

**British Medical Association
Science and Education Department**

A celebration of disabled doctors

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**Editorial board
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A web resource from the BMA Science and Education Department and the Equal Opportunities Committee.

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Abbreviations

BMA	British Medical Association
DDA	Disability Discrimination Act
DRC	Disability Rights Commission
DSL	Doctors Support Line
DSN	Doctors Support Network
EHRC	Equality and Human Rights Commission
ENT	Ear, Nose and Throat
EOC	Equal Opportunities Committee
GMC	General Medical Council
HJS	Hypermobility Joint Syndrome
NHS	National Health Service
QOF	Quality and Outcome Framework
UCAS	University and Colleges Admissions Service

Foreword
Dr Hamish Meldrum
Chairman of Council, British Medical Association

In recognition of the International Day of Disabled People, the British Medical Association's (BMA) Equal Opportunities Committee (EOC) has produced this resource celebrating the contributions of disabled doctors to the NHS.

The promotion of equality and diversity in the workplace is vital in order to create a supportive environment. The BMA is committed to ensuring that its members can practice in a safe and non-discriminatory environment.

The implementation of legislative instruments and duties has only brought us so far. The stories in this resource indicate that there is a continued need to ensure that disabled people are given an equality of opportunity to study medicine and once they become doctors that they are given equal opportunities for development and career progression.

In order to attract and retain the best individuals to work in the NHS, it is imperative that we respect and value everyone, regardless of their sexual orientation, gender identity, race, religion, disability or age. This will ensure that we develop and deliver health and social care services that are receptive to the needs and preferences of all groups in society. In doing so, we will enhance people's experiences of services and deliver equitable health outcomes to all patients.

The BMA recognises and honours the achievements of our disabled doctors, nurses and other healthcare professionals through this resource. The BMA is committed to equality and the elimination of unfair discrimination in all its forms. The Association will continue to support all doctors and promote equality and diversity within the medical profession.

Professor Bhupinder Sandhu
Chair, BMA Equal Opportunities Committee

The BMA EOC is committed to promoting equal opportunities for the medical workforce, and breaking down barriers to career progression. In this resource we are celebrating the contribution of disabled doctors who have persevered and not let their impairment prevent them from practising medicine.

Disabled doctors and medical students are both valued and valuable members of the medical profession. Living with their impairment and/or disability discrimination, they are uniquely placed to create awareness and respond to the healthcare needs of disabled people, helping to foster a diverse and inclusive environment within the NHS.

I hope that this resource and its contributions from individuals who have been honest and brave enough to share their experiences of working as a disabled doctors in the NHS, will help to break down some of the barriers and increase understanding of disability issues. I also hope that it inspires other disabled people to join the medical profession and for disabled doctors to continue contributing to and building a more diverse profession for us all.

Introduction

Awareness of disability is often focussed on impairments, particularly those which are visible or easy to categorise. Assumptions are often made all disabled people encounter the same barriers and experience the same difficulties and that if an impairment cannot be seen then a person is not disabled. Disability as a concept, however, covers an extremely diverse spectrum of conditions. Impairments and the impact of the impairment on daily life varies from person to person and may also change over time. This variability makes it difficult to categorise or simplify disability.

The Disability Discrimination Act (DDA) 1995 (as amended) defines a person as having a disability 'if he or she has a physical or mental impairment, which has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities'. The breadth of the definition can encompass long-term illnesses such as cancer or HIV/AIDS.

The DDA 1995 prohibits direct discrimination on the grounds of disability, making it unlawful for employers and service providers to treat disabled people less favourably, without justification, for a reason that relates to their impairment. It also requires them to make reasonable adjustments or accommodations to ensure that disabled people are not put at a substantial disadvantage. The DDA 2005 extended the DDA 1995 and introduced the disability equality duty; a duty on public authorities to actively promote equality of opportunity for disabled people.

The DDA 2005 does not extend to Northern Ireland since disability discrimination is a transferred matter under the Northern Ireland Act 1998. Instead, Northern Ireland has separate secondary legislation and Codes of Practice which provide similar protections for disabled people in Northern Ireland, including extending the definition of disability to include long-term illness, introducing a disability equality duty for public organisations and requiring reasonable adjustments for disabled people.

In 1999, Northern Ireland merged the Commission for Racial Equality for Northern Ireland, the Equal Opportunities Commission for Northern Ireland, the Fair Employment Commission and the Northern Ireland Disability Council to form the Equality Commission Northern Ireland. The Equality Commission Northern Ireland is responsible for promoting awareness of and enforcing anti-discrimination law on the grounds of age, disability, race, sex (including marital and civil partner status), sexual orientation, religious belief and political opinion.

In Great Britain, the implementation of the DDAs was supported by the Disability Rights Commission (DRC) which was established in 2000 to address discrimination and promote equality of opportunity for disabled people. In 2007, the roles of the DRC, Equal Opportunities Commission and Commission for Racial Equality were taken on by the newly formed Equality and Human Rights Commission (EHRC). The EHRC covers the areas previously covered by the independent commissions, as well as age, religion and belief, sexual orientation and gender reassignment.

In 2006, the DRC estimated that there were 10 million disabled people in the UK, with 6.8 million of these being of working age. There is little data on how many disabled people there are at medical school or within the medical workforce. Data from the University and Colleges Admissions Service (UCAS) suggests that approximately three per cent of medical students are disabled. The data from UCAS on disabled medical students and the issues they face is considered in more detail in the BMA report ['Equality and Diversity in UK Medical Schools'](#).

Under the disability equality duty, NHS organisations in their roles both as employers and service providers are required to:

- promote equality of opportunity between disabled people and other people
- eliminate discrimination that is unlawful under the Act
- eliminate harassment of disabled people that is related to their disability
- promote positive attitudes towards disabled people
- encourage participation by disabled people in public life
- take steps to take account of disabled people's impairments, even where that involves treating them more favourably than other people.

Despite the implementation of the disability equality duty, a series of reports produced by the BMA highlight that disability equality in the medical profession and within healthcare is yet to be reached.

The publication [‘Career barriers in medicine: doctor’s experiences’](#) identified a number of significant barriers for disabled doctors including: that disabled doctors feel stigmatised, the hospital or GP surgery environment provides little allowance for the health needs of doctors, poor contingency cover and that disabled doctors do not have enough flexible working opportunities.

The [‘Disability equality in the medical profession’](#) report highlights the under-representation of disabled people at medical school and looks at mechanisms for improving their representation, including: promoting medical careers to disabled people, integrating disability equality in admission and selection processes and providing adequate support in order to retain disabled medical students. The report also looks at what is required to enable disabled doctors to lead successful careers in the medical profession, including the role of effective disability monitoring and the importance of providing disability equality in the recruitment and selection of doctors.

In [‘Disability equality within healthcare: The role of healthcare professionals’](#) the negative health and access inequalities experienced by disabled people are examined and recommendations given of the steps that can be taken to reduce barriers to healthcare for disabled people. These include the commissioning of healthcare services, addressing attitudes and communication skills among healthcare staff and providing disability equality training throughout a health professional’s career.

As these reports outline, although the legislation, policies and frameworks are in place, there are still hurdles to achieving disability equality both within the medical profession and moregenerally within healthcare. The profiles which follow demonstrate some of the hurdles faced by disabled doctors, but they also celebrate their achievements and we hope that they promote understanding and provide inspiration.

Profiles

Dr Joyce Carter

As a child, I had an inflammatory disorder known as Juvenile Chronic Arthritis, which caused inflammation of my joints. Then in my second year as a Consultant I was diagnosed with Rheumatoid Arthritis (RA) and my condition deteriorated quickly and severely. Rheumatoid Arthritis is an ongoing inflammatory disorder which can affect all tissues and organs, but mainly it affects joints making them stiff and painful. This can result, for example, in difficulty walking and using the hands.

As a disabled person I have had the privilege of meeting other disabled people who introduced me to the social model of disability. Knowing about the social model is very empowering for disabled people. Rather than focusing on what disabled people can't do, the social model of disability looks at both society and the environment, and how these affect disabled people. So although I have RA, it is not the RA which impacts my daily life, but the barriers I experience in a society which takes little or no account of disabled people. For example, when I first got RA as an adult, my office was on the first floor of a building with no lift. Getting to the office caused considerable pain – but if I had been in an office building with a lift, that would not have happened. So I was disabled by the building, not by RA. Another example is that my job involves preparing a lot of papers and reports. Soon after developing RA, it became very difficult for me to write by hand for any length of time, and using a Dictaphone damaged my finger joints. When Word Processors became widely available, this meant that I did not have to write by hand. Later, using a keyboard was painful, so I got Voice Recognition software which meant I did not have to use a keyboard; instead I speak into a microphone and this is turned into text. Again it was not the RA that disabled me, but the initial lack of suitable technology.

I was attracted to medicine as a career as I had been in hospital a lot as a child, I liked science at school and was good at it, and I was a member of the St John Ambulance Cadets and enjoyed learning the theory and practice of First Aid.

The best thing about the NHS is that patients have access to expert help without having to pay at the point of service. This was particularly important when I was a child, because my family could not have paid for the treatment I had. As a doctor in public health, working for the NHS means that I can get involved in work that aims to address health inequalities, knowing that I am not constrained by an employer whose aim is to make a profit. But some NHS staff have a casual attitude and seem to think that they are doing a favour to patients by treating them 'for free', rather than understanding that they are being paid by the state to provide a service.

As a disabled doctor I feel that I can make a valuable contribution because I am able to relate to the medical profession and the general population. So I am in a very good position to advocate for the changes necessary in society in order to reduce disability discrimination. I also feel that disabled doctors make good role models because they demonstrate to both disabled and non-disabled people that disabled people can have a professional, demanding job.

In some ways I am treated differently at work but this is a good thing. In order to minimise the disabling policies, attitudes, physical barriers etc in society, I have to be treated differently. Equality is not about treating everyone the same, but ensuring that barriers to full participation are reduced. For example, if my computer develops a fault, I cannot use another computer whilst waiting for mine to be fixed. The effects of this problem are minimised because my employer has a policy that says disabled staff should be given priority by the IT department and thus have their computers fixed ahead of people who can use another computer while they wait for theirs to be fixed.

Generally the NHS has been slow to address disability and disability audits are often actually risk assessments – eg if something that is disabling is not addressed, what is the likelihood of legal action because of a breach of the Disability Discrimination Act? Health workers, especially doctors, spend a lot of time trying to change disabled people, for example by surgery or medication, etc, rather than addressing the disabling barriers in society. Since the DDAs 1995 and 2005, there has been more interest in addressing discrimination against disabled people, but there is still a lack of understanding of the barriers to full participation faced by disabled people. For example, it is still possible to see job adverts that state the post-holder must be a car driver, even though the job has nothing to do with driving. The job may involve travelling to different places in the course of the day, but there are more ways of doing this than driving oneself in a car.

Currently the NHS provides a service that is `zero-priced` at the point of service, but there is a realistic threat of this changing, resulting in some or all people having to pay at the point of service. This would be detrimental because it would put barriers in the way of access to healthcare, and therefore needs to be challenged.

In terms of disability, the biggest challenge for the NHS is to achieve a paradigm shift, so that the NHS becomes a service that puts no disabling barriers in the way of disabled people being employed by, or using, the NHS.

These two challenges are related, in terms of the NHS trying to ensure equitable access to services for the whole population.

Dr Fiona Donnelly

I'm happy to share my experiences of working as a disabled doctor in the NHS.

I am currently completing specialist training in psychiatry, working in the northwest deanery and I have a long history of recurrent major depressive episodes requiring hospitalisation on several occasions. I am also the Chair of Doctors Support Network (DSN)/Doctors Support Line (DSL) - a national charity providing peer support to doctors with mental health problems.

During my second year of speciality training, while on a psychiatry rotation, I began suffering from recurrent severe depressive episodes. During my first episode of illness I was in hospital for two months, then discharged for a month, then re-admitted for four months. I was compulsorily admitted under section 3 of the Mental Health Act and given a course of electroconvulsive therapy. The co-ordinators of the psychiatry rotation, medical staffing and occupational health were very supportive and I was then able to return to work full time.

Following this I have had 3 further hospital admissions – all but one were under section 3 of the Mental Health Act and one of these admissions was while pregnant. During all these admissions I have been treated with electroconvulsive therapy and been on several different combinations of medication.

On a daily basis the main effect of my illness is morning sedation due to the high night time doses of sedative antidepressants and mood stabilisers making it difficult to get out of bed. The medication at times also interferes with my ability to do on-calls, especially weeks of night shifts, although I have managed to do these at times. I also need to ensure that on a daily basis I look after myself, balancing diet and exercise, getting the correct amount of sleep, and trying to avoid excessive stress, all of which are difficult as a full time trainee.

Overall, the numerous hospital admissions have caused my training to be prolonged and disjointed which was a big disadvantage in the Modernising Medical Careers fiasco. I have only just achieved a fourth year training post in psychiatry although I have worked in psychiatry for 8 years.

The electroconvulsive therapy has caused several periods of amnesia and while it doesn't affect my medical knowledge it means that on occasions I can't remember people that I have previously worked with. It has caused problems with Royal College exams, I had to re-sit two of the College exams as although I passed the written exam, I wasn't well enough to do the practical exam and so had to re-sit the whole exam as they wouldn't let me carry over the pass.

I have been very fortunate in that the deanery; occupational health, clinical tutors and medical staff have been very supportive. They have allowed me after long absences to come back as part-time supernumerary in very well-supported posts. I am aware of how fortunate I have been.

There are some positive things that have come out of my illness; I am now Chair of DSN and DSL – a UK wide charity which provides peer support to doctors suffering from mental illness – we currently have about 600 members. This has given me fantastic experience and opened up opportunities to teach about doctors with mental illness to medical students across the country and also on occasions to consultants.

I was attracted to medicine as I have always been interested in the human body and while doing my GCSE's I was able to get work experience shadowing a hospital doctor for two weeks and instantly knew then that it was what I wanted to do. Following this I gained more

experience working during holidays and at the weekends as a bank nursing assistant, mainly on psychiatric/geriatric wards.

There have been a number of changes in the NHS since I started working. My first year of training after medical school was in 2000 and I went straight into psychiatry in 2001. Since then there have been some major changes towards evidence based treatment, the introduction of NICE guidelines, a stronger emphasis on curriculum design and structured training. In the last few years there has been the Modernising Medical Careers fiasco and the European Working Time Directive with its possible impact on training.

One of the best things for me about the NHS has been the large amount of support available to those with a disability. I may have found other professions much less supportive. There has definitely been an improvement in the management of trainees with disabilities. Suffering from a mental illness is becoming less of a stigma, with more and more people speaking out about it, however there is still a long way to go.

Many disabled doctors can work as well as their non-disabled colleagues, so their contribution is the same as their non-disabled colleagues. Disabled doctors can also be good role models to people with similar illnesses; if patients see that doctors with their illness can work then they may be inspired to do so also. Patients also say that when a doctor becomes ill they experience healthcare from a very different perspective and can be a steep learning curve; this often translates into better patient care on return to work.

It is difficult to say how the NHS as a whole compares to other healthcare organisations in its treatment of patients and staff, as different Trusts can have very different attitudes and policies. From the experiences shared by other doctors with mental illness via DSN there is a huge difference between treatment by occupational health and medical staff in different Trusts. I am lucky to have experienced excellent support throughout my illness.

Generally I don't think I get treated any differently at work. There was one occasion when another trainee was upset that I was not doing night-time on-call and so rostered me for extra daytime on-call but this was easily resolved after speaking to the college tutor.

I think the NHS' response to discrimination against disabled people varies hugely depending on the area of the country that you are working in, but in general things do seem to be improving. There is still a huge stigma surrounding mental illness compared to physical illness in the medical profession. Doctors are scared of admitting that they have a problem as they feel that this may be seen as failing. There is also a lot of concern surrounding being referred to the GMC on health grounds, these fears are not unfounded. Via DSN I know of several people who have been referred to the General Medical Council purely on the grounds that they have been off work with a mental illness and some of these referrals have come from the hospital managers. The NHS still faces challenges in terms of managing doctors with mental health problems and confidential specialist services are very poor despite the Department of Health white paper recommending that doctors should be treated by senior, specialist psychiatrists who are out-of-area. There is currently a trial of specialist services in London - The Practitioners Health Programme which has had fantastic success in treating doctors and keeping them in work hence saving taxpayers money. This service may be adopted UK wide depending on funding, but this is a long way off.

Information about Doctors' Support Network and Doctors' Support Line can be found at www.dsn.org.uk or email chair@dsn.org.uk

Support services are also available through the BMA Doctors for Doctors Advisory Service and BMA Counselling Service, information on these can be accessed at

www.bma.org.uk/doctorsfordoctors, by calling 08459 200 169 or emailing info.d4d@bma.org.uk.

Dr Yvette Hendricks

I have sickle cell anaemia, a blood disorder which causes my red blood cells to be misshapen and the complications that come with that. For example, I suffer from recurrent episodes of severe pain, extreme fatigue as my red blood cell count is usually only half of normal levels, and stiff painful joints resulting from the early degeneration of my joints, known as osteoarthritis, which leads to poor mobility.

I wanted to be a doctor from a young age. By the time I was three I had already decided that I wanted to help sick children, but now that I am qualified I find it hard to find a job to suit my disability. I can only work part-time because of exhaustion and only in the mornings because I have young children. No NHS post allows me to just work mornings so I am a permanent locum. Although I'd recommend medicine as a career I wouldn't recommend it to a blood relative, as it demands too much of the person's life.

I think that disabled doctors have a lot to contribute to the NHS as they are more sensitive to patient needs and can spot psychosocial effects of illness on health. They also have a unique perspective as they have experience of using the NHS as a patient. As a disabled doctor I don't get treated any differently as most people I work with don't know, so this ensures equal treatment. I think that the NHS deals with discrimination against disabled people well but only when the disability is visible. If I were in a wheelchair I would get more understanding and compassion. Because I look OK people think you may be exaggerating so it's best not to say anything. There hasn't been much change in the way my disability is perceived. If I tell anyone in the health profession they tell me I must be a carrier (someone who has inherited one regular copy of the gene and one sickle cell copy of the gene and does not suffer any of the symptoms of sickle cell anaemia) as 'seemingly' I don't have any problems!!!

Patients with sickle cell anaemia still encounter prejudice in the NHS as they can be perceived as drug addicts because they require strong pain killers to treat the severe pain of a crisis.

The greatest strength of the NHS is that it is free at point of need/delivery. In the future the NHS is going to face challenges in organising joined up care, particularly for people with chronic illness.

Dr Saima Salahuddin

I have Hypermobility Joint Syndrome (HJS), also known as Ehler Danlos Type III, which is an inherited genetic condition which causes defects in collagen (a type of connective tissue). It affects joint stability, muscle strength and stamina. I have injured my joints in the past and suffered from an extreme form of chronic fatigue syndrome known to be associated with it.

I can't play my favourite sports and it also affects my daily routine. Things like walking, cleaning the house, washing, handling moderately heavy objects or handling things requiring force are difficult and require adaptations. I get tired easily and find it difficult to concentrate on reading especially for long periods. My impairment, not being visible, has led to ignorant attitudes and to discrimination. This has resulted in extreme distress and low self esteem in the past.

I wanted to be a doctor before I was diagnosed with HJS. I wanted to be in a profession that interacted with people and could directly influence their lives. The desire to uphold the trust and caring at the core of the profession convinced me the most. Despite my difficult journey, I would absolutely recommend medicine as a career. Careful selection of a speciality in the light of personal disability, inclusion of appropriate adjustments and perseverance are the keys to success.

General Practice has evolved as an organised and unique speciality reflecting the change in training over the last few years. Recruitment and training are now competency based, tested by standardised tools and therefore more objective. Support for trainees with disabilities is still variable, depending on how willing the individual NHS Trust is to accommodate disability. + Although there is more awareness of disability discrimination laws in the NHS than in the past, its application is still patchy, with some Trusts providing the desired level of support and others either doing the minimum required to prevent legal action against them or evading any required action at all by finding ways to exclude disabled doctors.

I strongly believe that disabled doctors bring a personal understanding of suffering from a disease or condition which helps maintain the doctor-patient relationship and provide role models to other talented disabled individuals who may give up pursuing professions which they could do with some determination and adequate adjustments. They can also help the NHS become more aware of its shortcomings and of possible ways of supporting doctors when they are sick or disabled.

The NHS is distinct from other industries as it takes more responsibility of patients compared to 'clients' in other professions and the need for accountability and caring is much greater. Patients are increasingly having more control over the service than in other industries.

In some respects disabled staff have to be treated differently to help maximise the potential of individuals. I would call it a positive discrimination. Sadly, I have had many disappointing experiences in the past at work which reduced my optimism about how 'health care' professionals treat their disabled colleagues. I was treated differently, and not only because of the restrictions of my impairment but also by colleagues refusing to understand the impairment and benefit from my capabilities.

The NHS has started taking discrimination against disabled people seriously but in more of a defensive role than a supportive one. How well these matters are dealt with is variable among the Trusts and specialities. Nevertheless, it has improved during my career.

Some strong points of the NHS are the provision of free healthcare to those who could not afford it otherwise, and its relative support of evidence-based practise. There is a traditional

reluctance to change and when the change arrives, implementation is often without sufficient test drives. The NHS could improve the way it deals with change and needs to reduce the lengthy and bureaucratic procedures required to sort out nearly any kind of problem. This will be helped only by reducing the distance between the opinions of the NHS policy-makers and those of the majority of doctors working on the ground when decisions are being made.

Dr David Samuel

I was born with a congenital deformity of the lower right leg. I have three toes, my fibula (one of the lower leg bones) is totally absent, there are several bones absent or abnormally formed within the ankle and knee, and my right leg is approximately eight inches shorter than my left leg. I have damaged my right knee as a result of "wear and tear" as the cartilage has been damaged, ligaments have been torn and osteoarthritis (stiff painful joints from degradation) is beginning to develop. As a result of the postural adjustments required my left leg has suffered degeneration and the ligaments required reconstruction. There is also a marked deformity of my left leg as the lower leg bends inwards below the knee.

I wear a purpose-designed orthotic appliance which allows me to walk every day. I have chronic calluses which require regular podiatry care. I also suffer daily, constant pain that I treat with anti-inflammatory medications and gels. Despite this I lead an active life and take part in normal daily activities on the wards. It limits the distance I am able to walk and at the end of a day my leg becomes incredibly tired which impacts on my ability to work long hours.

I wanted to become a doctor from the age of 3 and my interest has never diminished. Having had a close relationship with the NHS from birth I wanted to give something back to the organisation and team of healthcare professionals that have enabled me to live a near normal life. I also wanted to help others who have similar problems and feel that I can offer empathy that others may not be able to. I also wanted to beat the disability by becoming a doctor and curing disease.

I think that disabled doctors are able to empathise and sympathise with patients as well as offer better explanations, especially when breaking bad news. They also increase the diversity of the workforce and offer other colleagues an insight into disability which they all have to deal with at work. In addition, showing what can be overcome is both an inspiration and a reminder to those who believe that disability limits your potential and talents.

On the whole I am not treated differently, I am merely "David" but on one occasion I felt that my leg and disability was seen as a "problem" and burden to the department, mainly because of rota crises and staff shortages which were not my fault. The overall support of my Trust has been exceptional and teaching and education has been tailored to meet my needs and capabilities.

Having only been a doctor for just over a year the experience of working in the NHS is always a new one day-by-day. I have not been disappointed and at this time, working in a constantly changing NHS in Wales, as well as seeing the impact that the European Working Time Directive will have will prove an interesting challenge over the months to come. Financial constraints and targets seem to be a mainstay in the NHS but their impact on care seems to be increasing. In addition, the fear of litigation is increasing and you feel you now have to be overly cautious even if this negatively impacts on care and costs.

The NHS is very supportive and on the whole colleagues do not discriminate and view you as just another colleague. The occupational health support offered to doctors is second to none and difficulties regarding training are addressed extremely well by deaneries. The flexibility of training has allowed many more disabled people into medicine than ever before. The whistle-blowing policies and DDA, as well as local occupational health policies have helped eradicate blatant prejudice. We must remain vigilant though.

The best part of the NHS is that it is a service that is free at the point of entry and despite limitations, attempts to offer a standard of care and service that is equal wherever you may live.

Access to care for those who cannot afford private healthcare is a gift to be cherished and protected – a rare breed in the medical world where money and private finance initiatives seem to drive markets more and more by the day.

There are too many pen pushers and too much paper work though. Allow doctors to do their jobs and make decisions based on clinical judgement and you may find that many more financial savings and improvements in care can be made. The postcode lottery still exists, but working in Wales the private industry is a banished product – and this deserves praise and thanks. Access to expensive medicines is a scourge that pharmaceutical companies should be ashamed of!

The biggest challenges facing the NHS are balancing books with ever increasing costs for treatments, an ageing population and more chronic disease. Angina and diabetes will become the major 'live with' diseases and obesity will become endemic. Where rationing comes into treating these patients is a question that must be addressed now – not tomorrow!

I would definitely recommend medicine as a career. It has surpassed all expectations and it is a privilege to give back to the NHS a fraction of what it has given me over the years!

Jemma Saville

I am partially sighted – I was diagnosed with dominant optic atrophy (loss of function in the optic nerve) during my second year of my degree. Day-to-day this means I need large print, don't drive, and use magnifiers and screen magnifiers. I don't find that the impact on my daily life is that significant, but take me into a clinical environment and suddenly all the fonts are ridiculously small, there are tiny needles, x-rays etc and clinical procedures which all prove problematic. Although, in future this will be less of a problem because I want to be a psychiatrist eventually!

I knew quite early on that I wanted to be a doctor. I love working with people, I find people fascinating and love the challenges that working with such a range of people brings. I really enjoy biology and chemistry, and love the problem solving aspect of diagnosis. I also enjoy being in the academic environment and teaching patients and other students about medical conditions; taking the complex and making it simple and easy to understand.

At the moment I can't get a job in the NHS. The GMC have registered me, I've passed my finals, and I've been waiting since November 2008 for a post! They are not prepared to put in the extra effort to see someone who doesn't quite fit the 'normal' mould become a success. Disabled doctors have so much to give; granted that with a disability you can't fit into all areas of medicine. I know I can't be a surgeon, and I don't want to be. But the system should recognise people's strengths, and play to them, not just quash anyone who can't do every single thing. Every person and every doctor has strengths and weaknesses, and disability is just an extension of this. In closing the doors to people with disabilities, the doors will be closed to all sorts of amazing talent (for example, disabled doctors are often more intuitive and empathetic as a result of their impairment). To graduate from medical school is challenge enough, but to do it with extra challenge and adversity is something which should be recognised and celebrated.

Unbelievably, I would still recommend medicine as a career! I do believe that it will take time, but that I will get to practise as a doctor eventually and when this happens, it will set a precedent for other graduates. Even with all the fighting, I loved my medical degree. Medicine is a wonderful mix of science, practical work and best of all, people. But I almost gave it up, because it's just such a struggle as a disabled person. And I would want people to be aware of that if they are considering medicine as a career.

When I was a medical student I had a few encounters with old consultants who felt it was their place to tell me I shouldn't be a doctor. Apart from this, most of my experiences have been extremely positive, and I was treated the same as my peers.

I think that the NHS (or certainly the Trust I have been involved with) can get away with discrimination by cloaking it in 'patient interest'. When I have worked in other companies they are extremely helpful, accommodating and accessible. They see solutions, not just problems, and want you to succeed.

The NHS is a massive, dedicated team of individuals who put the patients before anyone else. It may have its problems, but I think it's still something to be proud of.

Dr Omana Thachil

I was born with a congenital bone condition called Blount's disease. It affects both my legs and I walk with severe 'bow legs'. My gait was very awkward and difficult and I looked much shorter than I actually am. I have had many corrective surgeries. The last one was two years ago and I now walk straighter than before. My knees are still unstable though. I wear braces for the knees and one of the ankles, which means I am very restricted in what I can do.

I was born in India and it was my childhood ambition to be a doctor. Even as a child, I took my deformity as a challenge and wanted to achieve the best against all the odds.

The NHS has changed significantly in its outlook over the years in service provision and the attitude towards patients and employees. My personal experience is that the discrimination issues are better managed in the NHS than other employment services. The NHS is already facing a number of challenges and it will be a struggle to provide a full free service for all in future. I think we will see a number of changes in the short to medium term for its sustainability.

My personal view is that the disabled doctors are like any other doctors and are contributing to all areas of the NHS, both in clinical and academic contexts.

I have not experienced discrimination as an employee and I think that the NHS takes discrimination against disabled people seriously. I am not so sure about how the patients manage with their feelings when they are faced with a disabled doctor. This may need further exploration.

Dr Katherine Thomas

I had meningitis at three years old, which left me with a hearing loss of around 20 decibels in the lower frequencies, rising to around a 90 decibel loss in the higher frequencies. This was perhaps the best age that this could have happened as I was old enough to have acquired speech but young enough to accept and adapt. Without my hearing aids I cannot hear sounds such as birds singing, telephones ringing, and babies in the next room crying. I believe that good communication is the cornerstone of good medical practice and I am fortunate that, in spite of my hearing impediment, I can, with the aid of lip reading, hearing aids when needed, an amplified stethoscope and most importantly good listening skills, communicate very effectively. Most of my patients would not know that I was deaf and, as I do not remember anything different, it is not something I am conscious of on a daily basis. It does not define me – I am a doctor, a mum, a wife, and many other things before having a disability, and I'm sure that many of my colleagues who fall into so-called minority groups would feel the same!

When I was growing up I attended mainstream schools and had excellent support from a dedicated audiologist, who visited me at school and at home, and also fairly regular contact with an Ear, Nose and Throat (ENT) consultant, who was also very supportive. I am not sure why I wanted to be a doctor, I certainly said it from being a very young child and then maybe just stuck with it as it seemed to impress the grown-ups - not a good reason! When I seemed set on medicine as a career in my mid teens, my parents took me to my ENT consultant to ask his opinion - he was very supportive, even writing a letter supporting my application to university. I was the first from my family to go to university. I enjoyed both sciences and humanities at school, and medicine is certainly a good fusion of both. It also gives plenty of opportunities of interacting with people from all walks of life, which can be very humbling, and it is the privilege of these insights into other people's lives which keeps me inspired on a daily basis.

I think each disabled doctor, like any doctor, should be taken on their own merits and judged on ability rather than by their disability. Having said that, I think many disabled doctors may be more resilient than their peers and have greater determination, having had to fight harder throughout their lives at every point to prove themselves. They might also bring a different and personal perspective and insight into treatment, coping strategies, and management of patients with disabilities.

I don't feel I get treated any differently, particularly once settled into a position. Once people know me they gain an awareness that it helps me to hear them if I can see them, but I have no problem speaking out if I feel I have missed something. When starting new posts over the years I have sometimes encountered people who might start off by shouting at me with a slightly ridiculous pantomime of over-enunciation – but they soon stop!

If a school leaver was torn between medicine as a career and something else then I think they should go for the something else – however if they were determined to become a doctor and had a realistic idea of what it actually entails and the necessary grit and stamina then it is an intellectually stimulating and rewarding career.

The best thing about the NHS is the ethos of cradle-to-grave healthcare directed by need and not ability to pay. When teams work together well, with the aim of best possible practice within the financial constraints given, it is an organisation of which we should be very proud.

I think the NHS as a whole has become much more patient-centred. This has advantages such as greater transparency and accountability, better standardisation of chronic disease management via the Quality and Outcomes Framework (QOF), and shorter waiting times. Numerous changes and political and media pressures have put an immense strain on general

practice. The erosion of partnerships and inherent potential decline of the vocational side of general practice due to these pressures is cause for great concern. An over-complicated managerial structure further challenges service delivery. All this leads to the postcode lotteries that go against the “universal equitable provision” ethos, to insecurity, and a lessening of morale amongst staff on all levels.

I think the NHS compares quite poorly in many aspects to some parts of the private sector. My husband is an employee of a well-known American company and I have been amazed at how much a private-sector company, constantly in direct competition with similar companies, strives for equality and diversity, with mentoring and work life balance given high priority. Women are much better supported, particularly in areas such as maternity provision, which must lead to better morale and loyalty. There is more awareness in the private sector of being seen to support those with disabilities, whereas I think in the NHS, many employees, aware of a system already very stretched, opt to keep quiet and carry on. It would be virtually unheard of in a business setting not to have an idea of a salary prior to an interview, for example, yet this is commonplace in general practice – often people are even expected to accept or decline a job without this information. The one area the NHS compares very well is in job security – we are lucky to be in a fairly recession-proof profession.

Discrimination against disabled people is like any type of discrimination. I think much of it goes on below the radar – people are often reluctant to make a complaint in fear of being seen as a troublemaker, and may not know where to turn should they feel discriminated against. There is an ever-increasing awareness of the need not to discriminate but I think employers face a difficult task as there is a lack of awareness of help available to them in order to support disabled employees. I would like to think that the NHS takes discrimination against disabled people seriously but this is not an issue that can be grouped with discrimination against ethnic minority doctors or lesbian/ gay doctors as the latter two issues have no impact on an individual’s ability to actually do the job, whereas certain disabilities can, in reality, have an impact and this must always be considered fairly, so that the patient, at the end of the day, does not risk losing out.

The biggest challenge facing the NHS in the future is without doubt remaining a single, equitable public institution whilst providing ever more costly interventions free at point of need. I do not envy the political decision-makers this task but feel strongly that it could be better managed if most of the reins could be handed back to working clinicians who better understand the impact of the decisions made.

Dr Harry Walmsley

I had an above knee amputation on my right leg and reconstruction of the left knee when I was a senior registrar after a road traffic accident in 1987. I spent nearly 3 weeks on Critical Care and 5 months in hospital and received 92 units of blood in total. I got back to work 5 days short of the first anniversary of my accident and 3 months later I was appointed consultant at Eastbourne. Since then I have had two knee replacements on my left knee. I don't think my injuries have seriously impacted my working life but I try to take the lift at work rather than the stairs. In everyday life? I can't run, don't do sport and I'm reluctant to climb ladders! I try not to walk longer distances than necessary (400 yards maximum ideally) but I don't feel I have a second rate life.

I was motivated to become a doctor because I was good at science at school and my father was a doctor, so it was a natural progression. Although I often think I wouldn't recommend medicine to others as a career, as it has changed so much, if you are science-based there are so many varied and interesting job opportunities with a medical degree. So I guess I would still recommend it.

I think disabled doctors have the opportunity to talk to patients about things they themselves have been through so we can empathise with them. I do this in my own Trust. I like to think it helps. We are all human!

Up until now I have found working in the NHS a safe and very satisfying job. Although I think the interference in clinical care by targets etc and the European Working Time Directive have led to clock watchers rather than those who treat medicine as a vocation and a privilege.

The NHS treats professionals well. I still think we have reasonable freedoms, perhaps too many. I won't enter this debate now! But for patients, communication can still be very poor. I have never been treated any differently at work because of my disability and have never seen discrimination that I am aware of. I think in my experience in my Trust, people with special needs are very well looked after. I can't remember if it was worse years ago when I was a student and a trainee as I had two legs then and probably would have been unaware of discrimination against others. Has it affected my attitude to work? I have achieved a lot and worked well beyond my duties. Is this what I would have done anyway? Or is it to prove to others that disability does not mean that I cannot pull your weight? A secretary once said to me "what are you trying to prove and to who?" Am I trying to prove something? I don't know.

In the future the NHS is going to face challenges in providing the same safe core services in local hospitals that they have historically done, within the constraints of the European Working Time Directive and Modernising Medical Careers. I sometimes wonder if the NHS can afford resident consultants, which is the natural progression. Finance is going to be an even bigger issue as medical technology continues to outgrow available finance. This will be especially important in the coming years of financial constraint once the recession is over.