues and will need intensive treatment. However my waiting list for people-who-want-to-discriminate-against-me is currently full.

Miss Y Try admits that she lacks insight into the legal and ethical guidelines of her job, preferring a lets-see-what-happens approach. She shared delusional beliefs around her ability to read minds and diagnose patients based on 'her feeling', but was unable to indentify exactly what feeling she was experiencing. She became very agitated when asked to consider an opinion that differed from her own. She was not able to discuss facts which challenged her aforementioned delusions, and instead recited Jack Nicholson from the 1992 classic American film, 'A good few men': "You can't handle the truth!"

Miss Y Try denies coercing or manipulating situations to suit her need for power and attention, however she displays a concerning pattern of gas-lighting individuals who she perceives as vulnerable, so as to provoke a reaction and reinforce her sense of status. She refused to discuss the affect this has on those around her. Miss Y Try has adopted a fixed-mindset that results in black and white thinking: those who are on my side vs. those who are not on my side. This shields her from feeling guilt or responsibility for the pain she causes others.

Miss Y Try has very little awareness of her issues and will need intensive treatment. However my waiting list for people-who-want-to-discriminate-against-me is currently full. I would be very grateful if you could start her on a 10,000mg dose of Humanity and Empathy instead. In a crisis i suggest she tries a mindful bath.

Many thanks,
Luna Tic

Dear GP,

Thank you for referring me to this delightful consultant psychiatrist. Our appointment was over the phone due to the Covid-19 pandemic but I will assume he is a balding middle-aged man. Apologies if he does in fact have a full head of hair, or indeed, a hair piece.

Dr G seemed orientated to time and place, phoning at the time he said he would. This is a rare trait and not one I've experienced in my clinical history, so did take me somewhat off guard. In our previous consultation he phoned five minutes late and both acknowledged AND apologised for this, which is highly unusual. GP to check that Dr G is not in fact a mythical being.

Dr G asked appropriate questions and gave me adequate time to answer them. His conversational skills were very good and he is skilled in building trust and rapport. He also mentioned that he likes cats, which did not go unnoticed, and I can confirm those brownie points have been counted.

My only concern is that Dr G was so good at his job that it has been difficult to satirise in this letter to you.

I will not be seeing Dr G again owing to the fact that his position is temporary, as it's required to be under Sod's Law. I would be grateful if you could continue monitoring Dr G throughout his career to check for any signs of burnout or progression to Regular Psychiatrist Syndrome. Early symptoms include arrogance, condescension, poor time-keeping and a fast-growing sense of entitlement. This can then develop in the later stages into the wearing of a waistcoat or bow tie.

Yours sincerely,

Nell

Here are some REAL quotes from clinic notes we've received

This is what we're up against and why Dear GP exists!

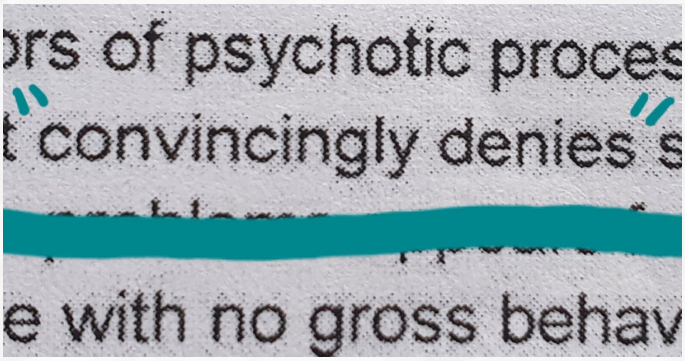
"hostile from the commencement of her appointment"

"Alert, well kempt, reactive. Confrontational in speech. Verbally challenging"

"cut his own hair"

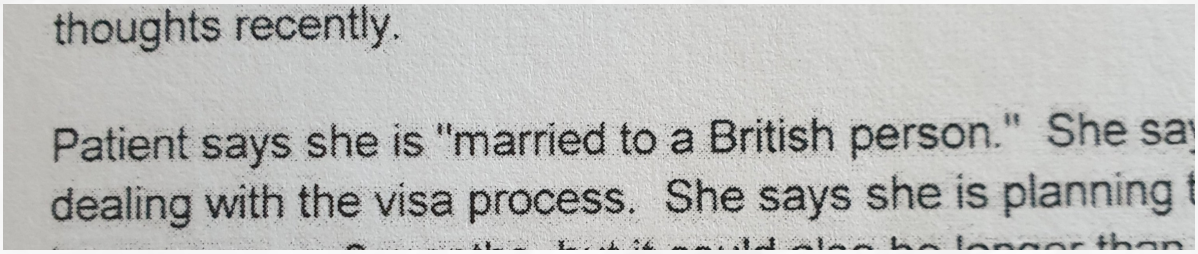
It's lockdown, what did they expect me to do?

"threatening suicide"



"Well kempt. Dressed in a non-depressive way"

"short, round and fairly plump"


thoughts recently.

Patient says she is "married to a British person." She say
dealing with the visa process. She says she is planning t

Why is this in quotes??? Nothing else from the conversation is - is this them suspecting me of being delusional about whether I have a wife?

"I am left with the impression that you are motivated primarily to receive the care to which you believe you're entitled, rather than a genuine desire to change"

"This lady has some background knowledge of psychiatry which she may use to her advantage"

"Risk to others: low socio-economic status/poor education"

X is a middle-aged Caucasian woman who sits comfortably and relaxed in the chair. She has staring eye contact.

"appeared unenthusiastic in engaging with the assessment"

"She has been starving herself for five months, though this has had a positive impact."

"Patient did however independently seek medical attention with means and ample opportunity to inflict further damage whilst unattended in transit to A&E. Intent does not appear to be genuine"

"She demonstrated a kind of belle indifference when talking about the overdoses and almost a playfulness about them"

"Overweight 40 year old Caucasian lady"

PRIVATE AND CONFIDENTIAL INFORMATION CONCERNING ONLY THE PATEINT, THE NHS, THE DEPARTMENT FOR WORK AND PENSIONS, ATOSAND ANYONE ELSE REQUIRING "PROOF OF DISABILITY"

Dr Ive Neverseen
Wrong Surgery
No-Time-Wasters Avenue
FU2 P45

Dear GP,

Many thanks for referral to this 30 something year old, right-handed, persistently-on-holiday rheumatologist wearing shoes. Dr Ziloren appeared well rested but highly tense and clearly agitated to see me once again.

Dr Ziloren wakes up at 7am every day, bathes in the blood of the misfortunate, dresses and forces herself to smile in the mirror before going into the workplace which is abundant with stressors – namely having to engage with the underclasses. She notes her generosity in spending more than five minutes with the buggers.

The purpose of this consultation was to assess potential rheumatological conditions as requested by yourself, but as Dr. Ziloren was quite concerned - and even preoccupied by- mental health concerns, this became the focus of the consultation.

I provided Dr Ziloren reassurance that these mental healthconditions have already been screened for and discussed at length by many other clinicians, but I would suggest 6 sessions of CBT (clinician behavioural therapy) to ensure no harm is inflicted not just to those around her, but to herself as she may indeed bare the burden of illness/disability one day and this may cause extreme distress considering her disposition towards invalids.

Any sounds of pain she was met with alarmed her terribly and resulted in her loudly shushing to the extent one must question her claim to have worked in a hospital for years.

It is important to note that Dr Ziloren became very aggressivewhen either her knowledge of psychology or the human body was challenged. She claimed an extensive knowledge of rheumatological conditions despite evidence to the contrary.

She agreed to some ultrasounds of two of the 30+ affected joints, dependent on a referral to a hypochondriac specialist(or psychologist) and complete withdrawal from all medications, but I would not be willing to do so as she was a right pain in the arse.

Yours sincerely,

Mx Al Waystired
BS(c), FYI, CGI, DiESD (*Diploma in Extra Special Doctoring*), BoML (*Bunch of Meaningless Letters*), MBChB (*Mousey Blonde Chubby Butch*), PLAB (*Pretty Lousy Abled Body*).

Specialist in putting up with this shit.

Want this letter in Welsh or an alternative format? Too bad.

@imoright_ta

WTF
FOUNDATION TRUST

FOR PROFESSIONAL USE ONLY

CLINICAL ASSESSMENT REPORT.

Based on your 5 minute assessment with the patient, please indicate what level of internal anguish they are experiencing.

If you have difficulty determining the patients needs, why not look for clues in their choice of hairstyle, fashion, or favourite colour.

TICK ONE	SEVERITY OF ILLNESS	TREATMENT PATHWAY
	LURKING	MINDFULNESS
	SIMMERING	MINDFULNESS
	HOPPING	MINDFULNESS
✓	BARKING	MINDFULNESS
	RAVING	MINDFULNESS
	COMPLETELY CRACKERS	HOSPITAL IN-PATIENT

By Luna Tic

Dear GP,

Today I had a telephone consultation with care coordinator M due to the current lockdown conditions. This was an unscheduled appointment and was preceded by a text message which stated that she wanted to talk to me straight away and was demanding of immediate contact without considering my prior commitments.

When we spoke to each other on the phone, M was in a jovial and friendly mood. She seemed to need reassurance about our working relationship due to comments from other staff members based on what she had said. She denied she had said anything to other staff members about our working relationship and stated “we work well don’t we?”. Her need for reassurance shows, I believe, an insecurity and possible fear of abandonment.

We then discussed my mental wellbeing. Here M was keen to show that everyone is struggling and dismissed suicidal ideation. Her concentration during this part of the conversation seemed to dip and she appeared to want this to end quickly.

Her next actions I believe confirm her fear of abandonment. She decided to put an end to our working together stating a too high workload. She did however say that I could always let her know good news. She seemed not to wish to cut ties completely showing difficulty with endings.

Overall I think M may need to work on her social skills but I do not wish to see her again and feel she will be fine under your care. Please do not rerefer.

Yours
Jo

MeAndMyMHMatter

> TS continues to exhibit delusions that he is able to know the minds of others more accurately than they know their own minds

Dear GP,

I met with TS today for a routine outpatient appointment via telephone. As I have never seen TS, I am unable to make glib comments about his appearance, although I assume he is a middle-aged, caucasian male who was reasonably well-kempt at the time of our appointment. TS was well-oriented to time and place, acknowledging that he was in fact 23 minutes late to our scheduled appointment.

TS continues to exhibit delusions that he is able to know the minds of others more accurately than they know their own minds, becoming noticeably irritable when challenges are posed to these delusions. TS appears unable to engage in reflexivity with regards to his own worldview or that of others, demonstrating significant cognitive inflexibility. TS displayed a marked lack of empathy throughout our meeting, which is cause for concern given his profession. Moreover, TS appears unable to appraise the effect that the style and content of his verbal communication has on other people, which suggests to me there may be deficits in his social cognition.

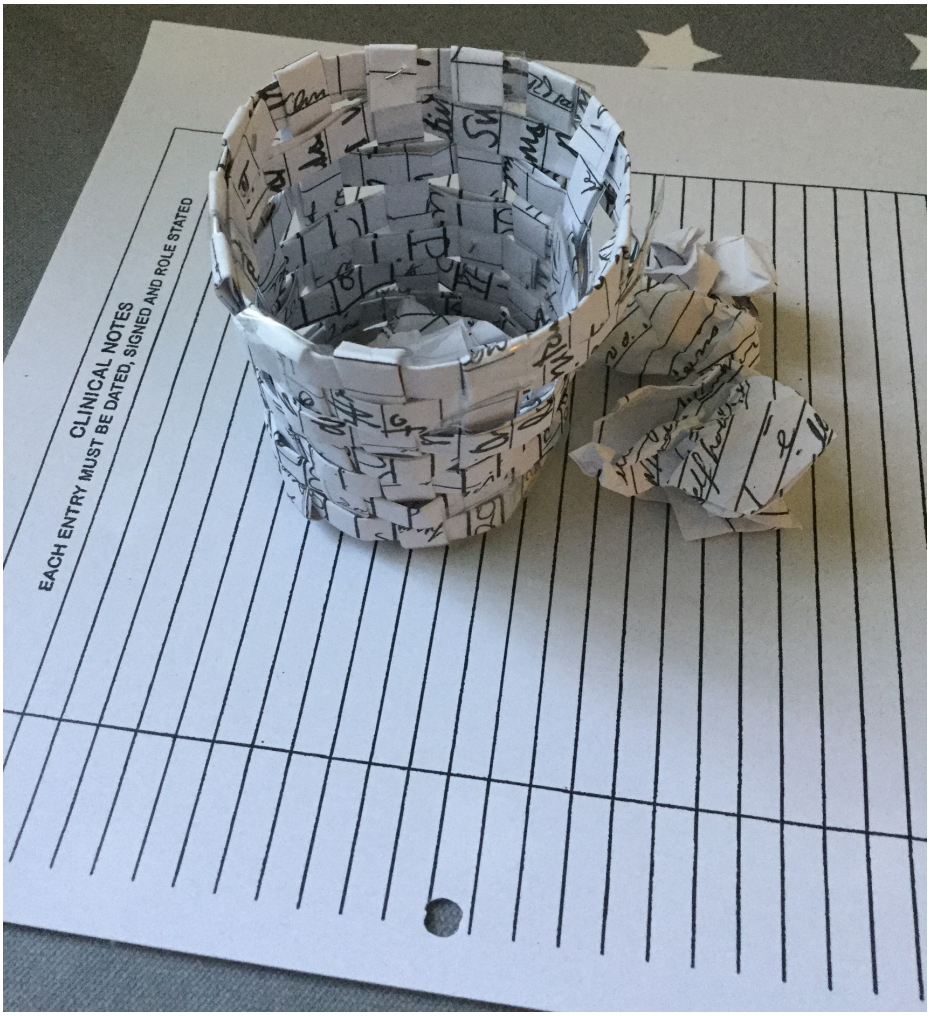
I propose that we do absolutely nothing to help TS, despite his presentation having significantly worsened since I last assessed him and despite his requests for more input, his assertions that he is 'not coping' and that the coping strategies he has are 'not working'. TS reports recurrent suicidal ideation and claims to be alarmed by these thoughts and feelings.

However, given that he has EUPD traits, I believe that to intervene would be counterproductive and I instead propose to leave him to suffer alone. We as a team will continue to be consistent in our inconsistency. TS should remember how 'lucky' he is to have been placed on a psychology waiting list of unknown length and leave me alone to get on with my more important tasks.

TS does not require a care plan, care coordinator or any regular input from the CMHT.

Yours sincerely,
CMHT Psychiatrist.

@SameOldCycle



Repurposed clinical notes by G

Dear GP

Re: Dr Hero Complex

Diagnosis:
Delusions of Grandeur
Cluster 2000: Tory voter

Dr Complex, a consultant psychiatrist working within WTF CMHT was referred to me after a sudden change in his behaviour a few weeks ago. I gave him a priority appointment because he is a psychiatrist and because his wife paid me a substantial amount. He clearly lacks insight into the Covid pandemic and has been neglecting his patients.

I have completed a formulation about him without him as per Trust policy:

He was observed self congratulatory clapping and banging a large saucepan with a wooden spoon outside his six bedroomed detached property on consecutive Thursdays.

He took part in a happy dancing video to a Peter Kay song that went viral on Twitter where he ignored social distancing rules and wasted valuable PPE. He denies that this was inappropriate. He repeatedly claims his is suffering from burnout despite no evidence of this being the case.

He believes the Government are doing a “fabulous job” and that the NHS is really well funded and not being sold off.

He keeps asking for a pay rise.

I am referring him for a 6 week therapy course for his naughty behaviour and his not right thinking. I am aware that there is a ten year waiting list so I will off-roll him and pass his care back to you.

Yours sincerely

A. Nonymous

By G


Dear GP,
I knew instantaneously that this lady was a classic BPD; it was glaringly obvious.
From her non-standard clothing and hair dyed all colours of the rainbow, to her many tattoos and piercings (also indicative of regular and repeated self harm).
In the circumstances, I have prescribed:
Risperidone, Venlafaxine, Clonazepam, Diazepam, Zopiclone and Trazadone.
These will be for life. I do not need to see her again.
GOD
@hine_dee

CQC REPORT

Announcement from WTF Comms:

WTF is pleased to share that following a recent inspection from the CQC, the Trust has retained its overall rating of 'Better Than Nothing'.

Several aspects of the CQC's report are highlighted below.

Community-based adult mental health services:

In the domain of 'effective' care in community-based adult mental health services, the Trust only narrowly missed out on achieving a rating of 'Almost Ok (Sometimes)'. Inspectors highlighted a conversation overheard between a qualified practitioner and a patient who had telephoned the CMHT Duty line. The mental health nurse on duty advised the service-user "If you really felt as hopeless as you claim, then you would have tried to end your life by now....Oh. Ok....Well you obviously didn't take enough then. You certainly need to take more *responsibility*, at minimum. I'm ending this conversation now, but I hope it's helped to remind you to use your Skills next time, before you go and do something silly. If you feel you need any more support later, please refer to your Care Plan; as you know, it's been developed in partnership with the Trust's lawyers. Do not call this number again."

Inspectors acknowledged that the Duty Worker's actions were in accordance with official Trust policy. Indeed, one Inspector reported feeling "heartened" by hearing the practitioner's passionate commitment to diagnosis-specific protocol and evidence-based treatment, later praising the staff member on what he reflected "must have been a very challenging situation, in which a less experienced member of staff may have been at risk of demonstrating empathy for the patient".

However, issues were observed with documentation corresponding to the telephone contact: the Duty worker had failed to document whether she had consulted the patient's records in order to confirm that a formal diagnosis of Personality Disorder had been established by the team's psychiatrist. Inspectors identified that failure to record this within the clinical note - as demonstration of rationale for the 'therapeutic intervention' - might leave the practitioner's clinical reasoning "vulnerable to scrutiny".

Inspectors expressed concern that these failings in record keeping, although seemingly minor, could lead to unintended consequences: for example, if this incident were to later be discussed in coroner's court, and it transpired that the patient (deceased) in fact had a primary diagnosis of Actual Depression, the Inspectors warned that it could be argued that this contact with WTF services constituted a 'missed opportunity'. Consequently, Inspectors were forced to qualify their rating for the Trust's community services as 'Almost Ok (On Occasion)'.

WTF official response: WTF understands the importance of accurate documentation. To avoid a repeat of failings highlighted by the CQC inspection, moving forwards all WTF patients will be automatically awarded a working diagnosis of Personality Traits (minimum) upon entry to the service, to ensure clinical expertise is best focused on telling people to take responsibility for themselves, and avoiding professionals having to waste time trawling through patients' notes searching for present and historic diagnoses to justify interventions of 'positive risk taking'. In addition to this, and in an attempt to further support our clinicians in their day-to-day duties, the electronic record keeping system's 'alerts' function will now automatically 'red-flag' patients who are female.

Crisis services

WTF is pleased to announce that its programme of improvements over the last three years has seen crisis services within the Trust achieve a rating of 'Probably Best You Don't Bother. For Everyone's Sake' - up one point from the 2017 rating of 'Non-Existent'.

Despite considerable improvements within this area, 'safety' was still noted to be of concern, particularly in the domain of medications management. Inspectors reported that crisis practitioners' adherence to local policy, NICE guidelines and BNF best-practice guidance was once again exemplary, with blanket prescribing of A Nice Cup Of Tea. However, they noted that patient safety may have been compromised on numerous occasions, after a routine audit revealed a product re-call notice had been issued by B&M Stores three months prior, for Best Generic Northern County Tea (180 teabags) - due to traces of wood-shavings and cyanide in the tea leaves - but that team leaders had failed to cascade the relevant information accordingly.

WTF official response: WTF takes patient safety very seriously. As part of our commitment to Lessons Learned, WTF has taken swift action: thanks to the dedication and professionalism of WTF IT Services in their work on a demanding project with tight timescales, the named Consumer-rights Champions that have been identified within crisis teams in each locality are now fully subscribed to both B&M *and* Iceland's weekly 'Product Re-call Alert' mailing lists.

A statement read by a WTF spokesperson advised: "We would like to reassure the public that no patients came to (more) harm (than usual) as a result of this 'near miss' incident - as WTF staff would never share their own office teabags with service-users (because BOUNDARIES). WTF clinicians continue to foster individuals' sense of independence (real or perceived), empowering service-users to buy their own teabags."
The Trust is also proud to report that, in line with this year's strategic focus of 'Personally Meaningful Recovery for All (TM)' (T&C's apply) and its ambitious goal (SMART-compatible) to equip all service-users with effective, recovery-orientated Coping Skills by the first Wednesday of 2032, the Trust's central Recovery College is working with key stakeholders to develop a new, interactive workshop entitled 'How to Check if Your Teabags Are Out of Date'.

Something I noticed from the very start was her obsession with the words discharge and discharged.

Dear GP

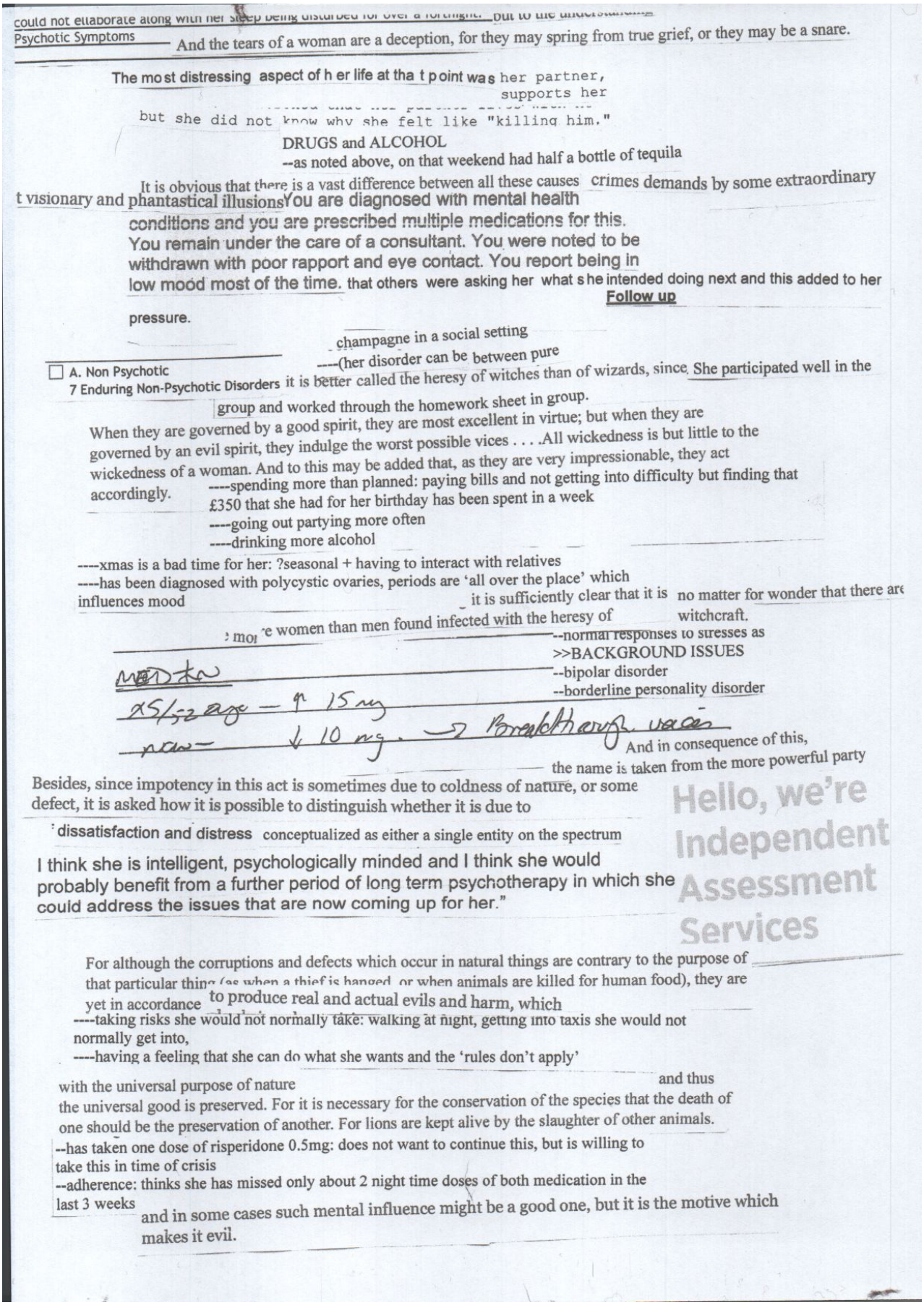
R:E Miss/Mrs DISCHARGE.

Thank you for your referral to see this lady in my clinic today. She was dressed appropriately for the appointment and had made the effort to put make up on. She seems to be able to take care of herself without any help. She spoke clearly but never introduced herself to me so I'm not sure whether this lady is the lady you sent to me - so apologies if not.

Something I noticed from the very start was her obsession with the words discharge and discharged. When it came to these two particular words I believe that she has a unhealthy obsession and she couldn't regulate her emotions as her tone and eye contact didn't go along with what she was saying. She kept on changing her mind on her opinion on whether her discharge should be happening in the near future.

She displayed behaviour which made me feel that she was in a rush to end our appointment including, TwirlIng her chair back and forth, her annoyance when I spoke and checking her watch constantly.

I feel that she felt that she was forced to attend this appointment against her will and would advise that in future she be rung to check on her welfare before and after any appointments with myself.


could not elaborate along with her sleep being disturbed for over a fortnight. but to the understanding

Psychotic Symptoms

And the tears of a woman are a deception, for they may spring from true grief, or they may be a snare.

The most distressing aspect of her life at that point was her partner, supports her

but she did not know why she felt like "killing him."

DRUGS and ALCOHOL

--as noted above, on that weekend had half a bottle of tequila

It is obvious that there is a vast difference between all these causes crimes demands by some extraordinary t visionary and phantastical illusions You are diagnosed with mental health conditions and you are prescribed multiple medications for this. You remain under the care of a consultant. You were noted to be withdrawn with poor rapport and eye contact. You report being in low mood most of the time. that others were asking her what she intended doing next and this added to her pressure.

Follow up

champagne in a social setting

☐ A. Non Psychotic

7 Enduring Non-Psychotic Disorders

----(her disorder can be between pure

it is better called the heresy of witches than of wizards, since She participated well in the group and worked through the homework sheet in group.

When they are governed by a good spirit, they are most excellent in virtue; but when they are governed by an evil spirit, they indulge the worst possible vices . . . .All wickedness is but little to the wickedness of a woman. And to this may be added that, as they are very impressionable, they act accordingly.

----spending more than planned: paying bills and not getting into difficulty but finding that £350 that she had for her birthday has been spent in a week

----going out partying more often

----drinking more alcohol

----xmas is a bad time for her: ?seasonal + having to interact with relatives

----has been diagnosed with polycystic ovaries, periods are 'all over the place' which influences mood

it is sufficiently clear that it is no matter for wonder that there are

more women than men found infected with the heresy of witchcraft.

--normal responses to stresses as

>>BACKGROUND ISSUES

--bipolar disorder

--borderline personality disorder

MEDS

25/52 ago — ↑ 15 mg

now — ↓ 10 mg. → Breakthrough vocal

And in consequence of this, the name is taken from the more powerful party

Besides, since impotency in this act is sometimes due to coldness of nature, or some defect, it is asked how it is possible to distinguish whether it is due to

dissatisfaction and distress conceptualized as either a single entity on the spectrum

I think she is intelligent, psychologically minded and I think she would probably benefit from a further period of long term psychotherapy in which she could address the issues that are now coming up for her."

For although the corruptions and defects which occur in natural things are contrary to the purpose of that particular thing (as when a thief is hanged, or when animals are killed for human food), they are yet in accordance to produce real and actual evils and harm, which

----taking risks she would not normally take: walking at night, getting into taxis she would not normally get into,

----having a feeling that she can do what she wants and the 'rules don't apply'

with the universal purpose of nature and thus the universal good is preserved. For it is necessary for the conservation of the species that the death of one should be the preservation of another. For lions are kept alive by the slaughter of other animals.

--has taken one dose of risperidone 0.5mg: does not want to continue this, but is willing to take this in time of crisis

--adherence: thinks she has missed only about 2 night time doses of both medication in the last 3 weeks

and in some cases such mental influence might be a good one, but it is the motive which makes it evil.

By Heather: Witch and mad person

Dear GP

Thank you for referring me to the Community Mental Health Team in October last year.

Due to unforeseen circumstances your letter got stuck down the side of a filing cabinet but someone from Estates has managed to fish it out with a long ruler and I'm on a 16 week list now for my initial assessment. Fingers crossed!

I had to do one of those Subject Access Requests to find out what happened to your letter and they sent me quite a bundle of paperwork. I'd be grateful if you could pass on my condolences to Mrs Jones in Lower Graig Street if you will. Terrible it is, what happened to her husband, there's no wonder she went mental, poor dab. No-one knows how her referral ended up on my file, and the system doesn't let them delete papers once they are uploaded but never mind, if they take what happened to her into account, I might get a few extra points on my PIP assessment! Swings and roundabouts, I say.

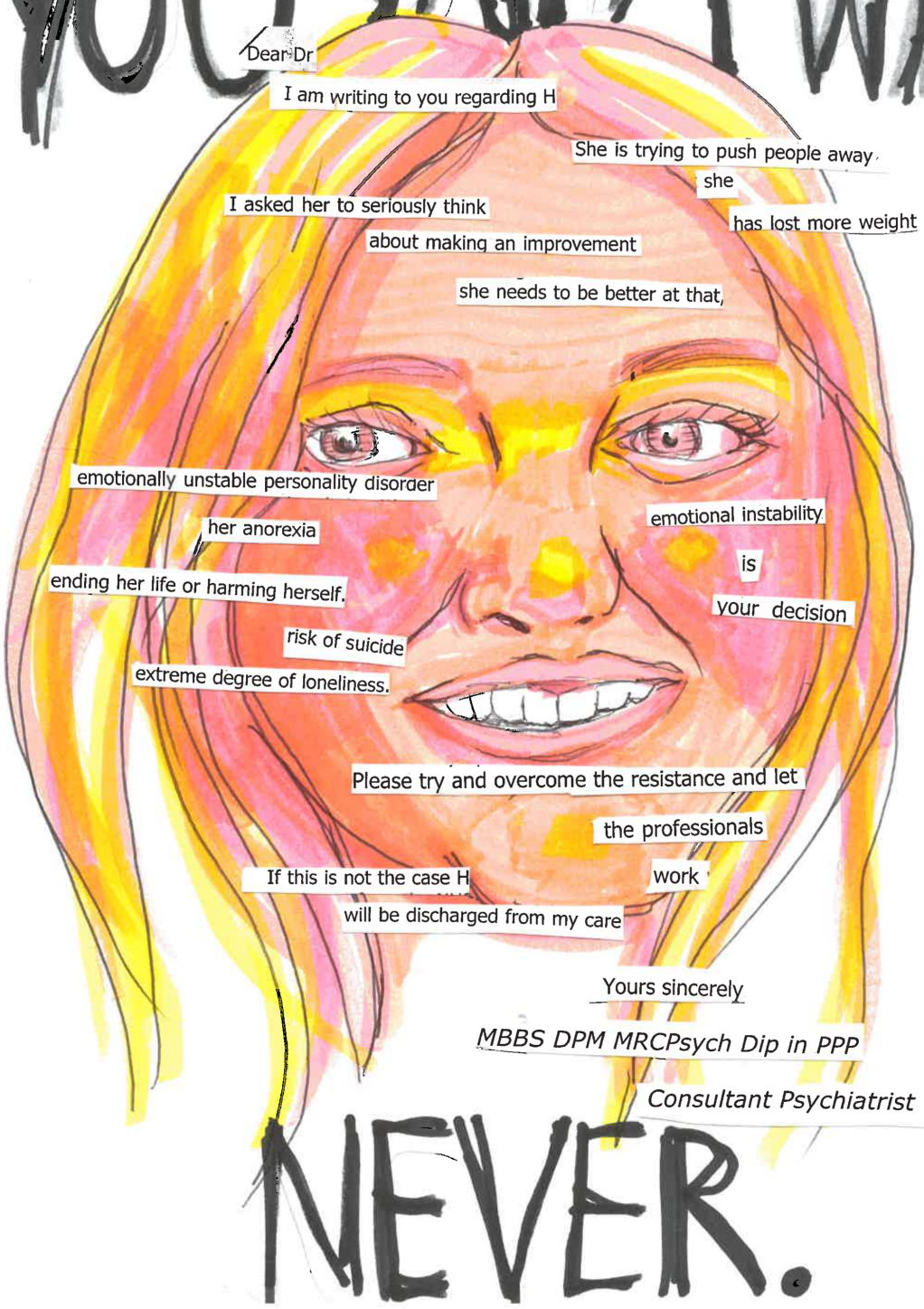
In the meantime, I'm thrilled to have found so many of the mental staff have accounts on Facebook and Twitter so I feel really updated about the situation every day. Bless them some of the young doctors have it hard, don't they? Working all those hours single-handedly and with such terrible managers and consultants. And still they are always so cheery and able to see the best in themselves. I weep sometimes to see how humble and delighted they all are about their achievements. Something to aspire to!

Like you told me, I'm not waiting for the mental team to wave a magic wand and make my problems go away. I'm being proactive and learning all I can while I wait. The psychologists are brilliant for that. When I see the way they carry on arguing with each other on the socials, it puts my own problems into perspective. Some of them have been miserable as sin with their colleagues for 30 years or more but they seem to thrive on it and there's a lesson in that for us all, I'm sure.

And the Coping Calendars you told me about! I really love the little tips they give every day. One thing I've started doing is taking a few deep mindful breaths in and out before I reply to anyone who wants something, and it's been like magic. Everyone has started leaving me completely alone!

Thank you again for all you have done for me. I will write again in 16 weeks to let you know how I'm getting on!

I WAS NEVER WHO YOU SAID I WAS.



NEVER.

Dear GP

I saw Dr C in ward round, at the end of my two month hospital stay. Dr C is a small, stout man who I am very familiar with by now and has seemed to become comfortable in his job as a not-quite senior psychiatrist over the last ten years.

Dr C seems to get along well with his peers. I was greeted by four other people in the room, who never introduced themselves, but seemed to help bolster Dr C's ego throughout the consultation. Whilst peer support is important, such a reliance on other people suggests a dependency that is quite troubling and may need further therapeutic work.

Dr C seemed orientated to time and place, regularly looking at his watch in a bored way, as though willing the session to be over. However, at one point he got up and left the room to answer his mobile phone while I was mid-sentence. I think we can take a watch and wait approach to his growing arrogance.

Speech was rapid and often unintelligible. Dr C is capable of spontaneous speech but seemed to choose not to answer certain questions, especially those related to medication side effects. This refusal was also evident when a fellow patient banged on the window to ask him his star sign.

Ultimately, I was delighted to hear that Dr C would discharge me from hospital. I hope never to see Dr C again and judging from the way he looked at me as though I'd pissed all over his flowers, I'm guessing the feeling is mutual.

Yours sincerely,

Anonymous

Opposite of Health NHS Foundation Trust
Mental Adult Hell Team (MAHT)
Water Fir Cup Hospital
Soggy chip lane
Where-dreams-go-to-die
No One Cares-ville
FUCK 0FF

Dear GP,

I am writing to you after a few meetings I had with this sorry (except he's not sorry) old chap you referred me to, but naturally I am going to pass judgement as if I knew him better than he himself.
I am sure you will be aware of the entertaining letter he sent to you and myself following these meetings. I hope that his confusing prevarication on the subject of diagnosis made more sense to you than it did to me. I must remark that his simultaneous endorsement yet questioning of multiple different diagnoses reminded mesomewhat of our Prime Minister's management of Coronavirus - except, without even the charisma. ("You must have this disorder. You also don't, because we don't have the money. But act as if you do…")

Mental State Examination
Mental state examination revealed an extremely distant, awkward, and privileged old white male, who lackedemotional substance and was clearly suffering from many interpersonal and communicative deficiencies. Hestruggled even with the use of a telephone, a problem to which he repeatedly referred. His bedside manner might perhaps best be pictured as a cold and miserable mop about to reluctantly and cluelessly tackle an inconvenient stain on the floor. His use of language was grandiose and markedly arrogant.
Dr Arrow Gent's behaviour was also revealed to be irresponsible and erratic. I would like to suggest that he refrains from randomly posting illegible prescriptions for antipsychotic drugs to my parental address in an envelope stamped in bold print with ADULT MENTAL HEALTH TEAM, WATER FIR CUP HOSPITAL. He may need help from his Chaos Co-ordinator with this inappropriate behaviour.
Dr A.G. might like to review his attitude towardsconfidentiality and privacy more generally. In the first appointment he was kind enough to inform me - halfwaythrough a very personal conversation about childhood trauma, which he insensitively forced me to have with him just five minutes into our meeting - that 'another couple of colleagues' had joined him and I was now on speakerphone being broadcast to presumably half the team wanting some lunch break entertainment.
His pharmacological competence was demonstrably lacking. This is especially worrying given that there are only about 5 drugs he ever prescribes, and that prescribing them is now his only task. He might like to consider including some instruction or advice as to how to switch from one neuroleptic to another, since heinstead decided to omit all three of the other drugs I am currently taking from my prescription. I can only assume he either wishes me to add a fourth drug to this concoction and happily stupefy myself into Neuroleptic Malignant Syndrome, or to stop the other three immediately and start

“This clearly demonstrates a severe case of distorted mental filter and therefore I have given him the same useless selfhelp.com worksheet that we give to all our patients.

hallucinating or convulsing. (But then again, I do solemnly swear that any withdrawal effects are just figments of my mad imagination.) I have therefore taken it upon my mad self to scourcommissioning guidelines to find out how not to die whilst switching these drugs, since I am now more qualified than any of Water Fir Cup Hospital’s doctors. You need not worry, I have done this many times before, and acquired quite a decent collection of psychopharmacology textbooks along the way.
Incidentally, whilst researching these guidelines, I discovered that comfortingly, the drug he prescribed is actually only licensed in the UK to treat disorders that I do not and have never had (as far as I am aware, but then again, I might just be lacking insight.) I imagine he has decided that this is simply irrelevant, as with any other piece of information I or NICE might supply. This clearly demonstrates a severe case of distorted mental filter and therefore I have given him the same useless selfhelp.com worksheet that we give to all our patients. (Well done me. I’m actually getting Employee of the Year.)
I was also concerned by his persistent difficulty withrecording accurate and consistent patient histories. For example, he came to the bizarre conclusion that the CBT I had supposedly ‘treated’ ‘the aftermath of post-traumatic events,’ when I said nothing of the kind and in fact spent most of those sessions being made to carry out ridiculous ‘behavioural experiments’ such as pretending I was a trainee psychologist and interviewing the hospital’s canteen staff about their soggy chips in an attempt to ‘treat’ my social anxiety.

Risk Assessment
Risk to Others: Upon risk assessment, it was clear that he poses a high risk of emotional and physical harm to patients. There have been multiple episodes of physical harm caused by poor Lithium monitoring and unsafe prescribing practices. He was completely unresponsive to repeated requests for basic safe prescribing guidelines to be followed. He has precipitated multiple episodes of serious self-harm in patients after belittling them and their self-worth. Further harm is caused by his arrogance and unresponsiveness to emotional distress or attempts to request proper care from him.
Protective factors:
There are clearly very few protective factors. However, there are many meta-injurious factors present, such as the systemic silencing of patient testimonies, an engrained culture of tolerating poor practice within the organisation, and the routine avoidance of responsibility by clinicians.
Risk to Self: None, as he is clearly extremely well practised in covering his own arse.

Professional competency

Dr A.G.'s ability to cast judgements remains exemplary. I was heartened to hear that he felt able to assess and completely invalidate my 'degree of social disability' within our 30-minute conversation, without actually asking me anything about my degree of social disability. I wonder how then he decided this - perhaps he moonlights with a crystal ball? Tarot cards? A telepathic? (Is his three-figure salary not enough?)

His diagnostic incompetency remains a chronic problem which has not responded to treatment, training or science. I would like to refer him to the multiple letters from his own colleagues (with whom he has naturally never communicated,) who in fact state the opposite of his diagnostic opinion. Yet, during a 30-minute phone call this year, he reversed their decisions and diagnosed me with a disorder that he himself also wrote was 'not appropriate' only last year (when prompted, he admitted that he had forgotten this encounter entirely...a trip to the Memory Clinic might be indicated.) He seems to have significant issues with consistency and suffers frequent swings of opinion. Unfortunately, those suffering from his condition frequently display this behaviour. (On the plus side, I am hopeful I'll be able to complete my ICD-10 bingo card of diagnoses by the end of this calendar year.)

He has now, it seems, also placed me in the service's Fake-Loony-Bin (FLB) reserved for those of us given the semi-diagnosis of 'personality difficulty' - basically half-fucked mediocre losers then, but not like, Incredible Hulk Level of Properly Disordered (IHL-PD)?

I can only imagine he is predictably applying the traditional (and thoroughly NICE-approved, of course) assessment criteria of how many suicide attempts I have made or how likely I am to bleed to death. This is consistent with observations I have made that the Mental Adult Hell Team, Water Fir Cup Hospital are blind to the suffering of those who do not externally perform it for them in their ridiculous theatre of chaos. He also acted in keeping with the presentation of doctors suffering from Water Fir Cup Hospital Disorder (WFC-HD) and enquired invasively and aggressively about specific details of my self-harm, when these details have already been recorded numerous times in numerous other letters and assessments (and then posted to me with no regard as to whether I might find those details triggering.) Perhaps he'd placed a bet in the staff room on what type of instrument I might use, and this explains the incessant eagerness to ask me?

We should signpost him for some help with this gambling problem, or better still, exclude him from the service until he has treated this co-very-morbid disorder (unfortunately, we don't offer a treatment pathway for WFC-HD…)

Recent Observations

More recently, I observed Dr A.G. in the reception of Water Fir Cup Hospital, Soggy Chips Lane. He was wearing extremely tight Lycra cycling shorts and a garish yellow visibility jacket, wheeling an expensive-looking track bicycle by his side (impulsive spending due to delusions of grandeur? Or just an inappropriately high salary?)

I was stood a few metres away like a calf cornered in a slaughterhouse, mortified and attempting to blend in with the wipe-clean furniture and death-beige walls. Others present were a few dirty plastic plants, and some unfortunate inpatients shuffling down the corridor to the Sedation Station.

In this episode his cognition did not appear to be intact, as he flung multiple prescriptions (all written for me, by different doctors, for different drugs, none of whom had communicated with each other) across the reception desk, repeating with disbelief: "well this is just crazy!"

Yes, indeed it is, Dr A.G.

> Unfortunately, his disorder has an extremely poor prognosis given the organisational culture he is working in.

What is crazy is your team's ability to get away with repeated prescribing and blood testing errors in my treatment with a notoriously toxic drug, and neglect to the point where I overdosed on it due to the stress of being made to feel so worthless and having to ring up to 25 times a day just to obtain the correct prescription every single week.
His next comment was made to the receptionists in a disturbingly back-hand tone, accompanied by a mocking, mood-congruent posh-old-man-laugh (POML): "well, they can't say we haven't tried!"
Yes, Dr A.G. Yes we can say that. We definitely can.
All of the above occurred in plain sight of me and other patients within earshot.
He then proceeded to make eye contact of such a quality that I almost metamorphosed into the piece of excrement he appeared to believe he was looking at, as any shred of dignity and self-esteem left alive in me combusted and burned a hole through the floor through which I fervently prayed I would disappear.
In short: on a scale of 1 to 10, with 1 being least-likely-to-make-you-off-yourself and 10 being most likely, I would rate Dr A.G. at a 25.5…

Impression and recommended management:

Axis I Being a Shit Doctor (ICD F8907000000006.2)
I would recommend the best long-term treatment for this common disorder would be an extensive education programme on empathy and any semblance of good mental health care. However, seeing as he is unlikely to engage in such a programme, I think the best treatment might be locking him in a room and forcing him to watch distressed children cry. I would persist with this treatment until he has gained sufficient insight (remains poor) into what emotional suffering, or even emotions, are. Then I would force him to take concoctions of antipsychotic drugs (at least 1000mg of Quetiapine) before withdrawing them suddenly, until he realises we are not making it up when we say we can't walk, talk or think properly.
An alternative second-line treatment might be to give him a brain transplant with literally anyone who has more compassion than him, which should be widely available and would probably cost less than one year of his salary.

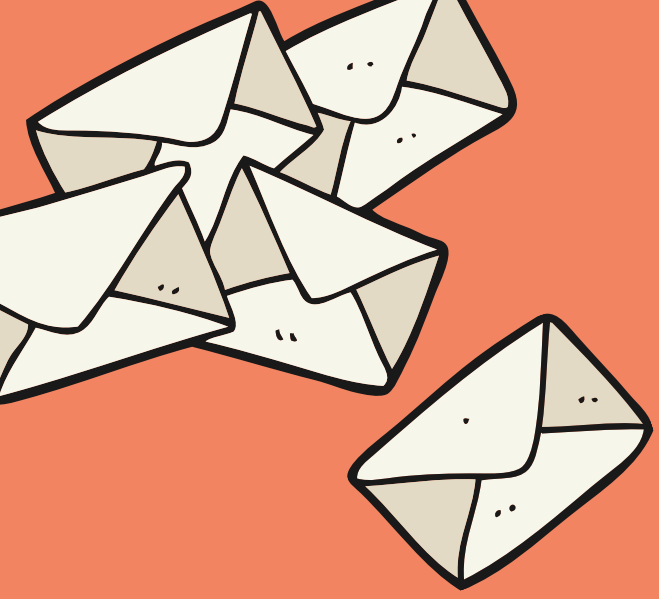
Axis II Being Part of a Shit System (ICD F2785000000004.3)
Unfortunately, this disorder has an extremely poor prognosis given the organisational culture he is working in. Perhaps the best course of action would be to re-deploy all staff of Opposite of Health NHS Foundation trust to work for the DWP as PIP assessors, where they would excel at being callous and arrogant whilst casting biased, devastating and completely random judgements with a jolly wave of their jaded hands…

Summary and Conclusion
I would like to thank him greatly for his completely useless speculation as to the cause of my distress.

However, I have decided I will not be wasting any more of my time involved in pointless merry-go-round conversations with members of his team, who seem intent only on obliterating any thoughts or emotions that I still manage to have (inconveniently for them.) Their only other purpose seems to be continually adding to their Biblical record of what is wrong with me, which they always manage to post to me in a letter but somehow always neglect to do anything about...
I am therefore discharging myself to the care of internet blogs, satirical publications, mental health memes, ASDA delivery drivers and the neighbourhood stray cats – all of which are much more effective than any of Water Fir Cup Hospital's bin-terventions.
I would recommend that you review me in never months, since by that time I'll be enjoying my lunatic life somewhere in Bali, far away from all of your crap.

Yours very insincerely,

Miss. "This is just crazy!"
Consultant Fake Loony



THANKS FOR READING!

"I found the first zine really resonated with me in terms of my experiences with both mental and physical health within the medical industrial complex - and how everything I share with doctors gets relayed back in the most cringe-worthy, painful and often cruel language. Writing my letter was so cathartic!"

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