17 May 2012

Postgraduate Board

To consider

Health and disability in medical education and training

Issue

1. Council agreed to establish a working group to oversee the first phase of a review of health and disability in medical education and training. The working group will develop a comprehensive picture of the challenges faced by disabled students and trainee doctors and advise on potential areas for improvement in the support they receive.

Recommendations

2.

   a. We invite the Board to note the summary of progress on preparations for the review including the working group and other work already underway (paragraphs 8 to 22).

   b. We would also welcome any further suggestions from the Board on areas we should be exploring as part of the review.

Further information

3. If you require further information about this paper, please contact us by email: gmc@gmc-uk.org or tel. 0161 923 6602.
Background

4. We committed in the Education Strategy for 2011-2013, that:

   By 2013 we will also examine the challenges that doctors with disabilities face at all stages of education and training and any implications for the regulatory framework.

5. As a starting point, we sought legal advice on the extent of our duties and powers in relation to the Equality Act 2010. The Undergraduate and Postgraduate Boards considered the legal advice and we reported it to Council.

6. The advice was helpful in clarifying the legal position, but the Boards felt there are wider questions that need to be addressed around health and disability. In particular, we need to examine the implications for student and trainee progression through the different stages of medical education and training.

7. Council has therefore decided to establish a working group to begin a wide ranging review. The Chair and members of the working group have now been appointed and details are at Annex A. The Chair is Sally Hawkins. In addition, we plan to invite an external person with expertise in the law on equality and how it applies in this context.

Discussion

What will the working group be covering?

8. The working group will consider the following issues and questions.

   a. How can we promote effective support and clearer transitions which enable students and trainees to progress?

   b. How should reasonable adjustments work in practice and is there equity in the way these are administered across the UK?

   c. What has been the impact of the Gateways guidance including on selection into medical school, and will it be possible for all medical students with disabilities to complete foundation and specialty training?

   d. How do we ensure that an appropriate balance is struck between protecting the rights and expectations of students and trainees whilst maintaining standards and protecting patient safety?

   e. What has been the experience of students and trainees (including those with longstanding disabilities and those who become disabled during their education and training) in accessing advice, occupational health services and other support?
f. Mental health issues amongst medical students, and how they can be supported.

9. The working group will also examine the suggestion that there should be different categories of registration that would restrict the scope of trainees according to particular disabilities.

10. As well as disability, we think the review should also consider the challenges faced by those with transient and long-term health issues and the arrangements designed to support them.

11. The plan is that the working group will provide a report to Council by December 2012 setting out conclusions and recommendations.

12. The working group’s report will mark the end of the first phase of the review of health and disability after which it will be disbanded. We expect there will be a second phase of the review to be taken forward in 2013, but a decision on this will need to be made by the reconstituted Council due to start in January 2013.

What else is happening?

13. We are undertaking several other pieces of work this year which support the review.

We held a roundtable with disabled students and doctors

14. In February, we held a roundtable meeting with disabled medical students and doctors. We heard a range of experiences. Issues raised included the value of guidance for disabled doctors early in their career, peer support networks, and the role of occupational health. A report of the discussion is at Annex B.

We are commissioning research into student mental health

15. We are commissioning research to develop a clearer picture of mental health issues amongst medical students and how they are supported.

16. The primary aim of the project is to produce guidance that will be helpful to medical schools.

17. An operational group, chaired by Stephen Whittle, is overseeing the commissioning of the research. The group held its first meeting on 7 March.

We will be issuing a statement to key interests

18. We will be issuing a statement explaining the current legal position on disability at all stages. This is aimed at key interests – particularly medical schools and deaneries where there have been calls for more clarity. A draft is at Annex C.
19. The statement follows the legal advice we have received about the implications of the Equality Act 2010.

20. The statement also provides details of the practical advice produced by the Higher Education Occupational Physicians/Practitioners (HEOPs). As members will know, HEOPs is a group of occupational health physicians and practitioners providing occupational health services for higher education institutions in the UK.

We will be establishing a reference group to gather views

21. As the work progresses, we think it will be important to capture the opinion of students, trainees and those who plan medical education and training. We are therefore establishing a reference group with which we can seek and float ideas.

22. We plan to hold a meeting in the autumn to test the early themes emerging from the working group on possible ways forward.

**Recommendation:** We invite members to note the summary of progress on preparations for the review including the working group and other work already underway.

**Recommendation:** We would also welcome any further suggestions from members on areas we should be exploring as part of the review.

**Resource implications**

23. We anticipate that costs associated with the working group will be in the region of £8,000.

24. In addition, the mental health research is expected to cost in the region of £50,000.

**Equality**

25. The issues which the Working Group will consider go to the heart of our commitments in the Education Strategy 2011-13, about our aspirations for a regulatory framework which promotes equality of opportunity and excellence in education.

26. We recognise there are students and doctors who need particular support through their career. This may include reasonable adjustments for doctors with disabilities and flexible working for those who are carers. The working group will need to consider our role as regulator, the continuum of education and how we can bring about change which maximises potential for students and trainees whilst maintaining standards and patient safety.
27. In 2011, the Equality and Diversity Committee decided that, as part of our monitoring of equality and diversity in education and training, we should collect data on disability (and ethnicity); the Postgraduate Board decided in January 2012 that this should be done through the trainee survey. The collection notice supporting the opt in categories within the trainee survey will be revised to notify trainees that equality and diversity information collected through the survey will also be used to analyse trends in trainee’s progression outcomes. This will be implemented for the survey scheduled for spring 2012, enabling valuable data on the extent of disability amongst trainees to be available to the working group by the summer.

28. A full equality analysis associated with this review will be prepared shortly.

**Communications**

29. This paper will be published on the website.

30. A similar paper to this one was considered at the Undergraduate Board on 26 April 2012.

31. We will set up a page on our website to provide details of the review and updates as the work progresses.

32. The statement referred to in paragraph 18 will be published on our website.
6 – Health and disability in medical education and training – Annex A

Members of Health and Disability in Medical Education and Training Group

GMC Council members

Ms Sally Hawkins – Chair
Dr John Jenkins
Ms Ros Levenson
Dr Joan Martin
Professor Jim McKillop

External members

Dr Phil Cotton – nominated by the Royal College of GPs
Dr Tim Crocker-Buque – trainee nominated by the BMA
Ms Fiona Edwards – Surrey and Borders Partnership NHS Foundation Trust
Professor Amanda Howe – nominated by the Royal College of GPs
Dr Andy Kent – nominated by the Medical Schools Council
Dr Peter Nightingale – nominated by the Academy of Medical Royal Colleges
Professor Bill Reid – nominated by the Conference of Postgraduate Medical Deans
Ms Alice Rutter – student nominated by the BMA
Dr Martin Tohill – nominated by the Faculty of Occupational Medicine
6 - Health and disability in medical education and training – Annex B

Report of the disability roundtable on 15 February 2012

Attendees

Jane Atkinson
Ian Barton
Nirit Braha
Emily Burns
Dawn Edwards
Kirsty Houston
Alyssa Jacob
Patrick Jones
Hans Mathew

Paula Newens
Ranil Perera
Bill Reid
Anna Severwright
Duncan Shrewsbury
Rhianwen Stiff
Rogan Thavarajah
Kimberley Williams
Katie Young

GMC Council members

Joan Martin
Jim McKillop

GMC staff

Aishnine Benjamin
Elaine Bromberg
Paul Buckley
Mark Dexter
Martin Hart
Nathan Lambert
Paul Myatt
Undergraduate

Applying to medical school

1. It was felt that awareness of, and support for, disabled applicants to medical schools is better today than in the past.

2. However, attendees who started medical school in recent years still reported mixed experiences.
   a. Awareness of the GMC’s Gateways advisory guidance among disabled applicants to medical schools varies.
   b. When applying to medical schools disabled applicants often do not have anyone they can approach for independent advice.
   c. It would be helpful if disabled applicants could find out whether or not their disabilities would be likely to prevent them completing a medical degree before they pay to sit aptitude tests.
   d. One option might be for medical schools to help disabled applicants explore whether with reasonable adjustments they would be likely to be able to perform the practical procedures set out in Tomorrow’s Doctors. If not, there is no purpose in them applying.
   e. Occupational health assessments during application, however, when done in a certain way, can put off disabled applicants. Occupational health colleagues can sometimes appear unhelpful with a poor understanding of applicants’ disabilities. It was suggested occupational health staff should demonstrate more respect for applicants’ ability to manage their own conditions.

Once at medical school

3. It was felt that medical schools seem more ready than in the past to make reasonable adjustments for disabled students, but the picture is still mixed across and within medical schools. A range of points emerged.
   a. Some disabled applicants would prefer medical schools to be more proactive in offering them reasonable adjustments, whereas others would prefer medical schools to wait until they ask.
   b. Medical schools should avoid appearing to try and force reasonable adjustments on disabled students.
   c. There is little flexibility in medical schools’ timetables. This creates challenges for disabled students, eg making it difficult to arrange routine
medical appointments related to their disabilities, or having to miss a whole year when they only actually needed a few weeks off.

d. Having to see a different occupational health staff person for each clinical placement can be frustrating and create anxiety, eg ‘what if this is the one who won’t let me continue?’

e. It was suggested that a ‘passport’ with information about students’ disabilities and reasonable adjustments likely to be needed, which could be given to occupational health staff, could be very helpful.

f. Individual medical school staff or doctors have often been instrumental in encouraging and helping disabled students to overcome challenges. They were often acting in an unofficial capacity, and it should not be necessary, and is not fair to anyone, to rely on goodwill which not always be available.

g. Some disabled students are not aware they may be entitled to claim Disability Support Allowance.

Postgraduate issues

Transitioning from medical school to the Foundation Programme

4. It was felt the transition can be a difficult one for any student and that having a disability can make it more difficult.

a. Some attendees felt the Foundation Programme application process does not currently take sufficient account of applicants' disabilities and the implications for the relative suitability of different placements.

b. It was acknowledged that applicants should do their own research into placements. But it was felt that currently the application process does not support early access to advice and information which would help applicants to work out which placements are likely to be suitable for them to train in given their disabilities.

c. The Transfer of Information Form (TOI) does not work well. One problem is that some of the questions discourage disabled students from answering fully. Another is that sometimes the TOI does not reach the deanery until after allocations have been made and so useful information they do contain is not considered in allocation decisions.

d. Disabled students often fear, unnecessarily, applying for Provisional Registration with the GMC because of the health component of fitness to practise. It was suggested the GMC could do more to reassure them and differentiate having a disability from other kinds of fitness to practise concerns, for example, a criminal conviction.
Experience of training programmes more generally

5. It was noted that deaneries can tailor training programmes for disabled doctors. Several points were made.

   a. There tends to be lack of expertise among all involved and disabled doctors can feel they are passed ‘from pillar to post’ as they try and make sure that their placement goes smoothly.

   b. Occupational health assessments, as at the undergraduate level, are important, particularly at the point doctors with disabilities move from one placement to the next. Many disabled doctors report bad experiences.

   c. It was suggested that occupational health staff should be trained to focus more on actual functionality and not anticipated lack of functionality or a diagnostic label.

   d. It was also suggested it would be helpful to have access to some occupational health staff with expertise in the field of medicine.

   e. Again, as at the undergraduate level, it was suggested that some sort of ‘passport’ with information about a doctors’ disabilities and reasonable adjustments they are likely to need, would be helpful.

   f. There is still a lot of stigma around mental as opposed to physical health conditions within the profession which needs to be addressed.

Flexibility in training programmes

6. It was noted that flexibility within the current system of training is limited by the legal requirement for doctors to meet all competence standards for their programme.

7. Another factor is that at present all UK graduates have to do the Foundation Programme, which is deliberately very generalist. This is one of the issues the Review of the Shape of Postgraduate Training will consider.

8. A number of points emerged.

   a. Some felt that, although the position on competence standards means some doctors will not meet them and will be unable to complete their programmes on account of their disabilities, this was not unfair.

   b. Others felt it is unfair and there should be more flexibility to allow some competence standards to be missed out if disabled doctors intend to practise in a field that does not require those competence standards. This would require changes to the Medical Act and the structures of training.
c. One suggestion was that doctors with disabilities should be able to enter ‘agreements’ to restrict their future practice to reflect any competence standards they cannot meet because of their disabilities. They could enter training on the basis of the agreement.

d. It was suggested that disabled doctors who are unable to complete training programmes can continue to have a rewarding career at staff and specialist grade.

e. It was felt it is a waste of resources for a doctor to leave the profession prematurely, having spent years at medical school and possibly further time in postgraduate training.

f. Concern was expressed that there may currently be some medical students with disabilities who are not aware of the possible challenges they will face when they apply to the Foundation Programme. It was suggested the possible challenges need to be communicated urgently.

g. Also, good careers advice is needed while people with disabilities are still at medical school, so that they have an idea of what kind of career they may and may not be able to develop. Such expertise does not usually reside in one person. Instead, schools may need to arrange for several people, eg medical school staff, occupational health, and practising doctors with disabilities – perhaps through a mentoring scheme – to give advice.

**Doctors outside of education and training**

9. It was suggested that support is also needed for disabled staff and specialist associate doctors, and consultants. This is particularly the case as these doctors may be older and the likelihood of having disabilities increases with age. Account needs to taken of the possible progression of the impact of a disability with increasing age

10. There is also a need to make sure that continued professional development is accessible to doctors with disabilities.

**Attitudes of patients and colleagues**

11. It was reported that patients are generally more positive than colleagues, such as other doctors and nurses, about doctors with disabilities.

12. Patients seem to take it for granted that all doctors are equally competent, whether or not they have a disability.

13. Some patients also seem to feel doctors with disabilities can better empathise with what they are going through.

14. It was suggested that the GMC could help make clear that it is unacceptable for doctors to be negative about doctors with disabilities.
**Possible areas for action to be explored as part of the review**

15. It was suggested the GMC might explore the following.

   a. Creating a central resource of information and contacts to support students and doctors with disabilities and medical schools and deaneries.

   b. How to reassure students who may unnecessarily fear applying for Provisional Registration with the GMC, because of the health component of fitness to practise.

   c. The desirability of extending the existing Gateways advisory guidance to cover postgraduate training.

   d. The desirability and feasibility of a system of ‘restricted registration’ for doctors with disabilities, allowing them to practise only in certain areas and to bypass parts of training not relevant to their ultimate career destination. The US was identified as having such a system.

16. It was suggested the GMC might encourage other bodies to explore the following.

   a. How to improve careers advice for disabled students at medical school.

   b. How the Foundation Programme application process and TOI can be changed to better support students with disabilities.

   c. The desirability and feasibility of disabled students and doctors being able to enter into ‘agreements’ about their future practice which then allow them not to meet competency standards that are no longer relevant.

   d. The desirability and feasibility of disabled students and doctors having a ‘passport’ with information about their disabilities and reasonable adjustments likely to be needed.

   e. How to make sure there are occupational health workers with expertise in medicine available for occupational health assessments of doctors.
6 - Health and disability in medical education and training - Annex C

Statement on disability in medical education and training - May 2012

Background to this statement

1. This statement provides a summary of the legal advice we have received about the implications of the Equality Act 2010, and, in relation to the standards we set for medical education and training, how this affects students and trainees with disabilities.

2. In addition, the statement provides details of some practical advice which is available to support those making assessments of the capacity of medical students.

3. Finally, we have provided a brief update about our other work which is examining the challenges that students and doctors with disabilities face at all stages of education and training.

Setting this in context

4. Many disabled doctors are practising successfully in the medical profession alongside non-disabled colleagues. Indeed, patients often identify closely with disabled medical professionals who can offer a unique personal insight and sensitivity.

5. However, the journey through the medical education and training system is not always an easy one. In some cases, even with reasonable adjustments, it may not be possible for everyone to successfully and safely undertake all stages of medical education and training.

6. In preparing this statement, we are conscious of the challenges which medical schools and postgraduate deaneries face in determining the level of support available to students and trainees with disabilities. In making decisions about the progression of a student or trainee, they have to balance the rights and expectations of the individual against the requirement to maintain standards and protect the safety of patients.
7. We hope that this statement will help provide greater clarity about the legal framework and assist medical schools and postgraduate deaneries in considering the support and guidance which students and trainees need and deserve.

**What the legal advice covers**

**The legal questions**

8. We asked Counsel to advise on two issues:

a. Whether the provisions contained within *Tomorrow’s Doctors 2009* and *The Trainee Doctor* (the standards for undergraduate and postgraduate medical education and training respectively) were consistent with the Equality Act 2010; and

b. Whether they might discriminate against students with disabilities.

9. The summarised advice which follows, sets out the extent of the General Medical Council’s (GMC) duties with regard to the Equality Act 2010 – particularly our role as a qualifications body (see paragraph 11 below) and the duty to make reasonable adjustments.

10. The advice explains how the Act applies in the context of the standards we set for undergraduate and postgraduate (including Foundation and specialty) training. In particular, we would highlight the reference to competence standards and our role in ensuring that these are set and maintained at a level which means doctors are equipped for service and, most importantly, which protects patient safety.

**Equality Act 2010 – GMC duties**

11. In addition to being listed in the 2010 Act as a public authority, the GMC is also a ‘qualifications body’—that is, ‘an authority or body which can confer a relevant qualification’.

12. Under the 2010 Act a ‘competence standard’ is defined as ‘an academic, medical or other standard applied for the purposes of determining whether or not a person has a particular level of competence or ability’.

13. There are a number of provisions in the 2010 Act concerning disability discrimination. This includes the duty to make reasonable adjustments where a provision, criterion or practice, or a physical feature, puts a disabled person at a substantial disadvantage. The duty to make reasonable adjustments applies to a qualifications body, however, section 53 provides that:

‘The application by a qualifications body of a competence standard to a disabled person is not disability discrimination unless it is discrimination by virtue of section 19 (that is, unless it is indirect discrimination).’
14. *Tomorrow’s Doctors 2009* sets out the standards for the delivery of undergraduate medical education and specifies the outcomes that all students must meet by the time they graduate. This includes the requirement to undertake a range of practical diagnostic and therapeutic procedures as listed in Appendix 1 covered on pages 77 to 81.

15. Counsel advised that the outcomes and practical procedures in *Tomorrow’s Doctors* would be regarded by a Court as ‘competence standards’ for the purposes of the Equality Act 2010, and as such the GMC is under no duty to require adjustments that would alter the standard of competency required. Counsel also stated that reasonable adjustments, in relation for example to modes of assessment of those outcomes and procedures (except where the method of performance is part of the competence to be attained) may be made. Medical schools and/or deaneries which organise the delivery of medical education are responsible for putting those arrangements in place.¹

16. Counsel also drew a distinction between the situation of a medical student seeking access to the profession and that of a qualified doctor. A qualified doctor may choose a medical career that does not require them to demonstrate competence in all of the practical procedures listed in *Tomorrow’s Doctors*. However, the GMC is entitled to set competence standards that all medical students are required to meet at the point of graduation in order to ensure that:

- All medical students who graduate will practise in a way that maintains patient safety.
- Those who graduate have sufficient competencies and skills to meet employers’ service needs.
- Those intending to enter the medical profession know in advance with reasonable certainty the core practical requirements of medical practice in circumstances where they lack the knowledge and/or experience to take decisions as to later career specialisation and given that the GMC has no power to adopt any form of restricted or limited registration.

*Postgraduate education*

17. The standards for postgraduate medical education and training (including Foundation and specialty) are set out in *The Trainee Doctor*. This includes, on page 52, the core clinical and procedural skills which provisionally registered doctors are required to undertake.

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18. Counsel's advice on postgraduate education was similar to that we had received for undergraduate education. Thus, the standards in *The Trainee Doctor* and specialty curricula are considered to be competence standards in respect of the 2010 Act. The fact that there is no facility for a trainee with a disability to obtain an exemption from demonstrating competences in postgraduate medical education and training is unlikely to amount to discrimination.

19. Counsel also provided advice on section 10A(2)(f) of the Medical Act 1983 which states that the GMC may determine:

> ‘[A]rrangements for a person with a disability not to be disadvantaged unfairly by the disability while participating in a programme for provisionally registered doctors’ (that is, the first year of the Foundation Programme).

20. Counsel advised that this does not require the GMC to alter or lower the substantive requirements of the Foundation Programme or to grant exemptions from meeting its requirements; it merely empowers the GMC to make arrangements that will make it easier or possible for trainees with a disability to participate in the Foundation Programme (for example, by determining that a trainee should undertake placements in particular specialties).

21. We recognise that, in the earlier stages of medical education, difficult judgments have to be made by those assessing whether a medical students' health condition or disability might prevent them from meeting the outcomes in *Tomorrow’s Doctors 2009* or in *The Trainee Doctor*.

22. There is some helpful guidance we would highlight, produced by the Higher Education Occupational Physicians/Practitioners, ‘Medical students – standards of medical fitness to train’. We think this is potentially a useful tool to assist in the assessment of a student’s capacity to meet the outcomes we specify in *Tomorrow’s Doctors*.

23. The guidance was developed with input from occupational health physicians based within higher education institutions with medical schools, among others. It is mapped against the outcomes in *Tomorrow’s Doctors 2009*. It takes a functional approach, in that its aim is to support the assessment of what capacity is required to achieve the outcomes, rather than specify particular conditions which may or may not preclude a student from satisfactorily completing a degree in medicine.

**Other work we are taking forward on health and disability**

24. The issues covered in this statement are part of a wider review of health and disability which we are taking forward. To this end, we made a commitment in our *Education Strategy, 2011-2013*, to examine the challenges that disabled doctors face at all stages of education and training and any implications for the regulatory framework.

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25. We are establishing an expert working group to advise Council and make recommendations where they consider regulatory change may be necessary. In building a comprehensive picture, the group is expected to consider a wide range of issues including the process for supporting reasonable adjustments for students and trainees and the transitions between different stages of training. The group will also look at the suggestion that there should be different categories of registration.

26. In addition, we will be commissioning research into the support available to medical students and trainees.

27. On the theme of practical advice, we will also be undertaking a project to consider how we can provide more ‘real time‘ advice to assist medical schools and postgraduate deaneries in interpreting and applying our standards.

28. We will provide regular updates on our website and through the *Education Update* as the work on health and disability develops.