

**Gateways to the Professions**  
**Advising medical schools: encouraging disabled students**

**Supplement: review of disability discrimination legislation**

This legal review was conducted by the Open University project team as part of the development of the advisory guidance. The legal review was completed by February 2008 and does not reflect subsequent changes in the legal position. The review was not a statement of the law from the GMC nor was it intended as such and it should not be relied upon as such. The views expressed in the legal review do not necessarily reflect the views or policy of the GMC, either in February 2008 or since then, and should not be relied upon as such.



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## INTRODUCTION

The project team was delighted to be chosen to prepare guidance on attracting and retaining disabled people in the medical profession. We considered a review of the relevant legislation as a pre-requisite for guidance preparation. This paper summarises the results of that review.

Section 1 is an overview of the Disability Discrimination Acts (DDAs) 1995 and 2005, with references to the legislation for Scotland and Northern Ireland, and of the legislation applicable to medical education and training. We do not cover those aspects of disability discrimination legislation not directly relevant to medical education and training, such as the law on services to the public or the recent amendments on transport, for example.

Section 2 focuses on the GMC's own role as a Qualifying Body under Part 2 of the DDA 1995.

Section 3 draws on the recent Disability Rights Commission (DRC) formal investigation into health and fitness standards that can deter disabled people entering professions. The Investigation concerned nursing, teaching and social work, but refers to medicine.

Section 4 analyses some international legal sources, focusing on the position on disability discrimination and on medical education, in international law, in Europe, and in four comparable countries world-wide.

There is an executive summary on the next page. The legal sources are listed in the Appendix. Please note that our draft Guidance is structured to match the student's 'journey' through medical education and training (for ease of use in practice). This paper, with its legal focus, follows the chronology and structure of the legislation.

## EXECUTIVE SUMMARY

1. Disability discrimination legislation now applies to all aspects and all stages of medical education and training, as well as to the employment of trainees and fully qualified doctors.
2. The Disability Discrimination Act (DDA) 1995 as amended by the Special Educational Needs and Disability Act (SENDA) 2001 in Great Britain and equivalent provisions in Northern Ireland gave disabled students and prospective students rights in higher education, and made it unlawful to put disabled students at a substantial disadvantage and to fail to make reasonable adjustment to policy, procedure and practice. The more recent Disability Equality Duty (DED) marks a move forward from responding to the individual requirements of disabled students and to building a positive culture and embedding institutional change. Northern Ireland is implementing similar rules, though in some cases a little later than Great Britain.
3. Disability discrimination legislation affects every aspect of medical education and training in the widest sense, from first contacts with potential students to qualification and beyond. In broad terms it covers: marketing; student admissions and exclusions; recruitment; frontline services; estates; procurement; health and safety; making reasonable adjustments and reviewing support; social activities; teaching and learning; assessment and exams; competence standards; work placements; staff training; and employment practices. The legislation (Part 3 of the DDA 1995) also covers services to the public, lettings and access to the public, but these are not directly relevant to the core objectives of the project to develop guidance for medical schools, so are not covered in this paper. It should be noted that damages for disability discrimination in some cases are uncapped: if a disabled student were awarded life-long earnings and pension rights because unlawful discrimination had prevented him or her from practising as a doctor the damages could be substantial.
4. The best sources of information are the Codes of Practice and guidance issued by the Great Britain Disability Rights Commission (DRC) (now subsumed in the Commission for Equality and Human Rights, known as the Equality and Human

Rights Commission (EHRC)) and the guidance issued by the Equality Commission in Northern Ireland. The Code of Practice and revised Code on post-16 education set out comprehensive guidance on all educational aspects of the relevant law and its practical implementation. The two Statutory Codes of Practice on the Disability Equality Duty (one for England and Wales, the other for Scotland) and the Northern Ireland Equality Commission's *New disability duties on Public Authorities - A Guide for Public Authorities* give further guidance to public authorities (including the GMC, medical schools and postgraduate deaneries) on new duties designed to eliminate institutional discrimination and to develop a proactive approach by promoting disability equality in their policies, practices and procedures. The *Codes of Practice for Trade and Qualifying Bodies* set out the relationship and duties of bodies which regulate professional education and training (including the GMC). The August 2007 guidance *Understanding the Disability Discrimination Act - a guide for colleges, universities and adult community learning providers in Great Britain* provides clear and concise guidance on all these matters. A revised Code of Practice on *Trade Organisations, Qualifications Bodies and General Qualifications Bodies* is, pending ministerial and parliamentary approval, available in draft form (with the authority of non-statutory guidance)

5. One crucial issue concerns academic, health/medical or other standards used to determine whether or not a student or potential student has a particular level of competence or ability. The question is the extent to which such standards (called 'Competence Standards') are genuine and relevant and may be considered lawful even where they discriminate against disabled people. The Codes of Practice emphasise that although there is no duty to make reasonable adjustments in respect of the application of a competence standard (so long as it is genuine and relevant), such a duty does apply to the process by which competence is assessed.

6. Medical schools need to ensure that the standard of fitness to practise required for graduation itself, and the process by which a person's fitness to practise is assessed at that stage, comply with the DDA especially to ensure that the standard itself is genuine and relevant and that reasonable adjustments, where required, have been made during the assessment procedure. The separate but equivalent process by which medical schools

determine whether a prospective student is fit to register on a course also needs careful review, again to determine the lawfulness of the standard and the assessment process.

7. It can be hard for a disabled potential student to find out about the requirements for admission to medical school, fitness to practise standards and how they are assessed. In particular, it is important that students and potential students (and those who advise them) do not have unjustified fears about the General Medical Council (Fitness to Practise) Rules Order of Council 2004 which do not apply to students and only apply to registered doctors where their fitness to practise is called into question and the GMC commences an investigation.

8. Section 10(4) of the Medical Act 1983 made provision for the GMC to make adjustments for a person with a long-term physical disability during their training while provisionally registered. Since August 2007 this has been widened as a result of the Medical Act 1983 (Amendment) and Miscellaneous Amendments Order 2006 which replaced Section 10 with a new Section 10A. The GMC Education Committee is now empowered to make 'arrangements for a person with a disability not to be disadvantaged unfairly by the disability when participating in a programme for provisionally registered doctors'.

9. Shortly before it became part of the Commission on Equality and Human Rights, the Disability Rights Commission completed a statutory formal investigation into professional regulation within nursing, teaching and social work and disabled people's access to these professions. The legal review and the Interim and Final Reports of that Investigation make it clear that the DRC considered that its findings were also relevant to other health professions, including medicine. The Final Report made a formal recommendation that regulatory bodies repeal health and fitness standards and that regulatory bodies within medicine, dentistry and other non-nursing health professions should 'review the findings and recommendations of the DRC's investigation (including the analysis of the health and fitness standards regulatory frameworks) and consider their applicability to these other professions'. We therefore summarise the recommendations relevant to medical education and training.

10. In Section 4 we analyse the relevant law at international and European level and in four comparable common law countries.

One point to note is that a disabled doctor who is registered in another European Union Member State has the right to work in the United Kingdom by virtue of the rules on freedom of movement and freedom of establishment. Another is that in New Zealand's transparent regime, performance assessments are separate from the professional conduct process and from disciplinary tribunal hearings.

**SECTION 1**  
**OVERVIEW OF THE MAIN PROVISIONS OF THE DISABILITY DISCRIMINATION ACT APPLICABLE TO MEDICAL EDUCATION AND TRAINING**

11. The Disability Discrimination Act (DDA) 1995 made disability discrimination in employment unlawful and thus gave rights to disabled medical trainees because of their employment contracts with Trusts and Health Boards and to doctors throughout their careers. (Please note that the Armed Forces are excluded from the scope of the DDA.) The rights of disabled students/trainees were clarified and strengthened by Council Directive 2000/78/EC establishing a general framework for equal treatment in employment and occupation (usually called the EU Framework Directive) which made it unlawful from 2006 for employers to discriminate against vocational students on work placements.

**1. THE DEFINITION OF 'DISABILITY'**

12. Under the DDA, a disabled person is someone who 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'.

13. The definition has been clarified in statutory guidance published primarily to assist adjudicating bodies like courts and tribunals in deciding whether a person is a disabled person. The current *Guidance on matters to be taken into account in determining questions relating to the definition of disability* came into force from 1 May 2006. It replaced the original guidance, published in 1996 which remains relevant for cases relating to discrimination before 1 May 2006. This guidance applies to England, Wales and Scotland. Similar, but separate, guidance applies to Northern Ireland.

14. The guidance restates the Act's requirement that to have rights under the Act a person must have an impairment that is either physical or mental. Whether a person is disabled for the purposes of the Act is generally determined by reference to the effect that the impairment has on that person's ability to carry out

normal day-to-day activities. The guidance states that ‘it is not possible to provide an exhaustive list of conditions that qualify as impairments for the purposes of the Act. Any attempt to do so would inevitably become out of date as medical knowledge advanced.’

15. However, it includes detailed guidance in Section A6. ‘A disability can arise from a wide range of impairments which can be:

- sensory impairments, such as those affecting sight or hearing;
- impairments with fluctuating or recurring effects such as rheumatoid arthritis, myalgic encephalitis (ME)/chronic fatigue syndrome (CFS), fibromyalgia, depression and epilepsy;
- progressive, such as motor neurone disease, muscular dystrophy, forms of dementia and lupus (SLE);
- organ specific, including respiratory conditions, such as asthma, and cardiovascular diseases, including thrombosis, stroke and heart disease;
- developmental, such as autistic spectrum disorders (ASD), dyslexia and dyspraxia;
- learning difficulties;
- mental health conditions and mental illnesses, such as depression, schizophrenia, eating disorders, bipolar affective disorders, obsessive compulsive disorders, as well as personality disorders and some self-harming behaviour;
- produced by injury to the body or brain.’

16. Section A of the guidance also covers specific advice on mental illness, ‘persons deemed to be disabled’, excluded conditions and past disabilities. Under paragraph A12, ‘certain conditions are not to be regarded as impairments for the purposes of the Act. These are:

- addiction to, or dependency on, alcohol, nicotine, or any other substance (other than in consequence of the substance being medically prescribed);
- the condition known as seasonal allergic rhinitis (e.g. hayfever), except where it aggravates the effect of another condition;
- tendency to set fires;
- tendency to steal;
- tendency to physical or sexual abuse of other persons;
- exhibitionism;
- voyeurism.'

The guidance also explains that 'disfigurements which consist of a tattoo (which has not been removed), non-medical body piercing, or something attached through such piercing, are to be treated as not having a substantial adverse effect on the person's ability to carry out normal day-to-day activities.' Significantly, 'a person with an excluded condition may nevertheless be protected as a disabled person if he or she has an accompanying impairment which meets the requirements of the definition. For example, a person who is addicted to a substance such as alcohol may also have depression, or a physical impairment such as liver damage, arising from the alcohol addiction. While this person would not meet the definition simply on the basis of having an addiction, he or she may still meet the definition as a result of the effects of the depression or the liver damage.'

17. Section B of the guidance covers the factors to be considered in deciding whether the effects on normal day-to-day activities are 'substantial': the time taken to carry out an activity; the way an activity is carried out; cumulative effects of an impairment; how far a person can reasonably be expected to modify his or her behaviour to prevent or reduce the effects of an impairment on normal day-to-day activities; and the effect of environmental conditions. Practical examples are given. In most cases, where an impairment is subject to treatment or correction, the impairment is to be treated as having the effect that it would have without the measures in question (for example, the effect of hearing loss is to be measured in terms of the person not wearing their hearing aid; the effect of depression is to be assessed as what it would be if the person were not having counselling). The one exception is sight impairment: the effects of the impairment

are to be assessed with the person wearing spectacles or contact lenses, not without them.

18. Increased protection (from the point of diagnosis) for people who have HIV, cancer and multiple sclerosis came into force in December 2005. Section B of the 2006 guidance therefore sets out the Act's current provisions about progressive conditions. 'These provisions provide that a person with a progressive condition is to be regarded as having an impairment which has a substantial adverse effect on his or her ability to carry out normal day-to-day activities before it does so. A person who has a progressive condition will be treated as having an impairment which has a substantial adverse effect from the moment any impairment resulting from that condition first has some adverse effect on his or her ability to carry out normal day-to-day activities, provided that in the future the adverse effect is more likely than not to become substantial.' Further examples of progressive conditions to which the special provisions apply include systemic lupus erythematosus (SLE), various types of dementia, rheumatoid arthritis and motor neurone disease. The guidance points out that this list is not exhaustive. There is specific guidance on severe facial disfigurements.

19. Section C covers the issue of whether the effects of the impairment are 'long-term', together with issues relating to recurrent and fluctuating illnesses.

20. Section D deals with the issues arising from the Act's provision that an impairment will only be treated as affecting a normal day-to-day activity if it involves at least one of a list of capacities. These are:

- manual dexterity
- physical co-ordination
- continence
- ability to lift, carry or otherwise move everyday objects
- speech, hearing or eyesight
- memory or ability to concentrate, learn or understand
- perception of the risk of physical danger.

21. The guidance states that ‘Account should be taken of how far [an activity] is normal for a large number of people, and carried out by people on a daily or frequent and fairly regular basis.’ The guidance gives, for each of these capacities, many detailed practical examples of what does and does not constitute a ‘substantial adverse effect’ in order to help those who have to assess whether a person’s impairment brings them within the definition of disability for the purposes of the Act.

22. The statutory Codes and guidance make it clear that ‘People who meet the Act’s definition of disabled persons are protected whether or not they themselves might consider themselves to be disabled.’

## **2. DEVELOPMENTS IN HIGHER EDUCATION SINCE THE DDA 1995**

23. By 1999 the Quality Assurance Agency for Higher Education (QAA) had adopted its (non-binding) *Code of practice for the assurance of academic quality and standards in higher education*, including a section on students with disabilities.

24. The 1995 Act was then amended by the Special Educational Needs and Disability Act 2001 (SENDA) and the equivalent Order in Northern Ireland (SENDO). These prohibited disability discrimination in the education sector, including all stages of medical education. SENDA inserted a new Chapter 2 into Part 4 of the 1995 Act. This is why the DDA Rules on disability discrimination in education are usually called ‘Part 4’.

25. The post-16 education duties came into force in Great Britain in three stages. Since 1 September 2002 less favourable treatment of disabled students for reasons related to their disability has been unlawful; education providers have been required to make reasonable adjustments for disabled students experiencing substantial disadvantage. Since 1 September 2003 post-16 education providers have been required to make adjustments by providing auxiliary aids and services. Since 1 September 2005 they have had to plan and to make reasonable adjustments to the physical features of premises. As well as current students, potential students (applicants) and former students benefit from

these provisions. All these provisions are also in force in Northern Ireland.

26. The DDA 2005 placed a duty on all public authorities in Great Britain, when carrying out their functions, to have due regard to the need to:

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

27. This duty is referred to as the Disability Equality Duty (DED), or the 'general' duty. The overarching goal of the general duty is to promote equality of opportunity. Some authorities' 'specific' duties are discussed below.

28. In Northern Ireland the situation is slightly different for historical reasons. Three of the five duties listed above had already been introduced by Section 75 of the Northern Ireland Act, so the Disability Discrimination (Northern Ireland) Order 2006 that introduced a new duty to promote disability equality by promoting positive attitudes towards disabled people and encouraging participation by disabled people in public life. (Enforcement under the Act and the Order respectively follows different procedures.) Public authorities are required to draw up disability action plans in a set format showing how they propose to fulfil the disability duties in relation to their functions. Some public authorities, including some Health and Social Services Trusts and Boards, have been formally exempted because of the impending review of public administration in Northern Ireland but are being encouraged to make progress towards meeting these obligations during the

transition period. Queen's University and its medical school do not have an exemption.

29. The Disability Discrimination Act 1995 (Amendment) (Further and Higher Education) Regulations 2006 (2006 No 1721) ('the 2006 regulations') implemented (for the whole of Great Britain) the provisions of the DDA 2005 by laying down detailed rules and implemented the provisions of EU Council Framework Directive 2000/78/EC in respect of Chapter 2 of Part 4 of the DDA. The equivalent provisions in Northern Ireland are the Special Educational Needs and Disability (Northern Ireland) Order 2005 (Amendment) (Further and Higher Education) Regulations (Northern Ireland) 2006 which came into effect on 1 September 2006 and which, amongst other things, made it unlawful for employers to discriminate against disabled students/trainees in the arrangement and conduct of vocational placements, reinforcing a dual responsibility of education providers and employers to protect the rights of disabled students/trainees.

30. The Disability Discrimination Act 1995 was amended by both the Special Educational Needs & Disability Act 2001 (SENDA) and the DDA 2005.

31. Disability discrimination legislation in Great Britain thus now has five main parts of relevance to medical education, training and employment:

- Part 1 Definition of Disability
- Part 2 Discrimination in Employment
- Part 3 Access to Goods, Facilities, Services and Premises
- Part 4 Discrimination in Education
- Part 5A Disability Equality Duty

32. Part 1 is explained in detailed guidance. Parts 2, 3, 4 and 5A of the Act each have at least one Code of Practice issued by the then Disability Rights Commission (which remain current and available from the EHRC) and there is a guide by the Equality Commission for Northern Ireland on interpreting and implementing the Act. As noted above, Part 5A is not yet fully in force in Northern Ireland.

### **3. SUMMARY OF DISABILITY DISCRIMINATION LAW IN HIGHER EDUCATION**

33. The DDA 1995 as amended by SENDA 2001 (and SENDO in Northern Ireland) gave disabled students and prospective students rights in higher education, and made it unlawful to put disabled people at a substantial disadvantage and fail to make reasonable adjustments to policy, procedure and practice. Employed trainees and doctors have had rights under the employment provisions of the DDA since the 1995 Act came into force, clarified and strengthened by the EU employment framework directive from 2006.

34. Further and higher education providers, qualifications bodies and employers have five duties towards potential students, students, trainee doctors and employed doctors who meet the definition of disability in the DDA as amended:

- not to directly discriminate (on grounds of a person's disability);
- not to discriminate for a reason relating to a person's disability, without justification;
- to make reasonable adjustments;
- not to harass a disabled person;
- not to victimise anyone supporting a complainant under the DDA, whether or not they are a disabled person.

35. Before 2006 failing to make a reasonable adjustment could be 'justified' if it could be shown that the reason for failing to make such reasonable adjustment was substantial (that is to say, not just minor or trivial); and was also material to the individual circumstances of the particular case. However, the 2006 regulations removed the 'justification defence' previously available for failure to make a reasonable adjustment. Under the new rules, there is no longer any justification defence for treating a student less favourably than someone else, or failing to make a reasonable adjustment in such circumstances. One situation in which discrimination may be justified is in the application of a competence standard (see below). Separate from the question of

‘justification’ is the question of when a proposed adjustment is truly ‘reasonable’.

36. There are few court judgements on education cases. The best sources of guidance are the Codes of Practice and guidance for both Great Britain and Northern Ireland which give many useful examples and explanations.

37. It is important to note that Section 59 of the DDA 1995 provides that ‘Nothing is made unlawful by the Act if it is required by an express statutory obligation’. For example, the duty to make reasonable adjustments for disabled employees under Part 2 of the DDA would need to be read in conjunction with the Management of Health and Safety at Work Regulations 1999 which require employers to undertake risk assessments as to the health and safety of employees and the public. However, it is only in cases where a statutory obligation is specific in its requirements, leaving an employer with no choice other than to act in a particular way that the provisions of the DDA may be overridden. Section 59 of the Act is thus of narrow application, and likely to permit disability discrimination only in rare circumstances.

38. In some circumstances, it is justifiable to impose academic or other standards even if they would otherwise amount to discrimination. This issue of competence standards is discussed in Section 2 of this paper.

#### **4. MAIN THRUST OF CURRENT DISABILITY DISCRIMINATION LEGISLATION**

39. The DDA 2005 marked a move forward from the duty to respond positively to individuals’ requirements for parity and reasonable adjustments and towards building a positive culture change and a systematic review and amendment of discriminatory policy, procedures and practices. The DDA 1995 as amended by SENDA (and SENDO) had given disabled students and prospective students rights in education and training, and placed a duty on institutions to make reasonable adjustments to policy, practice and physical features. It also expected institutions to anticipate the requirements of all disabled students as a whole, the ‘anticipatory duty to make reasonable adjustments’, rather than wait to respond to individual requests as they arose. The 2005

duties, however, require those involved in medical education and training to be proactive in the elimination of institutional discrimination and to promote disability equality via a review of their policies, practices and procedures initially by conducting impact assessments and involving disabled people in the review, planning actions for change, and monitoring and evaluating improvements.

40. Education and training providers have a duty to promote equality for all disabled staff, students and potential students, not just specific individuals. They need to create a Disability Equality Scheme (DES) with the involvement of disabled people, to systematically plan to eliminate barriers and keep those plans under annual review monitoring the effectiveness of improvements. Education and training providers are thus now expected to create a DES every three years and review it annually.

#### **4.1. Potter case**

41. Principles to be followed emerge clearly from the leading higher education case under the DDA, *Potter v Canterbury Christ Church University* (Claim No. 5CL14216, 13 March 2007). Mr Potter, a wheelchair user, graduated in 2004 at a ceremony at Canterbury Cathedral. While other students were able to receive a handshake on the dais from the Chairman of Governors, he received only a greeting at the bottom of the steps because no ramp was provided to allow him access to the stage.

42. The fact that he was not greeted by the Chairman of Governors on the dais, because the dais was not made accessible to wheelchair users, placed him at substantial disadvantage. He was not able to participate fully and with dignity in the degree ceremony and so was awarded damages against the University. All educational institutions have a duty to anticipate the requirements of disabled people and the adjustments they could be making to student services in advance of requests. In this case, the University failed in their duty, to their cost, to anticipate the need for access to their awards ceremony.

#### **4.2. Legal proceedings: burden of proof; damages**

43. In any legal proceedings dealing with a complaint of disability discrimination or harassment or victimisation, where the claimant

(prospective student, student or former student) proves facts from which the court could conclude that the education provider acted in a way which is unlawful, the court will uphold the claim unless the education provider proves that it did not so act. In effect, it will have to prove that it did not discriminate. The burden of proof is with the education or training provider to show they did not discriminate. This may make it easier for claimants to win their claims. It should also be noted that damages for disability discrimination in some cases are uncapped: if a disabled student were awarded life-long earnings and pension rights because unlawful discrimination had prevented him or her from practising as a doctor, the damages could be substantial.

### **4.3. The Codes of Practice**

44. The main guidance in this complex area is the guidance published by the then Disability Rights Commission for Great Britain (DRC) and by the Equality Commission for Northern Ireland. Some Codes and guides have statutory authority while others give clear guidance which it would be unwise to ignore. The DRC has since merged into the Commission for Equality and Human Rights (EHRC) but the Codes remain current and available on the legacy commission archive pages of its website and from The Stationary Office.

45. For example, the DRC Code of Practice on post-16 education set out legal and practical guidance on how to comply with Part 4 of the DDA. It included comprehensive guidance (over 210 pages) on all aspects of the law and its practical implementation. More concise guidance is set out in the *Revised guide for further and higher education institutions* available to download from the EHRC website. The Northern Ireland *Disability Discrimination Code for Further and Higher Education* is similarly detailed. The *DRC Code on Trade and Qualifications Bodies* is also key to medical education and training, particularly to the GMC itself in its United Kingdom wide role as a regulatory authority (a revised code is expected to be published by the EHRC shortly) but also to the Postgraduate Medical Education and Training Board (PMETB) and possibly to the Royal Colleges.

#### **4.4. The impact of the disability legislation on providers of medical education and training**

46. The DDA has an impact on every aspect of medical education and training in the widest sense, from website and printed publicity, open days and first contacts with potential students to qualification and beyond. In broad terms it covers: marketing; student admissions/exclusion; recruitment; frontline services; estates; procurement; health and safety; making adjustments and reviewing support; social activities; teaching and learning; assessments and exams; competence standards; work placements; staff training; and employment practices.

47. This is all set out comprehensively in the Part 4 (and Northern Ireland Further and Higher Education) Codes. For reasons of space we do not restate all their provisions here. The advisory guidance to medical schools follows the structure of the Codes as closely as possible, with special reference to the post-16 education Codes and frequent cross-references to help all those using it to comply with the Codes' legal requirements. This will enable those who use the guidance to have the essential information in the guidance itself and clear directions to all the information which they need.

#### **4.5. Legal position of medical students at undergraduate level**

48. Overall responsibility for complying with disability discrimination legislation within the higher education sector lies with the Governing Body of the University. The precise reference - for England and Wales - is to any 'institution within the higher education sector within the meaning of section 91(5) of the Further and Higher Education Act 1992 (1992 c.13)'; in Scotland, the reference is to 'Fundable bodies within the meaning of Section 6 and Schedule 2 of the Further and Higher Education (Scotland) Act 2005'. In Northern Ireland 'university' has the meaning given in Article 30(3) of the Education (Northern Ireland) Order 1993 (NI 12). Overall responsibility for medical schools' compliance thus lies with their university. St George's Medical School, London is responsible in its own right.

49. This means that a medical student has broadly the same status as a student in any other school, faculty or department. In most respects a disabled student has the same status under the DDA whether they are studying medicine or another subject. Disability Officers advise and support all the disabled students in the university, including those who are studying medicine. So, to take simple examples, a disabled student would be given support in obtaining wheelchair access to a lecture theatre or cafeteria, whether they were studying medicine or, say, chemistry.

#### **4.6. Legal position of medical trainees at post-graduate level**

50. Medical trainees at post-graduate level have a dual legal status, as trainees of a Postgraduate Deanery and as employees of a Trust or Board. Trusts and other employers of trainee doctors should be aware that disabled trainees have the same rights as other disabled employees under Part 2 of the Disability Discrimination Act 1995 (see below).

#### **4.7. Disclosure**

51. Unlawful discrimination does not occur if a student or potential student is treated less favourably for a reason related to their disability in circumstances when the provider did not know, and could not reasonably have known, that he or she was a disabled person. (The same goes for failure to make reasonable adjustments.) There is, however, a duty on education providers to seek to encourage disabled students to disclose their impairments throughout their course in order to promote cultural change and a positive acceptance. If it is clear that the person has an impairment, then the institution will be deemed to know and expected to act on making reasonable adjustments. Further, it should be borne in mind that in many circumstances reasonable adjustments should be made anyway as an anticipatory adjustment.

## 5. THE DISABILITY EQUALITY DUTY (DED)

52. The Codes explain that ‘The poverty, disadvantage and social exclusion experienced by many disabled people is not the inevitable result of their impairments or medical health conditions, but rather stems from attitudinal and environmental barriers....To deliver true equality of opportunity for disabled people requires more than treating them the same as everyone else’.

53. The DED is a requirement placed on public authorities to deliver better disability equality outcomes. They have to act proactively across the board rather than on an individual basis. This institution-wide approach complements the individual rights conferred by the DDA.

### 5.1. General duty

54. The general duty (under Section 49A of the Act) requires all public authorities (unless exempt in Northern Ireland) to have ‘due regard’ to the need to:

- promote equality of opportunity
- eliminate unlawful disability discrimination
- eliminate disability related harassment
- promote positive attitudes towards disabled people
- encourage participation by disabled people in public life
- take account of people’s disabilities even if this means treating them more favourably.

‘Due regard’ means taking action ‘in proportion to its relevance’ (2.34). This is an important principle in prioritising the action to take.

## **5.2. Specific Duty: Disability Equality Scheme (DES) in Great Britain**

55. In Great Britain, the GMC and medical schools (as part of their University) also have a specific equality duty. The specific duty is to publish a Disability Equality Scheme (DES) every three years and review it annually showing how the organisation intends to fulfil its general and specific duties. The August 2007 guidance sets this out at page 26. The DES should be prepared or at least signed off by the Vice-Chancellor or equivalent (3.116 of the Code).

56. Preparation of the Scheme must involve (not just consult) disabled people who appear to have an interest in the way the organisation carries out its functions in the development of the Disability Equality Scheme (where appropriate by using representative groups) (3.7). This means disabled staff, students, community members and organisations of and for disabled people. Schemes must include a statement of the way in which disabled people have been involved in its development (3.8). Similarly, disabled people are to be involved in monitoring the success of initiatives taken (3.11). An Action Plan must list the steps to be taken. The provider must state how the information gathered will be used to review the Action Plan and set out the methods for assessing the impact of policies and practices on disability equality. All these requirements are set out in more detail, with practical examples, in the Code.

57. Often public authorities wish to develop joint equality strategies and impact assessments (including disability, race and gender issues) which have the advantage of convenience and may be able to deal with potential multiple discrimination. However, public authorities must comply with the distinctive legal requirements for all three duties. There must be an impact assessment of each major policy and of each minor policy with potential major impact on disabled people (3.36). There is likely to be a 'back catalogue' of policies and activities which need to be assessed (3.40). Some more urgent policy and procedure assessments and reviews may take precedence where there is evidence that they have a substantial adverse impact on disabled people.

58. The DED also applies to contracting out and purchasing services from private and voluntary organisations.

### **5.3. Disability action plans in Northern Ireland**

59. Since 1 January 2007 public authorities are required to draw up disability action plans (in a set format) showing how they propose to fulfil their disability duties. Some public authorities, including Health and Social Services Trusts and Boards, are currently technically exempt because of public service reorganisation but working informally with the Equality Commission. Queen's University and its Medical School do not have an exemption.

### **5.4. Employment provisions of Part 2 of the DDA**

60. Part 2 of the DDA aims to prevent discrimination against disabled people at work, applying for work or training and progressing in work. As explained above, this applies to medical trainees once they have an employment contract, and also to work placements (see below). The main provisions are that:

61. Direct discrimination (treating someone less favourably directly because of their disability) is unlawful.

62. Treating someone less favourably for a reason related to their disability without good reason is also unlawful.

63. Failure to make reasonable adjustments in all aspects of employment, including the working conditions, job description and tasks and the work environment, is unlawful.

64. Discrimination is outlawed in all aspects of employment and occupation including:

- Recruitment and selection including advertising jobs
- Retention of employees
- Promotion
- Training
- Harassment at work.

65. Unlike educational institutions, employers do not have an anticipatory duty; they are not required to make adjustments to their premises or working practices until they employ or interview a disabled person. Employers do, however, have to take reasonable steps to find out if someone is a disabled person – by asking appropriate questions in letters of invitation to interview, monitoring forms and, once a job offer is made, enquiring about reasonable adjustments.

### **5.5. Reasonable adjustments**

66. Employers must make reasonable adjustments to the workplace, to working practices and to the job description when required. Adjustments that may be considered reasonable include adjusting buildings and access to buildings, altering working hours or providing alternative equipment. However, not every adjustment will be considered reasonable and it is dependent on the circumstances in each case. Employers must show that they have looked into the costs of adaptations and what funding is available. Alterations to physical features, assessments and additional equipment may be funded by the Access to Work scheme at the local Job Centreplus.

67. Employers must show that they have considered the implementation of reasonable adjustments, looked at funding available and made every effort to retain disabled people at work.

### **5.6. Work placements**

68. Work placements which are undertaken as part of a vocational training programme are also covered by the Act. It is unlawful for work placement providers to discriminate in:

- selecting work placement candidates
- the terms of the placement
- dismissal.

69. Reasonable adjustments must be considered by employers offering placements. Education providers therefore must take a proactive role in negotiating reasonable adjustments to placements

with employers and obtaining the student's permission. Additional equipment and other adjustments may be provided via funding from the student's sponsor and/or Disabled Students' Allowances from Local Authorities. The university Disability Officer will assist disabled students in applying for such funds. Reasonable adjustments may depend on the length of the placement, as an adjustment which might be considered reasonable for a one-year placement may not necessarily be considered reasonable for a one-week placement. In 2006 the DRC published guides for employers in England and Wales (Disability Rights Commission (2006), *Employment: A practical guide to the law and best practice for employers* (and a parallel guide for Scotland) which give more guidance.

<p style="text-align: center;"><b>SECTION 2: ACADEMIC AND COMPETENCE STANDARDS AND QUALIFICATIONS BODIES</b></p>
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**6. DISABILITY DISCRIMINATION LEGISLATION ABOUT STANDARDS**

70. In this Section we focus on the parts of the post–16 education Code and the Trade and Qualification Bodies Code which deal with the law on academic and other standards, and the extent to which such standards may be considered lawful even where they discriminate against disabled people. (This is also covered in Section 3.16 of the DRC publication *Understanding the Disability Discrimination Act: A guide for colleges, universities and adult community learning providers in Great Britain.*) Similar considerations arise from the Northern Ireland Further and Higher Education Code.

**6.1. The need to maintain academic or other prescribed standards**

71. The DDA recognises that higher education providers may need to maintain academic or other prescribed standards (see sections 6.3-6.6 of the post–16 education Code).

72. Sections 4.23-5 of the post–16 education code state that under section 28S (6)-(8) of the DDA less favourable treatment (of disabled students) may be justified only if one of the following conditions is fulfilled:

- it is necessary to maintain academic standards
- it is necessary to maintain other prescribed standards
- it is of a prescribed type
- it occurs in prescribed circumstances
- the reasons are both material to the circumstances of the particular case and substantial.

## 7. QUALIFICATIONS BODIES

73. Sections 3.13 and 3.14 of the DRC *Code of Practice on Trade Organisations and Qualifications Bodies* explain that the Act makes it unlawful for a qualifications body to discriminate against a disabled person in relation to conferring professional or trade qualifications. However, the Act does not prevent organisations or bodies from treating disabled people more favourably than those who are non-disabled.

### 7.1. Definition of Qualifications Bodies

74. Section 14A (5) of the Act defines a qualifications body as an authority or body which can confer, renew or extend a professional or trade qualification. A professional or trade qualification is an 'authorisation, qualification, recognition, registration, enrolment, approval or certification which is needed for, or which facilitates engagement in, a particular profession or trade'. The Code specifically refers to the General Medical Council in this context. The Postgraduate Medical Education and Training Board (PMETB) also seems to be a qualifications body in that the Certificate of Completion of Training which it issues is a key route to inclusion on the Specialist Register and the GP Register which is necessary for appointment to relevant medical positions. The Royal Colleges may also be qualifications bodies. Responsible bodies of schools and further and higher education institutions are deemed not to be qualifications bodies; their duties under Part 4 of the Act are discussed elsewhere in this review.

75. The five forms of discrimination which are unlawful are the same as in other parts of Part 2 of the Act:

- direct discrimination;
- failure to comply with a duty to make reasonable adjustments;
- disability-related discrimination,
- harassment and

- victimisation of a person (whether or not he is disabled) for making a complaint or giving evidence about alleged discrimination.

76. Section 3.19 of the same Code sets out the provisions of Section 14A(1) of the Act. In relation to conferring, renewing, or extending professional or trade qualifications (abbreviated to 'conferring'), the Act says that it is unlawful for a qualifications body to discriminate against a disabled person:

- in the arrangements it makes for the purpose of determining upon whom to confer a professional or trade qualification, or
- in the terms on which it is prepared to confer such a qualification, or
- by refusing or deliberately omitting to grant any application by him for a professional or trade qualification, or
- by withdrawing such a qualification from him or varying the terms on which he holds it.

77. Under Section 16B it is unlawful for those seeking candidates for qualifications to publish an advertisement (or cause it to be published) which indicates or might reasonably be understood to indicate:

- that the success of a person's application may depend to any extent on his not having any disability, or any particular disability, or
- that the person determining the application is reluctant to make reasonable adjustments.

78. If a disabled person or student can show that he or she has been treated less favourably than others for a reason relating to his or her disability, it is for the qualifications body to show that the action taken was justified for one of the reasons above and would have been valid even after a reasonable adjustment had been made.

79. The post-16 education Code sets this out in more detail in Chapter 5, from paragraph 5.70 onwards. The implications for qualifications bodies such as the GMC are explained in Chapter 8 of the *Trade Organisations and Qualifications Bodies Code*.

Briefly, there is no duty to make any adjustment to a provision, criterion or practice of a kind which the Act defines as a 'competence standard' if it can be shown to be genuine and relevant. However, the duty to make adjustments does apply to the process of assessing or demonstrating that a person meets the competence standard.

## **7.2. What is a competence standard?**

80. Section 28S (11) of the Act defines a 'competence standard' as an 'academic, medical, or other standard applied by or on behalf of an education provider for the purpose of determining whether or not a person has a particular level of competence or ability'. The standard has to be relevant to the course in question. For example, a level of knowledge or a particular practical skill would probably be relevant; requiring a person to complete a test in a certain time is not a competence standard unless the competence being tested is the ability to do something within a limited time period.

81. The Code states that 'sometimes the process of assessing whether a competence standard has been achieved is inextricably linked to the standard itself. The passing of an assessment may be conditional upon having a practical skill or ability which must be demonstrated by completing a practical test. Therefore, the ability to take the test may itself amount to a competence standard.' The Code states that this is relatively rare.

82. There is a special statutory test to assess whether disability-related discrimination of this sort is justified (see Chapter 6 of the Code). The test is whether the competence standard is genuine.

83. The Code emphasises that although there is no duty to make reasonable adjustments in respect of the application of a competence standard, such a duty does apply to the process by which competence is assessed. So an education provider needs to consider whether or not a reasonable adjustment could be made to some aspect of the process (see paragraph 5.70). Medicine is in a similar position to other professions (such as architecture and engineering) where both intellectual and practical abilities are required but may be demonstrated in creative ways by disabled

students using for example, personal assistants, British sign language, viva, audio transcription or other preferred communication methods.

## **8. LAW ON MEDICAL EDUCATION AND TRAINING**

84. The Medical Act 1983 ('the Medical Act') has been amended on several occasions. In this context the most important section is Section 5 (on the Education Committee's function of promoting high standards of medical education and co-ordinating all stages of medical education).

85. The current structure of postgraduate medical training was introduced by the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003 (2003 No. 1250) ('the 2003 Order'). Part 2 set up the Postgraduate Medical Education and Training Board (PMETB) and defined its role and objectives; Part 3 set out the rules on Education and Training. The Order expressly states in Section 3(12): 'The functions of the Board under or by virtue of this Order are without prejudice to the functions of the GMC or any of its statutory committees under the Medical Act.'

### **8.1. Core Education Outcomes**

86. The Medical Act sets out the GMC's duties and functions in relation to medical education. The GMC sets outcomes for undergraduate medical education in *Tomorrow's Doctors* (being revised for publication of new edition in 2009). In February 2006 the GMC Education Committee issued *Core Education Outcomes*, a position statement stating that: 'As long as they meet a university's regulations, anyone can graduate provided that they meet all the outcomes and curriculum requirements' (quoting *Tomorrow's Doctors*, paragraph 76).

87. *Core Education Outcomes* deals with the need for medical students to complete the core curriculum. It covers not just a person's inability to do so for reasons of disability, but also a person's wish not to do so on ethical grounds or even as a career choice.

88. *Core Education Outcomes* identifies two aspects of the distinct nature of a medical degree: ‘it is vocational and leads directly to entry into the medical profession’; and the ‘substantial direct and intimate contact with patients’.

‘All medical courses comprise two broad components: the core and options.... the core includes all the knowledge, skills, attitudes and behaviour that every medical graduate in the UK is expected to demonstrate. Two of the skills which are fundamental to the practice of clinical medicine are:

- The ability to “communicate clearly, sensitively and effectively with patients”, in order to elicit symptoms of illness and explain the diagnosis, investigations and management, and with colleagues from a range of health and other professions who may be involved in the patient’s care.
- The ability to “perform a full physical examination” in order to identify any signs of disease. This examination will include the need both to observe the appearance of the patient and to touch such parts of the body as may be relevant to the symptoms.’

89. The GMC restates that ‘by awarding a medical degree a university is confirming that the graduate is fit to practise as a PRHO [now known as an F1 trainee] to the high standards that we have set in our guidance to the medical profession, *Good Medical Practice*’ (restated from *Tomorrow’s Doctors*, paragraph 84).

90. The GMC calls on medical schools to ‘design detailed curricula and schemes of assessment to meet the knowledge, skills, attitudes and behaviour that we require of all medical graduates. The schools will need to consider what reasonable adjustments can be made to promote equality and value diversity, consistent with all graduates achieving our outcomes.’

## **8.2. MSC Guiding Principles for Admission 2006**

91. In 2006 the Council of Heads of Medical Schools (now the Medical Schools Council) issued revised *Guiding Principles for the Admission of Medical Students*.

92. The relevant paragraph is as follows:

'The medical school must evaluate whether there are particular circumstances that will preclude a candidate being able to practise as a doctor. Issues relating to a candidate's health will not be dealt with by an interview panel set up to assess personal qualities. Health matters will be separately considered by a Fitness to Practise Committee informed by an Occupational Health assessment. This process would be run in parallel with the general selection process. A disability, for example, need not be a bar to becoming a doctor if the student can fulfil the rigorous demands of professional fitness to practise as a newly qualified doctor. Students with disabilities should seek advice from medical schools well before the deadline for UCAS submissions so that their individual circumstances can be considered. Applicants are expected to declare a history of any serious physical or mental disorder, and each applicant's circumstances will be dealt with on a case by case basis. A history of serious ill health will not jeopardise a career in medicine unless the condition impinges on professional fitness to practise.'

93. The core qualities required of a doctor are stated to include 'good communication and listening skills'.

94. In the context of patient safety the principles state that 'Freedom from infection with blood-borne viruses is not an absolute requirement for those wishing to train as doctors, although an applicant who is a carrier must recognise that some areas, especially surgical specialties, will not be available as career choices. The nature of the medical course means that students found to be infectious carriers of blood-borne viruses on entry to medical school will need to comply with occupational health supervision and guidance from the responsible Head of Course to ensure they do not perform exposure-prone procedures.'

95. This principle may raise issues: blanket health and safety requirements for a group of people with a particular impairment or condition need careful consideration with reference to the DDA if they are not to be held unlawful.

### **8.3. Information for potential students about fitness to practise**

96. Many medical schools' and Postgraduate Deaneries' websites now have a section on disability and fitness to practise. The most common approach is to welcome applications from disabled students, offer advice from a Disability Officer, stress the importance of being fit to practise, and refer to the GMC website. The best point of access to the GMC website for students is: [www.gmc-uk.org/students](http://www.gmc-uk.org/students). Websites themselves must be accessible to disabled people so that information is not denied them. It would be good practice to present a clear explanation of disability equality policies and practices in a range of formats.

### **8.4. Medical students: professional behaviour and fitness to practise**

97. In September 2007 the GMC and the Medical Schools Council jointly published a booklet on *Medical students: professional behaviour and fitness to practise*. This guidance makes it clear that fitness to practise covers the professional behaviour expected of medical students. On health, it states clearly that 'It is important that medical students are aware that their own poor health may put patients and colleagues at risk' (paragraph 37); the same section gives advice to students on this issue. The guidance makes it clear (paragraph 105) that medical schools' fitness to practise policies and procedures should 'include the need for reasonable adjustments to be made for those students who need them'.

### **8.5. Link between graduation and provisional registration**

98. The Medical Act has been changed to allow the GMC to request proof of fitness to practise before a graduate can provisionally register as a doctor. There is no longer an automatic link between graduation and provisional registration and the Act allows the GMC to consider the fitness to practise of graduates. Graduates complete a declaration form at the point of registration.

## 9. GMC FITNESS TO PRACTISE RULES 2004

99. For the avoidance of misunderstanding it is worth noting that the General Medical Council (Fitness to Practise) Rules Order of Council 2004 (2004 No. 2608) sets out all the detailed rules about the GMC's Fitness to Practise procedures. Under Section 35C of the Medical Act where an allegation is made to the GMC against a fully registered or provisionally registered person that his fitness to practise is impaired, fitness to practise shall be regarded as 'impaired' by reason only of:

- a. misconduct;
- b. deficient professional performance;
- c. a conviction or caution in the British Islands for a criminal offence, or a conviction elsewhere for an offence which, if committed in England and Wales, would constitute a criminal offence;
- d. adverse physical or mental health; or
- e. a determination by a body in the United Kingdom responsible under any enactment for the regulation of a health or social care profession to the effect that his fitness to practise as a member of that profession is impaired, or a determination by a regulatory body elsewhere to the same effect.

Although there is no provision on the face of the Order for reasonable adjustments to be made for a disabled doctor (only for a vulnerable witness) we understand that these are made in practice.

<p style="text-align: center;"><b>SECTION 3: DRC FITNESS STANDARDS FORMAL INVESTIGATION: LEGAL REVIEW</b></p>
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100. The DRC had the power to conduct two different types of formal investigation: a 'general' formal investigation looking at an area of concern with a view to finding solutions within a relevant sector; and a 'named party' formal investigation when the Commission had reason to believe that an organisation may be acting unlawfully (or may have done so previously). The Commission had special powers to take additional enforcement action if its suspicions were confirmed by the conduct of a named-party formal investigation. The EHRC now has these same powers.

101. The DRC made a general formal investigation in 2006-7 into professional regulation within nursing, teaching and social work and disabled people's access to these professions to see whether the present law and procedures are sufficient to protect disabled people from discrimination. They launched this investigation because the Commission were concerned that people with impairments and long-term health conditions are sometimes seen as not fit to work in these occupations and that barriers prevent them entering professional education and training.

102. This investigation covered England, Wales and Scotland. The GMC gave evidence to the investigation.

103. The analysis of the impact of statutory frameworks, carried out on behalf of the DRC by a team led by Levenes solicitors and published by the DRC in November 2006, also covered relevant standards and frameworks in medicine. This section therefore reproduces some of the relevant sections of that regulatory review as a valuable source of guidance. It should be noted, however, that the sections quoted below represent the views of the team which carried out the regulatory review, not necessarily those of the GMC, its partners in the project to develop guidance for medical schools or the project team.

## **10. LEGISLATIVE FRAMEWORK FOR THE MEDICAL PROFESSION**

104. The review noted that ‘The Medical Act 1983 sets out the statutory framework for the functions of the General Medical Council (‘GMC’) for England, Wales and Scotland.’ (The DRC review extends to GB only; the GMC covers the UK.) ‘So far as is material to this report, the GMC is required to have an education committee (with a general function of promoting high standards of medical education and co-ordinating all stages of medical education), registration decisions and appeals panels, an investigation committee and fitness to practise panels. The GMC maintains a register of medical practitioners and the qualifications that they are entitled to have registered. The GMC also has power to provide advice for members of the professions on standards of professional conduct and of professional performance and ethics, which cover education and registration.’<sup>1</sup>

## **11. FITNESS TO PRACTISE PROCEDURES**

105. The DRC review states that ‘The ‘General Medical Council (Fitness to practise) Rules Order in Council 2004’, permit the appointment of specialist health advisers to advise in relation to medical issues regarding a practitioner’s health and performance advisers to advise on performance. Case examiners can require a practitioner to comply with undertakings imposing limitations on their practice. Continuing or episodic conditions, including those in remission at the time of the hearing, may be taken into account when determining whether a practitioner’s fitness to practise is impaired by reason of adverse physical or mental health.’<sup>2</sup>

106. The DRC Regulatory Review states that under the Medical Act 1983, grounds on which fitness to practise may be regarded as impaired include ‘adverse physical or mental health’. ‘In a health case, s37 provides that a person who is unfit to practice through illness may be suspended or his registration may be made

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<sup>1</sup> Page 45 of the regulatory review.

<sup>2</sup> Page 45 of the regulatory review.

conditional on his compliance, during such period not exceeding three years as may be directed, with such requirements as the Committee thinks fit to impose “for the protection of members of the public or in his interests”. S38 contains a power to order immediate suspension after a finding of impairment of fitness to practise in cases where the Fitness to practise panel is satisfied that this is necessary for the protection of members of the public or otherwise in the public interest or in the best interests of that person.” There are rights of appeal against such decisions, as provided for in section 40 of the Act.’<sup>3</sup>

### **11.1. Competence standards**

108. The reviewers’ view is that in general ‘Analysis of the way that the DDA operates in relation to competence standards would suggest that the more general the fitness standard, the more likely it is to give rise to direct discrimination or disability-related discrimination and the less likely it is to be a legitimate standard.’ They conclude that ‘Closer consideration could be given to whether health-related criteria are necessary, whether they can ever be non-discriminatory and whether standards should instead relate to the ability of individuals to carry out tasks competently and safely.’<sup>4</sup>

### **11.2. Disclosure of health conditions and impairments**

109. The DRC review notes that ‘The General Medical Council, in exercising its functions in respect of a practitioner’s fitness to practise, has the power to require disclosure of information about and from the practitioner concerned. This may, in some circumstances, require a disabled person to disclose his or her impairment.’<sup>5</sup> We understand that the GMC can ask for information but has no power to compel a practitioner who is subject to a complaint to provide any information.

110. The DRC concludes that the review of legislation and guidance has shown that the requirement for disclosure of health conditions or impairments relevant to fitness to practise often has a

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<sup>3</sup> Page 175 of the regulatory review.

<sup>4</sup> Summary of findings, page 8 of the regulatory review.

<sup>5</sup> Page 45 of the regulatory review

statutory basis but that even a statutory duty to disclose 'is problematic for several reasons. Some people may not regard themselves as disabled at all or not disabled for the purposes of the DDA or according to the meaning they interpret the professional body or higher education institution is giving to "disability". Others may consider that their disability is irrelevant for the purpose of the position for which they are applying or decide not to disclose their disability for fear of the consequences such as rejection.'

### **11.3. DED: Private providers of health and care services**

112. The DED applies to all public authorities. The DRC review argued that the definition of public authority under the DED should have, as the DRC has argued in *R (Johnson) v Havering Borough Council*, the broadest interpretation possible so as to be capable of covering those employers providing health care services contracted by the public sector. (Note that on 30 January 2007 the Court of Appeal rejected this argument in this case [2007] EWCA Civ 26.)

### **11.4. DRC Final Report**

113. The Final Report of the DRC Formal Investigation called on regulators and representative bodies within medicine, dentistry and other non-nursing health professions to:

'Review the findings and recommendations of the DRC's investigation (including the analysis of regulatory frameworks) and consider their applicability to these other professions.'

There are specific recommendations in the Final Report for regulatory bodies, higher education institutions, employers and occupational health services. This is an important recent source of guidance for all those involved in medical education. The GMC have referred the Report to its Committee for Diversity and Equality for consideration of the recommendations for regulatory bodies. The Recommendations for Higher Education Institutions cover the need to maintain high professional standards while not pre-judging the professional competencies of disabled applicants;

work placements; occupational health services; arrangements for assessing competence standards; impact assessments and monitoring. For employers, the recommendations cover recruitment procedures, occupational health providers' role in making reasonable adjustments; monitoring; impact assessments; the consequences of non-disclosure; and testing for blood-borne viruses. For occupational health services, the recommendations cover the use of questionnaires; the need for a supportive ethos; raising standards; disability equality training; and employment of disabled occupational health professionals. More general recommendations focus on topics on how to overcome the unwillingness to disclose caused in part by enduring stigma and how to foster an inclusive approach.

## **SECTION 4 INTERNATIONAL COMPARISONS**

### **12. UNITED NATIONS CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES**

114. A central provision of this 2006 Convention is Article 4.1(e) which commits States to 'To take all appropriate measures to eliminate discrimination on the basis of disability by any person, organization or private enterprise'. The Optional Protocol provides access for individuals or groups of individuals to the Committee on the Rights of Persons with Disabilities. The United Kingdom has signed the Convention but not the Protocol and has not yet ratified the Convention. A UN Convention must be implemented by means of national legislation.

### **13. EUROPE**

115. At European level there are two parallel legal systems. Within the Council of Europe, the European Commission on Human Rights and the European Court of Human Rights can provide remedies for those who suffer discrimination by national authorities in breach of the European Convention of Human Rights. Within the European Union, the European Court of Justice rules on questions of European Law, including the Treaty-based rights of free movement and the Directives adopted to implement them.

#### **13.1. European Union**

116. The EU now has 27 Member States. In the field of professional medical qualifications the rules have been extended to other countries in the European Economic Area (Norway, Iceland and Liechtenstein) and to Switzerland.

## **13.2. Freedom of movement**

117. One of the fundamental principles of the European Union is that people have the right to move freely between Member States to work on an employed or self-employed basis. European Directives on recognition of qualifications are designed to facilitate that freedom of movement. The relevant Directive for medicine is [Directive 2005/36/EC](#), a consolidation directive which applies to all Member State nationals wishing to practise a regulated profession (including medicine) in a Member State other than that in which they obtained their professional qualifications, on either a self-employed or employed basis.

## **13.3. Equal treatment**

118. The other relevant EU legislation is Council Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation. This is the directive which has been implemented by the DDA 2005 and the 2006 regulations.

## **13.4. Case-law**

119. The leading EU case on discrimination in the medical profession is *Malika Tennah-Durez v Conseil national de l'ordre des médecins* (Case C-110/01 dated 19 June 2003: OJ C 184 02.08.2003 p5). It concerned the French authority's refusal to recognise the qualifications of a Belgian registered doctor because part of her training had taken place outside the EU. The European Court of Justice ruled that 'the medical training required by the Council Directive...may comprise training received even mainly in a third country, provided that the competent authority of the Member State awarding the diploma is in a position to validate the training and to conclude on that basis that it duly serves to meet the requirements for the training of doctors laid down by the directive'. It is likely that similar considerations would apply to a disabled doctor qualified in one Member State wishing to work in another. For example, in Germany Article 7 of the *Gleichstellungsgesetz* (Equal Treatment Act) 2002 (2122-1) provides for disabled people to qualify as doctors so long as they are 'not incapable of practising on grounds of health'. It would be unlawful to refuse a German-qualified disabled doctor permission

to work if he/she had been validly registered in Germany. This would be illegal on grounds of nationality rather than on grounds of disability, but the effect would be the same. Similarly, disabled UK-registered doctors could benefit from this rule when seeking to work elsewhere in the EU.

### **13.5. European Convention on Human Rights**

124. The European Convention on Human Rights (1950) protects (in their order in the Treaty) the right to life, prohibition of slavery and forced labour, right to liberty and security, right to a fair trial, no punishment without law, right to respect for private and family life, freedom of thought, conscience and religion, freedom of expression, freedom of assembly and association, right to marry and right to an effective remedy. Article 14 of the Convention prohibits discrimination in these terms:

'The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.'

Disability is an example of 'other status'.

125. However, the European Court of Human Rights has ruled consistently that Article 14 only confers rights when read together with other articles of the Convention (that is, the rights listed above). It has no independent existence, since it has effect solely in relation to 'the enjoyment of the rights and freedoms' safeguarded by those provisions.' (See *Abdulaziz Cabales and Balkandali v the United Kingdom*, an immigration case; Series A no. 94, p. 35, § 71). So in *Botta v Italy* (153/1996/772/973) a disabled person could not rely on the Convention in his complaint about lack of disabled access because there had been no breach of the rights and freedoms protected by the Convention. For this reason the European Convention is likely to be of very limited relevance to disabled students in medicine.

### **13.6. Disability Rights**

126. The main Council of Europe Convention in the field of disability rights is the revised European Social Charter adopted in

1996. Article 15 covers the rights of disabled people to social integration.

127. As mentioned above, Council of Europe Conventions, being international treaties, must be implemented in national law before they come into force, and individuals then pursue their claims in national courts on the basis of that national legislation. The DDA and the DED give effect to most of Article 15's provisions.

## **14. COMMON LAW JURISDICTIONS OUTSIDE EUROPE**

128. The most comparable countries internationally are those whose legal systems share the common law approach of the United Kingdom, such as Canada, the United States, Australia and New Zealand.

### **14.1. Canada**

#### ***Disability Discrimination law***

129. In 1982 Section 15 of the Canadian Charter of Rights and Freedoms was the first national Constitution to create equal rights specifically for people 'with mental or physical disability'. Similarly, in 1985 the Canadian Human Rights Act (R.S., 1985, c. H-6) prohibited discrimination on grounds of disability, and permitted 'special programs' designed to prevent, eliminate or reduce disadvantages suffered by (among others) disabled people. Under Section 17 of that Act 'A person who proposes to implement a plan for adapting any services, facilities, premises, equipment or operations to meet the needs of persons arising from a disability may apply to the Canadian Human Rights Commission for approval of the plan.' Once the plan is approved, there can be no complaint on grounds of disability discrimination.

130. Canada's federal system means that grounds of discrimination vary slightly at federal and provincial level. Two leading Canadian cases in the Higher Education field are summarised below.

131. In *Marsden v Canada (Minister of Human Resources and Skills Development)* [2007] 2 F.C.R. D-3; 2006 FC 1246 (18 October 2006) a visually impaired student suffered deterioration of his sight during his course. He went bankrupt in part because of student debt. Mr. Marsden returned to University part-time hoping to complete his degree. The Canada Student Loans Program (CSLP) determined that he did not have a 'permanent disability'. The Court ruled that the CSLP had applied the wrong definition of 'permanent disability': the definition required only that the permanent disability 'restrict' not prevent him studying completely.

132. In the *Arnold* case (*Arnold v. (Canadian Human Rights Commission) (re Canada (Social Sciences and Humanities Research Council (SSHRC))*) [1996] F.C.J. No. 1193; [1997] 1 F.C. 582; (1996) 119 F.T.R. 241 September 18, 1996) a dyslexic student applied unsuccessfully for a doctoral fellowship in law. The Court ruled that the procedure followed by the SSHRC for awarding fellowships did not comply with Federal law on disability; that correct application of law will not necessarily guarantee him the fellowship he seeks, but he was entitled to accommodation of and by the SSHRC for his learning disability.

### ***Medical Education and Fitness to Practise***

133. The Medical Council of Canada is responsible for promoting a uniform standard of qualification to practise medicine for all physicians across Canada. The qualification, known as the Licentiate of the Medical Council of Canada (LMCC), remains acceptable to provincial medical regulatory authorities. This ensures portability across the country, while continuing to guarantee that each province and territory maintains the right to grant the licence to practise medicine.

134. A 2006 article by Katherine Manders on *Disabled Medicine* in the Canadian Medical Association Journal (<http://www.cmaj.ca/cgi/content/full/174/11/1585>) noted the very small percentage of medical students in Canada and the US with a disclosed disability and called for the current approach - adjustment on an individual basis - to be complemented by an institution-wide drive towards inclusion in order to minimise the emotional impact on the individual student.

135. Further details are set out in *Maintaining standards in British and Canadian medicine: the developing role of the regulatory body* by Lesley Southgate (CHIME) and Dale Dauphinee (Medical Council of Canada):

<http://www.bmj.com/cgi/content/full/316/7132/697>

## 14.2. United States

### ***Disability Discrimination law: Americans with Disabilities Act (ADA) 1990***

136. The ADA prohibits discrimination on the basis of disability in employment, State and local government, public accommodations, commercial facilities, transportation, and telecommunications. An individual with a disability is defined by the ADA as a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment.

137. Title II of the ADA requires that State and local governments give people with disabilities an equal opportunity to benefit from all of their programs, services, and activities (including public education). State and local governments are required to follow specific architectural standards in the new construction and alteration of their buildings. They also must relocate programs or otherwise provide access in inaccessible older buildings, and communicate effectively with people who have hearing, vision, or speech disabilities. Public entities are not required to take actions that would result in undue financial and administrative burdens. They are required to make reasonable modifications to policies, practices, and procedures where necessary to avoid discrimination, unless they can demonstrate that doing so would fundamentally alter the nature of the service, program, or activity being provided.

138. One education case involved the failure to make adjustments for a university student with schizo-affective disorder. On 6 July 2006, the US Court of Appeals upheld the student's rights under Title II of the ADA, holding that state sovereign immunity was not a defence (*Toledo v. Sanchez*, 454 F.3d 24 (1<sup>st</sup> Cir. 2006)).

## **Rehabilitation Act 1973**

139. The Rehabilitation Act prohibits discrimination on the basis of disability in programs receiving Federal funding by Federal agencies of the executive branch, by Federal government contractors and/or under any program or activity that either receives Federal financial assistance or is conducted by any Executive agency or the United States Postal Service.

140. Requirements include reasonable accommodation for employees with disabilities; program accessibility; effective communication with people who have hearing or vision disabilities; and accessible new construction and alterations.

141. A deaf student claimed that the University of Texas had breached Section 504 of the Act by failing to pay for a sign language interpreter for him. Although the Supreme Court upheld his claim that signing fell within the scope of section 504, several of the justices indicated that he might not receive funding because he was unlikely to qualify under the university's (reasonable) means-testing criteria. (*University of Texas v. Camenisch*, 451 U.S. 390 (1981) 451 U.S. 390).

142. In another case the Supreme Court held that 'Nothing...limits the freedom of an educational institution to require reasonable physical qualifications for admission' (*Southeastern Community College v Davis*, 442 U.S. 397 (1979) 442 U.S. 397)

## **Medical Education and Fitness to Practise**

143. To obtain a medical licence in the United States, a doctor must have completed a medical degree from a recognised or accredited medical school, postgraduate training, and a national, standardised medical licensing examination that includes assessment of clinical skills. Some states have additional requirements. Medical licences are granted by state licensing boards. All doctors are required to reregister their licences every one to three years, depending on the state.

144. For more details see *Obstacles to maintaining licensure in the United States* by Frances E Cain, Regina M Benjamin, and James N Thompson, of the Federation of State Medical Boards: <http://www.bmj.com/cgi/content/full/330/7505/1443>

### 14.3. Australia

***Disability Discrimination law:  
The Disability Discrimination Act 1992 (DDA)***

145. This Act requires that people with disabilities be given equal opportunity to participate in and contribute to the full range of social, political and cultural activities. This includes equal access to the goods, services and facilities provided by tertiary education institutions.

146. The *Disability Standards for Education 2005* clarify the obligations of education and training service providers, and the rights of people with disability, under the DDA. The Standards give students and prospective students with disability the right to education and training opportunities on the same basis as students without disability. The Standards also address harassment and victimisation of a student with disability. Education providers are obliged to put in place strategies and programs to prevent harassment and victimisation..

147. An education provider must make 'reasonable adjustments' to accommodate a student with disability. An education provider should ensure that the student, or an associate of the student, has timely information about the processes for determining whether the proposed adjustment would cause unjustifiable hardship to the provider (and hence not be made). The provider should also ensure that these processes maintain the student's dignity, respect, privacy and confidentiality and may consider all likely costs and benefits, both direct and indirect, for the provider and the student

148. If a person thinks that they are affected by a breach of the Standards, they can make a complaint to the Human Rights and Equal Opportunity Commission.

149. In the Australian system legal rights under the DDA are combined with provision for Higher Education institutions to draw up Action Plans. This is seen as a way to reduce the risks of having complaints made against it under the DDA.

150. The leading case is *Hinchliffe v University of Sydney* ([2004] FMCA 85 (17 August 2004) [2004] FMCA 85). A student with

visual disability required special assistance in the provision of course materials. Although the university provided some material in standard format and other material in large print on A3 paper and on computer disk, the student would have preferred audio format or A4 large print format. The court decided on the facts of the case that the student failed to establish a case of indirect disability discrimination under Section 6 of the DDA.

### ***Medical Education and Fitness to Practise***

152. Traditionally, a six year Bachelor of Medicine and Bachelor of Surgery (MBBS) was the primary means of undergraduate training in medicine in Australia. All Australian medical schools are accredited by the Australian Medical Council (AMC).

153. Graduates then enter the medical workforce - primarily in the major public teaching hospitals - as pre-registration Interns for a period of twelve months. Before starting a vocational training program most doctors spend at least one more year after their internship working in the public hospital system to gain more clinical experience.

154 Upon successful completion of the vocational medical training and other requirements of the relevant College, a doctor will be awarded a Fellowship of the College. They will be recognised under various industrial instruments, the Health Insurance Act 1973 and, in some cases, state Medical Boards, as a Specialist in that particular discipline.

## **14.4. New Zealand**

### ***Disability Discrimination law The Human Rights Act, 1993 (No 82)***

155. The Human Rights Act covers people who have physical, sensory, intellectual or other impairments or mental health illness, those with disease or illness from organisms in the body (e.g. HIV, Hepatitis), reliance on remedial means (e.g. guide dogs) and loss or abnormality of structure or function.

156. All organisations that provide goods, services, public facilities, transport, employment, education, training and accommodation must provide reasonable accommodations for people who are defined as having impairments under the Act. This includes all aspects relating to providing an inclusive environment such as teaching practices, support services, the provision of enrolment information or course material.

### ***Health and Disability Commissioner Act, 1994 (No. 88)***

157. The Health and Disability Commissioner Act, the associated Code of Rights and the complaint process cover all health and disability services, including those in tertiary education environments such as Student Health and Counselling Services. The aim of this Act is to 'promote and protect the rights of health and disability service consumers', including those with impairments.

### ***Inclusive Tertiary Education Environment for Students with Impairments***

158. New Zealand has few recorded formal cases of discrimination in tertiary education. The preferred approach is conciliation. There is a *Code of Practice for an Inclusive Tertiary Education Environment for Students with Impairments*. In 1998, the New Zealand government introduced Special Supplementary Grants, paid to Tertiary Education Institutions to contribute to support for tertiary students with impairments with high support costs. The Special Supplementary Grant is said to have contributed to a significant increase in the number of students with impairments participating in tertiary education.

### ***Medical Education and Fitness to Practise***

159. Medical Education through New Zealand University Medical Schools is closely linked with that in Australia (see above).

160. The Medical Council of New Zealand has a transparent system of fitness to practise rules. The NZ Health Practitioners Competence Assurance Act 2003 requires the Medical Council of New Zealand to be satisfied that applicant doctors are fit for

registration and fit to practise. This is to ensure that doctors are able to perform the functions required to practise medicine.

161. Applicant doctors must declare if they have ever been, or are currently, affected by a physical or mental condition or impairment with the capacity to affect their ability to perform the functions required for the practice of medicine. The functions required of a practising doctor include:

- making safe judgments
- demonstrating the level of skill and knowledge required for safe practice
- behaving appropriately
- not risking infecting patients with whom the doctor comes into contact
- not acting in ways that impact adversely on patient safety.

162. Conditions that may impair a doctor's ability to perform functions required to practise medicine include:

97. alcohol or drug abuse or dependence
98. psychiatric disorders
99. temporary stress reaction
100. infection with a transmissible disease
101. declining competence due to age related loss of motor skills or the early stages of dementia, and certain other illnesses and injuries.

163. The procedure and tools for carrying out Performance assessments are set out in a handbook for the doctor being assessed (due to be revised shortly). Performance assessments are separate from the professional conduct process (previously known as the complaints process) and are separate from disciplinary tribunal hearings held by the Health Practitioners Disciplinary Tribunal (HPDT).

## SOURCES

### **Codes of Practice and Guidance**

#### **(a) Great Britain**

*Please note that the Disability Rights Commission (DRC) has been replaced by the Equality and Human Rights Commission (EHRC). The EHRC helpline contact details are at the end of this section.*

DRC guidance and statutory Codes of Practice can at present be accessed by using one of the following links and scrolling down to choose the particular Code:

[http://83.137.212.42/sitearchive/DRC/the\\_law/legislation\\_codes\\_regulation.html](http://83.137.212.42/sitearchive/DRC/the_law/legislation_codes_regulation.html)

[http://www.direct.gov.uk/en/DisabledPeople/RightsAndObligations/DisabilityRights/DG\\_4001069](http://www.direct.gov.uk/en/DisabledPeople/RightsAndObligations/DisabilityRights/DG_4001069)

#### *Post–16 Education Code*

*The revised Code of Practice for providers of post-16 education and related services:*

[http://83.137.212.42/sitearchive/DRC/newsroom/notice\\_board/2007/new\\_post-16\\_education\\_guidance.html#new\\_guidance](http://83.137.212.42/sitearchive/DRC/newsroom/notice_board/2007/new_post-16_education_guidance.html#new_guidance)

*Understanding the DDA, a guide for colleges, universities and adult community learning providers can be chosen from the menu:*

<http://www.equalityhumanrights.com/en/publicationsandresources/Disability/Pages/Education.aspx>

The Codes of Practice on the Disability Equality Duty both for England and Wales and for Scotland can be chosen from the menu:

<http://www.equalityhumanrights.com/en/forbusinessesandorganisation/publicauthorities/disabilityequalityd/pages/disabilitye.aspx>

*A Revised Code of Practice: Trade Organisations, Qualifications Bodies and General Qualifications Bodies is, pending ministerial*

and parliamentary approval, available in draft form (with the authority of non-statutory guidance):

[http://83.137.212.42/sitearchive/DRC/the\\_law/legislation\\_codes\\_regulation/codes\\_of\\_practice.html](http://83.137.212.42/sitearchive/DRC/the_law/legislation_codes_regulation/codes_of_practice.html)

*A practical guide to the law and best practice for employers:*

[http://83.137.212.42/sitearchive/DRC/employers\\_and\\_service\\_provider/employment/a\\_practical\\_guide\\_to\\_the\\_law\\_a.html](http://83.137.212.42/sitearchive/DRC/employers_and_service_provider/employment/a_practical_guide_to_the_law_a.html)

*Disability Discrimination Act: Guidance on matters to be taken into account in determining questions relating to the definition of disability:*

[http://83.137.212.42/sitearchive/DRC/the\\_law/legislation\\_codes\\_regulation/guidance.html](http://83.137.212.42/sitearchive/DRC/the_law/legislation_codes_regulation/guidance.html)

### **(b) Northern Ireland**

Northern Ireland Code of Practice

[http://www.equalityni.org/archive/pdf/FHECOP\(SENDO\).pdf](http://www.equalityni.org/archive/pdf/FHECOP(SENDO).pdf)

Northern Ireland SENDO briefing guides

[www.equalityni.org/site/default.asp?secid=home](http://www.equalityni.org/site/default.asp?secid=home)

Exempt Public Authorities in Northern Ireland

[www.equalityni.org/archive/word/PublicAuthoritiesExemptions.doc](http://www.equalityni.org/archive/word/PublicAuthoritiesExemptions.doc)

### **Legislation**

*Please note that (unless otherwise indicated) the sources show the version of the Act at the time it was passed*

Medical Act 1983 (current version)

[http://www.gmc-uk.org/about/legislation/medical\\_act.asp](http://www.gmc-uk.org/about/legislation/medical_act.asp)

Disability Discrimination Act 1995 (1995 Chapter 50)

[www.opsi.gov.uk/acts/acts1995/1995050.htm](http://www.opsi.gov.uk/acts/acts1995/1995050.htm)

Special Educational Needs and Disability Act 2001 (2001 Chapter 10)

[www.opsi.gov.uk/acts/acts2001/20010010.htm](http://www.opsi.gov.uk/acts/acts2001/20010010.htm)

Disability Discrimination Act 2005 (2005 Chapter 13)

[www.opsi.gov.uk/ACTS/acts2005/20050013.htm](http://www.opsi.gov.uk/ACTS/acts2005/20050013.htm)

Northern Ireland Act, section 75

[www.opsi.gov.uk/ACTS/acts1998/80047--j.htm](http://www.opsi.gov.uk/ACTS/acts1998/80047--j.htm)

The Disability Discrimination Act 1995 (Amendment) Regulations (Northern Ireland) 2004 (Statutory Rule 2004 No. 55)

[www.opsi.gov.uk/sr/sr2004/20040055.htm](http://www.opsi.gov.uk/sr/sr2004/20040055.htm)

The Disability Discrimination (Northern Ireland) Order 2006

[www.opsi.gov.uk/si/si2006/20060312.htm](http://www.opsi.gov.uk/si/si2006/20060312.htm)

The Special Educational Needs and Disability Order (Northern Ireland) 2005 (SENDO) (Statutory Instrument 2005 No. 1117 (N.I. 6))

[www.opsi.gov.uk/si/si2005/20051117.htm](http://www.opsi.gov.uk/si/si2005/20051117.htm)

The Special Educational Needs and Disability (Northern Ireland) Order 2005 (Amendment) (Further and Higher Education) Regulations (Northern Ireland) 2006 (Statutory Rule 2006 No. 332)

[www.opsi.gov.uk/sr/sr2006/20060332.htm](http://www.opsi.gov.uk/sr/sr2006/20060332.htm)

Further and Higher Education Act 1992 (1992 c13)

[www.opsi.gov.uk/ACTS/acts1992/Ukpga\\_19920013\\_en\\_6.htm](http://www.opsi.gov.uk/ACTS/acts1992/Ukpga_19920013_en_6.htm)

Further and Higher Education (Scotland) Act 2005 (2005 asp 6)

<http://www.opsi.gov.uk/legislation/scotland/acts2005/20050006.htm>

General Medical Council (Fitness to Practise) Rules Order of Council 2004 (2004 No. 2608)

<http://www.opsi.gov.uk/SI/si2004/20042608.htm>

General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003 (2003 No. 1250)

[www.opsi.gov.uk/SI/si2003/20031250.htm](http://www.opsi.gov.uk/SI/si2003/20031250.htm)

### ***Other sources on professional education***

Medical Schools Council, *Guiding Principles for the Admission of Medical Students*

[www.medschools.ac.uk/publications\\_and\\_guidance/documents/RevisedAdmprinciples-Nov2006\\_000.pdf](http://www.medschools.ac.uk/publications_and_guidance/documents/RevisedAdmprinciples-Nov2006_000.pdf)

List of Higher Education institutions in England and Wales

[www.hefce.ac.uk/UniColl/HE/](http://www.hefce.ac.uk/UniColl/HE/)

List of Higher Education institutions in Scotland

[www.opsi.gov.uk/legislation/scotland/acts2005/50006--e.htm#sch2](http://www.opsi.gov.uk/legislation/scotland/acts2005/50006--e.htm#sch2)

*DRC Formal Investigation: Review of legislation, regulations and statutory guidance within professional occupations* (November 2006) and regulatory review

<http://www.maintainingstandards.org>

*DRC Formal Investigation: Final Report: Professional regulation within nursing, teaching and social work and disabled people's access to these professions*

[http://www.maintainingstandards.org/files/Summary%20report\\_final.pdf](http://www.maintainingstandards.org/files/Summary%20report_final.pdf)

### ***International***

UN Convention on the Rights of Persons with Disabilities

<http://www.un.org/esa/socdev/enable/rights/convtexte.htm>

Directive 93/16/EEC on the free movement of doctors and mutual recognition of their diplomas, certificates and other evidence of formal qualifications (current status)

<http://eur-ex.europa.eu/LexUriServ/site/en/consleg/1993/L/01993L0016-20040501>

Council Directive 2000/78/EC (OJ No. L 303, 2.12.2000, p.16) establishing a general framework for equal treatment in employment and occupation (the 'Framework directive')

[http://ec.europa.eu/employment\\_social/news/2001/jul/directive78ec\\_en.pdf](http://ec.europa.eu/employment_social/news/2001/jul/directive78ec_en.pdf)

EU Higher Education Accessibility Guide (HEAG)

<http://www.european-agency.org/site/info/index.html>

European Convention on Human Rights

<http://www.echr.coe.int/NR/rdonlyres/D5CC24A7-DC13-4318-B457-5C9014916D7A/0/EnglishAnglais.pdf>

Revised European Social Charter

<http://conventions.coe.int/Treaty/EN/Treaties/Html/163.htm>

*US law*

<http://supreme.justia.com>

<http://www.usdoj.gov/crt/ada/cguide.htm>

*Australian law*

[www.humanrights.gov.au/disability\\_rights/education/education.html](http://www.humanrights.gov.au/disability_rights/education/education.html)

*New Zealand law*

[www.hrc.co.nz](http://www.hrc.co.nz)

## **Equality and Human Rights Commission and Northern Ireland Equality Commission**

*Disability Helplines*

England

Equality and Human Rights Commission Disability Helpline  
(England)

Freepost MID02164

Stratford upon Avon

CV37 9BR

Telephone: 08457 622 633  
Textphone: 08457 622 644  
Fax: 08457 778 878

#### Wales

Equality and Human Rights Commission Helpline Wales  
Freepost RRLR-UEYB-UYZL  
1<sup>st</sup> Floor  
3 Callaghan Square  
Cardiff  
CF10 5BT

Telephone: 0845 604 8810  
Textphone: 0845 604 8820  
Fax: 0845 604 8830

#### Scotland

Equality and Human Rights Commission Helpline Scotland  
Freepost RRLG-GYLB-UJTA  
The Optima Building  
58 Robertson Street  
Glasgow  
G2 8DU

Telephone: 0845 604 5510  
Textphone: 0845 604 5520  
Fax: 0845 604 5530

#### Northern Ireland Equality Commission

Equality House  
7-9 Shaftesbury Square  
Belfast  
BT2 7DP

Telephone: 028 90 500 600  
Textphone: 028 90 500 589  
Enquiry Line: 028 90 890 890  
Fax: 028 90 248 687