

Gateways to the Professions

Advising medical schools: encouraging disabled students

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Glossary of abbreviations

CCT	Certificate of the Completion of Training
DDA	Disability Discrimination Act 1995
DED	Disability Equality Duty
DES	Disability Equality Scheme
DSA	Disabled Students' Allowance
ECU	Equality Challenge Unit
EHRC	Equality and Human Rights Commission
GMC	General Medical Council
SENDA	Special Educational Needs and Disability Act 2001
SEND0	Special Educational Needs and Disability (Northern Ireland) Order 2005

Preface

Becoming a doctor remains an inspiring goal for many people. I was fortunate as a teenager - apart from academic achievement there were no special hurdles placed in my way. Six years at two universities led into the NHS and a career I feel passionate about.

History would suggest that medicine will always be oversubscribed, but why should someone with a disability not have the same opportunity to compete and make a contribution to health services?

When I heard about the Gateways Disability Project it seemed to me to be an opportunity to level the playing field. I was keen to be involved as a representative of the Association of UK University Hospitals. I was delighted to be elected to chair the Project Board.

We should, of course, be under no illusion about the demands of both a university course and the training required to become a Consultant or General Practitioner. But students with a wide range of disabilities can achieve the required standards. Patients present an almost infinite variety of problems and disabilities - how reassuring and encouraging it must be if they are sometimes treated by someone who has overcome impairment and can be in a position to help and advise.

Before publication of this document in 2008 there was little guidance for medical schools in responding to or encouraging applications from people with a range of disabilities. There was a great deal of interest in this project and I was delighted to meet all the disabled medical students and doctors who came forward with suggestions and comments.

The advisory guidance resulted from a partnership led by the General Medical Council and financially supported by 11 medical schools. Match-funding was provided through the Development Fund of Gateways to the Professions, set up by the Department for Education and Skills (England), as it then was, to widen participation in professional education.

The Project Board included representatives of the GMC, the medical schools, the BMA Medical Students Committee, Skill: the National Bureau for Students with Disabilities, the Equality Challenge Unit for higher education, the Office for Public Management (as agents for the Department) and the Association of UK University Hospitals.

The Project Board commissioned a team led by Professor Janet Grant of the Open University which carried out surveys and interviews and drafted the first version of the advisory guidance to reflect all the comments and suggestions that we received.

It was very rewarding working with all these organisations on this guidance – my thanks to all of them, as well as to all the individuals who contributed their experience and expertise.

The guidance was intended to be advisory, to help medical schools consider how best to encourage medical students. It does not lay down new requirements, quality assurance standards or ‘policies’ from the GMC or any of the other organisations involved. The guidance does, however, refer to the statutory requirements facing medical schools and others involved in medical education, as well as providing a wealth of practical suggestions for medical schools to consider.

This guidance was first published in March 2008 and we were pleased by its reception and the number of medical schools who said they would follow our advice. Important developments since then include the publication in September 2009 of a new edition of *Tomorrow's Doctors*, the GMC's outcomes and standards for undergraduate medical education, which incorporates several references to the Gateways guidance and the importance of encouraging disabled students in the study of medicine. In England, Scotland and Wales, the Equality Act 2010 replaces the previous range of laws on discrimination, including the Disability Discrimination Act. The Project Board and the GMC have revised the guidance to reflect these and other developments up to Spring 2010 looking forward to the Act coming into force progressively during the coming months.

I know that medical schools will want to go beyond the statutory requirements to encourage and support disabled students. I hope the advice in this guidance helps to make that happen.

Dr Kathy McLean
Chair – GMC/Gateways Disability Project Board

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Executive summary

This summarises the steps that can be taken, or by law must be taken, by medical schools and providers of postgraduate training to ensure that disabled people are attracted to and retained in the profession. Each step is discussed in detail in the advisory guidance.

	Advice to medical schools
Understanding the framework	<p>The legal background</p> <ul style="list-style-type: none"> • Understand the definition of disability • Understand disability discrimination • Understand the anticipatory duty • Understand reasonable adjustments • Understand the Public Sector Equality Duty <p>Regulation</p> <ul style="list-style-type: none"> • Understand <i>Good Medical Practice</i> • Understand <i>Tomorrow's Doctors</i> and its requirements of medical students and medical schools <p>Models of disability</p> <ul style="list-style-type: none"> • Understand the impact of the medical and social models of disability
Preparing the ground	<p>Anticipatory duty</p> <ul style="list-style-type: none"> • Ensure that procedures, policies, practices and environments are not inherently discriminatory <p>Public Sector Equality Duty</p> <ul style="list-style-type: none"> • Involve disabled people • Advance equality of opportunity including removing or minimising disadvantage, taking steps to meet the needs of people with disabilities and encouraging people with disabilities to participate in public life. • Foster good relations between disabled and non-disabled people. • Eliminate discrimination, victimisation and harassment and any other conduct that is prohibited. • Promote positive attitudes towards disabled people • Take account of people's disabilities even if this means treating them more favourably

	<p>Disability Equality Scheme (DES)</p> <ul style="list-style-type: none"> • Contribute to the university’s publication of a DES and to annual reviews • Involve disabled people and their organisations in preparing, monitoring and evaluating the impact of the DES • Continue to publish a DES until the introduction of the Public Sector Equality Duty in 2011. <p>Competence standards</p> <ul style="list-style-type: none"> • Set out entry and assessment criteria for the course that are: <ul style="list-style-type: none"> • not discriminatory • relevant and genuine • necessary • linked to <i>Tomorrow’s Doctors</i> and <i>Good Medical Practice</i> <p>Staff training</p> <ul style="list-style-type: none"> • Review and update staff disability equality training programmes and/or develop new ones
Recruiting students for medical school	<p>Encouraging disabled people to apply</p> <ul style="list-style-type: none"> • Review and develop outreach activities • Ensure course information has positive images of disabled people in medicine • Provide information in accessible formats • Provide sufficient information to enable a disabled person to select a school that suits them <p>Confidentiality and disclosure</p> <ul style="list-style-type: none"> • Encourage applicants to disclose impairments or health conditions • Publish a confidentiality policy
Interviewing and selecting	<p>Reasonable adjustments to the interview</p> <ul style="list-style-type: none"> • Ask applicants in the letter of invitation to interview whether they have any requirements in relation to the interview place and process • Plan reasonable adjustments to accommodate the requirements of a range of disabled applicants

	<p>Interview questions</p> <ul style="list-style-type: none"> • Conduct the interview in the same way for disabled and non-disabled applicants • Avoid questions about an applicant's impairment <i>per se</i> <p>Selection</p> <ul style="list-style-type: none"> • Consider all applications on the basis of published academic performance criteria and personal qualities • Assess a disabled applicant as though reasonable adjustments required under the law had been made • Be wary of not offering a place on the basis of a judgement about hypothetical barriers to achievement and employment specifically associated with an applicant's disability <p>Justifying a decision, appeals and complaints</p> <ul style="list-style-type: none"> • Ensure fulfilment of legal duties on making a decision about offering a place and: <ul style="list-style-type: none"> • be prepared to defend this in the event of a legal challenge • keep a confidential record of the selection and interview processes • detail the reasons for any decisions, using university procedures and forms • Develop a process for dealing with complaints and appeals against a decision with copies made available, in a range of accessible formats, to applicants and students
<p>Providing reasonable adjustments</p>	<p>Identifying student requirements</p> <ul style="list-style-type: none"> • Ask all applicants offered a place to complete an equal opportunities monitoring form and a health assessment form provided by the occupational health service • Inform the disability officer that a disabled student has been offered a place so they can start agreeing reasonable adjustments • Gather in confidence information from disabled students during enrolment and induction about their requirements • Provide students with an ongoing confidential opportunity to disclose their existing, new or more serious impairments or health conditions

	<p>Reasonable adjustments and support</p> <ul style="list-style-type: none"> • Review the arrangements for students and determine how to adapt the course and related services to meet the requirements of disabled students • Design reasonable adjustments to ensure disabled students can study on an equal basis with non-disabled students • Make reasonable adjustments on a case-by-case basis • Bear in mind that whether an adjustment is reasonable depends on many factors • Record decisions and reasons to make or withhold adjustments <p>The physical environment</p> <ul style="list-style-type: none"> • Plan continually for improvements in reasonable adjustments to the physical environment • Conduct a risk and access audit of premises • Draft an access improvement plan involving disabled staff and students
<p>Providing induction and support</p>	<p>Induction</p> <ul style="list-style-type: none"> • Make adjustments to ensure a disabled student is introduced in a clearly structured and supported way • Use wherever possible the same health check process for all students <p>Support</p> <ul style="list-style-type: none"> • Develop effective support systems, including committed personal tutors with disability equality training • Provide students with an ongoing confidential opportunity to disclose disabilities • Provide effective careers guidance for every medical student, whether disabled or not, in appropriate ways and using a range of communication formats

	Advice to providers of postgraduate training
Understanding the framework	<p>The legal background</p> <ul style="list-style-type: none"> • Understand the definition of disability • Understand discrimination as it applies to disability • Understand that the anticipatory duty applies to the educational aspects of doctors in postgraduate training but not to the employment aspects • Understand that meeting the Public Sector Equality Duty requirements involves a proactive approach • Understand the requirement to make reasonable adjustments <p>Models of disability</p> <ul style="list-style-type: none"> • Understand the impact of the medical and social models of disability <p>Regulation</p> <ul style="list-style-type: none"> • Understand the roles of the GMC in the regulation of: <ul style="list-style-type: none"> • the Foundation Programme • specialty including general practice training <p>The UK Foundation Programme Reference Guide</p> <ul style="list-style-type: none"> • Follow the guidance on Foundation doctors with disabilities • Implement the flexible training provisions for Foundation doctors with disabilities • Implement the transfer of information process to support medical students as they move from medical school to Foundation School <p>The ‘Gold Guide’ to specialty training</p> <ul style="list-style-type: none"> • Follow the ‘Gold Guide’ endorsement of anti-discriminatory practice in recruitment • Implement the special eligibility of disabled trainees in relation to placements and flexible training <p>Risk management</p> <p>Provide supportive and enabling risk management for disabled trainees as employees of the NHS</p>

<p>Welcoming disabled doctors</p>	<p>Induction</p> <ul style="list-style-type: none"> • Take reasonable steps to find out if an employee or applicant is disabled • Address clinical duties and consider reasonable adjustments when a disabled trainee meets their educational supervisor <p>Health clearance and disclosure</p> <ul style="list-style-type: none"> • Provide health clearance for all new doctors • Develop effective risk assessment and close supervision for all trainees • Provide trainees with the opportunity to disclose any impairment or health condition in a reassuring climate and inform them of their rights and responsibilities
<p>Providing reasonable adjustments</p>	<p>Reasonable adjustments</p> <ul style="list-style-type: none"> • Make reasonable adjustments for disabled trainees and offer them appropriate facilities and support measures • Agree adjustments and arrangements with trainees on a case-by-case basis • Review examination and assessment arrangements in this light • Bear in mind the fluctuating and sometimes invisible character of mental illness

1. Introduction

The revised Gateways guidance takes into account the implementation of the Equality Act 2010. The Equality Act does not apply to Northern Ireland. Therefore notwithstanding the Equality Act coming into force in the rest of the UK, the Disability Discrimination Act will remain in force in Northern Ireland until further notice, as will the Special Educational Needs and Disabilities Order.

1.1 Who should read this advisory guidance?

This advisory guidance from a partnership led by the General Medical Council (GMC) is aimed primarily at medical schools. It will also interest organisations involved in postgraduate medical training and many individuals, including disabled doctors, students and potential students, and their teachers and careers advisers.

We advise service managers to familiarise themselves with the guidance to help them to understand the obligations of medical schools and deaneries to their students and trainees while in the work environment; and to be aware of some of the options available for supporting disabled students and trainees. The advisory guidance does not deal extensively with employment law for lack of space, but employers should always keep in mind the provisions and potential sanctions contained in the Equality Act 2010.

We would expect disabled people who are thinking of applying to medical school, and those who are already in medical education, to use this guidance to inform themselves of policies, practices and procedures that could apply in medical education and training.

1.2 How to use this advisory guidance

This guidance is organised to take medical schools along the disabled person's journey through medical education and training. It starts with the legal duties and responsibilities of universities, medical schools and the GMC. The GMC sets requirements of medical schools and medical students in *Tomorrow's Doctors*, including a clear list of skills that students must be able to perform in order to graduate.

It then covers the steps in that journey and the actions a disabled person can expect at each stage: from their initial enquiry about studying medicine through to their progress at medical school and postgraduate training. Much of the guidance is relevant to students who develop a new impairment while at medical school, in addition to those students who already have impairments before admission.

Throughout, there are links to other resources that provide further information and the legal background. Often situations are more complex than the

illustrative examples, so decisions always need to be made on an individual basis with the full involvement of the disabled person concerned. If the situation proves particularly complex, advice can be sought from the organisations listed below.

WEB LINKS: Helpful organisations

Helpful organisations can be found in the separate document on 'Useful organisations and sources':

www.gmc-uk.org

Those who are looking for a clear guide designed particularly for disabled students should consult the booklet *Into Medicine: Positive experiences of disabled people* (2007) produced by Skill: National Bureau for Students:

http://www.skill.org.uk/shop/shop_showProduct.asp?graphics=on&productID=3292359.

The Skill website has links to disability organisations:

<http://www.skill.org.uk/page.aspx?c=64&p=153>.

The Voluntary Organisations Disability Group (VODG) provides a useful link to the websites of member organisations at:

<http://www.vodg.org.uk/?lid=3012>

For Northern Ireland, Queen's University Belfast provides a link to useful organisations at:

<http://www.qub.ac.uk/directorates/sgc/disability/AdditionalResources>

The British Medical Association lists support organisations at:

http://www.bma.org.uk/doctors_health/d4dresourcesfordoctorsindifficultly.jsp#Disabilities

The Equality Challenge Unit promotes equality and diversity in higher education and has web pages and publications supporting the needs of disabled students and staff:

<http://www.ecu.ac.uk>

More information for disabled students is available from the Equality and Human Rights Commission at:

<http://www.equalityhumanrights.com>

HOPE for Disabled Doctors, an organisation working to achieve professional equality, is at:

<http://www.hope4medics.co.uk>

The Doctors' Support Network is a support group for doctors with mental health concerns:

1.3 The need for this advisory guidance

A research report from the Higher Education Academy concluded that:

‘Generally, there appears to be a positive swell of opinion regarding the admission of disabled individuals to the study of medicine.’¹

Despite this, the interviews that informed this advisory guidance revealed that there is still some way to go and a wide variety of perceptions:

‘In medicine, doctors don’t want to see other doctors as ill. The interaction is complicated.’

Trainee

‘Their attitude was that medicine is a stressful profession and given that I had mental health problems, I was better off out of it.’

Medical student

‘The whole blame culture in medicine needs to be shifted and, in particular, doctors and students with disabilities should be encouraged to be open, not penalised for being so.’

Member of Doctors’ Support Network

‘I was told by my supervising consultant that I should come into work even when feeling unwell as I had to “act and be professional”.’

Member of Doctors’ Support Network

‘I was told by the course director not to ask for reasonable adjustments because it would set a precedent he didn’t want.’

Medical student

But there were also many positive comments:

‘I was given a reduction of hours, a reduction of daytime on-call duties and no night time duties, no weekend calls and had very supportive consultants, occupational health and a psychiatrist who never had any doubt that I can and will continue my career.’

Member of Doctors’ Support Network

¹ Roberts TE, Butler A and Boursicot KAM (2005) *Disabled students, disabled doctors – time for a change? A study of different societal views of disabled people’s inclusion to the study and practice of medicine*. The Higher Education Academy. Special Report 4.

'I had the needs assessment today and, as well as quite a bit of DSA [Disabled Students' Allowance] funded stuff I didn't realise [what] I was entitled to. The recommendations included provision of reasonable adjustments such as clinical attachments being suitably located where possible, written exams being done in a small room as opposed to a large sports hall... and also to try and time OSCE exams so mine are earlier rather than later in the day. The assessor also suggested I have a mentor. It was a very useful meeting and I would never in a million years have thought to ask to be able to do my exams in a smaller room.'

Medical student

Disabled students and trainees made it clear that they want:

- good quality confidential medical care
- good quality occupational health supervision
- timely and accurate information
- reasonable adjustments to teaching and learning, and assessment
- understanding and supportive seniors
- the offer of help
- a representative who understands the rights of disabled people
- protection from discrimination
- a 'disabled friendly' environment
- unprejudiced career advice.

This advisory guidance forms part of the GMC's commitment to valuing diversity and promoting equality and to ensuring that its processes and procedures are fair, objective, transparent and free from unlawful discrimination.

2. The importance of disabled people in medicine

'Disabled people add immense value to the student body. They help any group understand and appreciate diversity. It made a huge difference to the medical school when the first student in a wheelchair was admitted.'

Medical teacher

Although about 19 per cent of people of working age are disabled, only 5.5 per cent of medical students or about 2100 individuals declared a disability in 2007/8.² Comparisons over time and between university courses are difficult because the figures are affected by declaration rates as well as the actual numbers of disabled individuals.

The medical profession can gain real benefits from having disabled people in its ranks. Accommodating and encouraging disabled students is not just about being responsive to equality legislation. It is also about enhancing the diversity and competency range of those who are enrolled in the medical profession, thus promoting the skills and knowledge of disabled people to undertake important roles in society.

Already many disabled people are actively practising in the medical profession alongside non-disabled doctors. And increasing numbers are applying to medical school year on year. Critically, with the implementation of appropriate policies and practices, disabled practitioners have demonstrated their ability to undertake their role within the profession to the same standard as their non-disabled peers.

Disabled people can make a unique contribution to patient care and, indeed, to medical research by providing direct experience and knowledge of particular health conditions or impairments. Patients often identify closely with disabled medical professionals who can offer insight and sensitivity about how a recent diagnosis and ongoing impairment can affect patients. Such experience is invaluable to the medical profession as a whole, and illustrates the importance of attracting and retaining disabled students.

There are many positive examples of disabled people being successful in medicine, along with much detailed advice on how others can follow in their footsteps.³

However, a number of people interviewed for this advisory guidance declared that the lack of role models was a problem:

² HESA Student Record 2007/08. HESA cannot accept responsibility for any inferences or conclusions derived from the data by third parties.

³ *Into medicine: Positive experiences of disabled people* (2007) is produced by Skill: National Bureau for Students with Disabilities. Available via www.skill.org.uk

‘Another barrier was that I had no role models I could look to. I knew of no psychiatrists who were open about mental health difficulties at that time. I am now open about my problems partly for that reason – that I want others to know that it’s OK to have such an illness and also be a professional.’

Trainee

All applicants to medical school should have easy access to information about the standards they have to meet. Reasonable adjustments should be put in place to ensure that disabled people can demonstrate their competence in appropriate ways.

WEB LINKS: Statistics

Statistical information about the numbers of disabled people among applicants to universities, students and the population as a whole is available from the Shaw Trust, the Higher Education Statistics Agency (HESA) and the Universities and Colleges Admissions Service (UCAS):

www.shaw-trust.org.uk

www.hesa.ac.uk

www.ucas.ac.uk

3. GMC guidance and disabled people in medicine

Three GMC documents form the backdrop to the training and practice of doctors:

- *Good Medical Practice*
- *Tomorrow's Doctors*
- *Medical Students: Professional behaviour and fitness to practise.*

3.1 Good Medical Practice and fitness to practise

The GMC aims to ensure that patients are able to trust doctors with their lives and health. The GMC uses the phrase 'fitness to practise' to refer to the package of qualities that makes it appropriate for a doctor to be registered with a licence to practise. *Good Medical Practice* sets out the principles on which good practice is founded. These principles apply to all doctors. Consequently, serious or persistent failure to follow *Good Medical Practice* will put a doctor's registration at risk.

The guidance in *Good Medical Practice* is arranged under the following seven headings.

Good clinical care

Doctors must practise good standards of clinical care, practise within the limits of their competence, and make sure that patients are not put at unnecessary risk.

Maintaining good medical practice

Doctors must keep up to date with developments in their field and maintain their skills.

Relationships with patients

Doctors must develop and maintain successful relationships with their patients.

Working with colleagues

Doctors must work effectively with colleagues.

Teaching and training

If doctors have teaching responsibilities, they must develop the skills, attitudes and practices of a competent teacher.

Probity

Doctors must be honest.

Health

Doctors must not allow their own health or condition to put patients and others at risk.

The GMC's 'Fitness to Practise procedures' are used to consider doctors who seriously or persistently fail to follow the guidance. The overwhelming majority of doctors will never have a fitness to practise referral. In this context the issue of 'fitness', while occasionally relating to health, is more often to do with attitude, behaviour and clinical competence.

The advisory guidance offered here is consistent with the principles of *Good Medical Practice*. However, medical students are not registered by the GMC and therefore are not subject to its Fitness to Practise procedures. The development of students' knowledge and clinical skills and their fitness to practise are considered through the medical schools' procedures.

3.2 Disability, ill-health and fitness to practise

It is important to differentiate between disability and ill-health in relation to fitness to practise. Having an impairment does not mean that a person is in a permanent state of poor health.

However, it must be recognised that the term 'disabled person' in the Equality Act 2010 covers people with long-term health conditions; and that means they are protected by its provisions on disability discrimination.

A disabled person can be in good or poor health. Some impairments, such as some mental health conditions, however, are also illnesses. Some impairments, such as HIV or AIDS, can also be infectious. Other conditions can fluctuate or deteriorate, which may affect performance.

Good Medical Practice does not stipulate that a doctor has to be in good health in order to practise. However, the GMC states strongly that, if necessary, doctors must seek and follow advice from a suitably qualified professional about their health.

This point is reinforced in *Medical students: professional values and fitness to practise*, published by the GMC and the Medical Schools Council (revised in 2009). This sets out how medical schools are expected to behave, bearing *Good Medical Practice* in mind. The guidance points out that 'Poor health can affect a student's fitness to practise either directly or by being a cause of misconduct' (paragraph 5). The guidance refers explicitly to the Gateways guidance as having 'particular relevance to the section on the scope of fitness to practise' (paragraph 6). That section (paragraphs 39 to 61) emphasises the relationships between health, disability and fitness to practise with reference again to the Gateways guidance. 'In most cases, health conditions and disabilities will not raise fitness to practise concerns, provided the student

receives the appropriate care and reasonable adjustments necessary to study and work safely in a clinical environment' (paragraph 50).

In particular, paragraph 38 of the 2009 edition of that guidance says that:

- students should be willing to be referred for treatment and to engage in any recommended treatment programmes
- students do not have to perform exposure-prone procedures (EPPs) in order to achieve the expectations set out in *Tomorrow's Doctors*; students with blood-borne viruses (BBVs) can study medicine but they may have restrictions on their clinical placements, must complete the recommended health screening before undertaking EPPs, and will need to limit their medical practice when they graduate.

In 2008, the Medical Schools Council and other bodies published guidance on health clearance. Testing for blood-borne viruses can take place after the admission of students to medical courses although it 'should be performed during the initial stages of medical training, before students have the opportunity to undertake EPPs'. Normally medical students will be screened for hepatitis B, hepatitis C and HIV. 'It is expected that the majority of students will agree to undergo testing.' Students who decline testing or who are found to be infected by a BBV will need to accept formally that they will not be allowed to perform EPPs which may have implications for other vaccinations and placements.

WEB LINKS: Disability, ill-health and fitness to practise

Good Medical Practice (2006) is at:

http://www.gmc-uk.org/guidance/good_medical_practice/index.asp

Tomorrow's Doctors (2003 and 2009) is at:

<http://www.gmc-uk.org/tomorrowsdoctors>

Medical students: professional values and fitness to practise (2009), published jointly by the GMC and the Medical Schools Council, is at:

http://www.gmc-uk.org/education/undergraduate/professional_behaviour.asp

Core Education Outcomes (2006) is at:

http://www.gmc-uk.org/Core_Education_Outcomes_1.0.pdf_25396917.pdf

The Medical Schools Council and other bodies have published *Medical and dental students: Health clearance for Hepatitis B, Hepatitis C, HIV and Tuberculosis* (2008) at:

<http://www.medschools.ac.uk/AboutUs/Projects/Documents/BBVsGuidanceFeb2008.pdf>

3.3 The implications of the GMC guidance for careers in medicine

Anyone can graduate if they meet all the outcomes and curricular requirements set out in *Tomorrow's Doctors* and meet the university's regulations. On graduation, they will obtain provisional GMC registration, subject to the GMC being assured about their fitness to practise. Many students with a wide range of impairments, illnesses and health conditions successfully achieve the required standards of knowledge, skills and behaviours to become a doctor and practise at the high level required to ensure patient safety.

Some prospective medical students and some existing students may not be able to progress with their studies, even with an appropriate range of adjustments and support in place. This might be the case, for example, if a student sustains a serious brain injury with a loss of cognitive skills that makes it impossible to continue learning; or if a student sustains an injury that makes it impossible to carry out some of the required clinical and practical skills. The 2009 edition of *Tomorrow's Doctors* includes a list of practical skills that graduates must be able to demonstrate from 2012: http://www.gmc-uk.org/education/undergraduate/tomorrows_doctors_2009_appendix1.asp

After graduation, doctors may develop a physical, sensory or mental impairment, in which case the following guidance applies:

- Reasonable adjustments may allow the doctor to continue to practise as they have been doing.
- In some cases, the doctor may need to modify their practice.
- If a doctor does modify their practice, there is no need for the GMC to be involved.
- Having a health condition, an illness or an impairment does not make a doctor unsafe as long as they recognise and work within the limits of their competence, as any good doctor should do.

Notwithstanding the arrangements for doctors in practice, all students seeking to graduate and acquire provisional registration must at that point be able to demonstrate all of the outcomes set by the GMC in *Tomorrow's Doctors*. The GMC has no legal ability to grant a conditional, restricted or limited licence to practise at the point of initial registration and the medical schools are not empowered to grant students dispensation from the requirements set in *Tomorrow's Doctors*.

3.4 Medicine: an array of different careers

Medicine is not a single career; it is a group of careers. The graduates of medical school become, among other things, surgeons, physicians,

psychiatrists, laboratory specialists, public health doctors, researchers, and policy makers. Medical schools have always accepted a variety of applicants for this variety of careers.

Nonetheless, all medical students must satisfy the outcomes and curricular requirements set by the GMC in *Tomorrow's Doctors*. As the GMC states in *Core Education Outcomes*:

'The point of a medical course is to produce a doctor fit for clinical practice. What doctors then choose to do with their career is a matter for them'.

In addition, all graduates who wish to practise clinically in the UK must achieve full GMC registration and will normally complete a Foundation Programme before proceeding to specialty training. The GMC has the authority to recognise modified Foundation Year 1 programmes for doctors with a disability, though the outcomes must still be achieved. The outcomes required for full registration, normally at the end of Foundation Year 1, are set in *The New Doctor*.

http://www.gmc-uk.org/education/postgraduate/new_doctor.asp

4. The legal background

The relevant provisions of the Equality Act 2010 came into force in October 2010.

The Equality Act does not apply to Northern Ireland and therefore the Disability Discrimination Act 1995 will remain in force until further notice, as will the Special Educational Needs and Disabilities Order.

4.1 Disability discrimination

In providing education, it is unlawful to discriminate against disabled people without justification, or to treat a disabled person less favourably than others because of their disability. The law also requires medical schools to make reasonable adjustments, thus avoiding putting disabled people at a substantial disadvantage. They must anticipate the adjustments that disabled people as a group will need when using any university or medical school services, from initial publicity and recruitment, through learning and assessment, to the awards ceremony.

Education providers have duties under Part 6 of the Equality Act 2010. Education providers will also need to consider all other provisions of the Equality Act 2010 which impact on employment, the provision of services and meeting the Public Sector Equality Duty (this Duty is expected to apply from April 2011).

Universities, medical schools, postgraduate deaneries and employers have four fundamental duties in relation to disabled people.

1. The duty to avoid types of unlawful discrimination against people with disabilities including:

- direct discrimination
- indirect discrimination
- discrimination arising from disability
- failure to make reasonable adjustments (including the anticipatory duty)
- victimisation
- harassment.

Direct discrimination for disability is when a person treats another less favourably because of their disability.

Indirect discrimination occurs where certain provisions, criteria or practices imposed by an employer or education provider have an

adverse impact disproportionately on one group or other.⁴

Discrimination arising from a disability is where a disabled person has been treated unfavourably because of something arising as a consequence of their disability.

Victimisation means treating someone less favourably because they have made a complaint of discrimination or are thought to have done so; or because they have supported someone else who has made a complaint of discrimination.

Harassment is unwanted conduct which has the effect (intentionally or unintentionally) of violating a person's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment which interferes with an individual's learning, working or social environment or induces stress, anxiety or sickness on the part of the harassed person.

The Equality Act also introduced the concept of combined discrimination but this was not brought into force in October 2010. Combined discrimination is similar to direct discrimination but it concerns adverse treatment relating to a combination of two characteristics (for example, disability and race) rather than because of a single characteristic. However, even where a person has more than one disability, disability can constitute only one characteristic for this purpose. For example, discrimination linked to both visual impairment and HIV cannot be combined discrimination under the Act since they are both forms of disability. A person who is treated less favourably because of two disabilities would be able to bring claims of discrimination for each disability separately.

2. The anticipatory duty. This requires consideration of, and action in relation to, barriers that impede people with one or more kinds of disability in advance of an individual using a service. This includes checking policies, practices, facilities and procedures as well as providing auxiliary aids and services, such as hearing loops, ramps and alternative print formats.

3. Reasonable adjustments⁵: The duty to make reasonable adjustments to policies, practices, facilities and procedures to meet the individual requirements of disabled people. Technology to assist disabled people (known as 'assistive technology') is developing rapidly,

⁴ The Equality Act 2010 provides an exemption for indirect discrimination where the relevant provision, criteria or practice is justified, i.e. it is a proportionate means of achieving a legitimate aim

⁵ Examples of reasonable adjustments are listed in the Appendix.

and the university disability officer should have full information on what is available. These requirements are:

- a. To take reasonable steps to avoid the substantial disadvantage where a provision, criterion or practice puts people with disabilities at a substantial disadvantage in relation to the provision of a service or exercise of a function.
- b. To take reasonable steps to avoid the substantial disadvantage, or to adopt a reasonable alternative method of providing the service or exercising the function, where a physical feature puts disabled people at a substantial disadvantage in relation to the provision of a service or exercise of a function.
- c. To take reasonable steps to provide an auxiliary aid where people with a disability would, but for the provision of such an auxiliary aid, be put at a substantial disadvantage in relation to the provision of a service or exercise of a function.

4. The Public Sector Equality Duty: The duty to promote equality and to eliminate discrimination. The Equality Act 2010 introduces a single public sector duty covering the six existing equality strands including disability. The single duty is not expected to come into force until April 2011 so it is therefore advisable that medical schools consider and apply the provisions in the Disability Equality Duty until further guidance is issued.

Overall responsibility for complying with disability discrimination legislation within the higher education sector lies with the governing body of the university. Medical schools throughout the United Kingdom have duties and responsibilities under Part 6 of the Equality Act 2010 as part of the university, unless the medical school is legally separate from the university. In this instance, medical schools providing services to the public are likely to be covered by Part 3 of the Equality Act 2010 and must alert staff to their legal responsibilities.

Medical trainees at postgraduate level are protected in two ways: as trainees of a postgraduate deanery and as employees of a trust or health board. At this stage in their training, not only do disabled trainees have rights to fair treatment in education, they also have rights under Part 5 of the Equality Act 2010 - the employment provisions.

Medical schools should be aware that the Act contains provisions which enable employers to take action to achieve fuller and more effective equality in practice for those who are socially or economically disadvantaged or otherwise face the consequences of past or present discrimination or disadvantage. These are known as positive action provisions.

Because universities and medical schools provide the education and training necessary for a student to register with a licence to practise as a doctor with the GMC, they must ensure that the examinations and tests for which they are responsible are free from disability discrimination. Medical schools, therefore, must ensure that all their policies, procedures and practices are equitable.

In the European Union, progress towards eliminating discrimination is on the basis of Council Directive 2000/78/EC of 27 November 2000 which establishes a general framework for equal treatment in employment and occupation. Once a disabled person is registered as a doctor in one Member State, they have the right to seek employment in another Member State..

European and international students have the same rights under the Act as home students. Medical schools need to ensure that they have in place the necessary systems to identify the needs of disabled students coming from outside the United Kingdom. However, international students are not eligible for Disabled Students' Allowances so institutions must fund any reasonable adjustments themselves.

WEB LINKS: Legislation

The legal review undertaken for the first edition of this guidance is available at:

<http://www.gmc-uk.org>

Information about SENDO is at:

<http://www.equalityni.org/sections/default.asp?secid=4&cms=Service+Providers+Education+SENDO&cmsid=130+424+613&id=613>

Guidance on all aspects of the Equality Act is available on the Equality and Human Rights Commission website:

<http://www.equalityhumanrights.com/legislative-framework/equality-bill/>

See also the Equality Challenge Unit pages:

<http://www.ecu.ac.uk/law/equality-bill>

<http://www.ecu.ac.uk/subjects/equality-act-2010>

The Northern Ireland Further and Higher Education Code has similarly detailed guidance.

The Learning and Skills Development Agency booklet *How to Actively Involve Disabled People* is at:

http://www.lsneducation.org.uk/dda/files/pubs/B1_062488.pdf

European Council Directive 2000/78/EC establishes a general framework for equal treatment in employment and occupation (OJ No. L 303, 2.12.2000, page 16) and is at:

<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:32000L0078:EN:HTML>

4.2 *Who is a 'disabled person'?*

The Equality Act 2010 defines a disabled person as:

'A person (P) has a disability if P has a physical or mental impairment which has a

- (a) long-term and
- (b) substantial adverse effect on P's ability to carry out normal day-to-day activities.'

As this is a legal definition, it is ultimately for a court or tribunal to determine to whom it applies. Where there is doubt about whether an individual will be covered, it is best practice to assume that they will be and focus on identifying reasonable adjustments that will assist them.

The effect of an impairment is long-term if:

- a. It has lasted for at least 12 months
- b. It is likely to last for at least 12 months or
- c. It is likely to last for the rest of the life of the person affected.

A 'substantial' adverse effect is defined in the Act as one that is 'more than minor or trivial'.

Medical schools, postgraduate deaneries and employers should use this definition when considering how to assess and support disabled applicants, students and employees. They should also encourage a greater understanding of who is protected by the Act, and seek to protect the rights of disabled people in their use of all the services at university and medical school.

People with a range of impairments and long-term health conditions are included in this definition, such as people who are hard of hearing or have mental health issues, multiple sclerosis, cancer or HIV. Importantly, others who would not usually describe themselves as disabled people, such as those with dyslexia, may be protected by the Act if the effects of the impairment are 'long term' 'adverse' and 'substantial' on normal day-to-day activities. People with hidden disabilities such as epilepsy are also covered.

Progressive or recurring conditions will amount to disabilities in certain circumstances.

Many people who are technically disabled, and so are covered by the Equality Act, do not describe themselves as such and so may not think of asking for reasonable adjustments.

Medical and social models of disability

The traditional medical model sees disability as a condition which may reduce the individual's quality of life. A person's medical diagnosis is used to define that person as well as affecting access to services and life chances. In this model, the impairment is seen as the problem.

In the social model of disability, the problem of disability lies with society, not with the disabled person. Barriers caused by attitudes in society as well as environmental and organisational barriers disable the individual. This model distinguishes between impairment (the loss of function) and disability (the discrimination arising from that impairment). Here, disability can be prevented or removed by dismantling the barriers affecting people with impairments. This is the thinking behind recent developments in disability legislation and informs the language and advice used in this guidance.

4.3 Mental illness and fluctuating conditions

People with fluctuating conditions, of which mental illness can be one, often require a different approach at each stage. Regular reviews are important, as is awareness that the current 'snapshot' may not be the whole picture.

Mental illness sometimes also has the added and unwelcome challenge of stigma that can affect people at each stage of their course, from disclosure onwards.

'Mental illness is not like any other disability - it is the 'black sheep' amongst other disabilities due to the attached stigma. On top of that we often feel embarrassed about the fact that we suffer from a mental illness or about some of the symptoms we experience. All this can affect the confidence we have in ourselves and in our ability to be a doctor. It can make it very difficult to be open about suffering from a mental illness. There is also the fear of our career being adversely affected - not necessarily by the mental illness itself but by the reactions and actions of our surroundings.'

Trainee

‘Unfortunately the myths and stereotypes associated with mental illness are still very much alive even amongst health professionals.’

Trainee

 **WEB LINKS: Definition of disability**

The Statutory and Non-Statutory Codes of Practice for the Equality Act 2010 can be found on the Equality and Human Rights Commission website

<http://www.equalityhumanrights.com/legislative-framework/equality-bill/>

5. Preparing the ground

Five considerations are important for education providers who must prepare the ground for future disabled students:

- the anticipatory duty
- the Disability Equality Duty (DED) and the new Public Sector Equality Duty when the latter comes into force
- the Disability Equality Scheme (DES)
- competence standards
- staff training.

5.1 *The anticipatory duty*

The anticipatory duty is the requirement to prepare for the inclusion of all disabled students, not just specific individuals. Medical schools should not wait until a disabled student has begun their course before making adjustments, as they may find they are already in breach of the law. Medical schools need to think ahead about the needs of a wide range of people with different impairments and plan to improve services accordingly.

Fulfilling the anticipatory duty makes a real difference:

‘Instead of identifying problems early on, and therefore having systems in place in advance should problems arise in the future, the attitude seems to be one of “waiting and seeing”. This then means months are wasted, and in my case I had to take a year out whilst things were put in place in order for me to return to work. I feel there should be more of a standardised system for people who declare that they have a disability, even if it is not affecting them greatly as a student.’

Medical student

‘Bristol strongly encouraged me to apply on the basis that they had an “access for deaf students” initiative, and would therefore be able to obtain all the necessary equipment and support I needed.’

Medical student

Medical schools should review all their estates, policies and practices to determine the reasonable adjustments that will remove potential barriers that may prevent people with a range of impairments from successfully applying to the school or succeeding on their course.

The reasonable adjustment duty has been strengthened under the Equality Act to clarify that it is almost always reasonable to provide information in alternative formats. In meeting the anticipatory duty and the strengthened reasonable adjustment duty it would be prudent therefore to consider the need to ensure that information is as accessible as possible for students.

The following are examples of areas worth considering:

- making notes available in electronic format to enable the use of assistive software, for example, for visually impaired or dyslexic students
- forming links with specialist organisations in case help is needed
- ensuring that material on the intranet is compatible with specialist software that might be used by, for example, visually impaired or dyslexic students
- making budgetary provision for unanticipated adjustments that might be needed, especially by overseas disabled students who are not eligible for Disabled Students' Allowances
- drawing up clinical attachment policies
- drawing up assessment methods and processes
- ensuring that the estates division is fully trained in systematically planning and costing improvements.⁶

The following physical features should be reviewed as part of the anticipatory duty:

- access to buildings, such as level or ramped entry
- emergency evacuation arrangements, such as flashing light fire alarms or vibrating pagers for deaf people
- fire refuges or alternative escape routes for people with mobility impairment
- accessible external paths and landscaping
- easy routes and interior layout within buildings
- effective lighting and signage, and colour or tone contrast on doors and walls to aid orientation
- acoustics appropriate for hearing aid users, and working loop systems in lecture theatres and reception desks
- desks, laboratory benches, work surfaces and reception desks at different or flexible heights
- appropriate seating
- access to services, such as catering facilities
- accessible toilets
- convenient and reserved parking spaces.⁷

⁶ These examples are based on the former Disability Rights Commission's post-16 Code of Practice.

⁷ These examples are based on the former Disability Rights Commission's post-16 Code of Practice.

WEB LINKS: Review of provision and facilities

See the 2010 version of QAA's Code of Practice in relation to students with disabilities:

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

The Centre for Accessible Environments offers publications on many details of physical building design at:

http://www.cae.org.uk/publications_list.html

The RNIB has a wide variety of publications in relation to design for people with sight loss at:

<http://www.rnib.org.uk/professionals/booksprofessionals/essentialguides/Pages/essentialguides.aspx>

The RNID offers information about equipment appropriate for people who are deaf or hard of hearing:

http://www.rnid.org.uk/information_resources/communicating_better/equipment_to_help_communication/

Information on preparing the learning environment for neurodiversity (including dyslexia, dyspraxia, attention deficit hyperactivity disorder, Asperger's, Tourette's and dyscalculia) is harder to find but a good place to start is:

<http://www.brainhe.com/resources/>

5.2 The Public Sector Equality Duty

The Equality Act 2010 places a single Public Sector Equality Duty on public authorities to ensure equality, including for disabled people. This replaces the Disability Equality Duty (DED) which was originally in place through the DDA. The new single Public Sector Equality Duty is expected to come into force in April 2011. Until this time medical schools are advised to comply with DED.

Organisations that deliver post-16 education are classed as public authorities and must involve disabled people and act proactively to eliminate disability discrimination. The DED requires all public authorities to do what they can 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 than others.

The single Public Sector Equality Duty requires all public sector bodies to do what they can to:

- advance equality of opportunity including removing or minimising disadvantage, taking steps to meet the needs of people with disabilities and encouraging people with disabilities to participate in public life.
- foster good relations between disabled and non-disabled people.
- eliminate discrimination, victimisation and harassment and any other conduct that is prohibited.
- take account of people's disabilities even if this means treating them more favourably

5.3 Disability Equality Scheme

A Disability Equality Scheme (DES) offers institutions the positive opportunity to set out a vision and to define really challenging goals for the removal of barriers and the total inclusion of disabled people.

Under the Equality Act 2010, public authorities are no longer required to prepare and publish discrete equality schemes. However, we suggest that medical schools continue to publish a DES until this is overtaken by alternative arrangements under the Equality Act.

Universities as public authorities had a duty to publish a DES every three years and to review it annually, to show how they intend to fulfil both their general and specific duties. The DES should be signed off by the Vice-Chancellor or someone of similar authority. Disabled people and their organisations had to be involved in preparing, monitoring and evaluating the impact of the DES.

The purpose of the DES is to eliminate disability discrimination from institutional practice and to promote positive attitudes towards disabled people. This is true in both academic and social terms, and should encompass the activities of students and staff. Isolation, harassment and bullying on the basis of disability are potential problems for institutions and require specific attention. Prospectuses, advertisements, departmental handbooks and similar publications, whether printed or online, should contain stories, images and policies that remind prospective and current students and staff of their responsibility to promote equality. The school's success in relation to disabled students should be a point of pride.

There are slightly different arrangements for Northern Ireland. These are set out in section 75 of the Northern Ireland Act 1998 - A Guide for Public Authorities.

Educational public authorities were required to set out in their DES:

- the arrangements in place for gathering information on the effect of their policies and practices on the educational opportunities available to, and on the achievements of, disabled students
- the arrangements in place for gathering information on the effect of their policies and practices on the recruitment, development and retention of their disabled employees.

The information gathered had to be analysed and used as the basis for preparing disability action plans, and for reviewing the effectiveness of those actions taken. The DES should also include a statement of the arrangements for making use of the information gathered. In particular, it should include arrangements for reviewing on a regular basis the effectiveness of the action plan and for preparing subsequent DESs.

Monitoring is therefore essential if an equal opportunities programme is to be effective. It is important to know the composition of an organisation to ensure that disabled people are not disadvantaged or under-represented. This is true in relation to medical school applicants and students, and the composition of selection panels. Without monitoring it is not possible to track positive steps and their effects. Monitoring should be regular, standardised and recorded.

The case for a purposeful, systematic, inclusive and documented approach to tackling disability discrimination along these lines will continue to hold good after the legal provisions relating to the DES format no longer apply.

Components of a monitoring scheme

With the introduction of the Equality Act 2010, it is suggested that medical schools monitor information on all the protected characteristics, including disability: undergraduate and graduate applications, offers and acceptances; profiles of new entrants; student progression and completion rates; awards to students.

Data should be reviewed regularly to identify representation of groups, imbalance or apparent disadvantage, varying outcomes, any actions required and taken, and their effectiveness.

This advice is based on the practice of University College London, which is at:

<http://www.ucl.ac.uk/disability/DES>

It is fundamental to meeting the requirements of the duties that public bodies assess the impact of what they do on different groups.

Under the Equality Act 2010 there is a move away from an emphasis on describing process to requiring public bodies to demonstrate, in a transparent

and accountable manner, outcomes and impact. Organisations can decide what process they take to achieve the latter. Public bodies must demonstrate how they have taken into account evidence of the impact on equality in the design of key policy and service delivery initiatives, and what difference this has made.

We suggest that medical schools continue to conduct equality impact assessments until the new arrangements have come into force in April 2011.

5.4 Competence standards

Competence standards apply to all parts of the course, including entry. These set out the academic, medical, or other standards 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. Competence standards must be reviewed from a disability discrimination perspective and must describe relevant and genuine competences that are strictly necessary for course completion.

Competence standards are, effectively, entry and assessment criteria. Reasonable adjustments do not have to be made to competence standards, but they do have to be made to the way that the standards are assessed or performed. It is important, particularly in examinations, to recognise that disabled doctors sometimes use different clinical methods to detect abnormality. So, for example, students with hearing loss may have to experiment with different combinations of electronic stethoscope and hearing aids until the process works effectively for them. Further, being able to answer a crash call summoning a resuscitation team to an emergency might not constitute a genuine competence standard, if reasonable adjustments could be made to the working environment or tasks so that answering such calls was not a necessary task for a particular team member.

Given the variety of curriculum types in the United Kingdom, competence standards can vary slightly from school to school but the curricula will be referenced to *Tomorrow's Doctors*.

5.5 What does *Tomorrow's Doctors* say?

*Tomorrow's Doctors*⁸ is the GMC's primary guidance on undergraduate medical education. It clearly lays down the 'curricular outcomes' required by the GMC for undergraduate medical education, setting out what is expected of new graduates. *Tomorrow's Doctors*:

- puts the principles set out in *Good Medical Practice* at the centre of undergraduate education
- makes it clear what students will study and be assessed on during undergraduate education
- makes it necessary to provide rigorous assessments that lead to the award of a primary medical qualification.

In 2009 the General Medical Council completed a full review of *Tomorrow's Doctors* and published a new edition. Medical schools must comply with the requirements in the 2009 edition from the academic year 2011/12 and in the meantime must comply with the previous edition published in 2003. The 2003 edition includes at paragraph 19 a requirement that new graduates (that is, those graduating up to and including 2011) must be able to perform safely and effectively a list of clinical and practical skills. The 2009 edition includes an Appendix listing practical procedures that graduates from 2012 must be able to perform safely and effectively. The 2009 edition refers to this Gateways guidance and the importance of encouraging disabled students in the study of medicine.

Although adjustments cannot be made to the curricular requirements and outcomes set down in *Tomorrow's Doctors*, reasonable adjustments can be made to the method of learning and the assessment by which the student demonstrates these skills. Likewise, specific conditions around these standards might be adjusted. For example, a requirement that a student should be able to complete a task within a certain time would only constitute a genuine competence standard if speed is an intrinsic part of the task.

Sometimes, it is the marginal requirements for entry to a course that lead to discrimination. In the same way, the use of blanket criteria can also discriminate against the individual. Such criteria might include skills, achievements or personal characteristics that are not relevant to the course, and that might be difficult or impossible for disabled people to attain.

Of course, a medical school is entitled to expect applicants to have certain qualifications, as long as these are genuine competence standards required for the course. As with any other applicant, a case-by-case judgement is acceptable. And in some circumstances it might be reasonable to waive the requirement for a particular qualification, especially if there is evidence that

the applicant has achieved the necessary level of competence in another manner.

Medical schools should therefore prepare a statement of genuine competence standards for potential applicants and for the different stages of the course and be prepared to negotiate on an individual basis the ways in which these competences will be demonstrated by disabled students.

WEB LINKS: Meeting legal requirements

Relevant Equality Challenge Unit publications include:

Conducting Equality Impact Assessments in Higher Education:
<http://www.ecu.ac.uk/publications/equality-impact-assessment-in-he>

Involving Disabled People in Disability Equality Schemes: Briefing paper for the higher education sector.
<http://www.ecu.ac.uk/publications/involving-disabled-people>

Disability Equality Schemes – the annual report:
<http://www.ecu.ac.uk/publications/des-annual-report>

Guidance on developing a disability action plan in Northern Ireland is at:
<http://www.equalityni.org/archive/pdf/GuidetoStatutoryDuties0205.pdf>

For Northern Ireland also see:
[http://www.equalityni.org/archive/pdf/FHECOP\(SENDO\).pdf](http://www.equalityni.org/archive/pdf/FHECOP(SENDO).pdf)

5.6 Training staff

Medical schools should review and update their equality training programmes for staff and, when necessary, develop new ones to keep staff informed of their legal duties, including those around disability. Often this is best done in collaboration with disabled students and staff and, if possible, by engaging disabled people's organisations to deliver the training.

Universities benefit from the knowledge and networks of disability officers; and medical schools should also consider having a designated person or committee to address the school's legal duties.

This advisory guidance should help the following staff in their work in medical education:

All admissions staff must be aware of the need to make reasonable adjustments. They should also be trained in communicating with a wide range of disabled people and encouraging them to disclose in confidence.

Teaching and ancillary staff also need to know what is expected on:

- making teaching and learning more accessible to disabled students
- how to put reasonable adjustments in place
- what advice and support services are available for disabled students.

Occupational health staff should also be considered for disability awareness training and be able to advise on making reasonable adjustments.

WEB LINKS:

Staff training

The Open University provides a training site that explains how best to make teaching inclusive at:

<http://www.open.ac.uk/inclusiveteaching/index.php>

The Equality Challenge Unit has published *Choosing and Using Equality and Diversity Trainers and Consultants*:

<http://www.ecu.ac.uk/publications/files/choosing-and-using-equality-and-diversity-trainers-and-consultants.pdf/view>

Disability etiquette

There are many publications that offer guidance on appropriate behaviour and communication with disabled people.

A *National Framework for Disability Equality and Etiquette Learning* is available at:

www.health.heacademy.ac.uk/news-events/dl/TheDEELNationalFramework

The BBC offers some useful tips and advice on how best to welcome learners with a range of different impairments at:

http://www.bbc.co.uk/ictcoach/accessibility/dle_p1.shtml

SCIPS (Strategies for Creating Inclusive Programmes of Study) is the result of an HEFCE-funded project conducted at the University of Worcester:

<http://www.scips.worc.ac.uk/>

The disability etiquette guidance from SCIPS, including useful suggestions on language and common courtesies, is at:

<http://www.scips.worc.ac.uk/etiquette.html>

The Employers' Forum on Disability also publishes a *Disability Communications Guide* on language and etiquette, specific impairments and preferred modes of assistance, and how to recognise and avoid attitudes and behaviour that can create misunderstandings and barriers:

<http://www.efd.org.uk/>

See also *A-Z Equality and Diversity* from the Equality Challenge Unit, the Association of University Administrators Equality Advisory Group and the Higher Education Equal Opportunities Network:

http://www.aua.ac.uk/networks/sigs/current/e_and_d/docs/azguide2009.pdf

6. Disabled students as potential doctors

That selection for medical school implies selection into the profession is clear. This is in the context of the varied medical careers and types of training available.

Medical schools have a duty to ensure that they have clearly identified which entry requirements are genuine competence standards (and so lawful) and which are not. All assessments of competence are subject to the reasonable adjustments duty.

The Medical Schools Council states that:

‘Selection for medical school implies selection for the medical profession. A degree in medicine confirms academic achievement and in normal circumstances entitles the new graduate to be provisionally registered by the General Medical Council and to start practising as a doctor.’

It also states that:

‘A disability...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 submission so that their individual circumstances can be considered.’

This should present no problem if competence standards have been screened to avoid disability discrimination.

Dr Alan Swann surveyed medical schools in 2005 and has reported that 29 out of 31 schools had an explicit entry requirement that applicants must have the capability to be fit to practise at the end of the course. The associated occupational health assessment was in all cases designed to establish that the student could complete the course, given reasonable adjustments, and to establish what those might be. The basis of this process should be the competence standards set by the school, and the required prior academic and other attainments.

WEB LINKS: Fitness to practise

The Medical Schools Council's *Guiding Principles for the Admission of Medical Students* are at:

<http://www.medschools.ac.uk/Publications/Pages/GuidingPrinciplesfortheAdmissionofMedicalStudents.aspx>

A GMC statement on the meaning of fitness to practise is at:
http://www.gmc-uk.org/the_meaning_of_fitness_to_practise.pdf 25416562.pdf

Mental Health and Employment in the NHS

This 2002 publication is available at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008361

Dr Alan Swann's report can be found at:

http://www.heops.org.uk/Fitness_to_practise.pdf

7. Applying for medical school

7.1 Encouraging disabled people to apply for medicine

It is unlawful to discriminate against a disabled person because of their disability:

- in the arrangements made for determining admissions
- in the terms of the offer to admit the disabled person
- by refusing or deliberately omitting to accept an application for admission.

Where applications are usually made by application form, it is best practice to offer to make application documentation available in a range of accessible formats. If the format is electronic, it should be accessible to a range of screen readers and assistive software.

A range of contact details should be given, for example including telephone, text phone and email options.

7.2 Course information and advertisement

The first direct responsibility that a medical school has in the journey of a disabled applicant is in the preparation of information about the course. This may be accompanied by direct outreach activities.

In all its information, a medical school should make clear that applications from disabled people will be welcomed. Publicity material should be reviewed to check that it contains positive stories and images of disabled students. Where disabled people have succeeded in gaining a place or a prize or graduating, these examples should appear in the literature.

It is illegal to suggest that the success of a person's application may depend on their not having an impairment or a particular health condition. However, the competence standards of the course should be made clear and easily available, so that all applicants can judge whether they are able to reach them as long as reasonable adjustments are provided.

7.3 Accessible information

As a reasonable adjustment, course information may need to be made available in accessible formats such as email, Braille, large print, audiotape and computer disc. As part of the anticipatory duty, most general information, such as university policies and course leaflets, should be offered in a range of formats.

The use of assistive technologies, such as text phones, can be of great help at the enquiry stage. A text phone is used by people who are deaf and it has

a keyboard for typing messages and a screen for reading them. Appropriate staff should be trained in their use.

Medical schools' duties also cover open days, campus tours, summer schools, recruitment fairs, taster courses and schemes with secondary schools. Accessible information should be provided on the role of the Disability Support Office to make applicants aware of all available support from an early stage.

Medical schools should provide clear, accessible information on their websites and in their literature about the competence requirements of medical education. All staff involved in applications, selection, counselling or occupational health should be aware of how competency can be measured and assessed using reasonable adjustments.

Where possible, and subject to the preferences of the individuals concerned, information should be:

- offered in both visual and audible formats available in different font sizes
- available with different background and foreground colours
- available without enhancements such as boxes
- easily navigable if electronic, using either a mouse or keys.

WEB LINKS:

For an example of an accessible website see the Equality and Human Rights Commission page:

<http://www.equalityhumanrights.com/footer/accessibility-statement/>

The RNIB Web Access Centre pages offer information and advice on making websites accessible:

http://www.rnib.org.uk/PROFESSIONALS/WEBACCESSIBILITY/Pages/web_accessibility.aspx

7.4 Helping the applicant in their choice of school

Disabled applicants are expected to review the information provided in the light of their own requirements. Different schools offer very different curricula, with differing amounts of group interaction, community participation, patient contact, and scientific, laboratory and anatomy work. They offer different types of student accommodation and support, and different relationships between university and town. It is a clear legal requirement that all these facilities are equitably available to students with a range of impairments. All this information should be made available to applicants. Disabled students, just like any other

students, should select the course and school which best suits their needs. To help them do this, they should be invited to discuss their individual requirements before making an application.

8. Confidentiality and disclosure

Although there is no legal duty on applicants to disclose their impairment, they should be encouraged to do so in order that reasonable adjustments can be made.

When completing the application forms, applicants should be invited to disclose their impairments, and be told why they are being asked. It should be made clear that it will have no effect on the decision of interview panels, but is simply to inform the school of their requirements for the interview and for assessment of the need for reasonable adjustments to be made if a place is offered. Some students already have confidence in declaring their impairment:

'I have a relatively hidden disability (brittle bone disease). I have always declared my condition on any forms I have filled in which required me to do so.'

Medical student

Medical schools should therefore be proactive in encouraging applicants to disclose an impairment. This might involve:

- asking applicants to declare their disabilities on application and enrolment forms
- publicising the provisions made for disabled students, or providing opportunities for students to tell tutors or disability officers in confidence
- defining competence standards against which all applicants can measure themselves
- asking students once they are on the course whether they need any specific arrangements because of a disability
- explaining to students the benefit of disclosure and how this information will be kept confidential.

It is also important to ensure that the atmosphere and culture are open and welcoming so that disabled people feel safe to disclose an impairment or health condition. This might include the assurance that support is available for students who experience discrimination from hospital or primary care staff, patients or carers.

Encouraging applicants to disclose an impairment or health condition requires a confidentiality policy to ensure that the information will not be misused, and to give applicants confidence in the system.

'Many people with a mental illness do not regard themselves as disabled...If these students are to disclose their disability, the inclusion of mental illness needs to be spelt out. It needs to be made clear that disclosure is necessary so that support can be provided, and that they will not be penalised. Disclosure is much more difficult for mental health disabilities than for physical disabilities due to the stigma which unfortunately is still very prevalent.'

Member of Doctors' Support Network

Where information on disabled students may come through different channels, there must be a suitably confidential means to bring the information together.

A disabled student has the right to ask that the existence or nature of their impairment or health condition is treated as confidential. In determining whether it is reasonable to make an adjustment, the medical school must consider how far making the adjustment is consistent with a disabled person's request for confidentiality. It is possible to share information with staff, with a disabled student's permission, that identifies the reasonable adjustment and not the impairment.

The school's confidentiality policy should be stated and circulated to all applicants and staff. It should be made clear how the information will be used and treated, and what are the consequences of contravening the policy.

9. Tests, interviews and selection

9.1 Test methods for selection

Prior or as an adjunct to the interview, applicants might take a variety of tests. These must all be non-discriminatory:

‘Selection to medical school used to be done by straightforward interview. Now they have introduced psychometric testing and OSCEs this might make it more difficult for disabled students unless adjustments are made.’

Medical student

Medical schools must be confident that tests relate to candidates’ suitability for selection. Reasonable adjustments should be provided – see the list of possible reasonable adjustments to assessments in the Appendix. A practice test could be sent to candidates beforehand so they can request reasonable adjustments; this could also provide reassurance to disabled candidates.

9.2 Reasonable adjustments to the interview

The letter of invitation to interview should ask if the applicant has any accessibility requirements for the interview. There might be a requirement, for example, for questions to be written, or for physical access arrangements to be made, or for lip-reading or large print information.

At this stage, and at all stages, it is important to ask about the person’s requirements rather than the impairment. For example, the question should enable a candidate to say that the room should not have fluorescent lighting, not that they have epilepsy.

Most medical schools use interviews as a crucial part of the selection process. It is therefore essential to plan the reasonable adjustments in advance to accommodate the requirements of a range of disabled applicants. It would be discriminatory not to interview an applicant because they have an impairment or long-term health condition if it is by interview that the school would normally seek additional information about an applicant.

Medical schools should anticipate reasonable adjustments that might be required by disabled people in general, and should be able to put them in place very quickly, if necessary.

9.3 Questions about impairment, health and disability

The interview itself should be conducted in the same way for disabled and non-disabled applicants. An applicant’s impairment at this stage is irrelevant. It becomes relevant only when the applicant is offered a place.

It is not part of the interview panel's role to assess for possible reasonable adjustments. In general, interview panels are not qualified to do this. To do so could unfairly limit the time available for a disabled applicant to show their skills and qualities compared to that available to other applicants.

Many schools have already adopted the policy that questions about an applicant's impairment should be avoided during the interview as far as possible and reasonable. Once a place is offered, occupational health staff and the disability officer should discuss with the applicant what reasonable adjustments might be necessary. If the panel feels that it would be odd not to mention a very evident impairment, it might be appropriate to discuss how training would be done, but not what might be impossible. A recent case⁹ in which a disabled applicant was asked questions at interview that were clearly inappropriate for him illustrates the need for discretion.

However, the Equality Act does not prohibit the interview panel from asking questions about the applicant's impairment, as long as the questions concern:

- the applicant's requirement for reasonable adjustments
- the applicant's ability to meet the competence standards for the course.

A general discussion of the impairment would not be acceptable and might be judged to be discriminatory.

The Medical Schools Council makes it clear that:

'Medical schools will first consider applications on the basis of academic performance and personal qualities, and at those schools that interview, interviewers will not mention or discuss or evaluate the applicant's disability during a selection interview intended to assess personal qualities.'

9.4 Selection

A disabled applicant's merits should be assessed as though the reasonable adjustments required under the Act have been made. This is in line with the Act's requirement to consider the need to take steps to account for disabled people's impairments, even if this means treating them more favourably than non-disabled people. If, after allowing for those adjustments, a disabled person would not meet the competence standards for the course, a place does not have to be offered. This, however, can be highly problematical for two reasons:

⁹ BMA News, 1 December 2007. Page 1. *Doctor with MS: I was let down.*

- Interview panels may not be aware of an 'invisible' impairment or health condition and so decisions may be skewed.
- More importantly, it is highly unlikely that interview panels will be able to say with confidence what a candidate could achieve without a proper assessment and the implementation of reasonable adjustments.

Assessment of the need for and feasibility of reasonable adjustments therefore should not be made by the interview panel. It should only be done by individuals with particular expertise in this area and only after it has been decided that the applicant merits an offer of a place based on standard criteria.

A disabled person should not be offered a place on less favourable terms than anyone else. An unacceptable condition might be, for example, that the disabled person has to have a personal assistant when they have not had one previously.

One disabled person interviewed for this guidance gave this advice:

'Don't generalise what a disabled person can or cannot do. Don't assume everything will be a problem. There seems to be an assumption that disabled people don't know what they can or cannot do! They know their skills better than anyone. Treat everyone as an individual.'

Trainee

Interview panels should be careful about rejecting an applicant based on a judgement of possible barriers to achievement specifically associated with the applicant's impairment or health condition.

WEB LINKS: Selection criteria and interviewing

The Medical Schools Council offers *Recommendations on Selection of Medical Students with Specific Learning Disabilities including Dyslexia* at:

<http://www.medschools.ac.uk/Publications/Pages/Recommendations-on-selection-of-Students-with-specific-learning-disabilities.aspx>

The Medical Schools Council's *Guiding Principles for the Admission of Medical Students* are at:

<http://www.medschools.ac.uk/Publications/Pages/GuidingPrinciplesfortheAdmissionofMedicalStudents.aspx>

The British Medical Association report *Disability Equality in the Medical Profession* (2007) makes a number of recommendations on selection, and discusses the experiences of disabled students and doctors at:

9.5 Justifying a decision, appeals and complaints

On occasions, a medical school may be asked to justify rejecting a candidate on grounds relating to disability. The decision may be justified because the person does not meet the genuine competence standards, once reasonable adjustments have been considered, or because there is another material and substantial reason.

An example of a material and substantial reason might be if a student applied to study medicine full-time, but their condition required that they regularly attend long hospital appointments two or three times a week. They would therefore miss large amounts of the course.

Schools should:

- keep a record of the selection and interview processes
- detail the reasons for any decisions, using university procedures and forms
- ask the applicant to confirm that the information written down is correct, if they are happy for it to be passed on, to whom and for what purpose, and to sign the form accordingly.

This information must be kept confidential under the Data Protection Act 1998. The principles of that Act are that personal information must be:

- fairly and lawfully processed
- processed for limited purposes
- adequate, relevant and not excessive
- accurate and up to date
- not kept for longer than necessary
- processed in line with the person's rights
- kept and processed securely
- not transferred to other countries without adequate protection.

At all stages, in relation to all applicants and students, it is good practice to have consistency in decision-making and bias-free written notes so that, if a complaint is made, the school has evidence to answer a charge of discrimination. It is the school's responsibility to prove that it did not discriminate.

An accessible and clear process for dealing with complaints and appeals against a decision should be developed with copies made available, in a range of accessible formats, to applicants and students.

WEB LINKS: Bringing a case to court

Information about how an applicant might bring a case to court in England and Wales is at:

<http://www.courtservice.gov.uk>

For Scotland, the information is at:

<http://www.scotcourts.gov.uk>

For Northern Ireland, see:

<http://www.courtsni.gov.uk>

The Office of the Independent Adjudicator for Higher Education ('OIA') operates an independent student complaints scheme, but does not cover admissions. The OIA may publish recommendations and organise seminars about how higher education institutions in England deal with complaints and what constitutes good practice. The OIA has taken a particular interest in disability issues and is at:

www.oiahe.org.uk

10. Providing disability equality

10.1 Identifying student requirements

As explained previously, it is recommended that as far as possible selection is separated from consideration of an interviewee's impairments. Once the applicant is selected, however, the student's requirements and any related reasonable adjustments must be addressed before the course begins.

'About six months before I was due to start at Cambridge, the new dean contacted me, asking if I would like to meet up. I mentioned about adapted stethoscopes, and she soon had the technician at the clinical skills department on the case. He did quite a bit of research, and came up with a number of options for stethoscopes that would be useful. I went back a couple of months later, and was able to try out the stethoscopes that most interested me.'

Medical student

It is common practice to ask all applicants who have been offered a place to complete a health assessment form. A letter and form have been drawn up by a working party of seven medical schools along with the Higher Education Occupational Practitioners group (HEOPS) and a version is included on the GMC website. The form is designed to identify in advance anyone who will need support to help overcome barriers presented by the course. It is also designed to identify anyone who is currently unwell or still recovering from a serious illness so that they might be advised to defer entry until they have recovered. This could be seen as a reasonable adjustment to accommodate a person with an impairment or health condition. Schools may also wish to afford this opportunity to people with temporary impairments, even though people with impairments of less than 12 months' duration are unlikely to be covered by the Equality Act.

The disability officer should be informed when a disabled applicant is offered a place so that the process of agreeing reasonable adjustments can be started. The disability officer should involve the student, the course leader, the occupational health physician and specialist organisations in deciding what reasonable adjustments are needed.

Enrolment and induction offer further opportunities to gather information from disabled students about their requirements. It is important at this point to use accessible venues and to provide disabled people with an opportunity to discuss their impairment and any reasonable adjustment requirements in confidence.

It is worth noting that the new provision under the Equality Act concerning discrimination arising from a disability requires medical schools to take steps to find out about an applicant's disability. This is because a medical school

could be liable for unlawful discrimination if the school could reasonably be expected to know about an applicant's disability or if the school has been told.

The University of Aberdeen has recently introduced a new admissions procedure which gives all medical applicants and students access to occupational health services. Occupational health staff will only assess students who have a confirmed place to study at the University of Aberdeen. The purpose of this procedure is twofold: to identify the need for any reasonable adjustments that would enable students to complete their course; and to ensure that patients are not put at risk by, for example, students with a blood-borne virus infection conducting exposure-prone procedures. Recommendations relating to adjustments in the clinical and educational setting will be made by the occupational health advisers and the university's disability advisers. Both services will continue to support students, as necessary, throughout their studies. In the exceptional situation where any serious issues of health or disability may not be compatible with achieving the outcomes set out in *Tomorrow's Doctors*, the relevant Occupational Health report would be considered by the Admissions Dean in consultation with the Associate Dean (Undergraduate Medicine) and the Head of School of Medicine.

10.2 Making reasonable adjustments and offering support

The duty to make reasonable adjustments arises when disabled people are placed at a substantial disadvantage compared with people who are non-disabled in relation to the environment, procedures, practices, policies and the provision of auxiliary aids and services.

The concept of 'reasonable' is central to the Equality Act. It means that those providing medical training have a duty to find out how they can adapt their course and related services to meet the requirements of the disabled student. This goes beyond simply avoiding treating disabled people less favourably than others. In some cases, it may also mean providing facilities that non-disabled people are not entitled to. One example might be setting aside car parking for disabled people.

Some factors to consider when assessing if an adjustment is reasonable are:

- whether the adjustment will actually overcome the identified difficulty
- how practicable it is to make the adjustment
- the financial and other costs involved
- the amount of disruption caused

- the money already spent on adjustments
- the availability of financial or other assistance.

Many reasonable adjustments can be inexpensive and, in some cases, Disabled Students' Allowances (DSAs) or other funding from external agencies may be available to cover some of the costs. DSAs are grants to help UK students meet the extra costs of studying that they face as a direct result of a disability or learning difficulty. The medical school is responsible for meeting any additional costs, and it would be unlawful to try to recoup these from the disabled student.

Whether or not an adjustment is reasonable depends on many factors, including cost effectiveness, the impact on other students, and health and safety. Medical schools have to consider whether they can make the adjustment in the light of the following:

- they do not have to make every adjustment that a student asks for
- they cannot claim that an adjustment is unreasonable simply because it is inconvenient or expensive
- it is not the responsibility of the disabled person to suggest what adjustments should be made (although it is good practice for the medical school to ask)
- if a disabled person does suggest an adjustment, the medical school must consider whether the adjustment would help overcome the disadvantage, and whether it is reasonable.

Once a medical school has become aware of the requirements of a particular disabled student or applicant, it would be reasonable to take steps to meet those requirements. This is especially so where a disabled person has pointed out the difficulty that they face in accessing services, or has suggested a reasonable solution to that difficulty.

The Equality Act does not override health and safety legislation. If making a particular adjustment would increase the risk to the health and safety of anyone, including the disabled student, then this is relevant in deciding whether it is reasonable to make that adjustment. Risk assessments should be used to help determine whether such risks are likely to arise and, if so, how to remove them. However, there is no requirement to eliminate all risk, and there should be reasonable adjustments that will remove or minimise risks. Disabled people should be encouraged to have a say in what presents a reasonable risk.

Risk management should be an ongoing process undertaken in consultation with disabled students. However, health and safety must not be used as an excuse to avoid making reasonable adjustments.

Once a reasonable adjustment is to be put in place, it is important to communicate that fact in an accessible form to the disabled student concerned. Failing to make them aware of the adjustment may be tantamount to not making the adjustment at all. It is also important to maintain the adjustment so that it continues to work.

Reasonable adjustments must be made on a case-by-case basis. A list of examples is in the Appendix.

WEB LINKS: Reasonable adjustments

Detailed information on Disabled Students' Allowances is available at:
http://www.direct.gov.uk/en/DisabledPeople/EducationAndTraining/HigherEducation/DG_10034898

Universities and colleges in England can provide extra financial support for students in hardship through their Access to Learning Fund:
http://www.direct.gov.uk/en/EducationAndLearning/UniversityAndHigherEducation/StudentFinance/Extrahelp/DG_171615

Information about accessible technology is at:
http://www.direct.gov.uk/en/DI1/Directories/UsefulContactsByCategory/DisabledPeopleContacts/OrganisationsAndCharities/DG_10014867

For Disabled Students' Allowances in Scotland, contact the Students Awards Agency for Scotland at:
http://www.student-support-saas.gov.uk/student_support

There is more information about reasonable adjustments in relation to Northern Ireland at:
[http://www.equalityni.org/archive/pdf/FHECOP\(SENDO\).pdf](http://www.equalityni.org/archive/pdf/FHECOP(SENDO).pdf)

While not directly applicable to medicine, interesting suggestions for reasonable adjustments for veterinary training can be found in *Time to Take Stock: Disability and professional competence* edited by Anne Tynan at:
<http://www.ltsn-01.ac.uk/diverse/resources/TimeToTakeStock.pdf/>

Also, the Nursing and Midwifery Council has published an 86-page literature review on *Reasonable adjustments in nursing and midwifery* completed in March 2009 by A Kane and C Gooding at:

<http://www.nmc-uk.org/Documents/Research%20papers/Reasonable%20adjustments%20literature%20review.pdf>

11. Preparing the physical environment

Medical schools and their universities should be planning continually for the reasonable adjustments they need to make, whether or not they have disabled students.

They should anticipate the requirements of disabled people and the adjustments that may have to be made for them. This is particularly relevant in respect of buildings, whether they are owned, rented or leased. In all cases, buildings must be accessible for wheelchair users and others with mobility impairments.

In many cases, it is appropriate to ask a student whether they have any particular physical requirements and, if so, what adjustments may need to be made. If the need is not identified in advance, the medical school may fail in its duty to provide adjustments.

Reasonable adjustment of the physical environment

The principles to be followed emerge clearly from the leading higher education case (*Potter v Canterbury Christ Church University*). Craig 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 was greeted at the bottom of the steps because no ramp was provided to allow him access to the stage. The fact that he was not greeted by the Chairman of Governors on the dais because he is a wheelchair user placed him at a substantial disadvantage. He was not able to participate fully and with dignity in the degree ceremony and so was awarded £4000 damages against the university by the court.

It would be appropriate to arrange a risk and access audit of premises and to draw up an access plan. By acting on the results of an audit, medical schools may reduce the likelihood of successful legal claims.

Access audit

An access audit should be conducted and an access plan prepared. Physical features for review will include: steps, stairways, kerbs, exterior surfaces, paving, parking areas, building entrances, exits, emergency escape routes, internal and external doors, gates, toilets, washing facilities, lighting, ventilation, lifts, escalators, floor coverings, signs, furniture, and temporary or movable items.

 **WEB LINKS: Risk assessment**

Schools should review their risk assessment procedures and conduct risk assessment reviews of the environment.

The Health and Safety Executive provides a useful step-by-step guide to risk assessment at:

<http://www.hse.gov.uk/risk/fivesteps.htm>

12. Student induction and support

The medical school may have to make adjustments to ensure a disabled student is introduced in a clearly structured and supported way with, if necessary, an individually-tailored induction programme.

12.1 Health checks

All medical schools make health checks on all students for the purposes of both patient and student safety. However, disability and health are different issues. A medical school will probably be acting unlawfully if, without justification, it insists on a special health check for a disabled person, but not for others. The fact that a person has an impairment or health condition is, in itself, unlikely to justify singling out that person to have a health check. On the other hand, a disabled person may be asked to undergo an assessment of their reasonable adjustment requirements, for example as part of the process of applying for Disabled Students' Allowance, or if a condition is intermittent or deteriorating.

It is worth remembering that people with mental illness are included in the Equality Act definition of a disabled person, although people with mental illness often do not see themselves as disabled people.

12.2 Support systems

It is important that all medical schools provide counselling and support for disabled students. Local 'buddy' systems involving disabled and non-disabled students could be established. Personal tutors who are committed to, and well-trained in, disability equality issues are invaluable. Many universities have academic disability coordinators in each department or school who act as a source of expertise and can provide the link to the support services.

The GMC/Medical Schools Council guidance *Medical students: professional values and fitness to practise* (revised edition, 2009) sets out the importance of pastoral care and support (paragraphs 41 to 45). Students should be directed to support services such as student health services, disability advisers, occupational health services, confidential counselling, student groups and personal tutors. The occupational health service should assess and advise on the impact of an impairment and if appropriate advice on adjustments in liaison with disability advisers (paragraph 52).

One student made the following suggestions:

'A matching system could be put in place for the allocation of a mentor to each student. This way, students with disabilities could have that one important contact within the school of medicine whom they can trust and use as a first port of advice. Clear information should be given to such students about whom to contact for advice on provisions

available to them, such as extra time in exams and disability allowance. A 'buddy scheme' should also be arranged between students in different years of study with similar disabilities; this provides mutual motivation and another person to turn to for advice.

'I feel that **clinicians** should be given guidance on how to manage a 'doctor-student' patient relationship. Many students' consultants are also their lecturers which may make them feel uncomfortable. Furthermore, training and guidance should also be given to all staff within the school of medicine about how to manage students with disabilities and how to provide ongoing support. It is vital to remember that even though a student may appear to be coping well, it does not mean that they are; they may still need some support, both academically and emotionally.

'Most importantly, I believe continuing motivation through placements in hospitals should be given to all students, especially during the non-clinical years of the medical course. One good day on the wards can remind every student why it was their dream to become a doctor!'

Medical student

13. Teaching and learning

13.1 What is involved in inclusive practice?

A medical school or university must not discriminate against a student because of the student's impairment or health condition, in relation to:

- permanent or temporary exclusions from all or part of the course
- student services.

It is discriminatory for universities to exclude students because of their impairment or health condition. This can happen if the university has not sought sufficient information from the student, for example about the reasons for their behaviour or absence. This can apply to students with mental health conditions who are sometimes unaware that they have been excluded because the university has not communicated with them in an appropriate way. So universities must take reasonable steps to find out if someone is a disabled person before considering exclusions, since otherwise they will be liable for legal challenge.

Being inclusive means making sure that all student services are equally accessible to both disabled and non-disabled students. The following are examples of student services that should be reviewed as part of the anticipatory duty, or for specific reasonable adjustments:

- teaching, including classes, lectures, seminars and practical sessions
- curriculum design
- examinations and assessments
- work placements in the United Kingdom or abroad
- research degrees and research facilities
- informal/optional study skills sessions
- learning facilities, such as classrooms, lecture theatres, laboratories and operating theatres
- learning equipment and materials, such as laboratory equipment, computer facilities and class handouts
- libraries, learning centres, information centres and their resources
- information and communication technology and resources
- job references
- employment-finding services
- graduation and certificate ceremonies
- leisure, recreation, entertainment and sports facilities
- the physical environment
- chaplaincies and prayer areas
- health services
- counselling services
- catering facilities

- childcare facilities
- campus or college shops
- car parking
- residential accommodation
- accommodation-finding services
- financial advice
- welfare services.¹⁰

13.2 Course design

When designing courses, medical schools should be conscious that they have a duty to consider the requirements of disabled students in advance. They should therefore design courses and assessments to be as accessible as possible and flexible in their delivery so as not to disadvantage people with impairments or health conditions. They should regularly review with disabled students how courses are delivered and assessed as part of their disability equality duty and scheme. If new elements are introduced, new competence standards should be drawn up and assessed for any negative impact on disabled people.

WEB LINKS: Inclusive teaching and learning

The Higher Education Academy offers the following publications to support inclusive teaching and learning practices:

Embedding Success: Enhancing the learning experience for disabled students

This publication provides an account of innovative practice to improve the experience of disabled students and is at:

http://www.heacademy.ac.uk/assets/York/documents/resources/resourcedatabase/id594_embedding_success.pdf

Conference Report: Innovations in disability education

A summary of the projects presented, key outcomes and recommendations from a meeting held at the Royal College of Physicians, London in 2005 is available at:

<http://www.medev.ac.uk/newsletter/01.11/>

The Scottish Funding Council offers guidance on preparing an accessible curriculum at:

<http://www.teachability.strath.ac.uk/>

The Open University has published *Making your Teaching Inclusive* at:

<http://www.open.ac.uk/inclusiveteaching/>

¹⁰ These examples are based on the Disability Rights Commission's post-16 Code of Practice.

13.3 Clinical placements

Practical sessions should be accessible to disabled students and should be regularly reviewed. Relevant questions include:

- Have work placements been audited for accessibility? Are tutors aware of the barriers the environment may pose for disabled students?
- Have work placement providers been trained in disability equality or how to work with disabled students?
- Are students invited to disclose an impairment or health condition when placements are being organised? Are they asked about any particular needs?
- Are disabled students supported in finding placements that meet their requirements?
- Are arrangements made to ensure that disabled students can take personal assistants or purchase assistive technology if necessary?
- Are placement providers clear on who will take responsibility for paying for and making adjustments?
- Do tutors keep in touch with disabled students on placements so that they can take action if problems arise?
- If a placement cannot be made accessible, what alternative learning opportunities are available?¹¹

WEB LINKS: Clinical and practical work (including electives)

Relatively little has been written about disabled students and clinical placements. However, the Chartered Society of Physiotherapy offers a comprehensive guide to *Supporting Disabled Physiotherapy Students on Clinical Placement*. This publication is available to Society members at: <http://csp.org.uk>

A further useful resource is *Access to Practice: Overcoming the barriers to practice learning for disabled social work students* at: <http://www.swap.ac.uk/docs/Accessstopractice.pdf>

¹¹ These examples are based on the Disability Rights Commission's post-16 Code of Practice.

14. Supporting student progress

14.1 Assessment

Assessment is one of the educational components subject to the Equality Act's requirements. Schools should set out the rules for student progress, in such terms as attainment, experience, time frames, performance and behaviour. These should all be reviewed in terms of the Equality Act and reasonable adjustments made where appropriate.

All assessments should be based on defined competence standards which, in any case, may be part of the process of mapping tests onto the curriculum ('blueprinting') during test development.

Some possible adjustments are listed in the Appendix.

It would be appropriate to:

- determine before the examination, through personal discussion, whether disabled students need reasonable adjustments
- offer disabled students a contact with whom they can discuss their requirements
- decide with individual students what adjustments should be made, notify the student and officers, and discuss with them how the adjustments will be implemented.

Whatever adjustments are made, it should be shown that these do not affect the reliability and validity of the outcome of the assessment process.

It would be wise to invite the university or medical school disability officer to inspect assessments such as OSCEs to ensure that there is no inherent discrimination.

'The exam paper was enlarged and someone transferred the true/false answers onto the computer paper. With OSCEs the school enlarged the pictures and text.'

Trainee

'I was allowed to sit at the front of the exam halls to hear the announcements.'

Medical student

WEB LINKS: Inclusive assessments

The SPACE Project on inclusive assessment is at:

<http://www.plymouth.ac.uk/pages/view.asp?page=10494>

14.2 *Students who develop an impairment or health condition*

‘As they get older there is more chance of trainee doctors developing disabilities. Deaneries need to be aware of this. They are often not good at accommodating change, and are often quite dismissive of those who develop a disability. We all have varying abilities which change over time. Trainees need advice based on their abilities, not disabilities. A change of attitude is needed.’

Medical teacher

‘Accessing any information after an accident part way through training was a nightmare.’

Trainee

Students should have an ongoing confidential opportunity to disclose an impairment or health condition. This is so that if circumstances change during their time as a student, they can have reasonable adjustments made.

Medical schools should ensure that all students know whom to contact for advice if they do develop an impairment or health condition during their course. A process should be in place for determining the reasonable adjustments that such a student might need. They should be assured that having an impairment or health condition need not threaten their career or progress.

14.3 *Career guidance*

Career guidance is an important issue for every medical student and junior doctor, whether disabled or not. Anyone providing career guidance should be able to do so for all students. Officers should know to communicate with a range of disabled people using many formats and understand issues of exclusion and how to promote inclusion. The interviews undertaken for this advisory guidance revealed that tailored advice is lacking at every level and is greatly needed.

‘There was no careers guidance and it was badly needed.’

Disabled trainee

‘I have not had any specialist help. And with having specialist needs this would have been useful and would have saved me a lot of worry and uncertainty.’

Disabled trainee

‘There has been virtually no support...I have sought careers guidance myself and again have found this very difficult to obtain. It has made my training a very difficult and disappointing time for me as I have

been left feeling very isolated and unsupported. I tend to have had very little in terms of postgraduate options.'

Disabled trainee

'Trying to get careers advice from the deanery, faculty tutors and Colleges was hopeless. Consultants were fantastic but they do not know about specialties other than their own.'

Disabled trainee

14.4 Preparation for the Foundation Programme

Medical schools need to ensure that students are well prepared for the Foundation Programme. It is important that medical schools support disabled students in considering the issues involved and forms of support and reasonable adjustments that could be provided. Foundation Schools should be more likely to have made appropriate arrangements where students declare disabilities in their applications to the Foundation Programme.

15. Postgraduate training

The support given to disabled students before and during medical school applies largely to the educational, rather than the employment, component of postgraduate training.

There are, however, some differences.

15.1 Responsibility for postgraduate training

The Foundation Programme lasts for two years, the first of which is before full registration with a licence to practise and the second after full registration. From April 2010, the General Medical Council has ultimate regulatory responsibility for all postgraduate training. That includes the Foundation Programme and the subsequent specialty including GP training up to the final Certification of Completion of Training (CCT).

The Foundation Programme curriculum reflects a developmental approach to postgraduate medical education. Under the *curriculum*, foundation doctors have to demonstrate that they are competent in a number of areas, including professionalism, communication and examination skills, patient safety and team work as well as the more traditional elements of medical training.

The framework for this structured two-year training programme gives foundation doctors exposure to a range of career placements across a broad spectrum of specialties, including accident & emergency, general surgery and geriatric medicine.

The curriculum therefore sets out the competence standards for completion of Foundation Programme training. Thereafter, medical Royal Colleges have written curricula for all specialist training programmes. Some of these will have specific implications for disabled junior doctors which might require effective and accurate careers advice.

Realistic and honest careers advice should be made available to all trainees. Advice should be free from negative assumptions about the employability of disabled doctors.

WEB LINKS: Postgraduate training

The Foundation Programme curriculum is at:

<http://www.foundationprogramme.nhs.uk/pages/home/key-documents>

15.2 Legal requirements

Postgraduate deans, clinical tutors, educational supervisors, medical Royal College trainers and advisers, and the Colleges and specialties themselves should be familiar with their legal obligations. They must know about and apply, as a minimum, the provisions in relation to:

- what is unlawful discrimination
- making reasonable adjustments
- the anticipatory duty
- genuine and relevant competence standards
- termination of employment
- the Public Sector Equality Duty.

These responsibilities reflect the position at medical school. However, the trainee is now not only a doctor in training, but is also a doctor in employment providing, under supervision, a clinical service to patients.

With the contract of employment, different legal provisions come into play. Under Part 5 of the Equality Act, discrimination is outlawed in all aspects of employment and occupation including:

- recruitment and selection, including advertising jobs
- retention of employees
- promotion
- training.

The main provisions of Part 5 are that:

- direct discrimination (which includes treating someone less favourably directly because of their disability) is unlawful
- discrimination arising from disability (treating someone less favourably than others for a reason relating to their disability) is unlawful
- reasonable adjustments are expected in all aspects of employment, so must be made to working conditions, job descriptions, training, progression and the workplace environment to enable or help disabled people to do their job
- harassment at work is discriminatory
- an employer must not victimise or treat unfavourably someone disabled or not, because they have made allegations of discrimination or brought a complaint or any action under the Equality Act. A complaint of discrimination may be presented to an Employment Tribunal (Industrial Tribunal in Northern Ireland).

Part 5 also refers to combined discrimination (which includes treating someone less favourably because of their disability and another characteristic such as their race). However, this was not brought into force in October 2010.

The main difference from the education provisions of the Equality Act 2010 is that employers do not have a 'duty of anticipation'. This means that they do not have to make adjustments to their premises or working practices until they are actually needed by a disabled employee or applicant. Employers must, however, take reasonable steps to find out if an employee or applicant is a disabled person. And many would regard taking up the anticipatory duty as best practice in line with the DED, regardless of the letter of employment law.

The duty to anticipate the requirements of disabled people remains in relation to the education and training components of the postgraduate period. This means that improvements must be planned in advance, reviewed and updated on an ongoing basis. Clinical supervisors should have training in disability equality made available to them.

Medical schools should also be aware that it is unlawful under the Equality Act to ask job applicants specific health related questions in job applications, except in prescribed circumstances.

15.3 Responsibilities of employers towards doctors in training

The former Disability Rights Commission and the Health and Safety Executive (HSE) made the following statement in January 2007:

'We believe that health and safety law and its implementation is in the interests of all employees, whether disabled or non-disabled, and of the employer. Disabled people should expect effective and enabling risk management in the workplace.

'Health and Safety law and the Disability Discrimination Act when used appropriately will work together to increase the employability and retention of disabled people. A positive and sensible approach to risk management can and should in most circumstances encourage the inclusion of disabled people in the workplace.

'Risk assessment should not focus unduly on an individual's disability. It should look more broadly at the overall demands of the work and how best to manage associated risk.

'We want:

- employers to develop a working environment in which employees feel safe and supported to disclose and discuss its impact (including potential barriers to engagement, development and advancement within the workplace) on the management of their disability or long-term health condition;
- employees to work collaboratively with employers to help manage risk and to discuss positively with their employer approaches to making reasonable adjustments;
- the findings of risk assessments to provide clear recommendations wherever appropriate on how reasonable adjustments and timescales for implementing them are to be built into successful risk management.

‘Health and safety should never be used as a false excuse to justify discriminatory treatment. It will be the exception rather than the rule to exclude disabled people from particular jobs and tasks.’

‘Regarding disability and employment, it is not straightforward. There is a lot of under-reporting. Applicants don’t wish to divulge disability for fear of discrimination. It is, however, a legal requirement to know about disabled staff including doctors. Organisations need to show that they are positively encouraging disabled staff to be there, and that they are being supported.’
NHS employer

WEB LINKS: DRC/HSE joint statement

The joint statement on overarching principles of health and safety management and disability is at:

<http://www.hse.gov.uk/aboutus/meetings/hscarchive/2007/090107/c15a.pdf>

15.4 Induction of disabled doctors in postgraduate training

A report to the Royal College of Physicians, *Doctors with Disabilities: Clearing the way*, makes the following recommendations for the first meeting between the educational supervisor and the trainee:

- ‘Ask all trainees, not just those who seem to be disabled, if they have any health problems.
- Be frank when asking about the disability rather than avoiding talking about it.
- Respect clinical confidentiality.
- Find out what the trainee finds challenging, and the ways in which he or she manages such situations. For instance, some trainees

need time away from work within their working week, and others make a more effective contribution if they work intensively for three days.

- Ask them what adjustments, if any, they need to be made; for example, slowing their ward rounds, or help in carrying notes, recognition of hypoglycaemia by colleagues, etc.
- Ask if they need pre-arranged sick leave where they can sort out their health-related issues, make any necessary adjustments to on-call rotas or night duties.
- Get them to outline realistically the practical procedures which they might be unable to perform.
- Talk to them about professional exams and their special requirements for those exams.
- Discuss their long-term goals and try to help them choose a specialty in which their disability will not interfere in their career progression.'

Of particular concern might be mental health. The BMA publication *Doctors' Health Matters* points out that:

'Evidence shows that doctors are more likely to suffer from work-related mental ill health than other professions, with the prevalence of any common mental disorder in doctors as high as 28 per cent, compared with 15 per cent in the general population. Deep prejudices exist against people working in the NHS with mental illness. The myth that you cannot be a doctor if you are mentally ill is shown to be false and, although burnout and stress are important in medicine because of their frequency and disability caused, severe depression, near lethal suicide attempts and psychotic features are also all too frequent. Other studies have identified the major factors in mental illness as the long hours worked, the high workload, the pressure of work and their effect on the personal lives of doctors.'

It is important, however, to note that many disabled people have impairments that are not related to a health problem, since they are not ill.

WEB LINKS: Disabled people in medical practice

Into Medicine: Positive experiences of disabled people

This guide by Skill: National Bureau for Students with Disabilities 'features profiles of disabled people who are doing training or already working in the medical profession, as well as practical information and advice about the different routes into medicine and the fitness to practise assessment'. The guide can be bought at:

www.skill.org.uk/shop/shop.asp

Doctors' Health Matters: The work of the Doctors for Doctors Unit in supporting doctors and promoting wellbeing within the profession, a report by the Health Policy and Economic Research Unit (April 2007), is at:

http://www.bma.org.uk/doctors_health/doctorshealth.jsp

See also references on doctors' health listed at:

http://www.bma.org.uk/doctors_health/doctorshealth.jsp?page=7

15.5 Health clearance and disclosure

All new health care workers must now undergo health clearance, including screening for blood-borne viruses for those performing 'exposure prone procedures'. The aim is:

'...not to prevent those infected with blood-borne viruses from working in the NHS, but rather to restrict them from working in those clinical areas where their infection may pose a risk to patients in their care.'

An important feature of postgraduate training is the trainee's direct responsibility, under supervision, for patient care. Patient safety, risk assessment and close supervision should be key to all postgraduate training programmes whether the trainee is disabled or not.

It is vital that trainees are confident to disclose an impairment or health condition. During the application and induction process, they should be informed of the importance of disclosure and be assured of confidentiality and their safety in complying.

A career change may be needed if a trainee cannot complete some of the components of skills training. Advice should be sought before such decisions are made

Trainees may not wish to discuss their impairment with their supervisor and it should be made clear that occupational health staff are there to help, in the first place through the disability officer.

Providers of postgraduate training should develop policies to ensure that they share information about a disabled trainee's requirements and the reasonable adjustments that might be made. However, they must protect confidentiality at all stages and limit information to those who need it. It is distressing for junior doctors to have to explain repeatedly their condition and requirements. Steps should be taken to avoid this. Once the student or junior doctor has disclosed, then the institution is said 'to know' and must take steps to pass on information with the signed permission of the disabled person.

WEB LINKS: Health clearance

The Department of Health report on health clearance is at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073132

15.6 Provisions of the UK Foundation Programme Reference Guide; and of the 'Gold Guide'

The Foundation Programme Reference Guide published in March 2010 sets out a process for the Transfer of Information (TOI) as a means of supporting medical students as they move from medical school to Foundation School (paragraphs 8.37 to 8.47). The Reference Guide also sets out guidance for Foundation doctors wishing to train flexibly, one of the main reasons for which is a disability, where the doctor needs individual arrangements.

The *Guide to Postgraduate Specialty Training in the UK*¹² (known as the 'Gold Guide') endorses anti-discriminatory practice in recruitment (paragraph 6.1) and sets out the special eligibility of disabled trainees in relation to placement (paragraph 2.18):

'In placing trainees, Postgraduate Deans or their representatives must take into account the needs of trainees with specific health needs or disabilities. Employers must make reasonable adjustments if disabled trainees require these. The need to do so should not be a reason for not offering an otherwise suitable placement to a trainee.'

In relation to flexible training (paragraph 6.77) and transfers between postgraduate deaneries (paragraph 6.119), priority will be given to trainees with:

- disability
- ill health
- responsibility for caring for children
- responsibility for caring for an ill or disabled partner, relative or other dependant.

WEB LINKS: The Foundation Programme and the 'Gold Guide'

The Foundation Programme curriculum and Reference Guide is at:

<http://www.foundationprogramme.nhs.uk/pages/home/key-documents>

The 'Gold Guide' is at:

<http://www.mmcwales.org/specialty-training/gold-guide>

¹² The paragraph references and quotations are drawn from the 2007 edition.

15.7 Support for disabled trainees and reasonable adjustments

Although there is no anticipatory duty in relation to employment, there remains the duty to make reasonable adjustments for disabled trainees.

Medical Royal Colleges should review their examination arrangements against a policy background such as the *Consideration of Disabilities and Special Needs in MRCP (UK) Examinations* of the Federation of the Royal Colleges of Physicians, which sets out the following provisions:

- Candidates should provide information about their disability or additional needs
- The Board can then agree to make appropriate arrangements which might include:
 - extension of the registration and completion period
 - enlargement of exam scripts
 - use of scribe or communication assistant
 - use of appropriate aids during the clinical examination
 - extra time for assessments.
- An arbitration process in case of dispute should be provided.

One deanery reported the following case:

‘A trainee was training for a double CCST¹³ in respiratory medicine and clinical pharmacology. His MS (known about at appointment) deteriorated such that he was unable to perform bronchoscopies (particularly as he had optic nerve problems). However, he was encouraged to focus on the clinical pharmacology, which he completed successfully, and, in view of his progressive disability, accepted the advice that a career in the pharmaceutical industry was safer than direct patient contact. He was successful in completing the relevant CCST.’

In another case, a trainee who had a malformed upper limb was excused from cardiac compression and intubation during CPR training.

15.8 Support and reasonable adjustments in the case of mental illness

The following account of a trainee with mental illness diagnosed during postgraduate training suggests a number of possible reasonable adjustments and support measures that might be useful:

‘The consultant I worked for at the time of my diagnosis was great. We used most of the weekly supervisions to discuss my diagnosis and

¹³ Certificate of Completion of Specialist Training

possible consequences including the risk of relapse, the possible impact of mental illness on performance and fitness to practise, and the importance of insight. He managed to reduce some of my fear and anxiety about being stigmatised and discriminated against for the rest of my professional (and private) life.

'We agreed that I would continue to work full time but stop night on-calls for the time being to reduce some of the pressure and to allow a regular sleeping pattern. My psychiatrist later referred me to occupational health to get more advice on possible work arrangements.

'The next year was difficult due to being off sick for months in a row and feeling very guilty about that, coming back to work and trying to sit the exam in between aiming for the right combination of medication, and relapsing due to sleep deprivation when trying to re-commence on-call work. I worked nine to five and had a reduced workload. At one point, it seemed that we had reached the limit of how much adjustment to a job is possible. But my clinical tutor suggested that the deanery would find me a staff grade post within the Trust and that my place on the rotation would be kept open for me to come back. However, we decided against this option. Eventually, I was offered a six months extension of my rotation and passed the Part 2 Exam.

'After that I had very useful meetings with my clinical tutor, occupational health consultant and my educational supervisor to discuss my strengths and weaknesses due to suffering from a mental illness, the choice of a sub speciality and different locations/Trusts to work as an SpR.

'I have started my full time post as an SpR. Occupational health has agreed to allow me to try night on-calls again. The condition being that I will have backup by a consultant who knows about my illness so that I could ring the backup consultant any time if things get too much and he/she would take over.

'When I wasn't so well earlier this year my consultant agreed on flexible working hours. These sorts of adjustments are very helpful, I needed it only for two weeks, but I'm sure it played a part in not further relapsing.

'I made sure that the Program Director of the SpR Rotation is aware of my illness and our agreement is that I apply for/attend the programmes as everybody else; however, should I feel it becomes too much I could discuss it with him etc. He also reassured me that he would always be available in the background.

'There are several aspects which have to be considered in order to ensure as much mental stability as possible and ongoing fitness to practise:

- be aware of warning signs for possible relapse and alert for changes
- involve people around you and work together with the support system available
- my safety net consists of my psychiatrist, my occupational health consultant, the consultant I work for and myself
- I also always encourage my educational supervisor to tell me if he/she thinks something isn't quite right
- in my experience it is helpful to be open with colleagues I work with closely as they usually appreciate to know what is going on and therefore find it easier to help if needed.'

'It did take a lot of determination from myself and everybody else involved to finally get me where I am now. It took a lot of emotional support as well. I needed a lot of support from my psychiatrist, consultants and occupational health consultant. We talked for hours, wrote endless emails, and probably repeated ourselves a million times but it helped to restore a lot of my self-confidence. It also restored my belief that I am able to have a career in psychiatry.'

Disabled trainee

15.9 Teaching and learning in the clinical arena

Although periods of prescribed clinical work are set out in postgraduate curricula, it is no longer a requirement for full GMC registration with a licence to practise to have completed surgical and medical attachments while provisionally registered. This changed when Sections 10 to 13 of the Medical Act were replaced by Section 10A.

Neither the Foundation Programme curriculum nor any specialty training curriculum makes any special provision for disabled trainees. That provision will derive from the legislative framework outlined in this guidance. According to the Foundation Programme curriculum, the competence on behaviour in the workplace requires that in all interactions with patients or colleagues a Foundation doctor takes account of factors pertaining to the individual's age, colour, culture, disability, ethnic or national origin, gender, lifestyle, marital or parental status, race, religion or beliefs, sexual orientation, or social or economic status.

🔗 **WEB LINKS: Regulation of postgraduate training**

The Medical Act in full is at:

http://www.gmc-uk.org/about/legislation/medical_act.asp

The GMC displays all approved specialty including GP curricula and its equality and diversity policy at:

<http://www.gmc-uk.org>

16. The GMC and the Medical Act

The Medical Act is the legislation that established the GMC and sets out the statutory basis for registration and the licence to practise. It also sets out the regulatory requirements for medical education and training all the way from entry to medical school to award of a Certificate for Completion of Training.

The law gives the GMC four main functions under the Medical Act:

- keeping up-to-date registers of qualified doctors
- fostering good medical practice
- promoting high standards of medical education
- dealing firmly and fairly with doctors whose fitness to practise is in doubt.

Registration and the licence to practise exist to show the public that doctors are fit to practise, as part of a profession with nationally recognised standards set by law. The Medical Act states that the main objective of the GMC is 'to protect, promote and maintain the health and safety of the public'. The advisory guidance set out here is in line with that objective.

Appendix

Examples of reasonable adjustments

Medical schools could keep a record of reasonable adjustments they have made and the costs involved, so that they can share their experiences and perhaps achieve future economies of scale.

At the start of 2010, medical schools provided the GMC with examples of reasonable adjustments that they had made. These are included below, along with potential reasonable adjustments set out in the 2008 edition of this guidance.

Physical environment

- ramps to all necessary locations
- accessible lifts and lift buttons
- automatic doors
- accessible external paths and landscaping
- accessibility within buildings, including their interior layout
- vibrating and light fire alarms for deaf people
- adapted fire alarms and door bells in university accommodation
- vibrating pagers
- fire refuges or alternative escape routes for people with mobility impairments
- quiet refuges and first aid facilities where people with epilepsy, for example, might go after an attack
- rooms without fluorescent lighting
- enhanced signage and colour or tone contrasts to aid orientation
- enhanced lighting to facilitate lip reading
- effective sound system with T loops
- desks, laboratory benches, work surfaces and reception desks at varying or flexible heights
- appropriate seating
- reserved areas in all teaching and learning locations, including the library
- accessible technology, including screen readers, and libraries
- accessible toilets
- accessible services, such as catering facilities
- convenient and reserved parking spaces
- lowered kerbs.

Application process

Reasonable adjustments to the application process:

- text phones for the enquiry stage
- information, such as university policies and course leaflets, in potentially accessible formats: such as email, braille, easy read, large print, audiotape, and computer disc
- electronic information that can be accessed by a range of screen readers and assistive software
- staff trained in communicating with a wide range of disabled people.

Where possible, all information should be:

- offered in both visual and audible formats
- available in different font sizes
- available with different background and foreground colours
- available without enhancements such as boxes
- easily navigable, if electronic, using either a mouse or keys.

Teaching and learning

Reasonable adjustments involving documents:

- plans, summaries, notes, handouts and overheads available in advance of lectures
- prioritised reading list
- glossary of technical terms/specialist vocabulary
- copies of overheads, diagrams and so on created in class provided also in paper form
- additional inter-library loans
- documents printed on different coloured paper
- documents printed with larger font
- subtitled / transcribed video material where this is used in lecture situations
- availability of notes in electronic format to enable use of assistive software (such as text to speech; speech to text; mindmapping software)
- intranet material that meets established guidelines for compatibility with specialist software
- availability of searchable reference texts
- written materials available in audio format
- comments on course work in alternative formats

Reasonable adjustments through human assistance:

- proof reader for written assignments
- note-taker to attend lectures
- teaching staff asked to face the class at all time when giving a lecture
- additional regular 1:1 tutorial support
- support in researching booklists for those unable to 'browse' in the library
- provision of study skills support covering essay writing or dissertation skills

Reasonable adjustments through allowances:

- extensions to deadlines
- extended Library Loans
- permitted periods of absence
- breaks permitted in teaching sessions
- assignment work marked with a yellow sticker and appropriate guidance issued to markers

Reasonable adjustments through equipment:

- staff using a microphone for all lectures
- permission to record lectures
- LOOP system during teaching
- laptop to take notes
- use of an amplified stethoscope
- stethoscope linked to a display screen
- chair available in teaching sessions
- hand-held devices for taking notes
- spell checkers
- screen readers
- microscopes linked to CCTV screens
- compatibility of online teaching resources with the student's software magnification programmes

Reasonable adjustments to the teaching and learning environment:

- good lighting during lectures
- elimination of background noise

- adjustments to the physical environment
- additional training for teachers in making teaching and learning more accessible to disabled students.

Assessments

Reasonable adjustments involving documents:

- coloured overlays
- exam papers on coloured paper, for example pale yellow, cream, salmon pink or grey
- exam papers in larger or non-serif font
- single side papers
- larger size papers or exam sheets
- instructions in written form

Reasonable adjustments through allowances:

- extra time in written or oral exams
- additional reading time to view exam paper
- breaks permitted in exams for example for rest or toilet breaks
- permitted to use eat, drink or use insulin, medication, eye drops or inhaler
- extensions to individual assessment deadlines
- no penalty for poor spelling, grammar, punctuation, syntax or structure where the meaning is clear

Reasonable adjustments through equipment:

- computers for exams or in-course assessments
- spellchecker
- A3 optical mark reader for MCQs or slides (the marks then transposed onto A4 sheets for marking)
- special lighting
- desk with extra space
- writing slope
- supportive furniture or cushion or lumbar support

Reasonable adjustments relating to locations:

- private rooms or separate supervision, for example so questions can be read allowed
- a smaller, separate venue
- seat near the door to allow student to have toilet breaks
- seat at the front or the back of the examination room

Other reasonable adjustments to written exams:

- a scribe
- a reader
- scrap paper available
- student circles her answer on her question paper and after the exam has finished she sits with a member of staff who completes the optical mark sheet with her
- gap of at least two hours between exams
- scheduling so that student did not take two exams in one day
- visual prompts given to signal the start and end of exams
- oral instructions given individually

Reasonable adjustments for practical assessments such as OSCEs:

- chairs
- gloves
- ear defenders
- sphygmomanometer with a red flipper valve for a Blood Pressure station
- amplified stethoscope
- student permitted to summarise verbally at the end of each station
- student permitted to use an agreed alternative word or expression
- student permitted to write down a word if unable to verbalise it
- extra question reading time
- paper copies of the instructions for each station
- extra time at station assessments that do not directly replicate clinical practice
- student individually timed at each station once they had entered that station
- physical stations in OSCE to be followed by a rest station or placed at the end of the exam
- where OSCEs are being held at more than one location, efforts made to place candidates at the site which is easiest to navigate
- allocation to a specific morning or afternoon slot
- face to face interaction ensured with student positioned suitably for all sessions
- a reader

- a 'competent other' provided in the station who could be instructed by the student in conducting the resuscitation task
- additional practice sessions and support given prior to the OSCE
- timing of OSCE exams to earlier rather than later in the day
- individual circuit for OSCE assessments
- OSCE stations made more accessible, for example a resuscitation manikin placed on a couch
- examiners briefed about individual trainee requirements
- a signer entering the assessment cubicle with the student to place a microphone on the manikin while the student reads the instructions.

Other reasonable adjustments to assessments and examinations:

- appropriate timing during the day
- flexibility in ways of enabling students to answer, such as: an oral rather than written assessment; a written exam, extended essay, or PowerPoint presentation rather than a verbal presentation
- partial retakes and deferred exams for those with illness
- extension of the registration and completion period for Royal College examinations.

Clinical placements

- avoidance of immuno-suppressed patients
- placements arranged close to student's home
- car parking
- placements with good transport links or which are otherwise easy to access
- taxis to placements
- rotations in more manageable order
- additional coaching and mentoring
- opportunities to sit down
- additional support for students in finding placements that meet their requirements
- buildings made accessible for wheelchair users and others with mobility impairments
- checking of lighting and obstacles
- alternative learning opportunities where placements cannot be made accessible
- an electric scooter for getting around a hospital
- replacement sets of wheels for entry to the operating theatre

- training of work placement providers in disability equality and how to work with disabled students
- increased supervisory support
- slowing of ward rounds, help in carrying notes
- arrangements made to ensure that disabled people can take personal assistants or assistive technology with them where necessary
- amplified stethoscopes
- compatibility of patient records, X-rays and test results with the individual's software magnification programmes
- flexible working hours
- adjustments to working hours, for example reduced hours, reduced daytime on-call duties, fewer or no night time duties or weekend calls
- adjustment made to duties, for example no crash calls for wheelchair users
- part-time placements
- extra time and time out
- time off to fit treatment schedules, therapy and out-patient appointments
- placements modified to allow attendance at signing and lip reading classes in the evening.

Other support

- mock PBL session set up for applicants to medical school
- tutors made aware of student's condition
- student allowed to wear medic alert and carry medication at all times
- Student Support ID card asking for reasonable adjustments
- specialist ICT equipment in accommodation
- option to use personal radio system in exams, taught sessions, ward rounds and theatre sessions
- time out from studies for those with illness
- appropriate treatment assured
- links with specialist organisations if help is needed, for example by dyslexic students
- a mentor or additional mentoring
- local 'buddy system' between disabled and non-disabled students
- disability-awareness training for staff to increase awareness of common disability related issues
- staff in accommodation blocks made aware of the disabled student's needs
- staff trained in communication with a hearing impaired person..