Team Experiences – Dr Kelly Lockwood

Since first developing what I would class as a physical impairment as a result of my condition in F1, I have taken a very stop/start, indirect route to CCT and employment as a GP and learned many lessons along the way. It is these lessons, and the emotional and physical trauma that I experienced in learning them, that inspired me to set up and establish this support network. Many of the lessons I have learned over the years are included in the sections of this website for anyone to benefit from and, hopefully, avoid the turmoil and training disruptions that I encountered. I hope that the lessons learned were learned for all ill and disabled doctors, not just myself.

My first significant lesson was ***how to go about changing specialties***, which I did twice! Firstly from GP to ACCS Anaesthetics because I wasn't selected for ACCS first time around and didn't enjoy my first year in GP training. In retrospect this may have been because my GP program was a long way from where I lived so involved a 1.5 hour commute whilst working an A&E rota. The change from GP to ACCS was simple enough, a letter of resignation and a new application. Herein lies **lesson one**. *If you find yourself resigning from a post due to reasons completely unrelated to a medical condition you have, firstly make it very clear that you are NOT resigning for health reasons despite having a certain diagnosis and, secondly, do NOT burn your bridges in the wording of your resignation. You never know what the future holds and you may find yourself having to make a case for requesting to return to the post you are leaving and you must word your resignation in such a way that this is possible.*

Changing from ACCS back to GP training was more problematic with my previous program director opposing the request because I had inadvertently given him the impression that I was settling for second best because I felt it was the 'easier' option. Of course this was never the case. I have never taken GP to be an easy option in any sense. It was, however, physically easier for me to undertake than the very active requirements of a speciality such as anaesthetics.

Lesson two was more emotive. I had worked, in various guises, in the prehospital care arena for almost a decade when I started to experience physical impairments. Sadly, my symptoms meant it was no longer a safe option for me to continue this. After 10 years of spending most of my spare time working in prehospital care, a speciality that I dearly loved,

I had to step down. This was certainly the right decision but one of the more difficult I've had to make. The key lesson here being ***listen to your head****, not your heart and keep yourself safe no matter what the cost to your career. Careers can be changed, re-planned, adapted. You can learn to love another speciality, even though it may not feel like it at the time of changing. Embrace the fact that you can still be a doctor, you can still make a difference and earn an income doing something you love. Accept the hand that life has dealt you, and move on. Difficult things to do but the only things you can do if you want to succeed.*

My next big lesson was ***learning to accept delays in my training and progress to my CCT***. All the way through my education to that point, I had never encountered any 'delays'. I had in my mind this concept of getting to my CCT as young and as efficiently as possible and I held this concept as something very important to me. When I changed specialities and when my GP training was delayed for various reasons connected to my health, my CCT date kept moving further and further away and this was a very difficult thing for me to come to terms with. **Lesson three** *is to focus on staying in practice and staying as well as possible in the process. Do not hold on to the concept that life starts at your CCT and there is a rush to attain in. This is your life, training or not, it makes little difference. You are practicing as a doctor either way. You have to stay up to date and undertake assessments either way, be it for training or for revalidation. At the end of the day, in matters not how old you are when you get your CCT. The importance is that when you do get your CCT, you can continue to work rather than being so unwell that your CCT date is also the date you had to stop practising.*

Lesson four came when I was stepped down from one of my training posts because, due to the nature of the post and the extreme understaffing that existed on that particular rota, I sustained a number of serious injuries within the space of a few weeks whilst at work. The Trust did not feel they could allow me to continue because of the risks it was exposing me to, and the subsequent legal risks it was exposing them to. My training program directors tried to find another more suitable post for me. However, as the weeks rolled by I became more and more frustrated that, having recovered from my injuries, I was essentially and fit and able doctor sat at home ***not working due to administrative delays***. I had assurances from the Deanery that they would count some of these weeks towards training but, obviously in the end this was not possible and certainly was not something to Royal College would have allowed. Do not be plicated by such false reassurances if you find yourself in a similar situation. Also, do not rely upon program directors, human resources, etc to find an alternative post in good time in this situation. I found myself a training post by speaking to all of the department leads at my hospital and I organised Occupational Health review of the working environment to have the post cleared by them as being suitable for me to undertake. In the end, this delayed my CCT by around seven weeks but it would have been much longer I suspect had I not stepped in. *Lesson four is therefore to take control of a*

situation where administration is causing unacceptable delays to you being able to work. Do not rely upon other people and accept long delays if you don't have to.

Lesson five is that, as a disabled doctor in training, you do have a strong case for ***supernumerary funding*** in order to be able to continue training in a safe way. Supernumerary funding is a finite pot held by each school within the deanery. It is therefore well guarded and access to it is often denied or deflected. However, *if supernumerary funding is the only way in which you can continue to train in a safe manner (both for you and your patients) then you should be granted it. If you encounter resistance, get an Occupational Health review and specifically ask for their opinion on the appropriateness of supernumerary working and, if they agree, get them to out it in writing*. It would then be a brave or foolish deanery to deny you access to this funding pot which basically pays your salary as an addition to the general budget held for doctors to enable you to be taken off the main rota and to work the hours that are suitable to your particular situation without the requirement to be committed to on calls, nights, weekends, 12 hour shifts, etc.

Related to this was the very valuable lesson, **lesson six**, about ***how to make the most out of your Occupational Health department***. Many chronically ill doctors feel that OH is used against them by human resources and can end up dreading OH reviews. In order to make good progress in your career as a chronically ill/disabled doctor, you have to make OH work for you instead. There are various ways to do this and my approach to using OH is detailed in the *'Occupational Health' section of the website.*

This takes me up to the point of my CCT, after which I was faced with the prospect of convincing a GP practice that it was a good business decision to take on a disabled GP. A very different challenge to making my case to be allowed the flexibility I required to complete my training. Post CCT, a business such as a GP practice has absolutely no obligation to employ a disabled GP if they do not think it in their best interests. They do have to show they are giving disabled doctors fair opportunities in applying for posts and throughout the selection process. However, as a wheelchair user who cannot safely undertake home visits, any GP practice could argue I was unable to meet the job requirements and subsequently not employ me. And… this is what happened. So, I worked as a locum GP for almost two years, which gave it's own challenges. What this did achieve it to show a large number of practices first hand that, despite my disabilities, I am a very hard worker and it also illustrated to them that fact that we are as a group already more than aware of. That being a disabled/chronically ill doctor often makes you a better doctor. My patients sang my praises to the practice managers, I cleared the practice admin while everyone else was out on visits and, soon, practices were actively trying to find way around the fact I couldn't do home visits in order to be able to employ me. So, **lesson seven**, ***if at first you don't succeed, try try again***. *Don't give up. You know you are good at what you do so do whatever it takes to show people this is the case. All you have to do is engineer the*

opportunities to show people what you can do and they will want to offer you the same opportunities, despite your impairments, in the end. It may just take a little more time.

So, there they are. The seven most useful lessons that my journey to date has taught me. Please learn from them so you can avoid some of the pitfalls I found and avoid some of the challenges that I encountered. Also, please share the lessons that you have learned with others so that they may do the same. Send us your experiences and key lessons by email or via our contact us form. As you'll see in our outstanding work section, we are trying to put together a compendium of experiences as well as useful/successful work adaptations, etc. Anything you feel comfortable to submit to us would be gratefully received to help improve working conditions for chronically ill/disabled students and doctors all over the world, not just in the UK.

Thank you.