

**Education Discussion Document**  
Number 0.3

**Today's Disabled Students: Tomorrow's Doctors**  
**The Implications of the Disability Discrimination Act**

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*The views in this discussion document are circulated to stimulate discussion. They are not intended to represent the views of the Education Committee or the GMC and are entirely distinct from the outcomes and standards set in Tomorrow's Doctors.*

This is one of a series of documents reflecting perspectives on issues of contemporary importance to medical education. The documents are intended to be of interest to medical schools, GMC education visitors and the wider community, and to suggest further reading and issues to consider. The first three documents are:

- 1. Undergraduate Interprofessional Education by Hugh Barr (December 2003)*
- 2. Patient-Centred Care – Tomorrow's Doctors by Christine Hogg (March 2004)*
- 3. Today's Disabled Students: Tomorrow's Doctors by Anne Tynan (December 2006)*

## Disabled Students And Medical Education

The General Medical Council works with doctors throughout their careers from student days onwards, aiming to deliver and protect the highest standards of medical ethics, education and practice, in the interest of patients, public and the profession. For most disabled students, their career path into the medical profession is the same as that of any other student. There is therefore no reason why any special consideration should be given to their position.

This is not the case with all disabled students, however. Changes in disability legislation, combined with improvements in primary and secondary education of young disabled people, mean that medical schools are increasingly faced with making decisions with and about disabled medical students. This can be an exciting but challenging process for all involved, particularly when staff have not had the opportunity previously to explore such issues. It can also be a daunting process for the students themselves, often keen to lay claim to their rights under disability legislation but not always sure how to demonstrate that they can be fit to practise as doctors.

This discussion paper will explore these issues briefly, providing an overview of relevant disability legislation and the responsibilities of medical schools. One section explains the process of providing 'reasonable adjustments' which can make a significant contribution to the ability of disabled students to function competently. The paper goes on to explain why a strong cohort of disabled 'tomorrow's doctors' will help to build a medical workforce fit to serve the future population of the UK. The discussion paper concludes with a list of points that could be considered in visits, followed by a short annotated bibliography.

## Defining disability

The following definition underpins the content of this paper:

The Disability Discrimination Act (DDA) (1) defines disability as:

**a physical or mental impairment, which has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities**

This definition includes many long-term, fluctuating or progressive health conditions such as some mental health conditions, diabetes and multiple sclerosis.

This discussion document focuses on potential discrimination in the training and assessment of disabled medical students.

## **The Disability Discrimination Act 1995, Special Educational Needs and Disability Act 2001, The Disability Discrimination Act 2005**

The Disability Discrimination Act 1995 – known as ‘the DDA’ – provided new protection for disabled people in key areas including Education, Part IV of the Act. At the time, however, legislators recognised the inadequacy of this Part of the Act in relation to the complex nature of educational provision. In 2001, the Special Educational Needs and Disability Act 2001 (‘SENDA’) (2) amended Part IV by creating new duties for education providers including medical schools. Separate secondary legislation and Codes of Practice exist for Northern Ireland (3).

The Disability Discrimination Act 2005 (4) amended the DDA 1995, extending the Act to cover qualifications bodies and placing a new ‘Disability Equality Duty’ on all public sector authorities (including universities) from 5 December 2006. These two aspects are not explored here but it is important to note that medical schools must simultaneously protect students against disability discrimination and promote disability equality.

## **Legislation and ‘models of disability’**

The diligent implementation of legislation is not the only factor determining whether medical schools develop best practice in dealing with disabled medical students. Various ‘models of disability’ exist that can also determine the quality of the treatment that disabled students receive.

### **‘Social model of disability’**

According to this model, disability is not something inherent in those who have impairments but is created by society’s failure to remove physical, organisational and attitudinal barriers. If these barriers were to disappear, disabled people would be able to participate fully in society. This model encapsulates the ideas of the modern disability rights movement.

### **‘Medical model of disability’**

This is the more traditional model, reflective of thinking in the past regarding disabled people as ‘victims’ of their impairments. Disabled people need to be ‘cured’ by others (doctors, physiotherapists), and may need to strive to ‘fit in’ with the rest of society and adapt to it. This model is likely to become less influential with time as the impact of legislation begins to take root and as society recognises the need to ensure that barriers and prejudices are removed. However, it may remain the case for example that some people who acquire disabilities in adulthood will still pursue cures for their new condition, while also recognising that their disability is compounded by society’s failure to make adjustments.

### **Implications for medical schools**

The medical model’s perception that doctors have a role in ‘curing’ disabled people may mean that this model persists in some medical schools. Where this is the case, medical educators need to be alert to the potential impact

upon disabled medical students. Students may experience discrimination because of an assumption that they are 'not good enough' to be doctors or that they will be 'a danger to patients'. There may also be a well-meaning temptation to feel sorry for them, which could lead educators to overlook areas of legitimate concern about a student's fitness to practise. Finally, disabled medical students may encounter unreasonable attitudes when they are trying to negotiate legitimate 'reasonable adjustments'.

### **Responsibilities of medical schools in the training and assessment of disabled students**

### **Requirements of *Tomorrow's Doctors***

*Tomorrow's Doctor*' (5) sets the outcomes and standards relevant to Quality of Assurance of Basic Medical Education (QABME) visiting, in line with the GMC's role set out in the Medical Act.

The sections on 'Assessing student performance and competence' and 'Student health and conduct' are of most relevance to this document. Key points include:

Only those students who are fit to practise as doctors should be allowed to complete the curriculum and gain provisional registration. (70)

Medical schools must have robust and fair procedures, including an appeals process, to deal with students who are causing concern on academic and non-academic grounds, such as ill health... (71)

(The GMC has) no direct statutory role in matters of student health and conduct. However, the award of a medical degree automatically entitles the graduate to be provisionally registered by us and to practise under supervision as a doctor. As a result, we have a strong interest. The purpose of this guidance is to provide help to universities and medical students in dealing with matters of health or conduct. (75)

As long as they meet a university's regulations, anyone can graduate provided that they meet all the outcomes and curriculum requirements in these recommendations. Our view is that students with a wide range of disabilities or health conditions can achieve the set standards of knowledge, skills, attitudes and behaviour. Each case is different and has to be viewed on its merits. The safety of the public must always take priority. (76)

### **GMC Core Education Outcomes**

A Position Statement issued in February 2006 by the GMC Education Committee entitled *Core Education Outcomes* has provided further clarification (6). The document covers a range of diversity issues including disability. It states that the core component of all medical courses includes all the knowledge, skills, attitudes and behaviour that every medical graduate in

the UK is expected to demonstrate. Two skills which are fundamental to the practice of clinical medicine are:

- a. 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
- b. 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.

The implications for disabled medical students are quite straightforward: provided they can meet the outcome requirements, they can graduate.

### **Implications of the Disability Discrimination Act**

How do the requirements of the Disability Discrimination Act align with the above demands placed upon medical schools by the Medical Act and by the GMC's Education Committee?

In the first place, it is important to understand that the DDA does not necessitate any lowering of standards; hence, defining core outcomes is a legitimate process that does not in itself discriminate against disabled people.

The duties that the DDA imposes are the following:

- Medical schools **must not discriminate** against disabled students by treating them less favourably than others.
- Medical schools **must provide 'reasonable adjustments'** in situations where disabled students might otherwise be substantially disadvantaged. This includes making adjustments to physical features of premises where these put disabled students at a substantial disadvantage.

Meeting some requirements may be beyond the direct control of medical school staff – e.g. building access, liaison with external support services – and may therefore require discussion and negotiation with other departments or agencies as well as with the students concerned. This will certainly be the case when medical students are undertaking vocational placements in external organisations. However, medical schools retain responsibilities for their students. Staff must strive to ensure that disabled students can access every aspect of the teaching and learning environment, even if this is done via the provision of reasonable adjustments.

## Definition of a 'reasonable adjustment'

'Reasonable adjustment' is a legal term introduced under the Disability Discrimination Act 1995. It is not specified but refers to any arrangement that prevents a disabled person being placed at a substantial disadvantage in comparison with others who are not disabled. A reasonable adjustment may involve simply doing something in a different way or it may necessitate the provision of equipment or adjustments to physical features of buildings.

## Examples of reasonable adjustments

Before explaining the context in which they are provided, it may be useful to give some concrete examples of types of reasonable adjustments that medical schools might grant to disabled students. These are listed according to types of impairments and some reflect legal judgements made in cases brought by the Disability Rights Commission. Even if medical students are not the subjects of such legal cases, the judgements made can have implications for medical schools. This information is taken from *'Time To Take Stock: Disability and Professional Competence'* (7), which provides a more in-depth overview of each area with extensive information about legal cases including online links.

## Mental Health Difficulties

**Types of adjustments:** Flexible work schedules, extra rest breaks, access to necessary sources of support, agreed strategies for dealing with panic attacks etc.

### Legal case

#### **DRC/00/457 Withdrawal of job offer as civilian fingerprint officer with police force because of disclosure of history of manic depression**

This case contains helpful information relating to Health and Safety requirements.

## Dyslexia or Specific Learning Difficulties

**Types of adjustments:** use of tape recording equipment and computer software, colour coded paper.

### Legal case

#### **DRC/03/8637 Student with dyslexia refused place on Nursing degree course**

## Hearing Impairments

**Types of adjustments:** use of amplified stethoscope, radio microphones, induction loop systems, advance provision of lecture notes.

## Legal case

**DRC/01/253 Refusal to employ (in an NHS Trust) individual with severe hearing impairment on the grounds that he could not deal adequately with incoming phone calls**

### Physical Impairments or Mobility Difficulties

**Types of adjustments:** use of ergonomic and adapted equipment, provision of seating, extra rest breaks

## Legal case

**DRC/00/218 Failure of employer to make reasonable adjustments to accommodate mobility impairment**

### Reasonable adjustments for medical students in training

#### Reasonable adjustments: entitlement

Students are entitled to reasonable adjustments if their condition meets the legal definition of 'disability'. In isolated cases where an individual's mental or physical condition has not been definitively diagnosed, it may not be clear if he/she meets the legal definition and therefore has a legal entitlement to adjustments. Medical school staff might be advised to explore such issues with their institutional disability officers in the first instance. Good practice would be to consider the needs of the student rather than simply meeting the legal requirements.

#### Reasonable adjustments: outcomes of medical education

The duty to provide reasonable adjustments does not require medical schools to compromise essential academic or professional standards (cf. GMC *Core Education Outcomes*). Legitimate health and safety factors (which apply to everyone) have to be taken into account in deciding whether a particular adjustment is reasonable. There should therefore be no undue concern as to whether the provision of reasonable adjustments might create 'second class' doctors: the purpose of reasonable adjustments is not to change standards but to facilitate disabled people in being able to meet them. Additionally, the use of a reasonable adjustment is of no significance in itself but should simply be regarded as another tool enabling a particular individual to demonstrate competence as a doctor.

#### Reasonable adjustments: the cost factor

Many reasonable adjustments may simply involve doing something in a slightly different way to avoid a disabled student being placed at a disadvantage and have no cost implications e.g. lecturers make sure that they face students when talking to them during lectures; handouts are produced in a format suitable for all students; teaching rooms are chosen to meet the access needs of all students in a particular class.

Other adjustments may involve providing auxiliary aids or services such as computer software, an audio loop or a personal assistant, which may all involve a cost. The Disability Discrimination Act does not define the term 'reasonable', meaning that a court would be the final arbiter, but cost is a legitimate factor that must be considered. The financial cost may unfortunately be beyond the means of the organisation making the adjustment not a viable option.

Students who receive 'Disabled Students' Allowances' (DSAs) (8) from their Local Authority may be able to fund some costs in relation to their own specific needs from their allowance. Where this is not the case, or where making reasonable adjustments will result in additional costs that the medical school cannot meet within its current budget, discussions with the university disability service and the finance department might be necessary.

Since 1 September 2005, medical schools have been legally required to make reasonable adjustments to their premises where physical features might place disabled students at a substantial disadvantage.

### **Reasonable for: the disabled student**

Who must be considered when the impact of a reasonable adjustment is being considered? An adjustment must be reasonable in the first place for the disabled individuals concerned, allowing them to function using methods to suit their particular circumstances. Disabled students must necessarily be involved in determining reasonable adjustments being made for them, even though they may need assistance in establishing that the adjustments are appropriate for the situation in hand.

### **Reasonable for others: staff and students**

Assistance is often needed when establishing the potential impact upon others of a particular adjustment. Medical educators may not be able to meet some of the needs of a disabled student requiring support if this is likely to interfere with the ability to carry out other aspects of the teaching role e.g. through providing extra tutorials for disabled students. However, it is quite reasonable to ask lecturers to wear a radio microphone. Students with hearing impairments will benefit but there may also be benefits for other students as well. Reasonable adjustments may therefore help to improve the quality of the learning experience for all students without imposing excessive additional burdens on teaching staff (a common fear).

The role of other medical students in the process of providing reasonable adjustments poses interesting questions. Most adjustments will have no impact upon other students but some may create a ripple effect that must be considered. A student with a medical condition may request an adjusted work schedule, for example one that does not include night duties. Whilst in itself such a request might be reasonable, it may also result in other students having to work extra night duties. Each case must be considered 'in situ', with the necessary issues of confidentiality being clarified with the disabled student concerned. Situations may arise where a reasonable adjustment cannot be provided because a disabled student does not wish others to know about their condition. This creates a serious dilemma if it means that the student cannot

meet the requirements of the course. Disabled students have rights but they also have duties and responsibilities and (like all medical students) must be aware of the impact of their actions on others. This is the case when considering how a proposed adjustment might affect patients.

### **Reasonable for others: patients**

Disabled medical students must make the care of patients their first concern: this applies to all doctors without exception. Hence, the process of determining reasonable adjustments for disabled medical students must take into account the requirements of *Tomorrow's Doctors* (7) and *Good Medical Practice* (9). This is the only way to provide an ironcast guarantee that adjustments meet the test of being reasonable for patients.

For example, the litmus test of an adjustment for a student with a speech or hearing impairment is whether the adjustment enables the student to develop and maintain successful communication with patients. Although the student's communication methods might differ, the outcome must be the same. Similarly, adjustments for students with a mental illness that counts as a disability must be instrumental in facilitating their ability to deal with difficult situations and to cope with the high levels of stress they might create.

For many patients, encountering an obviously disabled doctor is likely to be a new experience. Medical schools might need to consider how they can assist disabled students in communicating information about reasonable adjustments to patients. This may only be necessary in situations where patients might need some reassurance about the fitness to practise of a student, e.g. the use of an amplified stethoscope might give rise to concerns that a patient might not want to address with the student directly. This is an issue of long-term importance, relating as it does to the pivotal role that disabled doctors will play in providing healthcare to the UK's increasingly ageing and therefore increasingly disabled population over the next century.

### **Reasonable adjustments and assessment**

The assessment of medical students is a crucial process for medical schools and – ultimately – for patients because it is how a student's competence as a doctor is determined. When considering reasonable adjustments and assessments, an important distinction must be made.

The ability to take many examinations, particularly those that are written, is not in itself an aspect of the skills or knowledge being tested. In this case, reasonable adjustments can generally be granted without difficulty. Hence, students who have dyslexia may be granted extra time for a written examination if taking longer to do the exam is no reflection on their fitness to practise. Where there is a difference between a skill and the process by which attainment of it is determined, there should not be an issue.

By contrast, the process of assessing an essential clinical or practical skill is often inextricably linked to the skill itself and may be the only way that it can be assessed. In this case, reasonable adjustments might not be appropriate if they were to change the very nature of the assessment and therefore prevent

the disabled student from demonstrating competence. Medical schools need to consider carefully what reasonable adjustments can be made without affecting the competency being measured. The ultimate goal of the medical school is to produce doctors who are fit to treat patients and this cannot be compromised for any student, whether disabled or not. This is particularly important in light of the potential that disabled medical students have to contribute to improved healthcare for future generations of patients.

### **The role of disabled doctors in the changing patient population**

Efforts to improve provision for disabled medical students will have a direct repercussion on provision for disabled patients and vice versa. If the physical environment of a hospital and the services that it provides are made more accessible for patients, disabled students will also benefit. Similarly, patients will benefit from the implementation of the social model of disability in the medical school environment.

Given changes to the UK's population, with growing numbers of people born with a disability surviving infancy, and with more people likely to live into their 90s and therefore more likely to become disabled, working with disabled medical students will help other medical students to be better equipped for the challenges ahead. Medical students need to be prepared to be doctors for their epoch while still at medical school. For many students, contact with a disabled peer will be the first step towards understanding the rights and perspectives of disabled people and therefore offering them better healthcare provision.

Tomorrow's patients will need generations of doctors equipped to deal with their needs. The successful integration of today's disabled students into medical schools is key to achieving the quality of workforce required for tomorrow.

## Questions that could be considered at medical schools

1. Do staff in the medical school understand that the Disability Discrimination Act relates directly to their work with disabled students?
2. Are staff familiar with the models of disability, and understand how they may either reinforce or undermine the effects of legislation?
3. To what extent does the medical school use the *QAA Code of practice for the assurance of academic quality and standards in higher education: Section 3: Students with disabilities - October 1999* as the basis for work with disabled students?
4. Have medical school staff taken any action in relation to recommendations made in the reports *Pushing the Boat Out* and *The Sequel* (listed in the bibliography)?
5. Have they begun to consider how *Time To Take Stock: Disability and Professional Competence* can help to inform best practice, particularly in relation to the provision of reasonable adjustments?
6. Does the medical school have procedures in place to ensure that the needs of disabled students are addressed at all stages of strategic planning and resource allocation?
7. To what extent are the physical environment and facilities of the medical school accessible, and how are any shortcomings being addressed?
8. Is there an identifiable line of responsibility within the medical school for disabled students, e.g. a named member of staff?
9. What procedures are in place to ensure that disabled students receive the appropriate levels of support?
10. Has the medical school established an efficient working relationship with the university-wide support services for disabled students, and with other external services as necessary?
11. What system has been put in place for considering requests for reasonable adjustments from disabled students?
12. Has the medical school established clear channels of communication in relation to disabled students and reasonable adjustments, taking into account confidentiality issues?
13. Are issues relating to disabled students included in staff development programmes for academic and personal tutors?
14. Is the medical school's assessment strategy inclusive of disabled students?

15. Are disabled students happy with provision made by the medical school, and do they have any suggestions for improvements?

## References (Accessed online 14 November 2006)

1. HMSO. (1995) *Disability Discrimination Act 1995*.  
Available HTTP:  
<<http://www.opsi.gov.uk/acts/acts1995/1995050.htm>>
2. HMSO. (2001) *Special Education Needs and Disability Act 2001*  
Available HTTP:  
<[http://www.drc-gb.org/PDF/ddasenda\\_2001.pdf](http://www.drc-gb.org/PDF/ddasenda_2001.pdf)>
3. DDA - Northern Ireland  
The DDA extends to the whole of the United Kingdom, with separate secondary legislation and Codes of Practice for Northern Ireland. Schedule 8 to the Act sets out the modifications that apply to its application in Northern Ireland.  
Available HTTP:  
<<http://www.opsi.gov.uk/acts/acts1995/95050--r.htm#sch8>>
- HMSO. (2005) *Special Education Needs and Disability (Northern Ireland) Order 2005*.  
Available HTTP:  
<<http://www.opsi.gov.uk/si/si2005/20051117.htm>>
4. HMSO. (2005) *Disability Discrimination Act 2005*.  
Available HTTP:  
<<http://www.opsi.gov.uk/acts/acts2005/20050013.htm>>
5. General Medical Council. (2003) *Tomorrow's Doctors*.  
Available HTTP:  
<<http://www.gmc-uk.org/education/undergraduate/tomdoc.pdf>>
6. General Medical Council. (2006). *Core Education Outcomes: GMC Education Committee Position Statement*.  
Available HTTP:  
[http://www.gmc-uk.org/education/core\\_education\\_outcomes.pdf](http://www.gmc-uk.org/education/core_education_outcomes.pdf)>
7. Ed. Tynan, A. (2005) *Time To Take Stock: Disability and Professional Competence*. DIVERSE: The Royal Veterinary College. (Online)  
Available HTTP:  
< <http://www.medev.ac.uk/diverse/resources/TimeToTakeStock.pdf> >
8. Department for Education and Skills. (2006) *Help for students with disabilities in 2006. Disabled Students' Allowances*.  
Available HTTP:  
<[http://www.dfes.gov.uk/studentssupport/students/stu\\_students\\_with\\_d\\_1.shtml](http://www.dfes.gov.uk/studentssupport/students/stu_students_with_d_1.shtml)>
9. General Medical Council. (2006) *Good Medical Practice*.  
Available HTTP:  
<[http://www.gmc-uk.org/guidance/good\\_medical\\_practice/index.asp](http://www.gmc-uk.org/guidance/good_medical_practice/index.asp)>

**Section One: Disability Codes of Practice and Guidance**

**Introductory note**

The Disability Rights Commission (DRC) is an independent body established in April 2000 by an Act of Parliament to stop discrimination and promote equality of opportunity for disabled people. An important part of the role of the DRC is to produce policy statements and establish good practice in relation to disabled people. The DRC operates in England, Scotland and Wales, with the Equality Commission for Northern Ireland promoting disability rights in Northern Ireland.

**Disability Rights Commission. (2004) *Code of Practice for providers of Post 16 education and related services.***

Available HTTP:

[http://www.drc.org.uk/Docs/2008\\_187\\_DDA\\_Pt4\\_Code\\_of\\_Practice\\_for\\_Post\\_16\\_education.doc](http://www.drc.org.uk/Docs/2008_187_DDA_Pt4_Code_of_Practice_for_Post_16_education.doc)

This Code has been replaced by the 2006 guidance cited below and is now relevant only to cases prior to 1 September 2006.

**Disability Rights Commission (2006). *New DDA Post-16 Education Regulations and Code of Practice.***

Available HTTP

<: [http://www.drc.org.uk/Docs/Post\\_16\\_Code\\_of\\_Practice.doc](http://www.drc.org.uk/Docs/Post_16_Code_of_Practice.doc)>

This Code of Practice covers the duties set out in Chapter 2 of Part 4 of the Disability Discrimination Act 1995 (as amended by the Special Educational Needs and Disability Act 2001 and the Disability Discrimination Act 1995 (Amendment) (Further and Higher Education) Regulations 2006).

The duties imposed on the majority of post-16 education providers changed on 1 September 2006. The changes are as a result of the Disability Discrimination Act 1995 (Amendment) (Further and Higher Education) Regulations 2006 which implement the European Employment Framework Directive (2000/78/EC) in respect of vocational training in the further and higher education sector. The Directive is available HTTP:

<[http://europa.eu.int/smartapi/cgi/sga\\_doc?smartapi!celexapi!prod!CELEXnumdoc&lg=EN&numdoc=32000L0078&model=guichett](http://europa.eu.int/smartapi/cgi/sga_doc?smartapi!celexapi!prod!CELEXnumdoc&lg=EN&numdoc=32000L0078&model=guichett)>

This Code of Practice replaces the earlier “Code of Practice for providers of Post-16 education and related services”. This earlier code relevant for claims of discrimination which took place before 1 September 2006.

Available HTTP:

[http://www.drc.org.uk/Docs/2008\\_187\\_DDA\\_Pt4\\_Code\\_of\\_Practice\\_for\\_Post\\_16\\_education.doc](http://www.drc.org.uk/Docs/2008_187_DDA_Pt4_Code_of_Practice_for_Post_16_education.doc)

**Disability Rights Commission. (2004) Code of Practice: Trade Organisations and Qualifications Bodies.**

Available HTTP:

< [http://www.drc-gb.org/PDF/COPtrade\\_qual.pdf](http://www.drc-gb.org/PDF/COPtrade_qual.pdf) >

Chapter 8 of this Code explains what the DDA says about competence standards, relevant for issues relating to professional competence for medical students.

**Equality Commission for Northern Ireland. (2005) Disability Code of Practice: Trade Organisations and Qualifications Bodies.**

Available HTTP:

< <http://www.equalityni.org/uploads/pdf/DisTradeCOP05F.pdf> >

This is a similar Code for Northern Ireland.

<p><b>Section Two: Current Guidance – GMC; Council of Heads of Medical Schools; Quality Assurance Agency for Higher Education</b></p>
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**General Medical Council. Fitness to Practise Procedures Factsheet. (Online).** Available HTTP:

< [http://www.gmc-uk.org/concerns/complain/fitness\\_to\\_practise\\_procedures\\_explained.pdf](http://www.gmc-uk.org/concerns/complain/fitness_to_practise_procedures_explained.pdf) >

This is relevant in so far as a medical student's health (physical or mental) might call into question their ability to practise when registered. This applies to disabled and non-disabled students alike.

**Council of Heads of Medical Schools. (Revised November 2004). Guiding Principles for the Admission of Medical Students. (Online).**

Available HTTP:

< <http://www.chms.ac.uk/downloads/Revised%20Adm%20principles%2029%2011%2004.doc> >

Point 5 refers specifically to disabled students.

**Council of Heads of Medical Schools. (Updated July 2005). Recommendations on Selection of Medical Students with Specific Learning Disabilities including Dyslexia. (Online).**

Available HTTP:

< <http://www.chms.ac.uk/downloads/Dyslexia%20Final%202005.doc> >

This document provides advice to medical schools on issues relating to students who have physical or mental disabilities, with more specific indications relating to dyslexia.

**The Quality Assurance Agency for Higher Education. (1999) QAA Code of practice for the assurance of academic quality and standards in higher education: Section 3: Students with disabilities - October 1999. (Online).**

Available HTTP:

<<http://www.qaa.ac.uk/academicinfrastructure/codeOfPractice/section3/default.asp>>

The 24 Precepts of the QAA Code provide a helpful and detailed overview of the issues that medical schools should consider in relation to disabled students.

### Section Three: Issues, Attitudes, Practice and Patients

**Byron, M., Howell, C., Bradley, P., Bheenuck, S., Wickham, C., Curran, T. (2005). *Different Differences: Disability Equality Teaching in Healthcare Education*. Partners in Practice project, Universities of Bristol and the West of England and the Peninsula Medical School. (Online).**

Available HTTP:

<<http://www.bris.ac.uk/pip/framework.pdf>>

This framework is aimed at professionals delivering healthcare education - curriculum planners, module leaders, lecturers and assessors of pre- and post-qualification healthcare training. This document provides a practical tool for delivering disability equality in health and social care curricula, and provides a useful insight into the perceptions of disabled people. It explores issues relating to the models of disability.

**Disability Rights Commission. (2005). *Equal treatment: closing the gap. An investigation into Health Inequalities*. (Online).**

Available HTTP:

<<http://www.drc-gb.org/newsroom/healthinvestigation.asp>>

This report is part of the Disability Right's Commission's ongoing campaign to achieve equality of treatment in healthcare provision for disabled people, one of the DRC's '10 Priorities for Change'. The focus of this particular study is people with learning disabilities and/or long term mental health problems.

**Ed. MacDonald, R. (2004). *Training & Working with Disabilities*. BMJ careers, career focus information Guide. (Online).**

Available HTTP:

<<http://careerfocus.bmjournals.com/misc/disability.pdf>>

Disabled medical students and doctors describe their experiences, with issues relating to visual impairment, epilepsy, chronic fatigue syndrome and Asperger's syndrome all being explored. Other articles also focus on the impact of the Disability Discrimination Act, equality and diversity in the workplace and training in undergraduate and postgraduate medicine for disabled people.

**Morgan, L. and Chambers, R. (2004). *Enabling Disabled Doctors: Scoping Exercise*. Faculty of Health and Sciences, University of Staffordshire. (Online).**

Available HTTP:

<<http://www.hull.ac.uk/pedds/documents/disableddoctorsreport24sep04.doc>>

This is the final report of a research exercise commissioned by the Disabled Doctors Action Group. It includes a survey of medical schools, which indicated varying levels of support for disabled medical students.

**Roberts, T.E., Butler, A. and Boursicot, K.A.M. (2004). *Disabled students, disabled doctors – time for a change?. Special Report 4. The Higher Education Academy: Medicine, Dentistry and Veterinary Medicine (Online).***

Available HTTP:

<[http://www.medev.ac.uk/docs/roberts\\_final.pdf](http://www.medev.ac.uk/docs/roberts_final.pdf)>

This report is described as ‘a study of different societal views of disabled people’s inclusion to the study and practice of medicine’. It was the result of a study undertaken to assess the views of different sections of society, both lay and professional, towards admitting disabled people to the study of medicine. Six groups were identified and interviewed: admissions staff, disabled students, non-disabled students, disabled doctors, and both disabled and non-disabled members of the public. The acquisition of disability once admitted to medicine is also discussed.

**Tynan, A. (2003) *Pushing the Boat Out: An introductory study of admissions to UK medical, dental & veterinary schools for applicants with disabilities.* LTSN-01 (the Learning and Teaching Support Network subject centre for Medicine, Dentistry and Veterinary Medicine). (Online)**

Available HTTP:

<[http://www.medev.ac.uk/resources/features/pushing\\_the\\_boat\\_out](http://www.medev.ac.uk/resources/features/pushing_the_boat_out)>

**Tynan, A. (2004) *The Sequel to Pushing the Boat Out.* LTSN-01 (the Learning and Teaching Support Network subject centre for Medicine, Dentistry and Veterinary Medicine). (Online)**

Available HTTP:

<[http://www.medev.ac.uk/resources/features/pushing\\_the\\_boat\\_out](http://www.medev.ac.uk/resources/features/pushing_the_boat_out)>

These two reports explored a range of issues relating to disabled students training for medicine, dentistry and veterinary medicine, arising from a study of the relevant websites. Issues addressed include: fitness to practise, the role of occupational health and disability services in higher education, mental illness, addiction and the DDA, and support organisations.

**Ed. Tynan, A. (2005) *Time To Take Stock: Disability and Professional Competence.* DIVERSE: The Royal Veterinary College. (Online)**

Available HTTP:

< <http://www.medev.ac.uk/diverse/resources/TimeToTakeStock.pdf> >

This study can provide important pointers for medical schools, particularly the section on the types of reasonable adjustments that can be made. The status of risk assessments, and other health and safety issues, are also covered in this document.

**Tynan, A. (2006) *Disability and omnicompetence: facing up to the challenges in the training of veterinary practitioners,* in M Adams & S Brown (eds), *Towards Inclusive Learning in Higher Education:***

***Developing curricula for disabled students*, Routledge, London, pp. 107-118.**

This chapter explores relevant issues of fitness to practise, limited licensing and professional competence. Quotations from the BMA medical students' committee and the Chairman of the Disability Rights Commission about issues relating to medical students make interesting and thought-provoking reading. The chapter concludes with a list of recommendations.