The Doctor podcast | Episode 5 | Doctors living with Parkinson’s

Voiceover: Living and working with Parkinson’s disease is a challenge – especially if you have a busy, stressful job in medicine. And it can take years to realise you have the condition, even if you care for patients with Parkinson’s.

Two doctors, Jonny Acheson and Richard Prettyman, talk about learning to ‘live well’ with Parkinson’s, challenging stereotypes, and finding the hope in a life-changing diagnosis.

Jonny Acheson: If you say Parkinson’s to people, even doctors, they will think older, they’ll think tremor, they’ll think shuffling gait, they’ll think hunched over. If you Google ‘Parkinson’s’ that’s the image you’ll see, of a man hunched over like that.

Whereas in reality, there are 10,000 people in the UK who have been diagnosed with young onset Parkinson’s, which is people who are less than 50. Twenty per cent of people don’t have a tremor.

Voiceover: Welcome to The Doctor podcast, brought to you by the British Medical Association. Each month we bring you conversations inspired by stories featured in The Doctor magazine.

This episode builds on the feature article ‘No one knows about tomorrow’: Doctors living with Parkinson’s by Seren Boyd. You don’t need to have read the article to enjoy this episode, but if you’d like to do so you can find a link to it in the show notes and at thedoctor.bma.org.uk/podcast.

Jonny: My name is Jonny Acheson. I’m an A&E consultant in Leicester, originally from Northern Ireland. I’m married to Heather, I have two kids. And I was diagnosed with Parkinson’s in 2016, when I was 41. So I’ll have been diagnosed, next week, nine years.

Richard Prettyman: My name’s Richard Prettyman. I’m retired now, but until three years ago I was an old age psychiatrist. I was diagnosed with Parkinson’s disease about three years ago. So it turned out that I stopped working and was diagnosed around about the same time, but the two things were not actually connected. I’d always intended to retire when I was 60; it just so happened to coincide with the point at which I received my diagnosis.

Voiceover: Dr Acheson helped set up a support group for people who work in the NHS and are living with Parkinson's. He wanted to bring together people with similar experiences – and to challenge a few misconceptions about the disease.

Jonny: I think when you get diagnosed with Parkinson's, you all get put in the same book.

For the first two years, I didn't really speak to anybody else with Parkinson's. I didn't really know anybody else with Parkinson's. I had met one nurse, who was living with Parkinson's, and working in the NHS. That was Claire Allison. I said to her, you know, do you think we could find more people? So we sent out a post on social media, and within two weeks we had 12 people.

It wasn't just doctors specifically – it was doctors, it was nurses, it was physios, it was paramedics and a pharmacist. It was anybody who worked within the NHS. We moved quite quickly to include people who had retired in the NHS as well, and that's when people like Richard came in, because we realised that they offered another aspect of life after working in the NHS.

If we found people who were working or had worked in the NHS with Parkinson's, you know, you have something else in common with them. So, yes, you have Parkinson's, but you also worked in the NHS. I think there was a connection there wasn't there, around that setup, and I think suddenly from feeling isolated, you suddenly felt as if you had a lot of people who understood what it was like.

Richard: There's a big contrast for me between the experience I've had being a member of this group, and the support I've got from being in this group, and my initial experience of support groups. They do a grand job and I'm not knocking them, but I went to a couple of meetings very early on, just after I'd had my diagnosis, and I didn't feel I could really identify very well with a lot of the other participants.

On the whole – and I'm generalising a bit here, but on the whole – the people that I met through that sort of system were much older, they were frailer, they clearly were quite disabled, had a lot of other co-morbidities, probably. By contrast I still considered myself to be fairly fit and active. And my idea of a fun afternoon wasn't sitting around with a half-filled cup of tea, doing gentle chair exercises or listening to a talk on continence aids. That wasn't going to float my boat, I'm afraid.

It was a refreshing change, I guess, to find a group of people who I did have something in common with, in terms of currently or recently working, active for the most part, generally a bit younger.

It's much easier to feel hopeful when you're surrounded by examples of people who are living well despite having a challenging problem, and are leading fit and active lives – productive lives – than if the people around you are all frail, disabled people, which is… you know, that's not their fault, but it's hard to get back from people with more established disabling conditions any sense of hope for the future, really.

Jonny: I mean, I think that's right. For me, working in an emergency department, that's all I saw of people with Parkinson's. So people with advanced Parkinson's who were very dependent, very frail. And for two years, three years after diagnosis, I simply couldn't look at it, because all I could see was, is this me? Is this me in the future? And if it is, when is that going to happen?

It really was quite scary because you don't really know. You know, you're told it's a progressive condition for which there's no cure. The medication just masks the symptoms. And, you know, you don't know how quickly your progression is going to be. Some people progress more quickly than others. It really is quite a frightening time after diagnosis.

Richard: Ironically, when I was working as an old age psychiatrist, one of my specialist interests was in neurodegenerative disorders, including Parkinson's disease. So I'd seen plenty of people with Parkinson's disease, but as Jonny was alluding to, the people I saw were all people with late stage disease, complicated disease. Generally, by definition, they had got neuropsychiatric complications. Many of them got dementia. Many of them were very frail, with multiple physical comorbidities.

So my own immediate clinical experience with Parkinson's made me feel quite alarmed at the prospect of, you know, what I might experience, in short order. I mean, I feel a lot better about it now, but at the time I just had my diagnosis, my expectations for the future were inevitably quite heavily coloured by my own experience as a clinician and the examples of patients that I tried to help and treat during that time.

Jonny: If you say Parkinson's to people, even doctors or people that work in the health service, they will think, you know, older. They'll think tremor. They'll think, you know, shuffling gait. They'll think hunched over. And if you Google 'Parkinson's', that's the image that you'll see – of a man hunched over, like that.

Whereas in reality, you know, there are 10,000 people in the UK who have been diagnosed with young onset Parkinson's, which is people who are less than 50. Twenty per cent of people don't have a tremor. And, you know, it affects both sexes. Yes, men are more commonly diagnosed than females, but there are females out there who have Parkinson's.

I think educating people around what Parkinson’s is like is really important for anybody who’s treating people in hospital who have Parkinson’s. Because it’s not just those things that people commonly associate with it.

Voiceover: Being diagnosed with Parkinson’s can be a long journey, even for doctors. Many symptoms are not easily recognised as part of the disease.

Jonny: In your own case, did you know that you might have Parkinson’s? What were the symptoms that got you to the neurologist?

Richard: Did I think I had Parkinson’s? Latterly, yes, I was suspecting that. But for several years I’d had some symptoms which were really quite non-specific and not obviously motor symptoms. And those symptoms consisted particularly but not exclusively of fatigue; some mood disturbance, sleep disturbance, and some unglamorous things like severe constipation. As a result of these symptoms, I had been down a number of therapeutic avenues already.

Looking back, with hindsight, I can see now that that was probably all part of the prodrome of my Parkinson’s disease. When they finally arrived, my neurological symptoms were quite limited and focal. I started off with a bit of tremor in my left foot, and a bit of what I now recognise as dystonia in my left foot. And the penny was starting to drop for me now that I’d probably got some sort of neurological problem.

So that was what caused me to ask for a referral, and I got referred and I got assessed in the clinic, and I had a DaT scan, and I had a diagnosis. And that was my story.

What about you, Jonny? What led to the recognition of your symptoms, and the referral for a diagnosis?

Jonny: Mine was slightly different. So, about six months before I was diagnosed, my in-laws had come over to our house, and whenever they’d left, they said to my wife, he’s not himself. You know, what’s wrong with him? There’s nothing really specific, I just was a bit distant and a bit vague and not really engaged.

I didn’t really think anything of it. And then, one night, we were with friends in our house, and one of my mates had been to a Bollywood dancing class, and he stood up and he goes, I’ll show you how to do the ‘change the lightbulb’ dance. So we put our arms in the air, rotated both the wrists quickly, and I realised that I couldn’t move my left wrist very quickly at all.

It was quite fortunate in a sense that that happened, because I realised that there was something wrong. I went to my GP – I literally walked in and said, there’s something wrong with me and I don’t know what it is. She was really, really good that day. Took loads of time; her clinic was running late by the time she'd finished. She brought out the fact that when I walked, when I was tired I would scuff my left foot as if it hit a kerb, and it would go forward, and then I'd look back and the kerb would be flat.

So she said I needed a CT scan of my head and I needed to be seen by the neurologist. I went to the neurology appointment and, you know, he got me to walk across the length of the clinic. And I do that most days I'm working; it's sort of weird having to do it yourself. I was really keen not to scuff my foot, so I walked really slowly and gently across the clinic, turned around, came back, sat down, and thought, that's great, I didn't scuff my foot. And he said, you don't swing your left arm very much. Now I hadn't noticed that. My wife hadn't noticed it, nobody had noticed it. Why would you notice it?

And then he leaned forward and he said, Jonny you need a DaT scan. I didn't know what a DaT scan was. I did go to most of my lectures at medical school, but I never remember anybody mentioning what a DaT scan was. My wife, who was an old age psychiatry trainee at that stage, she used to order DaT scans in the clinic to decide whether it was really about a dementia picture or Parkinson's. And she just leaned across and said, he doesn't know what that is.

So she was sitting knowing the diagnosis; I didn't have a clue. And the neurologist just looked at me and said, you've got idiopathic Parkinson's disease. So absolutely huge shock; wasn't expecting it at all. I sort of said, I thought I was just stressed. You know, I thought it might have been MS, multiple sclerosis, or motor neurone disease, or a brain tumour. But Parkinson's just wasn't on the list. It was as if someone had pressed the pause button on my life.

Richard: I think something I'd like to add to that is what happened after I'd got the diagnosis, which was the neurologist I saw was keen to start treatment right away. This was actually a revelation because within about a month of being on levodopa, I just felt so much better, and it was only then that I realised how much *not* better I'd been over the preceding several years.

That provided a contrast. And I realised that this kind of prodrome of fatigue, lack of energy, lack of motivation at times as well, this had all been part of the early presentation of the disease, because once I was treated, that all got a lot better. And bizarrely, I actually felt the best that I'd felt for at least five years and possibly 10 years.

Just to put this in context, I've done quite a lot of running in the past. I've run four or five marathons, I've run more half marathons than I can count. But over the year or so before the diagnosis, because I'd had a lot of backache and stiffness, I almost stopped running completely, which was not normal for me at all. But then once I was on treatment, I found I was running again.

Voiceover: Having a demanding role in medicine can make symptoms even harder to recognise. Dr Acheson and Dr Prettyman both found it easy to dismiss symptoms such as tiredness as ‘just occupational hazards’.

Jonny: So, Richard, you said a couple of years before you were diagnosed you had various symptoms. Do you think your work as a psychiatrist influenced how you interpreted those?

Richard: During the last few years that I was working, which was actually during the pandemic and immediately afterwards, I was working in a team, and that job was quite demanding, quite stressful. It involved an awful lot of walking. We were walking all over the hospital, all the time. I would get tired more easily.

We had a very… what I can only describe as an unsatisfactory office arrangement, where we were all kind of hotdesking. Because of that, I used to find that my legs would get very stiff from being sort of crunched up under a too-small desk and not having enough space to move around in. That, combined with the amount of walking I was doing, meant at the end of the day my legs would feel very tired and stiff, and I’d have what I now recognise as a slight dystonia in my left leg and left foot.

I suppose I was discounting that to some extent, but I now know that that was probably a feature, an early motor symptom of the Parkinson’s. I guess I kind of dismissed a lot of it as just, you know, work-related stress.

I came out at the end of that feeling, I could really do with a break now. You know, this has been a very tiring experience. But now I know that some of that exhaustion and fatigue was just the emerging neurological problem that I’d got.

Jonny: I was slightly different in the fact that I work in a specialty that was making my symptoms worse. Emergency department doctors thrive on adrenaline, because we never know what’s coming in through the door. It can range from a massive road traffic accident with multiple people to somebody with a splinter in their little finger.

So what was happening with me was, with the really serious cases, I was obviously… it was like fight or flight. You know, you felt yourself adrenalised. People remember from biochemistry days, or may not: adrenaline is made from noradrenaline, which is made from dopamine. So what was happening with me was, I was producing adrenaline from my dopamine stores, which I didn’t have a lot of, and therefore I was getting symptomatic. I would feel really stiff down my left side – it didn’t just tremor in my left hand – and I was absolutely exhausted.

So I was finding after those cases that I had to sit down for maybe 5 or 10 minutes just to reset. But it wasn't sustainable. I ended up having to get reasonable adjustments made in work, that *were* made – basically the trust have been very, very good, University Hospitals of Leicester, to enable me to still be working nine years after diagnosis.

If somebody told me in 2016 that I would still be working as an A&E consultant, nine years after diagnosis, I wouldn't have believed them. But here we are. I think it's probably down to the adjustments that have been made, and trying to live as best as I can, and having a support system around you that keeps you on the straight and narrow.

I always say having Parkinson's is like being a Weeble – which is those 1970 toys where you push them, you push them and they sort of want to keel over. But then they came back in the upright position. And I think Parkinson's sometimes makes you – not physically keel over, although I can do – sort of, you know, mentally. You can have a bit of a wobble, as I call it, and then people help you back.

Voiceover: One thing that many members of the Parkinson's support group have found very helpful is keeping physically active. It's also something that they've been promoting by example to others with the disease.

Richard: There's an important message, I think, around physical activity in Parkinson's which we've tried as a group – haven't we Jonny? – we've tried to promote and draw attention to.

Some of it relates to the general health benefits of keeping active as you get older, which is true for everybody. But beyond that, there are some important bits of positive messaging to make around physical activity. One is that there's growing evidence that physical activity itself may have some disease-modifying effects. Well, we strongly suspect that it has a disease-modifying effect. So it alters the course and the trajectory of Parkinson's. So, that's an important message to get out.

And to get the most benefit of that sort, all the evidence seems to be that you need to do quite a lot of quite vigorous exercise. So sitting in a chair – you know, lifting a beanbag up and down – isn't going to cut it. It's the sort of vigorous cardiac exercise that's going to get you hot and sweaty. So, you know, a spin bike class, going out for a long hard cycle ride, running for half an hour or an hour. These are the kind of things that are needed, really, to get that benefit.

The other bit of positive messaging, which I think sort of attaches to that, is that by making yourself active or keeping yourself active, if you're already doing sport and physical activity – it can be a source of hope. It can help people regain a sense of agency and feel that they're able to do something about their condition, rather than accepting in a nihilistic kind of way. 'There's nothing that can be done, it's just going to get worse. It'll just sort of run its course, whatever that may be.'

I think it's important for us who have this condition to feel that there are things we can do, that may make a worthwhile impact on it. Both in terms of prognosis and current symptoms. And that these are things that we have control over, these are things that we can do something about.

Jonny: Yeah that's right. I mean, I remember when I was first diagnosed, I didn't really know what to do. I read a lot of information from Parkinson's UK, but also a website in America called Davis Phinney, the Davis Phinney Foundation. He was an Olympic cyclist and in the Tour de France, and he was diagnosed at 41. So I sort of felt a bit of a connection to him. He had a young family at the time.

I'm obviously not a Tour de France cyclist, and I've never been in the Olympics – I don't think I ever will be! But I think exercise is really important. I joined a gym four weeks after I was diagnosed, and the gym trainer there didn't know anything about Parkinson's, but he said, what do you need? And I said, I need a cardio workout, a cardio session, and I need strength and I need balance. And he set up a programme for that, which was great. And I stuck at it.

But we, me and Richard, we sat and had a coffee this time last year, and we were trying to come up with a way of encouraging people in the group who maybe haven't exercised or not exercised for two and a half hours of high-intensity exercise a week, what we could do as a group to try to – together as a team – to try to encourage that. So we knocked a few things about and then we finally came up with one that we thought would work.

Richard: You're talking about the Great Wall of China.

Jonny: Yeah.

Richard: So, we came up with a challenge to take place over the course of a year. And over the course of a year – this was a team effort, so this wasn't sort of individuals within the group competing with each other, this was everybody working together – we were going to try and run, walk, bike, hike, swim, whatever.

Jonny: I even counted painting the garden fence because I got sweaty.

Richard: A distance equivalent to the length of the Great Wall of China, which we took to be about 21,000km. So the good news is we've just finished it, haven't we? Just this week.

Jonny: Yeah, this weekend. We did it.

I think what it showed was, 21,000km seems like a massive distance. But actually, if you do your two and a half hours of exercise a week, it's what you should be doing anyway, so it shouldn't be, you know, an increase or a decrease. Now that it's finished… I did an exercise class this morning, Richard's going to go for a run after this, so we'll still continue to do our exercising.

Next year we'll try to encourage a few more people from the group maybe, to just join in. I think maybe going to the moon and back might be a bit far, but we'll see. We'll see.

Richard: Well, I did wonder about that, yeah…

Jonny: Around the world. I don't think we'll do it in 80 days.

Richard: I thought about that as well. We might need a bit more than a year to do that.

Jonny: It could be a two-year challenge, or a five-year challenge. So yeah. It's been very helpful. It's really good, so.

Voiceover: Talking about other, lesser-known effects of the disease is really important too. Its mental impacts can be even more debilitating than the physical ones, especially for younger people with early-onset Parkinson's.

Jonny: Parkinson's is defined as a movement disorder, but it's not just a movement disorder. So movement disorder, motor symptoms, but it's also a normative disorder or a disorder of the mind, in a sense. Some of the symptoms involve the head.

And, you know, I don't think that's very well recognised. A lot of people, especially younger people, have more problems with their non-motor symptoms. And those non-motor symptoms are more disabling than the motor symptoms, and I don't think they're addressed as well as the motor symptoms. Or do you think that's a fair comment?

Richard: Yeah, no, I think it's a very fair comment, and it comes back to what you were saying earlier about, you know, the popular stereotype of someone with Parkinson's is an old man, hunched over, sort of shuffling along with a tremor that's a bit worse on one side than the other. But there's so much more to Parkinson's than tremor, and mobility problems – important though those are, there's a lot more going on. Certainly what's going on, sort of emotionally and mood wise, is kind of complicated and, you know, a real problem in its own right as well.

There's a double whammy for us there, really, because on the one hand, there are neurochemical changes in our brains that make us more susceptible to becoming depressed and anxious. But in addition to that, there's another whole layer of relationship that's to do with the emotional impact of having a disabling or potentially disabling condition, and the uncertainty about the future, and there's a kind of psychologically mediated emotional response which affects us as well.

Jonny: Yeah, I think that's right. I think what's missing in the UK, within the services, is the psychological support at diagnosis. I think the first year or two years are really, really important. It's just not there. And a lot of people end up trying to learn about it themselves, learn about it through other people who have the condition, if they know anybody.

That was one of the reasons why the group was set up, because it does help people, psychologically to… not necessarily come to terms with it, but maybe start to learn about it, and then adapt. It is a condition that you need to adapt to and make changes as they occur.

Voiceover: There's a good reason why Dr Acheson has been able to continue working in emergency medicine for nine years after his Parkinson's diagnosis. He says his trust is understanding and has made reasonable adjustments for him.

Richard: So, Jonny, you talked earlier about the reasonable adjustments that needed to be made, with your working life, and how accommodating the trust had been. Can you say a bit more about what form those adjustments took? What had to change?

Jonny: The first thing that happened was after I was diagnosed, that day my neurologist said to take four weeks off work. I think that was a really key bit of advice, because it gave me time to go and learn about the condition and try to start to get my head around it. I mean, I'm still getting my head around it nine years later.

But the neurologist that I saw wrote to occupational health, and the occupational health team were very good. So the first thing that happened was, I was taken off on-call pretty much immediately. An A&E consultant in Leicester, where I work, when they're on-call, they work from 6pm to 1am. Then they go home if they think the department's under control, and if not they stay on a bit. And you get in the door expecting to be phoned potentially through the night.

My kids were 10 and six when I was diagnosed, and they were up jumping on the bed at 7am. So I felt naturally tired. Whenever the on-call was taken off, what was really good was, my life suddenly became organised. I was working 8am until 6pm, and I was able to plan things in, so I could plan to exercise. So that was really good.

After about a year, maybe 18 months, I stopped working in resus because I was just finding that it was making my symptoms worse. I couldn't really manage it.

I was very fortunate to be in the position that adjustments could be made. And you can still add value. Last week there was someone who presented with one thing, and actually it turned out to be another diagnosis. And the registrar said to me, how did you know? How did you know that? And I was like, well, it's just seeing loads of patients over many years of being a doctor.

And, you know, that was a good confidence booster. Because you can still add value despite the limitations that you've got.

I always said I would get to 50, when I was diagnosed. I got to 50 in November, and now I'm not really sure when to set the next thing. I mean, my daughter is 16 next year. When she leaves school, I think that's the time for me and my wife to sit down and go, right, I've been working with Parkinson's for 12 years now. Medicine has got the best years, probably, of my life, living with it. And I want to have some time not in medicine, but with the family, before I don't have any more time left.

Richard: I think that's really important, Jonny.

I think it's important in this discussion about, you know, how work impacts Parkinson's and reasonable adjustments, to consider that as and when the time comes to stop working – for whatever reason, whether that's on ill health grounds or because you're going to anyway, like I was – it's really important that you've got a plan. To feel that that next chapter in your life, after you stop being a clinician, is also going to be productive and good time, well spent – that it's not just all about things stopping, but, you know, new opportunities starting.

That's how I've tried to see it. When I retired three years ago, I retired completely; I de-registered and didn't really have any involvement with clinical medicine or teaching or anything. I've done a little bit of writing since then, but that's all. I've tried to see it as starting a new chapter in my life.

I've got no regrets about my career. I had a fantastic time, I really enjoyed being a doctor. But there has to be life after that. Particularly if you are obliged to stop working because of your circumstances of work, and the way that your Parkinson's has affected you. You need to have a plan for what you're going to do next and how to make the best use of, you know, what time you have available after that.

Voiceover: Being a doctor *and* a patient can make you feel very differently about your work. Alongside all the challenges, there can be benefits too, including greater insight and empathy.

Jonny: Training as a doctor, then suddenly becoming a patient, is a very humbling experience. And you see things from a totally different perspective. It's really on your life experience isn't it? So doctors who have a condition will be more empathetic to patients who have the same condition, and will, you know, try to be in a corner and advocate for them.

I walked into the department one morning, and I looked through the glass screen and a patient sort of beckoned me in. I could see that she was quite frail, and she was visibly tremoring, and her voice was very soft. So I leaned across, and put my ear to her mouth, and she said, 'I have Parkinson's, and I need my tablets.' And I said to her, 'So do I, and I am going to help you.' And she literally gave me the biggest squeeze of my hand that I've ever felt.

With Parkinson's, it's nearly like you have to integrate it into your life, because you have to learn how to live with it. It sort of becomes… not your friend, but like, you can't get rid of it, if you know what I mean?

Richard: A constant companion.

Jonny: A constant companion, that's a really good way to describe it.

I think, as doctors, there will be certain experiences in life of people who have had that influence, you know, how they react or how they interact with patients. We all do the best we can to treat people as best as we can in the circumstances that we're in. But I think there are certain people, patient groups, that you might spend that little bit longer with, and that's just a personal thing, and they really benefit from that.

So, Richard, throughout your career you saw lots of people with Parkinson's in your clinics. Having been diagnosed now three years, is there anything you would have wanted to tell them now?

Richard: Having sat at the other side of the table, I've clearly got a different insight into the condition, the subjective experience of having it, than I ever would have done before.

And even though I consider myself reasonably well-informed as a clinician about Parkinson's, there's so much that I know now that I didn't know then, to do with – well, a bit like some of the things we've talked about really – the importance of the non-motor symptoms and how that affects people, the way that people process the information about the diagnosis, the kind of impact it has on them and their families.

I understand that far better now than I did then. If I'd been diagnosed while I was working, it would have, I think, inevitably had an effect on my outlook and the way I related to patients who've got this condition.

Voiceover: Despite his health challenges, Dr Acheson has written a book about living with Parkinson's, called *When your neurons dance*. He's hoping it will help doctors and patients understand more about the disease.

Richard: So, Jonny, I know you have a book coming out in the near future. Do you want to just tell us a bit about that, and what led up to that?

Jonny: Yes, sure. So, I actually was diagnosed with testicular cancer in April last year, and I had surgery and chemotherapy. I was sitting recovering after the surgery, thinking to myself, how have I managed to get diagnosed with a condition, at 41, that's more common in older people? And how have I been diagnosed with a condition at 49 which is more common in younger people?

That's just the way life works. But I was sitting on the sofa recovering, and I thought to myself, I'm going to write down what I've potentially learned over the past nine years.

So I'll just read out a bit of the preface for you. The book explores the dynamic of how I as a patient had to learn to live with Parkinson's to enable me to keep practising. Because the truth is, at diagnosis, I didn't know very much about Parkinson's, but with education came the ability to adapt, and with adaptation came acceptance.

As a society, we like to comment on the extraordinary. And that's necessary. It's the extraordinary that inspires, lifts the bar on possibility and gives rise to invention. But this book is an effort to dissect the ordinary – a lived experience common to millions of people – in the hope of challenging how we think about the ordinary, to transform the everyday.

And the title, *When your neurons dance*. It seems like quite a strange title, but I was sitting and exercising one day, and I for some reason was watching a video of two neurons under a microscope, and I had my AirPods in. Whenever you exercise, neuroplasticity can occur, and that's when neurons are trying to make new connections, and that's potentially why exercise might slow down progression, because new pathways are made in the brain.

So I've called it *When your neurons dance* because whenever I was exercising that day, and when I still exercise, I still picture my neurons dancing, and I'm trying to reach out to make new connections. And they also do that when you learn new things, you take up new hobbies.

It's a book about adaptation and change. And it will help, hopefully, people who have been diagnosed with Parkinson's, and hopefully it will help people within medicine understand what it was like as me, as an emergency medicine doctor, to be diagnosed, and the effect that it had in work.

So I'm very excited. And we'll see what happens.

Voiceover: Thank you for listening to this episode of The Doctor podcast.

From 1 May, the BMA is running a survey to understand the experiences of medical students and doctors who are disabled, have long-term health conditions or are neurodivergent. This will help us identify areas which need improving so we can better focus our lobbying activity and raise awareness. The survey is open until 27 May – you can find the link in the show notes.

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