

Reasonable adjustments: your stories

Feedback has shown that students and doctors in training feel more could be done to improve how reasonable adjustments are managed.

We have gathered some personal accounts from disabled students and doctors on reasonable adjustments made throughout their medical careers.

These personal stories focus on:

- positive experiences and challenges faced
- types of reasonable adjustments provided
- the transition between different stages of medical education and training
- suggested changes to improve support for disabled students and doctors.

The anonymised accounts in this document give personal views of experiences of reasonable adjustments.

Get involved

We would like to thank all those who have contributed. If you would like to share your experience of reasonable adjustments during your medical education and training, please let us know on 0161 923 6602 or education@gmc-uk.org.

Your stories

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Student stories

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Amina is a final year medical student with a mental health condition

What have been the positive experiences and challenges faced during your study?

'In a clinical environment, some of the consultant teaching methods are not helpful – in groups on ward rounds or in group tutorials, the consultant asks questions to each student. If they don't know the answer, someone else who does know jumps in and answers it. I find out what I don't know but I am not 'taught'. Sometimes the consultants don't seem to know how to speak to students.

Having a hidden disability is hard as I have to keep explaining it to teachers and consultants. They may think I am falling behind because I am being a poor student and slacking rather than because of my disability, that I am not trying.

I have had really inspiring tutors who've supported my growth. I've been taught:

- skills in how to self-assess my fitness to practise, to know what to do if I'm not comfortable in a situation
- professionalism (making sure I account for absences).

My tutors have told me that I will be a better clinician for my experience.'

What types of reasonable adjustments have been made to help with the training and working environment?

'My medical school allowed an interruption of my first year for recovery/diagnosis – this was helpful although I had to restart the year.

The GP surgery associated with the university liaised with the medical school welfare team and also the university accommodation team to arrange accommodation for me on campus near the GP surgery for my 2nd year when I needed regular support.

The GP surgery had in-house psychotherapists and CBT (cognitive behavioural therapy) therapist – this is really helpful and important for the student population.

Placements:

- I could submit a preference to be close to where I was living so I could attend health appointments, it was less stressful.

- In my 3rd year I had to take absences and couldn't complete the required time for placements, so the medical school organised a remedial placement during the summer – this was good as it meant I didn't have to repeat the year.

The welfare team at the medical school are excellent – once a student declares a health issue to them, they keep in touch regularly by face-to-face meetings and emails so when/if a problem comes up there would be a familiar face.'

What support was received between different stages of medical education and training, and from the training to the working environment?

'My transition points during medical school have been from years 1/2 (lecture-based) to 3, 5 and 6 (clinical), and 4 (BSc).

The welfare team recognised that I needed to address my health problems, which first occurred during my 1st year. They guided me so that during my 4th year (BSc) I completed a necessary course of CBT as we felt it is better not to do it when on a demanding clinical placement (it can make symptoms worse before they start to improve). This benefitted me as it enabled me to get through my 5th and 6th year clinical placements.

Rotating through clinical placements has been challenging. At each new post another consultant is responsible for signing me off as competent – experiences are mixed depending on the individual when I tell them about my disability and that I may require absences for appointments. The welfare team told me to tell the consultants that they are aware of my needs so I didn't need to go into any detail, but I found it hard having to identify myself as different to the rest of the group. Some consultants didn't seem to know how to handle the situation.'

What changes can you suggest to improve support for disabled students and doctors?

'Teacher training for consultants – if they have a student/trainee who isn't doing well, they should be taught how to deal with it in a supportive way. Better training in communication skills for some is needed.

Passport – the idea highlighted in the health and disability working group's report (pdf) about students and trainees carrying around a record of their vaccinations and reasonable adjustments is good as I won't have to keep explaining my disability every time I change rotation. The student on the 'Experiences shared' videos mentions that he had an F1 who did the explaining for him acting as an advocate – this is also a really good idea.

Try to make medical school a less competitive environment – currently many of the students at my medical school are trying to outperform academically on an individual basis. The exam system encourages this by awarding distinctions to the students with highest exam scores. This is fine to encourage students to work harder, but it creates the mindset in students that asking for help is a weakness. For someone with a mental health disability, it is much harder to come forward and admit you are struggling and seek help when this is frowned upon. Students should also be rewarded for overcoming difficulties at medical school.'

Karen is a Year 2 medical student with dyslexia

What have been the positive experiences and challenges faced during your study?

'Exams have been the major challenge. This is particularly evident when learning to spell terms. Anatomy proved challenging as often the terms are very long and contain many vowels. Words with many vowel or silent letters are the most challenging for me to spell.'

Lecturers do not always seem to be aware about the condition. This has come to light most in practical examinations. Lecturers do not seem to be aware that dyslexic people are often also slow readers. Extra time is needed for each station and not just at the end to correct spelling. Answer sheets with room to sketch attempted spellings of words would also be very useful.

In some practical anatomy examinations none of the allowances have been made as it is seen as too difficult to implement.

On one occasion an essay was marked down because of the spelling of the word haemoglobin. I felt this was highly unfair and that the marker most probably hadn't read my disability statement.

The allowances in the written exams have been very helpful.'

What types of reasonable adjustments have been made to help with the training and working environment?

'I have been given 25% extra time in exams in addition to allowance for spelling and grammar.'

What changes can you suggest to improve support for disabled students and doctors?

'Ensure all members of staff are aware of the challenges of disabled students and when invigilating exams or marking are aware of the individuals disability statement.'

The allowances should be made in all exams.'

Janice is a Year 3 medical student with a mental health condition, currently not in studies

What have been the positive experiences and challenges faced during your study?

'As my first year of medicine came to an end my medical condition became worse. I managed to get through my first three years. I began my fourth year and I became very unwell resulting in me interrupting. The following year I returned to medical school, back into my fourth year and managed to continue with the course for four months and I decided to interrupt again due to on-going health reasons.

It is evident that the time I spent near my family was beneficial. I established a great relationship with the care team where I lived. I also had great support from my family. My condition became more stable and I believe that the upheaval of having to go back to medical school where I had no family support, inadequate community health care support, lack of friends and lack of medical school support and understanding caused my condition to relapse.

I've attempted to transfer to both medical schools that are nearer home, but most medical schools don't accept transfers. I am faced with the large decision as to whether to return.'

Managing my attendance and appointments

'The amount of appointments I was required to attend i.e. at least 2 a week every week and this was difficult to fit in. Lack of acknowledgement and understanding was shown by the medical school.

An example of another attendance issue occurred when my close relative had to undergo surgery. I had to be at home to give support and so that if there was a complication I would be there, not over 4 hours away. I found the medical school to be extremely unsupportive as all they were concerned with was attendance.

I am aware that attendance is essential and I understand medical schools have to set a precedent but there are some situations where people have to miss a week or two due to such issues.'

Knowing where to go for support

'One of the main and most concerning challenges I have had is the attitude of the medical school and occupational health. I also sought support from the medical school's student

support system in my second year, where I was referred to occupational health but neither of them made me aware of the Disability Support Office at the university until one year after I interrupted (4 years after I started the course).

I feel it is necessary when having meetings with members of student support to involve members of the university, probably from the Disability Support Office, to take notes as they are specialised with working with people with a wide range of disabilities.

There are also occurrences where the medical school has tried to give support and reasonable adjustments which are not helpful. This is why Disability Support Offices at universities exist. They provide specialist information and guidance and support with reasonable adjustments, whereas the medical school is not specialised in this area, which is why I feel it is imperative that medical schools and universities work together.

On a more positive note, some of the support I received from medical support at my base hospital was great.'

The way we use consent forms

'Another challenge faced was liaisons with and between occupational health and the medical school. During my period at medical school I was required to sign consent forms for information such as clinic reports to be sent to occupational health. I believe that specialist reports etc. should be summarised by an occupational health doctor and passed onto the medical school.

Also this raises the issue of data protection and confidentiality. I am aware that our files are kept confidential and within the laws of data protection but the number of hands the confidential file passes through are enormous. Therefore would it be better to have a separate confidential file containing health details that only certain people can access? Also we should be able to give permission as to who can access this information.'

What types of reasonable adjustments have been made to help with the training and working environment?

'After my first interrupted year the medical school held a meeting about my return and reasonable adjustments. The main reasonable adjustment made was regular appointments with occupational health and members of the medical school student support. Although I understand this is imperative due to fitness to practise issues, it was also a hindrance.'

Not all disability support is the same!

'I am still enrolled in the medical school in question; however I decided to apply for a Masters course at a university near home, resulting in me studying at a different university for the last academic year.

Before I began this course I was made aware of the university's Disability Support Office.

They put reasonable adjustments in place, including:

1. Mental health mentor who I see every week for an hour but if needs be can see for longer or telephone appointments etc. I have found this very beneficial as I feel she is an advocate for me. She has been very pro-active in sorting any of my concerns and problems out.
2. Specialist mental health co-ordinator in the Disability Support Office who is obtainable if necessary.
3. Separate examination room. If needed support to the examination room and after the exam.
4. Liaising with the school about any attendance issues for appointments etc.

Overall I feel that these adjustments, the support and general understanding of my condition and the problems people with my condition may face incredibly helpful. I believe this help and support has allowed me to remain on the MSc course of which I am on track to obtain a distinction.'

What support was received between different stages of medical education and training, and from the training to the working environment?

'The transition from non-clinical (years 1 and 2) to clinical (year 3) years was fine. I feel I thrived on patient interaction and the clinical and therapeutic side of medicine as well as the insight gained into the healthcare system. I performed well in clinical placements and OSCEs. Support given by my base hospital was better than the main student support at the medical school.'

What changes can you suggest to improve support for disabled students and doctors?

Work with others

'To improve support at medical school they need to involve and work with the university's facilities and expertise in disability, i.e. the Disability Support Office. I am aware that some medical schools don't have their own student support system but work through the university's one, which appears to be more successful.'

Have an advocate/mentor

'One key point that I believe needs to change in order to help medical students in the future is the use of an advocate or mentor from the university. As mentioned before, I feel that I was forced to sign consent documents for my private and delicate information to be distributed when I was unwell. I did not have anyone of authority within the medical school or university help me make these decisions.'

I feel that the support of another member of staff who understands disability and university policies as well as GMC policies should be offered to all students with disability.'

Jennifer is a Year 4 medical student with diabetes mellitus type 1

What have been the positive experiences and challenges faced during your study?

'There have been no major obstacles.

At times, not knowing timetables/ lengths of clinics and classes makes it difficult to organise meal times and insulin.

I expect it will be more of a problem once I've qualified due to increased demands and night shifts and regulating blood sugars during this.'

What types of reasonable adjustments have been made to help with the training and working environment?

'Having a fridge in my accommodation to store insulin.

Being given special consideration during exams - I'm allowed to leave the room to eat and test blood.'

What support was received between different stages of medical education and training, and from the training to the working environment?

'When moving from medical school to peripheral hospitals during 3rd and 4th year attachments, I have received appropriate support in the form of a fridge in accommodation.'

Sarah is a final year medical student with a mental health condition

What have been the positive experiences and challenges faced during your study?

Others' stigma

'When starting a new block I would let the block lead know a little about my history (I had been off for two and half years and returned to my fifth year of study, during my time away I'd been unwell and spent nearly 6 months as an inpatient). Eventually I realised that consultants would treat me differently.'

Learning valuable skills

'I have learnt skills from being an extremely vulnerable patient that I would never have learned at medical school, no one can teach you that feeling. I know I've overcome a great deal to get where I have done today and I feel very proud of this.'

I feel a more confident person and despite encountering others' prejudices I will not let it beat me down. I know my health is paramount and I am far more confident in picking up clues that I'm becoming unwell and getting on top of it early, I know who and how to contact.'

What types of reasonable adjustments have been made to help with the training and working environment?

'I was given:

- a more experienced academic tutor
- extra time in exams
- extra funding after I had a disability assessment
- support from a mentor independent from the medical school.

In general a closer eye has been kept on me (this has been a good and bad thing).'

What support was received between different stages of medical education and training, and from the training to the working environment?

'I completed a special circumstances form so that I could be given the deanery where I attended medical school for continuation with my care team.

I made contact with the GMC pre-reg checks team ASAP so more time could be given to any investigation/supportive measurements for foundation training.

I contacted the post-grad centre at the deanery to arrange a supportive educational supervisor (also the lead for F1).

I found out what my first surgical placement was.'

What changes can you suggest to improve support for disabled students and doctors?

'In particular regarding mental health, everyone just needs to lose the stigma! 1 in 4 says it all and yes there are varying degrees of mental illness but this attitude of infallibility in medics is unsustainable and is reflected in the amount of sick time the NHS has.

Give information and if any fitness to practise issues are ever raised keep the person informed, applying a framework and providing support along the way.

Make help more accessible.'

Adam is a Year 1 medical student with visual impairment

What have been the positive experiences and challenges faced during your study?

'On rare occasions (at the very beginning of the course), there have been a couple of conversations where students have questioned my ability to train, and indeed, practice as a future doctor. At the extreme end, there was the opinion that I shouldn't be wasting my time as it's entirely unrealistic to enter this profession with a sight-impairment (fair enough – I welcome all views).

Interestingly, this opinion was purely based on knowledge that I was partially-sighted, without any further insight, for e.g. the degree of sight-impairment or seeing me within a clinical setting.

Generally speaking, attitude of others has never been a problem for me - I certainly get treated no differently by other staff / students because of my disability.

There will of course most probably be further instances in the future, where I come across individuals who take a negative view – but I personally find it a positive experience: it's often questions that I've contemplated about myself (so there's no difference if someone else asks) and it provides opportunities for me to explore potential issues that I've perhaps been too naïve in considering.

Ultimately I have more respect for those individuals that express their views directly to me.'

What types of reasonable adjustments have been made to help with the training and working environment?

Being prepared

'The medical school ensured that appropriate meetings took place very early on (in the first teaching week). They were impressively forward-thinking and open to an array of possibilities. There is a very experienced team here, between members of the medical school and main disability services that work to always ensure that I receive all the help needed.'

My personal helper

'My medical school was incredibly forward-thinking and suggested that it would be beneficial to have an individual prepare material (print out in larger format) for me prior to all lectures to ensure that access to the lecture-environment was not compromised.

In such, medical school senior staff emailed all module leads to ask, where possible, to ensure that material can be emailed through earlier so that this could be done. This also ensured that my time could be utilised efficiently by having another individual take this role.'

Sitting exams

'Close liaison with the Examination Office ensures that all special examination arrangements have been put in place: enlarged papers, extra-time, amanuensis (a scribe), and use of a computer if needed.

The school ensures that all instructions for OSCE examinations are in a larger format, posted on the door prior to entry. These instructions provide information about the OSCE at hand.'

Supporting me in learning clinical skills

'From the outset I informed the medical school that clinical skills could be an issue: I have to get very close in order to see practical demonstrations, so on and so forth, not entirely possible in a group-learning environment. The school was outstandingly supportive and ensured that when needed, a qualified academic could run through, on a 1-to-1 basis, practical demonstrations to ensure that I had complete access to the curriculum.'

Out and about

'The medical school always ensures that for placement purposes, I am allocated nearer establishments, taking on board the fact that I am unable to drive. Always very welcomed!

After seeking my permission, the medical school informs other individuals involved in delivering teaching (e.g. phlebotomy training leads) of my sensory difficulties. This ensures that when away from the medical school environment, that my disability is catered for where possible. E.g. in a CPR training session, led at a local hospital, because the staff member was already informed, they ensured that the demonstration table was much nearer the front seating row so that I wouldn't be disadvantaged.'

What changes can you suggest to improve support for disabled students and doctors?

Follow the example of my medical school

'I consider myself very fortunate and privileged to be a student at my medical school. The support has been phenomenal. To improve support for disabled students, I can only draw on how the school has led the way.

They have always adopted a 'can do' view – they have been exceptionally supportive at all times and importantly don't stop and consider the 'here and now,' but are always looking into the future and asking important questions: 'What difficulties may you face in the future, and what can we do at this stage to plan for that?' They are open-minded and draw on a team of experienced individuals to find solutions to potential challenges.

They ensure an 'open-door policy' at all times, so very comforting in going and openly discussing potential issues at any period.

Most importantly, they allow me freedom – and this is perhaps what I find most supportive. Freedom in the sense that they allow me space and recognise / understand my desire in wanting to get through this course as independently as possible – yet instil a sense of security in knowing that as an institution they will always be there to support me: quite a tricky balance to strike!

Disabled students need a positive attitude

'Disabled students' attitudes are also imperative, and often supportive to their own progress. I can only support myself better if I take a realistic view to my future, and take the leading role in considering potential challenges and with it, potential solutions.

In such, what I've found incredibly supportive is a small network of key contacts, doctors with the same disability that have successfully gone through the system – with their insight and experience I am always able to plan ahead and have an inspirational set of individuals to communicate with whenever I need some advice, e.g. suitable technology / gadgets.

It would be advantageous, where possible, for current students to be linked with doctors who have similar disabilities – it took me a couple of years to hunt down a few contacts, but the time and effort has been worth it.'

Tom is a Year 2 medical student with dyslexia

What have been the positive experiences and challenges faced during your study?

'The main obstacles so far have been written work and learning via reading long journals or textbooks.

I find written work to be the biggest challenge but the course has been designed so that learning is quite interactive.'

What types of reasonable adjustments have been made to help with the training and working environment?

'The university has given me a laptop and recording equipment for recording lectures which has been a great help.

The lecture notes and slides are all on e-format so they can be downloaded and adapted on my computer.'

What changes can you suggest to improve support for disabled students and doctors?

'Possibly more education about the different disabilities so that we can have better perspectives into the challenges disabled doctors and students face.'

Stories from doctors in training

[Alison is a less than full time \(LTFT\) GP trainee with lymphoedema of dominant arm](#)

[Cath is a GP trainee with right side hearing loss/facial paralysis](#)

[Ann is a Foundation trainee with mobility issues, not currently in training](#)

[Ben is a Foundation trainee with dyslexia and depression](#)

[Rebecca is a Public health trainee with visual impairment](#)

Stories from less than full time GP trainees

The London School of General Practice has gathered stories from four trainees about their experiences of reasonable adjustments as part of our review:

[Click here to open GP trainees with disabilities or long term illness \(pdf\)](#)

Alison is a less than full time (LTFT) GP trainee with lymphoedema of dominant arm

What have been the positive experiences and challenges faced during your study and training?

'My disability relates to my ability to carry out certain physical duties. My main issues are therefore related to practical procedures, manual handling and repetitive arm use. I intermittently need to use a glove and sleeve for compression and this is a problem with patient contact and infection control.'

Because my condition is not immediately obvious to others, people can be sceptical when I can't do certain things. Having limitations on physical tasks can potentially cause service issues when doing hospital-based placements in specialties that undertake a lot of procedures. It isn't really a training issue as they are procedures that I will not need in my future role as a GP, but a short term service issue that has to be addressed before I start in a role.

Moving between placements after very short periods means that I often have to contact people and address Occupational Health issues for the next post. Having to set up reasonable adjustments so frequently does cause me a fair amount of stress, and obviously results in me having to discuss confidential medical details with lots of different people.'

My decision to change specialty

'I decided shortly after returning to work after my illness that my role as an SpR in Acute Medicine was no longer realistic due to the practical procedures and long-term undertaking of long busy shifts. I therefore made a decision to retrain in a speciality that was more suitable and was fortunately able to secure a training post.'

I do find that once my role has been adjusted to allow for my disability that I am able to work well and comfortably within my role, and I know that once I have finished training all will be much easier as when I am in Primary Care I have very few issues.

Working as a doctor with a disability, and also extensive experience of being a patient sitting the other side of the desk has obviously helped my clinical skills and made me a better, more understanding doctor.

The main positive outcome in my case is that I managed to transition back to work within a clinical role, and am now managing to retrain into a specialty that is suitable long term.'

What types of reasonable adjustments have been made to help with the training and working environment?

Limiting practical procedures and heavy work

'Within the post I am doing currently (Orthopaedics) I do not assist in theatre, and therefore spend my time on the wards and in clinics.'

Limiting procedures and heavier work is especially important when I am working on wards and am unable to use compression garments due to infection control.'

Considerate allocation of posts

'The training programme is involved in allocating me posts that I am able to drive to with a comfortable commute as excessive driving can cause me issues.'

My training programme also tries to identify posts that are less physically demanding, whilst still fulfilling the training requirements. I am training on a LTFT basis, which is important for me to be able to work within busy specialties whilst training.'

What support was received between different stages of medical education and training, and from the training to the working environment?

'I went from being a Medical SpR in year 3 of training to being a GPST1, and simply moved over at the start of the August changeover. There were no transitional arrangements, but I am not sure that any were really needed.'

I had the support from Occupational Health when returning to work initially, and to help me arrange reasonable adjustments for posts where this was necessary. I still have their support when needed, but it is up to me to contact them when required.'

What changes can you suggest to improve support for disabled students and doctors?

'Make better arrangements for keeping things consistent when transferring between training posts. It really is very stressful and frustrating to have to revisit issues every 4 months when moving between placements.'

Increase the understanding of administrative staff within the training programme. In my case, by arranging sensible training posts many of my issues (and trusts service issues) can be avoided by advance rotation planning. Sadly in my deanery this seems to be difficult, especially in combination with being LTFT.

Training posts have become far better at ensuring trainees are aware of who their educational and clinical supervisors are, but it is still often not clear who to go to when you need some emotional or pastoral care.

Try to increase awareness of doctors training with restrictions or health issues. There is still very much an expectation that we all fit into our roles in a certain way and people are not really used to dealing with variations from that expected norm.

Finally, make young doctors aware that the best way to get the support needed is by early appointments with Occupational Health to put things in writing.'

Cath is a GP trainee with right side hearing loss/facial paralysis

What have been the positive experiences and challenges faced during your study and training?

'I don't think there have been any positive outcomes except making sure my patients that suffer from facial palsy, for whatever reason, get the right care and know what help is available for them.'

Challenges:

- Difficulty using a stethoscope as can't get it in my bad ear, and can't hear on that side.
- Eye watering a lot, vision blurring.
- Having to use eye drops and do face physio exercises during the day, which all takes time.
- People staring at my face and making me feel uncomfortable and self-conscious.
- People (colleagues and patients) asking what happened/what the scars are from etc – I don't want to talk about it.'

What types of reasonable adjustments have been made to help with the training and working environment?

'None at work.'

For CSA GP exam (practical exam) – I had the following adjustments:

- Patient to be on my left side so I could hear them better.
- Examiner to be on my left side so they can see my facial expressions.

Examiners aware that:

- I can't use a stethoscope or ophthalmoscope in the conventional manner.
- I might have to adjust my hearing aid, which will look like I'm playing with my hair.
- I may have to use my eye drops.
- My eye might water/I may keep touching it.'

What changes can you suggest to improve support for disabled students and doctors?

'Awareness of the problems faced by people with facial palsy and deafness.

Acceptance by staff that you have to go to hospital appointments - it can't be helped, and it shouldn't be made an issue of.'

Ann is a Foundation trainee with mobility issues, not currently in training

What have been the positive experiences and challenges faced during your study and training?

The attitudes of others

'After working full time as a new Foundation Year 1 (FY1) for a few months, my health issues escalated and I was forced to step back from training. I returned the following year as a supernumerary doctor working 60% full time equivalent.

I battled throughout my training with the attitudes of others, both of the colleagues I worked with on a daily basis and of those who were in charge of organising my training and caring for me in it. On the wards I was isolated and side-lined from the teams I was part of because I was a supernumerary doctor and not there all day every day. Some FY1s that I worked with took charge of the daily ward jobs that needed to be done and pushed me aside.

With my deanery and occupational health consultant I began to feel as though I was an inconvenience and as time went on and I had to repeatedly refuse the use of a wheelchair which they were strongly proposing I used (contrary to the advice of my own doctors who said it would have been detrimental to my health).

I felt as though I was deemed as uncooperative and I slowly felt them 'give up' on me. Despite the difficulties I faced, there were some colleagues that I worked with who went out of their way to accommodate me and ensured everything was being done for me to be able to function with a team.'

Lack of equal opportunities

'I strongly feel that the training I received was greatly inferior to that of my peers and I did not receive opportunities equal to theirs that would have enabled me to grow and gain experience as a doctor. I received fewer educational or clinical opportunities and faced isolation.

Some of the jobs that were created for me were largely administrative and whilst on paper I was working 'in surgery' for example, and could be signed off as having completed my required time in that field, the majority of my daily work was simply to see patients in pre-assessment clinic, fill out the necessary forms and check patients were suitable for surgery.

I was given very little variation to my work, and other than signing for fluids there was no difference to what I was doing compared with that of some of the nurses. In contrast to this my peers were on the wards every day, learning from ward rounds and from the seniors they worked with. I was unsupervised, had no team, and had no one to ask if I was unsure or wanted to learn more about something.'

The journey I face to return to medicine

'If I am honest, I cannot say there have been any long-lasting positive outcomes to my experience thus far as my journey resulted in leaving medicine, which is something that saddens me greatly. Before my health difficulties when I was working full-time in 'mainstream' FY1 I enjoyed my job hugely. After returning to work as a part-time supernumerary my experience could not have been more different.

I have always been extremely passionate about medicine. I made the incredibly difficult decision to leave work because I could see no further way forward for me to be able to combine getting the required training and experience needed to become a good doctor with the limitations put on me by my disability and the attitudes of others towards this.

After leaving medicine and having time to focus purely on my health, my physical condition improved dramatically to the point where I was keen to return to my training. At this point however I was offered no support but was simply told I would need to repeat my FY1 year (nothing I had done previously would count despite having already completing 4 months full time, then a further 3 years part time of FY1), I was told I would need to sit the eligibility exam with no support, guidance, or way for revising for the practical side of that exam as I am not currently in a clinical environment.

It seems like all doors are shut to me at present. If things were to change within medicine and the attitudes and support towards disabled doctors I would return in an instant, and it seems such a waste that someone who is more than capable of being an excellent doctor has faced so many obstacles in pursuing what should be a very attainable goal of becoming a GP.'

What types of reasonable adjustments have been made to help with the training and working environment?

'I was:

- able to work at 60% full time equivalent in a supernumerary role
- not required to do on calls or participate in resuscitations

- frequently pressurised to use a wheelchair as those involved in arranging my training felt that this was the best way forward, but this went contrary to the advice of my health care providers and so I repeatedly refused this.'

What support was received between different stages of medical education and training, and from the training to the working environment?

'I transitioned from medical school to the working environment easily because at this stage my health issues were well controlled and did not affect my work and I fitted easily into the system. However once my physical condition began to impact upon my work I noticed a big difference in the support and guidance provided to me during my return to work and then during the transitions between each of my rotations.

As a supernumerary FY1, working less than full-time hours, jobs were created for me that were intended to be tailored to meet my physical needs. In theory this was great, however the reality was that I was given virtually no input into what these jobs were, I was sometimes given less than a week's notice regarding what my next rotation would be, and I felt I had no say in being able to shape what experience I would get or what educational input I would receive.

The whole process felt to me like it was more about 'ticking the boxes'. On paper I was provided with jobs that were suitable to my needs and which would meet educational requirements. The reality of these jobs were very different and I was isolated both in my day to day work and from other FY1s and their educational opportunities, and I was also given extremely minimal and poor overall clinical experience in comparison to my full-time colleagues.

I felt lost with regard to my future and was offered no guidance in planning out how my career path may look, what opportunities were available, and how things may be different for me as a doctor with a disability. The future (both immediate in terms of meeting GMC competencies, and long term with regards to my choice of specialty) was a blur and I began to feel like there were no options for me within medicine and that despite loving being a doctor and being able to genuinely help people, there was no choice available for me other than to leave medicine.'

What changes can you suggest to improve support for disabled students and doctors?

Clearer career guidance

'Clearer, and more readily available, immediate and long term career guidance for doctors who do not fit into the 'mainstream' of training, with extra support given to such trainees.

This should include regular meetings with an educational supervisor who is specially trained to help disabled doctors and recognises that we they require different support and opportunities compared to their peers.

They should be able to discuss issues such as how they can make up for any shortfalls in their training which may happen if they work part time or have reduced duties, and they might require 'outside of the box' thinking to provide ways of gaining the necessary clinical experience that they might lack in their day to day work.'

Provision of an alternative training path

'This should be provided for those doctors who do not fit into 'mainstream' training programmes but who would be very capable of working as a doctor and achieving the necessary competencies with a more tailored approach to their training. This is based on my experience that I believe I could become an excellent GP and could physically do that job with no difficulty at all, but I have faced extreme difficulty fitting into the current training system in order to get to the point of becoming a GP.

I feel that there should be the option for tailored training for those who need it (surely this would be more cost effective than training a doctor through medical school who then cannot work?) I also think there should be scope for doctors such as myself to be trained up in a particular field (such as general practice) which would mean that our qualifications were suitable only to that field, enabling us to work well as a GP for example, but excluding other specialties we had not been trained specifically in.'

Equal opportunities should be given

'The GMC should give clearer guidance to the LETBs/deaneries and have more involvement regarding what jobs/roles disabled trainees are given. This is to ensure that they are provided with the same opportunities as their peers.'

Misconceptions eradicated

'A goal should be set to eradicate the misperceptions and prejudices disabled doctors face in the work place, beginning with raising awareness amongst all clinical staff as to what challenges we face simply because of the stereotypes, thoughtlessness and attitudes of a few others.'

Support, support and more support!

'A network and pooled source of resources to enable disabled trainees to talk to others in similar positions and gain support, advice, guidance and encouragement from one another.

Working as a disabled doctor is extremely isolating. As time went on I became increasingly aware that the opportunities I was given were extremely limited and in no way equal to those of my peers. I became ever more anxious that I was falling further and further behind but with no one to turn to and no idea about how to change things for the better and to gain the experience I was missing.

I saw no way of me meeting the competencies I was required to meet simply because I was given no opportunity to do so and there is a limit as to how much fighting you can do to get these opportunities for yourself.'

Ben is a Foundation trainee with dyslexia and depression

What have been the positive experiences and challenges faced during your study and training?

Learning agreement set up

'The medical school sent a 'learning agreement' prior to starting, which clearly set out what they would do to help with regards to my dyslexia and what they expected. This was very limited, but no other medical school I applied to made such a provision.'

Mentor was helpful

'The school employed an individual to help learners with difficulties (ranging from welfare issues, mental health problems and learning difficulties) who was immensely helpful, approachable and knowledgeable. Unfortunately they only created the post and employed her towards the end of my time at the medical school and she has since left and not been replaced.'

More support needed

'Although the medical school gave us lectures on learning in medicine, I remember really struggling with getting my writing style up to standard. The feedback from assessments was bland, non-specific and unhelpful, and there never seemed to be enough staff to offer one-to-one support or feedback. The central university support was not specific enough to be useful to the demands of medicine, and I wonder if medical students with difficulties would benefit from more specifically tailored support.'

Self-help

'I continue to be an extremely slow reader, which makes keeping up with reading difficult. I have since found innovative ways of augmenting my learning (online resources, Massive Open Online Courses offered by other universities, YouTube tutorials etc) but I have found that academic practice tends to be entrenched in a set of values that is not always conducive to finding your own way, nor is it geared up to helping you effectively navigate the paths they set.'

A few uncomfortable situations

'I have struggled, as a junior doctor, when put on the spot, or pressured to speak publicly-reporting results or x-rays, getting muddled and humiliated. Or on surgical ward-rounds when the consultant sees a patient long enough to say 'good morning', barely giving me

enough time to find the notes, never mind the right page and start writing an entry... this has often left me in the tricky situation of going back to the notes later, after the consultant has left, to write something along the lines of what I think I remember from the jumbled whirl-wind of a ward-round. This overwhelms my coping strategies (such as keeping a list of jobs to do).

There have been times where consultants have humiliated me in front of their colleagues or medical students. Once, I was writing up a case-report and the consultant cc'd in her colleagues (who had nothing to do with the case) openly berating my spelling mistakes (as I was using British-English, the spell-checker function highlighted lots of things, such as haemoglobin, so I didn't pick it up).

I imagine lots of non-dyslexic people have these difficulties, but the humiliation hit hard. On another occasion, I was put on the spot and asked to report on an x-ray in front of a group of medical students on a ward-round. I got flustered and kept on getting my left and right mixed up.'

What types of reasonable adjustments have been made to help with the training and working environment?

'The only adjustments I have received have been with regard to assessments at medical school and in one written exam for specialty recruitment. I was awarded 25% extra time. On occasions I was allowed to sit my exam in a separate, smaller, quieter room- but this was not consistent.'

What support was received between different stages of medical education and training, and from the training to the working environment?

'I didn't receive any postgraduate support at all. None of my supervisors were aware of the information on the Transfer of Information form, and none knew enough about dyslexia.

Additionally, when I talked about my mental health difficulties with one he replied: 'don't be silly, doctors don't get depressed' and suggested "have you thought of joining a sports team or something".'

What changes can you suggest to improve support for disabled students and doctors?

'Primarily, what is needed is a little more understanding, patience and support.'

Raise awareness of imperfection (ie humanity) in the profession - train those involved in supervision to recognise and support those with difficulties, and provide some sort of more accessible / friendly person to go to at trusts if people have these sorts of problems. It is very difficult to raise these issues at the time.

Medical schools and LETBs/Deaneries should have a visible, accessible policy on disabilities, difficulties and support. These should not just be the punitive services that people are referred to when they do something wrong / fail, but should be proactive in helping.'

Rebecca is a Public health trainee with visual impairment

What have been the positive experiences and challenges faced during your study and training?

'My visual acuity although reduced, had been stable throughout medical school. On commencing my PRHO post, I was wearing high-power (but conventional) spectacles and could read small print without any additional assistance. I could successfully undertake all practical procedures required without any modifications.

My acuity deteriorated overnight as an SHO – adjusting to considerably reduced acuity was very difficult. Ongoing deterioration of my acuity is difficult to manage – just as I develop strategies to adapt, a further deterioration requires me to readjust. This impacts on my ability to work efficiently and effectively, and also impacts on mine and my supervisors' confidence and perceptions of my ability to work and successfully progress through a career in medicine.'

Poor/absent specialist Occupational Health advice

'Upon deterioration in my acuity I was advised to retire on the grounds of ill health. I was left to source my own advice and support, and felt very isolated and vulnerable. In addition to managing my health, I was faced with losing my employment, with the concurrent implications for my mortgage etc.'

Accessing electronic information

'Screen magnification software allows me to access IT based records (clinic notes/letters; test results; digital radiography etc). The willingness to install screen magnification software onto hospital computer varied considerably between different hospitals / NHS Trusts. Although 'Access to Work' and Occ Health had recommended this reasonable adjustment (along with other recommendations), I was the one who had to keep chasing for the adaptations to be put in place.

On the positive side, a different NHS Trust proactively arranged to meet me prior to commencing the post; had constructed a list of adjustments that they had anticipated would be of assistance and had all adjustments in place before I started the post.'

Changing my career direction

'Alteration / standardisation of postgraduate specialty training during the course of SHO training in my previous specialty contributed to my change in career direction. Some specific requirements for training would not have been possible for me to achieve – even

though myself and consultant colleagues within the specialty concerned thought that I would be fully capable of undertaking a consultant role within that specialty.

It is a disappointment, but I would not be in favour of adapting specialty training requirements in order to make the specialty accessible to a disabled doctor. The training requirements of a specialty should be defined by the knowledge and skills required to competently work within that specialty. I feel that modifying training could undermine patient/colleague confidence, engender resentment from colleagues and ultimately impair rather than empower a doctor with a disability from undertaking the role.'

Consultants/colleagues for whom you are both a patient and trainee

'Confidentiality can be an issue (or its absence), as can feeling uneasy about disclosing information to your treating consultant for fear that it will impact on your trainer-trainee relationship / career development.

Consultants/supervisors who aren't your treating consultant, but who seek to 'cure' you or provide clinical advice about your condition are also an issue.'

The reaction of others

'Patients have overwhelmingly responded positively and have often mentioned that they feel I listen to them more. Certainly, I have learned to improve upon some of the doctor-patient interactions where I have been in the patient role.

Patients have also told me that they find me more approachable, ironically, more 'normal' than a non-disabled doctor because they can see that I'm not perfect and find it easier to relate with a doctor who may share some common experiences with them.

Any adverse perceptions/presumptions have predominantly been from staff, not patients.'

How I work with others

'My current post involves little direct contact with patients, and much of my work with stakeholders is achieved via e-mail/post/telephone. I'm always pleased when I turn up to meetings/conferences etc where no-one has any idea that I have a disability. With relationships already established by phone/e-mail and with people already having confidence in my clinical competence, I don't have to 'prove' my competence as a doctor with a disability and overturn any potential adverse pre-conceptions. I am known to them as a competent doctor; not a disabled doctor who is competent.'

What types of reasonable adjustments have been made to help with the training and working environment?

'Within my current post:

- I have screen magnification / screen reader software to be able to use my laptop. Although it's a huge help, specialist screen readers and specialist NHS IT systems aren't always compatible. It also means that training locations are limited and I can't readily 'hot-desk' as the software can only be installed on individual computers, and not over a network.
- I have a portable CCTV device, which links to a laptop via a USB port: it has a camera that captures a digital image of any document (e.g. a paper tabled at a meeting), and then converts the image into a format that is accessible for me to use – for example, speech output or specific font style/size/colour and background colour combination displayed on-screen.
- I arranged adjustments with the Faculty of Public Health when sitting my Faculty exams (enlarged print, extra time, typing rather than writing responses).

My acuity is dependent on wearing a sclera contact lens in addition to high-reading-add spectacles and use of magnifiers, but I can only comfortably wear the contact lens for a limited number of hours, so:

- travel time/ public transport links are considered when choosing training locations so I can maximise my productive working day.
- IT solutions found to allow me to work remotely on projects initiated from workplaces that cannot be practicably reached by public transport.
- flexible working hours available if, for example, I cannot wear my contact lens due to an acute problem.

My ability to undertake on-call was assessed in the same manner as all other StRs in Public Health in my area – and no alteration to on-call arrangements have been necessary.'

What support was received between different stages of medical education and training, and from the training to the working environment?

From med school to PRHO

'As for all other final year medical students in my year, I had shadowed the house officer in the post which I was due to commence in August. This proved very useful – it gave me a good idea of the logistics: ward layout, where forms/equipment was stored; ward/department/lab locations within hospital etc. It also demonstrated to hospital staff that I was fully able to undertake the role – dispelling some of their anxieties/perceptions.

I ensured I maximised efficiency e.g. compiled a folder of commonly used request forms which I carried with me and therefore was able to be time efficient and complete requests whilst on the ward round rather than having to forage for the appropriate form which would be stored in a completely different location on each ward.

The consultant for whom I was due to start work was supportive and suggested I spoke with Occupational Health in case there were any other adjustments that could be suggested. Occ Health's response was that I shouldn't have been allowed into medical school. Thankfully the medical school Dean and consultant for whom I was due to start work did not share this opinion and were extremely supportive.'

As a junior doctor

'SHO rotations were tricky – adapting to ongoing changes in my visual acuity and the impact on my clinical abilities e.g. needing a magnifier to read ECGs/small print. I spent a long period of time as outwith the SHO rotation. Once returned to the SHO programme, the ease of transition between hospitals/departments/Trusts very much depended upon the individual consultant/Medical Director and their willingness to ensure reasonable adjustments were in place.'

Changing specialty

'Choosing to change my long-term career goal was a difficult personal decision. I had to balance the uncertainty of my diagnosis/prognosis with my desire to work in an acute specialty whilst maintaining a realistic perspective and above all, ensuring the safety of patients within my care.

Having commenced as a StR in Public Health, the support I have received from my Training Programme Director and current Educational Supervisor have been exemplary.'

What changes can you suggest to improve support for disabled students and doctors?

'Have positive role models – people with disabilities fully integrated into the workplace across all specialties.

Educate of all medical and nursing students and staff – it still seems to come as a complete surprise to many nurses and doctors that disabled people and people with long-term health problems are actually able to work, and some of us actually work within medicine.

Give career advice which is up-front, realistic, honest and tailored specifically to the individual doctor and their abilities.

Give Occupational Health advice which is specialist (consultants with specific interest/knowledge on managing chronic illness/disability in doctors), timely, appropriate and tailored to the individual doctor and their abilities.

The student/trainee doctor should not have to arrange their own reasonable adjustments at each change of placement / training location. This should be a managed process – linking across Deanery-NHS Trust-Occ Health-student/doctor. Reasonable adjustments should be pre-determined and put into place before the student/doctor begins the placement. If adjustments are left until the placement/rotation commences, the doctor is immediately disadvantaged in comparison to their colleagues.'

Doctors' stories

[Michael is a GP Principal with colour vision deficiency](#)

[Juliet is a GP locum with sickle cell anaemia](#)

[Tina is a Consultant anaesthetist with physical/neurological disability post metastatic disease](#)

[Patricia is a GP Principal with progressive bilateral sensorineural hearing loss](#)

[Scott is a Consultant anaesthetist/critical care with above right knee amputation and left knee damage](#)

[Ruth is a Consultant in public health medicine with physical disability \(now retired\)](#)

[Stephen is a GP Principal with colour vision deficiency \(now retired\)](#)

[Paul is a GP Principal with colour vision deficiency \(now retired\)](#)

Michael is a GP Principal with colour vision deficiency

What have been the positive experiences and challenges faced during your study and training?

'The challenges have been rare and not severe. The main problem is not knowing what I am missing/ not knowing what it is like to be normal in this respect. This leads to moments of uncertainty, e.g. interpreting urinalysis, being told by a patient they have a rash and being unable to see anything that resembles a rash.'

What types of reasonable adjustments have been made to help with the training and working environment?

'No one else has made any adjustments for me (I don't think they needed to).'

I have been aware that my colour perception and differentiation may not be as good and so occasionally sought the view of another health professional or even used the patients' eyes to verify my own opinion.'

What support was received between different stages of medical education and training, and from the training to the working environment?

'This issue did not impact on moving from training to working environment, there was no support and I did not need it.'

Actually it was probably easier once I left medical school. I think I was lousy at histology as I couldn't see the differently stained cells/microbes. My chosen career pathways – Sports Medicine and Primary Care – did not present many significant problems.'

What changes can you suggest to improve support for disabled students and doctors?

'Expert information for doctors/medical students with colour blindness issues should be made available through medical schools, BMA, Royal Colleges and experts made available for advice or consultation. I did not need this as my problems are minor – some others are not so lucky.'

Juliet is a GP locum with sickle cell anaemia

What have been the positive experiences and challenges faced during your study and training?

'When I started my medical training there were no facilities or understanding of the needs of disabled doctors so I didn't have a very good experience during my training. I met with a lot of negativity as if having a medical condition was somehow 'letting the side' down. I was told that I shouldn't have been allowed to study medicine.'

What types of reasonable adjustments have been made to help with the training and working environment?

'None were available at the time.'

What support was received between different stages of medical education and training, and from the training to the working environment?

'The transition was very difficult. During training the hours were less gruelling so I was ok. I lived across the road from the hospital as travelling in cold weather would have made things very difficult.'

I qualified in the time when junior doctors were expected to work a 1 in 3 rota with prospective cover. There were no defined break times so occasionally the dehydration & physical exhaustion of long weekend on calls could trigger off a crisis.

When I asked to change from a 1 in 2.7 to a 1 in 4 on call rota I was sent to see the occupational health doctor who, after just checking my Blood Pressure and measuring my height & weight, told me I was fit to work a 1 in 2.7. He didn't ask me what symptoms I had or how my illness affected me. I found the 1 in 2.7 rota as a medical registrar in a busy district general hospital completely exhausting and a weekend on call (Friday morning to Monday evening) would occasionally trigger off a crisis. No locum would be provided if I had to go off duty, so I felt guilty leaving my colleagues in the lurch. Often I had to try to continue working while in pain.

During my time as a junior doctor, part-time training was introduced. When I applied I was told only women with small children would be considered not doctors with health problems, so in the end I had to leave hospital medicine half way through my registrar training.

I eventually went back and completed my GP training, but when I applied for a partnership my trainer told the practice where I had been accepted that I suffered from sickle cell anaemia and the offer for partnership was withdrawn. They didn't even offer me a trial period to see if I could do the job.

Subsequently some practices have offered me partnerships knowing of my condition when I did locums for them but by then I had lost confidence in the whole system. I have worked as a permanent locum and done a couple of salaried posts, since qualifying as a GP. Not being accepted meant that my career aspirations and chance of working for a proper NHS pension were thwarted.

In the time since I started at med school I have had less than 8 weeks off sick in total, so all I needed was a little leeway in the number of hours worked. It would have been no problem now with the European Work Directive.'

What changes can you suggest to improve support for disabled students and doctors?

'I think things have improved, just by the reduction in junior doctors' hours over the years. But I think more compassion & understanding would have gone a long way at the time! I felt I was always trying to prove I was just as good as the healthy doctors.

Also recognising that part time working shouldn't have been restricted at the time to just working mums.'

Tina is a Consultant anaesthetist with physical/neurological disability post metastatic disease

What have been the positive experiences and challenges faced during your study and training?

'When disability strikes after training (as mine did) there may be a need to change role or specialty. I was urged to take early retirement or move to SAS grade. No other options were given.

What was not good was having the issue addressed under 'competency to practice' rules rather than disability. I had to suggest a supported return to work – this was not put into practice helpfully by my employers. I did however have rapid access to an excellent consultant in Occupational Health (not from employing health board).

Once it was recognised as a disability issue, my colleagues were very supportive and non-theatre roles were taken on until my condition stabilised.'

What types of reasonable adjustments have been made to help with the training and working environment?

'I was:

- removed from the out of hours rota
- given an extension of my deanery/national education role.'

What changes can you suggest to improve support for disabled students and doctors?

Students and doctors in training should have support from their medical school or deanery.

In the case of doctors in training this can move through the supervisor roles from clinical supervisor up to the doctor in difficulty APD (Associate Postgraduate Dean) and careers APD who should work closely together on these issues. Deaneries should be able to provide some remedial funding.

Students should receive career advice at an early stage and should also have an early occupational health assessment to inform specialty choice.

Psychological help should be available for all, especially when disability is developed during your career. Denial is a significant problem for medics as is loss of self-esteem.

There should be a database of those who would be interested in helping others with similar problems.'

Patricia is a GP Principal with progressive bilateral sensorineural hearing loss

What have been the positive experiences and challenges faced during your study and training?

'I have had a progressive bilateral sensorineural hearing loss since I was a child. Since my hearing loss has continued to progress, the challenges I have faced have changed over the years.

On qualification, my main difficulty was following busy ward rounds – since I lip-read to supplement my hearing. In addition, I had some difficulty on the telephone – particularly with strong accents or where English was a second language.

Through my training, my difficulties have changed. I now cannot consistently understand what is said on the telephone, and so I use the Action on Hearing Loss Text Relay service. I also can find large meetings and groups difficult to follow.

I would say my main difficulty, however, has been the attitude of a small but significant number of senior doctors I have worked with, who felt any degree of hearing loss (and particularly a significant degree such as mine), was incompatible with a career in medicine, anaesthetics (where I initially trained) or general practice.

Often, they have used the concern of 'patient safety' as their main argument, without consideration of any alternative methods that I could use to ensure that my hearing loss is not a significant hindrance, or the dismissal of an alternative method being used that is different from the normal way of doing things.

They have also suggested reasons for my hearing loss being incompatible with a career in medicine which are unrealistic (i.e. one doctor who, after being reassured in regard to my one-on-one ability and reasonable adjustments for the telephone and meetings, then suggested that because I may have 'difficulty following conversations in the coffee room', this should then be considered a precursor).'

What types of reasonable adjustments have been made to help with the training and working environment?

'Repeating information back where appropriate.

Ensuring patients and colleagues are aware of my hearing loss and that I lip-read as well as hear.

I use the Action on Hearing Loss Text Relay service, which is a confidential service that uses a third party, highly-trained but non-medical operator to transcribe speech to a textphone, whilst I am still able to talk to patients or colleagues.

I also can struggle with large meetings and have in the past used an electronic notetaker (as paid for by Access to Work) to ensure that I am picking up important information.

I may choose to utilise email (through my confidential nhs.net account) instead of telephone for some correspondence.'

What support was received between different stages of medical education and training, and from the training to the working environment?

'My ST2 GP trainer arranged for a doctor from the Deanery Career Development Unit to visit to discuss what sort of practice I may prefer to work for after qualification as it would be better to work with colleagues who were open to facilitating the few small adjustments I use to work with.'

What changes can you suggest to improve support for disabled students and doctors?

'A network so that disabled doctors and medical students can link in with each other and ask for advice (via email would be fine).

Improve awareness/training amongst GP trainers of types of disability, the Equality Act 2010 and various steps that can be put in place to help their colleagues or trainees if they have or experience a disability (I feel that generally we are not as good as we should be at looking after our colleagues when they have difficulties).'

Scott is a Consultant anaesthetist/critical care with above right knee amputation and left knee damage

What have been the positive experiences and challenges faced during your study and training?

'When I first got back to work as a SR in anaesthetics (a year after my accident) I was concerned about moving quickly in theatre in a case of emergency. Not actually a problem as I would stay with the patient and other members of the team would fetch the things needed.

Standing for a long time causes pain in my left knee but fortunately I'm able to sit a lot as anaesthetists do. If I had been a surgeon it would be more of a problem. No problem carrying out practical procedures as I use my hands which were not damaged in the accident. Others were and have been great. When I first got back to work a colleague said 'you haven't changed'. This meant a lot.

I was hugely supported by consultants in places I had worked in when I applied for my consultant job. These departments had also bought me a computer during my recovering period.'

What types of reasonable adjustments have been made to help with the training and working environment?

'When I first got back to work I was put into a Lecturers post for 3 months which only had about 3 operating lists a week. This allowed me time to adjust whilst the rest of my time was spent teaching and doing research. Prior to returning to work I had had a month probationary period doing lists 3 days a week with consultants. This allowed me time to get back into practice and polish up my skills.

Since being a consultant I have been given my own parking space near the hospital for access when on call and to keep my walking to a minimum.

I have a chair that suits me in theatres. Nothing special or fancy but easy for me to get in and out of quickly and has arms to push myself up.'

What changes can you suggest to improve support for disabled students and doctors?

'It depends very much on the disability. I can only really comment on physical disability. Getting back to work caused an amazing amount of tiredness and it took about 2-3

months to get back to normal stamina. I'm not a great believer in phased returns to work but this may be one time when I think it might be useful.

Make sure there is appropriate parking and hospital lifts that work!

Create opportunities to do other things at work – different career pathways and opportunities. I have always been worried that my legs would not survive until the end of my career and I wouldn't be able to practice medicine anymore. As a result I took the opportunity to start getting involved in medical management 2 days a week in my Trust. I always thought that in the worst case scenario I could hopefully go into hospital management full time which I could do on crutches or in a wheelchair if needs be.

But most importantly you must have self-motivation. I don't let anything beat me and my career has been long and full with a CV to support that.'

Ruth is a Consultant in public health medicine with physical disability (now retired)

What have been the positive experiences and challenges faced during your study and training?

'I became disabled in my second year as a consultant. The professionals involved in my care initially lacked knowledge of what changes could be made to enable me to continue working. The NHS occupational health service and my employer also lacked this knowledge. They said I could have whatever equipment I needed, but they didn't know what equipment was available.

I learned from other disabled people (not NHS staff) what assistive technology was available and about the then government Access to Work programme, which provided funding towards equipment needed to keep people in work. As a result, I was able to explain this to HR and arrange for equipment to be supplied.

I also worked with other agencies to establish the post of Disability Equality Officer, which resulted in an increased focus on making services, employment, and training accessible. A disabled staff network was set up in my employing organisation and at times I acted as an advocate for other disabled employees.

In terms of continuing professional development, I was not able to go to all the conferences and courses that should have been available to me, because some were not accessible. Eg I had to withdraw from part of a residential course because it involved working late into the night, and I needed normal rest periods to maintain my health. Usually, if I found that a course or conference was not fully accessible, I would explain the barriers to the organisers and explain their duty to make reasonable adjustments, in the hope that, in future, barriers would be removed.'

What types of reasonable adjustments have been made to help with the training and working environment?

'My job involved a lot of preparing papers, and going to meetings. Discussion with other disabled people (as above) meant that I was able to get voice recognition software, armrests, and a leg rest, so that strain on my joints was reduced.

I was allowed to go for physiotherapy, hospital appointments etc during working time.

I used teleconferencing sometimes, instead of expending energy going to meetings.'

What support was received between different stages of medical education and training, and from the training to the working environment?

'I did not become disabled until I was a consultant. I would have had a harder time if I had been still a junior doctor taking exams. The support I received initially was because I arranged it myself. My employer did not know what was available, but said I could have anything I needed.'

What changes can you suggest to improve support for disabled students and doctors?

'I've noticed a marked change in attitude over the past 10 -15 years as employers and healthcare staff have become more aware of the requirements of the Disability Discrimination Act and subsequently the Equality Act. But attitudes still need improvement, with an understanding of the social model of disability. This model locates disability in society, not in an individual person. So addressing disability means changing society in order to remove the barriers to full inclusion.

In terms of disabled doctors and students, the GMC, employers, and universities need to understand the barriers that people face because of the way society is organised, and work to remove these.

The medical profession needs to understand that disabled people are the experts in disability. This includes recognising the positive contribution that disabled doctors and students make to the profession.

The more exposure students and doctors have to disabled people, the more they will understand the disabling barriers in society. As a matter of course, training and exams should involve disabled people, but not necessarily in connection with their impairment. For example, if a person with heart disease is needed as a patient for an exam, universities and colleges could ask a blind person with heart disease to be the patient. Or for an orthopaedic exam, a person with learning disabilities could be asked to be a patient.'

Stephen is a GP Principal with colour vision deficiency (now retired)

What have been the positive experiences and challenges faced during your study and training?

'My colour vision deficiency was discovered by Ishihara test incidentally aged 8 by my father who was a GP.'

I was unaware of any significant clinical impact on my medical career until my voluntary participation in a study to quantify the size of the problem. Thereafter I took precautions, for example when using urine testing strips such as not using those that changed colour through red brown and green colours or asking colleagues to check if replacements were unavailable.

Whilst doing international work for the RCGP my associated night blindness resulted in me falling down a three feet wide and four feet deep storm drain in an unlit street and rupturing an artery in my leg which was repaired in theatre, so thereafter I would always use a torch on night visits etc.'

What changes can you suggest to improve support for disabled students and doctors?

'Maybe screen students for colour deficiency to increase detection of the condition. Mine was relatively minor and subjectively I was unaware that the colours that I perceived were any different from people with normal vision.'

Once identified, reasonable adjustments can be made which might be specialty specific. In general practice, special care should be taken when dealing with any physical signs in the red brown spectrum. Examples include fundoscopy with the use of green filters, otoscopy with injection of the tympanic membrane, reagent strips as above, blood in stool.'

Paul is a GP Principal with colour vision deficiency (now retired)

What have been the positive experiences and challenges faced during your study and training?

'Main obstacle: the developing awareness that one has a limitation in clinical skill due to one's colour vision deficiency. One can fail to discriminate between certain colour, name certain colours, and to match them. For example working as a GP one might fail to observe the pallor of a patient, see fresh blood against a dark background, and there are many other examples. Without awareness of this possibility the student or doctor is more likely to make errors.'

A positive outcome is that with awareness of the effects of the deficiency one can learn to find ways of avoiding errors, e.g by asking help of others. But this is not always possible because one is not always aware of when one is making a mistake, for example when one simply fails to observe a physical sign.

Another is that if aware of the effects one is able to choose an appropriate specialty.'

What types of reasonable adjustments have been made to help with the training and working environment?

'I think that little has been done. Registrars need to know how to advise such students but at present I suspect this is not done. Career guidance is also needed. Hospital lighting often needs improvement and this can need the advice of an expert. Students need to be aware that they may receive comments or advice from those who know little of the subject.'

What support was received between different stages of medical education and training, and from the training to the working environment?

'I received no support, but that was a long time ago. At present some students are developing their own methods and choosing appropriate careers. Or have even taken their refusal of acceptance by a medical school to court and won (not in UK). One surgeon shouted at me when I failed to see the pallor of severe anaemia.'

What changes can you suggest to improve support for disabled students and doctors?

'Teachers are needed who are aware of the difficulties of those with this deficiency.'