

Able medics transcript – episode three

Supporting the individual – reasonable adjustments, flexibility and career transitions

TANITA: Hello and welcome to *Able medics*, a podcast from the General Medical Council. I'm Tanita Cross, producer of this series and the GMC's Digital Content Officer.

We've just published updated guidance for educators on how to support disabled people to become doctors – during their time at medical school and in the workplace.

To help us draft the guidance, we spoke to lots of disabled medical students and doctors, and we want you to hear their voices and stories too. All views shared in this series are personal and do not reflect the views of the GMC.

You can visit www.gmc-uk.org/ablemedics to find out more about our guidance, which is called *Welcomed and valued*.

And if you want to share your story or give us feedback on the podcast, we'd love to hear from you. Tweet us @gmcuk and please use the hashtag #ablemedics.

IOANNA: Hi, I'm Ioanna Maraki and I'm an Education Policy Manager here at the GMC. For the last two years, I've led our review on health and disability and that has made me passionate about making sure medicine is an accessible and inclusive profession.

Last time on *Able medics*, we heard about how disability is viewed by patients, colleagues, educators, and by disabled doctors themselves.

Today, in episode 3, we discuss how flexibility and tailored reasonable adjustments can help keep more medics in university and at work and support them through challenging career transitions.

IOANNA: In 2017, we published new standards called *Excellence by design* to help make postgraduate training more flexible for all trainees. For those with health needs, flexibility is vital to enable them to pursue their chosen career in medicine.

HANNAH BARHAM-BROWN: *I think a lot of the time, particularly in this time that is very litigious and we're all very much obsessed with guidelines and policies, we need to be flexible – and yes that's coming from a very bendy doctor! But we need that flexibility in the system to be able to go, you know what, this person could be a fantastic doctor or is a fantastic doctor, just because they can't do this one specific task – we'll find a specialty where they don't need to do that specific task and then go from there.*

I see all too often trainees, particularly with disabilities, being forced through hoops that they simply can't be expected to fit through. And if we lose them, we lose years of training that the taxpayer has paid for, and we lose a potentially incredible asset to the NHS simply because of a lack of flexibility on the part of our training programme. And that's horrific to think about – that's somebody's life, that's somebody's career, that's somebody's aspirations. And to take that away from them purely because we can't be flexible makes me very, very cross.

SU SUKUMARAN: *I suppose it is a bit of a culture shift that's required, and being clear about what the training – and you know, CT1 years – involve. In my time, it involved doing six months of medicine and six months of surgery as a house officer. And that included being part of a crash team and running to cardiac arrests. Now if I was a houseman and I had my stroke, I wouldn't have been able to do that – run to cardiac arrests, at least not on my own, but I could have been part of a team once we got there to help do stuff. But I do know people who did become disabled just before their house years who then had their training amended. They were let off doing certain duties but could still carry on and do most of their training and become fully qualified doctors that they wanted to be.*

IOANNA: That was Dr Hannah Barham-Brown and Dr Su Sukumaran. Dr Anita Bishop agrees with them that flexibility and the willingness of others to adapt is crucial for disabled doctors. But, for Anita, it begins with communication.

ANITA BISHOP: *I think it's important for people to know that actually it's a really positive thing to disclose your health condition because if we know about it, we can then maybe tailor your foundation programme to consider your health condition and to suit your physical need.*

For example, at one point in my medical career – and just in my life – I had to use a mobility scooter. In one situation, there was a certain ward that I couldn't go on because physically I couldn't use the mobility scooter around the reception desk, so I couldn't actually go around. So, they accommodated that by placing my in a different area, where I still got good clinical experience, but it was all on one level.

IOANNA: Under the law in all four countries of the UK, education bodies – so for medicine, that’s universities, postgraduate deaneries and HEE local teams – they have a duty to make reasonable adjustments to make sure that disabled learners aren’t put at a substantial disadvantage during their training.

This is a very complicated area in law, but organisations must exercise judgment and balance a range of factors when deciding what adjustments are reasonable. This may be made easier by consulting the disabled person about their day to day needs, and what will make a difference for them.

For the rest of this episode, you’ll hear doctors talking about the adaptations that have enabled them to stay in training and educators giving examples of the adjustments they’ve put in place to support trainees.

Here’s Foundation School Director in Wessex, Dr Mike Masding.

MIKE MASDING: *There’s the reasonable adjustments that we can make within their work. There are things like, for instance, physical disability – we’ve had a couple of people whose mobility is not so good and one person who is confined to a wheelchair. We made some changes in the curriculum, for instance, saying that you didn’t have to do cardio pulmonary resuscitation, you just needed to know how to do it and how to lead it.*

We’ve had a couple of people with hearing difficulties who have amplified stethoscopes. And actually, the most important thing with those two individuals was getting them to make their colleagues aware, so that when in things like handover meetings and what not, they would face them, so they could read their lips and simple things like that. And if you do that, it works exceptionally well.

HANNAH BARHAM-BROWN: *One of the trusts I was in gave me a laptop that went on my lap, which doesn’t sound like rocket science at all. But everybody uses these giant laptops on trollies that you have to push around the ward. And firstly, it’s higher than my head so I was kind of typing above my head. And I can’t push the trolley when I’m pushing me, and so once I pointed this out and I had a laptop that I could put on my lap, actually I was faster than everybody else because I wasn’t having to push this blimmin’ trolley round, I was just pushing me as I would anyway normally. So, I think actually there are little adaptations which, if done well, can make me more functional than the able-bodied doctor [laughter]. So, yeah, it’s just about trying different things and seeing what works.*

SU SUKUMARAN: *In terms of adaptations, I guess what I’ve generally needed is admin support – to set things up for me, get files out, bring patients to the clinic, those sorts of every day practical help. In recent years, I’ve been able to have more formal occupational health assessments and then had office chairs that would be more supportive of my back and shoulder, and having a designated parking space, and Dragon: assistive dictation software.*

KELLY LOCKWOOD: *Do you know, silly as it sounds, actually looking at that good old accessibility into buildings problem. I know there are minimum standards, and all hospitals and GP surgeries have to meet those minimum standards. But actually, when you look at it, those access standards are there for patients. Staff access areas that patients don't access, I mean, in a lot of cases, you can't access those staff areas in a wheelchair. And that's just never been looked at.*

IOANNA: As an undergraduate educator, Professor Kate Thomas, Vice Dean and programme director for medicine at the University of Birmingham, admits that it can be harder for medical students to access practical reasonable adjustments when they go on clinical placements.

KATE THOMAS: *You might come across physical difficulties, just very simple things that are really quite difficult to get changed for a student. So, enabling them to have some equipment that's at the right height for them or is aligned in the right way, can be quite difficult, because the trust and the general practices see the student as a transient person and not their member of staff. So sometimes we do find those sorts of physical barriers come into play. But I think it's our job to have a battle with people, not the student's.*

IOANNA: Even within the medical school, Kate and her team are continually testing out new ways to make disabled students' lives a little easier.

KATE THOMAS: *We have encountered times in exams, for example, where examiners have said 'what's the matter with your stethoscope? What's that? Are you trying to cheat?' even though we always send information in advance saying this student is using an amplified stethoscope, please let your examiners know. And this really didn't work very well for us because it kept happening – for various reasons, in exams.*

We had a student with quite a bad speech impediment who, one of the ways he coped, which he'd been taught by a speech and language therapist, was to circle his hands to help him establish a rhythm, so that he could get his words out. And, again, we would send a message in advance of the exam, and then we would get remarks back, you know 'this student was very anxious, kept flapping his hands.' So, we decided that this method was clearly not working, and the poor students, you know, the exam's stressful enough, the OSCE is stressful enough without having the examiner cross-examining you about something that is nothing to do with the exam.

So, we adopted an idea which UCL used which was we now have a blue laminated card which the students carry with them and give to every examiner at the beginning of the station, which just says 'this student will have to sit down or will have to stand up or will circle their hands'. We don't tell them why, we just tell them it's going to happen, and they have permission to do this and it's got the university crest on, so it looks super official. And that's helped that, and we haven't had those sorts of problems since we implemented that.

IOANNA: Once medical students graduate and join the foundation programme, things can get even more complicated as they enter the workplace, and frequently move between training posts. Here's Dr Mike Masding again, talking about how the foundation programme can often be tailored to someone's health needs.

MIKE MASDING: *Adjustments like not putting people on night shifts or out of hours work if their healthcare professionals thought it would disturb their mental health. People working less than full time. An awful lot of doctors now work less than full time, it's becoming "normal", we shouldn't see it as being something strange. And indeed, the evidence from the GMC training survey is that those who work less than full time seem to do very well. So, there's all sorts of adjustments that can be made.*

HANNAH BARHAM-BROWN: *I'm quite lucky in that every job I've had has always been really flexible with me and have done a lot to try and make things as easy they can. For example, in the last year, the rotations I picked were, in a way, quite deliberately not spread out everywhere. So, I did a GP job for four months where I was very much based in one clinic room, and there's only so much I can injure myself walking across a clinic room. But then I did an A&E job, and while it was quite a big department, it was all very much in one place and you didn't have to trek around the hospital.*

IOANNA: When I spoke to Mike, he told me the story of a young doctor with mental health issues who he first encountered at a fitness to practise panel at their medical school. By getting to know the student before they joined the foundation programme, Mike was able to work with them and his colleagues to put a range of reasonable adjustments in place that ultimately enabled the student to successfully complete foundation training.

MIKE MASDING: *The jobs, the posts that that person did were in very specific departments where perhaps people were a bit more supportive, certainly at the start, than in other departments – so we did handpick some jobs. Although I have to say, by the time they came around to F2 we didn't handpick the jobs, they just got the ones that were there. And because I think they'd had a very successful F1 year, that made it very easy and F2 was fine.*

IOANNA: Out of all the possible reasonable adjustments that can be put in place, though, Mike ended our conversation by reminding me of the most important piece of the puzzle.

MIKE MASDING: *Rarely in my experience have reasonable adjustments involved very much other than just a bit of re-organisation really and getting the right people. People are very important. I think people focus on physical things, like buildings and what not, but actually the people looking after and supervising these young doctors are the most important thing.*

IOANNA: Next time, in episode four of *Able medics*, we ask our interviewees what general support initiatives would help disabled students and doctors pursue their chosen career.

In the meantime, please tweet your feedback on this episode @gmcuk and visit gmc-uk.org/ablemedics to find out more about our *Welcomed and valued* guidance and to read more stories like these.

Thank you for listening.

TANITA: *Able medics* is a podcast by the General Medical Council. It was hosted by our Education Policy Manager, Ioanna Maraki, and it was produced by me, Tanita Cross.

Thanks to Nick Drew, Lorie McManus and Steph O'Connor from the GMC for their support. And thanks to our guests, Hannah Barham-Brown, Su Sukumaran, Anita Bishop, Mike Masding, Kelly Lockwood and Kate Thomas.