

<b>Agenda item:</b>	<b>6</b>
<b>Report title:</b>	<b>Health and disability work programme – revised guidance for public consultation</b>
<b>Report by:</b>	<b>Ioanna Maraki</b> , Policy Manager, Education & Standards, <a href="mailto:ioanna.maraki@gmc-uk.org">ioanna.maraki@gmc-uk.org</a> , 020 7189 5249
<b>Action:</b>	<b>To consider</b>

## Executive summary

We have been undertaking a work programme on health and disability for the past year, centred on the revision of our guidance in this area, *Gateways to the professions*. We have engaged with an external group of experts, chaired by Professor Bill Reid, to develop a new version of the guidance. We have also built a wider 'reference community' of individuals and organisations, including through nine roundtable events across the four countries. And we have presented the ongoing work to key stakeholder groups to get their feedback.

The new guidance maintains the core principles from *Gateways to the professions*, but the structure and content has been re-organised to address our stakeholders' requests for the new version. There is a new chapter explaining the concepts of disability and reasonable adjustments in more detail, as well as our considerations as a professional regulator at each stage of medical education and training. There are separate chapters explaining the expectations from undergraduate and postgraduate providers (and employers), and offering practical suggestions about how these organisations can apply their duties. One of the key aspects is a process framework with seven steps, included for the undergraduate and postgraduate setting, which organisations can adapt to help with decision-making. There is also advice for particular aspects of medical education, such as clinical placements, practical assessments and Annual Reviews of Competence Progression (ARCPs). The content has been distilled in summaries and infographics, and the chapters include our considered responses to commonly asked questions in this area, presented as 'panels' throughout the guidance.

## Recommendation

The Board is asked to note the proposed revisions to guidance on health and disability and agree the proposal for a public consultation on the revised guidance in April 2018.

## Why are we addressing this subject?

- 1 We have been working in the area of health and disability since 2008, when we first published [Gateways to the professions](#). This guidance was last updated in 2013. In 2016, our Education and Training Advisory Board (ETAB) and other external stakeholders agreed they would like to see a further revision. The former Strategy and Policy Board (SPB) [approved a work programme](#) to complete this in February 2017.
- 2 The work programme is closely linked to our standards for medical education and training ([Promoting excellence](#)), which require organisations to support learners, including making reasonable adjustments for disabled learners. It also helps us embed fairness in medical education.

## What is the proposed approach

- 3 We have largely re-written the *Gateways to the professions* guidance to meet the needs of our stakeholders. The main changes and the structure of the new version (proposed name: Welcomed and valued) are set out in the next few paragraphs.
- 4 Overall changes:
  - a The principles of the previous version of the guidance have been maintained, but very little of the actual content has been copied across in the new version.
  - b The majority of the content has been re-organised to reflect a balance between the role and considerations of the GMC, the medical schools and postgraduate providers. The guidance contains the following chapters:
    - i Chapter 1: Health and disability in medicine – our considerations as the professional regulator.
    - ii Chapter 2a: What is expected of medical schools?
    - iii Chapter 2b: How can medical schools apply their duties?
    - iv Chapter 3a: What is expected of postgraduate providers and employers?
    - v Chapter 3b: How can postgraduate providers and employers apply their duties?
  - c Each chapter has a summary of key messages and infographics to help readers digest the content, as requested in the external research we commissioned to inform the work programme. The key messages can be seen in Annex A.

- 5 Each chapter addresses different needs communicated by our stakeholders who will be affected by the guidance: medical schools, postgraduate providers, medical students and doctors.
- 6 Chapter 1 seeks to clarify exactly what the GMC considerations are in relation to disabled learners, at each stage of education and training and beyond. This is because our stakeholder engagement showed there are several perceptions about the GMC's involvement regarding disabled students and doctors; for example, what we think about disabled people studying medicine and registering a disabled graduate. So we want to provide a definitive position. The chapter also gives detailed explanations on the definition of disability and the concept of reasonable adjustments in equality legislation, both consistently requested by our stakeholders.
- 7 Chapters 2a and 3a aim to answer the question of what different organisations are expected to do for disabled learners. The chapters bring together various sections of the previous version of the guidance, so that each organisation type only needs to read one part of the guidance to understand their duties. The expectations fall into two main categories: following equality legislation by avoiding discrimination and making reasonable adjustments; and meeting our *Promoting excellence* standards for supporting learners. These chapters also use examples to illustrate how the different types of discrimination would apply to situations in medical education and training, and examples of making reasonable adjustments.
- 8 Chapters 2b and 3b aim to provide examples of good practice and practical advice on how organisations apply their duties, both requested by our stakeholders. We do this by outlining a seven-step framework on providing support in the undergraduate and postgraduate settings, which organisations can adapt to their own processes as they see fit. The frameworks were developed with input from experts in occupational medicine. The chapters also signpost to existing resources and processes, for example the Transfer of Information (TOI) and Special Circumstances processes for applying to FY1, the educational review process in postgraduate education, the Disabled Student Allowance (DSA) and Access to Work. Both chapters have specific sections for unique components of medical education, including clinical placements, practical assessments, and ARCP.
- 9 Throughout the document, there are panels that answer complex queries that are often asked in face-to-face sessions on this topic, to give a consistent GMC answer and messaging.
- 10 When the guidance is published, it will be accompanied by a 'hub' of resources, including short films, written accounts, links to relevant publications and organisations. This is in response to our stakeholders telling us they want more resources in this area (the SPB approved this approach in February 2017).

## Equality and Diversity

- 11 We have engaged with the Equality and Diversity team throughout this work programme, including for the development of the draft guidance.

## Implications

- 12 For the development of the guidance, we have engaged with experts through our external steering group, chaired by Prof Bill Reid and including representation from a range of organisations (see Annex C). We have listened to the issues through nine roundtable sessions across the four countries, with medical students, doctors, educators and employers; we also commissioned research to understand the issues in more depth (see Annex B). We also gathered thoughts about the work programme from a number of stakeholder groups, including ETAB, the Medical Schools Council (MSC) Education sub-committee, the MSC Selection Alliance, the Foundation School Directors committee and Health Education England Deans.
- 13 The revised guidance has been reviewed by the steering group, selected external organisations (Mind and the British Dyslexia Association) and internal colleagues (Equality & Diversity and Legal teams).

## 6 – Health and disability work programme – revised guidance for public consultation

### 6 – Annex A

#### Key messages from each chapter of the guidance

##### Chapter 1: Health and disability in medicine – our considerations as the professional regulator

- 1 As the professional regulator, we firmly believe disabled people should be welcomed to the profession and valued for their contribution to patient care.
- 2 Doctors, like any other professional group, can experience ill health or disability. This may occur at any point in their studies or professional career, or long before they become interested in medicine.
- 3 No health condition or disability by virtue of its diagnosis automatically prohibits an individual from studying or practising medicine.
- 4 Having a health condition or disability is not a fitness to practise concern. We look at the impact a health condition is having on the person, which will be unique.
- 5 This guide covers the legislation and other requirements for supporting disabled learners, but the principles and advice apply beyond medical students and doctors who meet the legal definition of disability.
- 6 Medical students and doctors have acquired a degree of specialised knowledge and skills. We should utilise and retain this within the profession as much as possible.
- 7 A diverse population is better served by a diverse workforce that has had similar experiences and understands their needs
- 8 Legally, disability is defined as an ‘impairment that has a substantial, long-term adverse effect on a person’s ability to carry out normal day-to-day activities’. This covers a range of conditions, including mental health conditions if they meet the criteria of the definition.

- 9 If there is doubt about whether an individual will be covered by the legal definition, it is best practice to assume that they will be and focus on identifying reasonable adjustments and support that will assist them.
- 10 Organisations must make reasonable adjustments for disabled people. Making reasonable adjustments means making changes to the way things are done to remove the barriers individuals face because of their disability.
  - a Organisations must consider all requests for adjustments, but only have the obligation to make the adjustments they consider reasonable.
  - b The main factor for deciding if any adjustment is reasonable is whether it removes the disadvantage for the disabled person.
- 11 Our considerations as a professional regulator:
  - a We are bound by the public sector equality duty, promote equality and eliminate discrimination
  - b We also have education standards saying organisations must support learners, including through making reasonable adjustments
  - c Learners and organisations have a shared responsibility for looking after wellbeing (GMP and AGMP)
  - d We do not have a remit on admissions, but we believe it is logical for schools to take into account how likely a candidate is to meet the required level of knowledge and skills to be awarded a PMQ.
  - e Any student can graduate as long as: they are well enough to complete the course; they have no SFTP concerns; they have met all the *Outcomes for graduates*, with adjustments to the mode of assessment as needed.
  - f We ask for health information to provisionally register doctors but that is not a barrier to registration
  - g All medical students and doctors, regardless of whether they have a long-term health condition or a disability, need to meet the competences set out for different stages of their education and training. This includes the *Outcomes for provisionally registered doctors* at the end of Foundation Year 1 and the learning outcomes of their curricula through training.
  - h We rarely need or ask for health information after full registration

## Chapter 2a: What is expected of medical schools?

**12** There are two overriding expectations for all medical schools in the UK. Firstly, medical schools must comply with equality legislation. Secondly, medical schools must meet our standards and requirements for medical education and training in the UK.

**13** Complying with equality legislation means:

- a** Avoiding unlawful discrimination. This includes several types of discrimination:
  - i** Direct discrimination: Medical school staff have to avoid a student being treated less favourably than another student because of their disability. It is not direct discrimination against a non-disabled student to treat a disabled student more favourably.
  - ii** Indirect discrimination: Medical school staff have to ensure the way they do things for all their students do not particularly disadvantage students with a disability.
  - iii** Discrimination arising from a disability: Medical school staff have to avoid treating students unfavourably because of something connected with their disability.
  - iv** Medical school staff have to avoid victimisation and harassment.
- b** Making reasonable adjustments: Medical school staff must take positive steps to ensure that disabled students can fully participate in the education and other benefits, facilities and services provided for students.
  - i** Medical school staff have to take reasonable steps to avoid substantial disadvantage for disabled students from a provision, criterion or practice (simply put, the way things are done), a physical feature, or the absence of an auxiliary aid.
  - ii** The duty is anticipatory. This means medical school staff must anticipate the needs of disabled students.
  - iii** The duty is ongoing; it is not discharged once one adjustment has been made. If the adjustment is not effective then the medical school must think again.
  - iv** Reasonable adjustments should be considered on a case by case basis, taking into account the individual's circumstances and the specific barriers or disadvantages they are experiencing.
  - v** Medical schools need to keep an audit trail to demonstrate they have considered whether an adjustment is reasonable, including factors like: how

effective the adjustment would be; how practicable it is to make; the costs incurred; and the organisation's resources.

- vi Medical schools owe this duty to applicants, existing students, and, in limited circumstances, to disabled former students.

**14** Meeting [our standards for medical education and training](#) means:

a Following the requirements for supporting learners:

- i Giving access to resources support health and wellbeing (R3.2)
- ii Ensuring learners are not subjected to behaviour that undermines professional confidence, performance or self-esteem (R3.3)
- iii Making reasonable adjustments for disabled learners, and ensuring learners have access to information about reasonable adjustments with named contacts (R3.4)
- iv Considering needs of disabled learners when moving between different stages of education and training (R3.5)
- v Supporting learners where reasonable to overcome concerns on progress, performance, health or conduct and, if needed, giving advice on alternative career options (R3.14)
- vi Medical students who are not able to complete a medical qualification or to achieve the learning outcomes required for graduates must be given advice on alternative career options, including pathways to gain a qualification if this is appropriate.

**15** Medical schools and universities should focus on whether there are support measures or reasonable adjustments they can make to enable a student to demonstrate the required competence standards. They should not focus on what support and adjustments might ultimately be provided in a workplace.

## **Chapter 2b: How can medical schools apply their duties?**

a Identified principles of good practice in supporting disabled learners:

- i Fostering a positive culture towards health and disability
- ii Supporting students in sharing information early
- iii Having established and clear processes for supporting disabled learners
- iv Effective communication across stakeholder groups

- v** Individualised tailored support
  - vi** Inclusive learning environment
  - vii** Investing in staff training and workshops
  - viii** Monitoring and review
- 16** According to the research, students faced communication barriers, physical barriers, financial barriers, cultural barriers, and rare experiences of discrimination
- 17** Before any new student arrives, medical schools must make sure everything about the course is inclusive and welcoming for disabled learners. This covers the physical environment, auxiliary aids, and ways of doing things (provisions, criteria or practices). Schools have a duty to anticipate the needs of disabled learners, even if there are no disabled students on the course at a given time.
- 18** A school must take steps to find out about a student's long-term health condition or disability. Once this information is shared, the medical school must address the student's requirements for support and reasonable adjustments as soon as possible. We encourage medical schools to adopt the case management model as good practice supporting disabled learners.
- 19** Using a stepwise process, medical schools should develop an action plan for each of your students considered.
- a** Step 1: Deciding who to involve in the student's support group
  - b** Step 2: Deciding who will be the key contact
  - c** Step 3: Further confidentiality arrangements
  - d** Step 4: Case conference / support group meeting, reaching a shared decision about how the student would be affected by the demands of the course.
  - e** Step 5: Deciding whether the student can be supported to meet the Outcomes for graduates. If the student can be supported to meet the outcomes, the school must make every effort to support them in doing so.
  - f** Step 6: Forming an action plan. Once a decision has been made on whether the student can be supported to meet the Outcomes for graduates, the medical school must formulate an action plan with the student. The action plan should elaborate on what support and reasonable adjustments will be given to the student to help with each component of the course, including accommodation / transport, academic components, clinical placements and assessments. The action plan should also take into account care arrangements for the student, for example how much time off

they may need to attend medical appointments. If the school decides that the student cannot be supported in meeting the Outcomes, it must encourage the student to consider alternative options, including gaining an alternative degree from the university and other career advice.

- g** Step 7: Implementation, monitoring and review. There is a shared responsibility for implementing the action plan between the medical school and the student.
- 20** It is good practice to involve occupational health services with access to an accredited specialist physician, with current or recent experience in physician health.
- 21** Enrolment and induction offer further opportunities to gather information from disabled learners about their requirements. Make it clear that some students will inevitably suffer from health conditions or disabilities in the duration of the course. The medical school knows this will happen and has services in place to support its students.
- 22** Medical schools should continuously promote health and wellbeing for their students. Medicine is a demanding and stressful course and students should be empowered to look after their health and wellbeing through activities by the school.
- 23** Schools must be prepared to respond to evolving needs of their students. The needs of students might change in the duration of the course – this includes a student's condition evolving, a student receiving a new diagnosis, or a student sharing new information with the school. Some students may become unwell during their studies and need to take time away from the course to recover.
- 24** Assessment is one of the educational components subject to the Equality Act's requirements. All assessments should be based on defined competence standards, and reasonable adjustments should be made in the way a student can meet those standards.
- 25** Medical schools must only graduate medical students that: Meet all of the outcomes for graduates AND are deemed fit to practise. Disabled learners should be encouraged to use the Transfer of Information (TOI) and Special Circumstances processes to ensure they are allocated to an appropriate post for their Foundation training.

### **Chapter 3a: What is expected of postgraduate providers and employers?**

- 26** The expectations from postgraduate educators fall in the same overarching categories as medical schools: complying with equality legislation (avoiding discrimination, making reasonable adjustments) and meeting our standards for medical education and training.
- 27** 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, advertising jobs, retention of employees, promotion and training.

- 28** The main difference to the education provisions of the Act is that employers 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 duty to make reasonable adjustments as best practice in anticipation of employing a disabled person, regardless of the letter of employment law.

### **Chapter 3b: How can postgraduate providers and employers apply their duties?**

- 29** Sharing information early is key for doctors receiving appropriate support. Doctors and postgraduate educators have a shared responsibility to make sure this happens, although doctors only need to share information that is pertinent to them receiving support.
- 30** The TOI and special circumstances processes can facilitate early sharing of information and putting the appropriate support in place in a timely fashion.
- 31** Disabled doctors should be encouraged to consider working less than full time (LTFT).
- 32** Educators and employers can follow a stepwise approach to understand a doctor's needs (7-step process adapted for postgraduate training).
- 33** Monitoring and review can be integrated in existing processes for doctors in training. The educational review process can be used to ensure continuity of support and to respond to evolving needs. The Annual Review of Competence Progression (ARCP) is another opportunity to ensure the appropriate support is provided and for the doctor to raise any concerns.
- 34** There is a case for minimising transitions for disabled doctors, as the support they receive is likely to be linked to their employer's location. It is crucial for information to be transferred in transitions (in a lawful way and with the doctor's consent).
- 35** It is good practice to empower doctors to communicate needs to colleagues and patients.
- 36** Colleges and Faculties must design and run assessments fairly. You don't have to change competence standards but you should revise or remove if redundant.
- 37** Educators and employers must make sure doctor has access to career advice.
- 38** Having a health condition or disability does not mean a doctor's fitness to practise is impaired. Having a health or disability also does not mean there is an inherent risk to

patient safety. A reasonable adjustment or support measure requested for a doctor with a health condition or disability is not inherently a risk to patients.

- 39** A doctor's fitness to practise is brought into question in relation to their health if it appears that: The doctor has a serious medical condition including addiction to drugs or alcohol AND the doctor does not appear to be following appropriate medical advice about modifying their practice as necessary (*The meaning of fitness to practise statement, April 2014*).

## 6 – Health and disability work programme – revised guidance for public consultation

### 6 – Annex B

#### Findings from external research and roundtable sessions

##### External research

- 1 The table below is based on this [action plan document](#). The full report from the research can be found [here](#).

	Key insight: What the research showed	What we will do
1	76% of those surveyed think the current guidance should be updated. Undergraduate education providers were more familiar with the guidance than postgraduate providers.	The research findings will inform the revised guidance. We will work on raising awareness of the new guidance among postgraduate providers, as it will include an expanded postgraduate section.
2	<p>Respondents said they wanted the revised guidance to include:</p> <ul style="list-style-type: none"> <li>■ a clearer explanation about who is 'disabled'</li> <li>■ specifics about reasonable adjustments</li> <li>■ assurance for decision-making processes</li> <li>■ help for having difficult conversations with students and doctors.</li> </ul>	We will explain the definition of disability in the revised guidance. We cannot give specifics on reasonable adjustments because these can only be decided on a case-by-case basis. But we will give guidance on what factors should be considered when making decisions. We will also include tips about having difficult conversations.
3	Respondents wanted options to quickly access and interact with the content. It is critical that we make the guidance available in accessible formats.	The new guidance will meet this requirement through summary sections, interactive videos, infographics and flow charts. All our

		publications are available in accessible formats, and our Publications team accepts bespoke requests.
4	<p>There are 8 key principles for supporting learners with long-term health conditions (LTCs) and disabilities that apply across stages of medical education:</p> <ul style="list-style-type: none"> <li>■ Fostering a positive culture</li> <li>■ Clear established processes</li> <li>■ Supporting information-sharing</li> <li>■ Tailored support</li> <li>■ Effective communication</li> <li>■ Universally accessible environments</li> <li>■ Staff training and workshops</li> <li>■ Monitoring and review.</li> </ul>	We will highlight the 8 elements of good practice within the revised guidance. We will also provide examples of how these have been applied in practice by organisations, for example through the use of named contacts and the case conference model.
5	<p>Current practices for supporting students and doctors are variable. There isn't a single process followed by medical schools or postgraduate providers, although similarities exist. Processes seem less standardised in postgraduate training<sup>1</sup> compared to medical school studies.</p>	We will include a stepwise process and decision-making framework in the revised guidance. In the undergraduate setting, we will advocate for clear and robust processes, highlighting the elements that work well for medical schools and their students (e.g. using experts like occupational health physicians). In the postgraduate setting, we will advocate for more standardised processes through existing mechanisms. However, some degree of variability is inevitable.
6	<p>Students involved in the research felt strongly that any form of revised guidance should be</p>	The primary audience for the revised <i>Gateways to the professions</i> guidance

<sup>1</sup> NB. This is based on a small sample of qualitative interviews with postgraduate deans and vice deans

	<p>made available to them. This is so they could be better informed and understand their rights.</p> <p>The BMA Medical Students Committee (represented in our external steering group) also supports this.</p>	<p>is education providers, however the guidance will also be addressed to medical students and doctors. We will make sure our communication activities around the guidance include medical students.</p>
7	<p>Medical students with LTCs and disabilities encounter different types of barriers:</p> <ul style="list-style-type: none"> <li>■ Communication and information barriers</li> <li>■ Physical barriers</li> <li>■ Financial barriers</li> <li>■ Cultural barriers</li> <li>■ Rare experiences of discrimination.</li> </ul>	<p>We will highlight the different types of barriers students come across in our revised guidance, and link them to the 8 elements of good practice. This is to help medical schools in thinking about how effective their support systems are against the different barriers. We will also take a strong stance against any discrimination against students – however rare.</p>
8	<p>Students sometimes did not share information about their health because they did not know or were not sure whether their condition was considered a disability. They were also unsure what support would be offered and were worried about fitness to practise implications.</p> <p>(The research did not include doctors, but doctors attending roundtable events at the GMC gave us similar feedback).</p>	<p>We will highlight the benefits of sharing information early in our revised guidance. We will also highlight what could happen otherwise, for example students not receiving the support they need and having to take time out of their studies later on to recover. We will also emphasize that having a health condition or a disability is <u>not</u> a fitness to practise issue.</p>
9	<p>Although the Transfer of Information (TOI) process is very useful, the TOI forms do not always contain enough information about the needs of individuals with LTCs or disabilities. This can hinder postgraduate providers from preparing the training environment.</p> <p>Anecdotal feedback from our stakeholders shows this is also an issue in other transition points, where the information does not travel with doctor.</p>	<p>We will highlight the TOI and special circumstances processes in the guidance. The revision guidance will also discuss the importance of sharing information and note there is a shared responsibility between students / doctors and education providers to achieve this.</p>

10	Postgraduate providers were concerned it can be difficult to create an inclusive, open and supportive culture within the workplace. This is partly because of the constraints in time and resources within an already resource-deprived NHS.	This is a much wider issue than the GMC work programme. However, within the remit of the guidance, we will advocate using existing mechanisms and processes as much as possible. The revised guidance will also explain that the financial resources of an organisation is one of the factors taken into account when deciding on what is reasonable to provide, although this should be evidenced.
11	Postgraduate providers were worried that in some circumstances, a LTC / disability or adjustments may be detrimental to patient safety, which is the focus of postgraduate training (e.g. speed of response to patients).	We will outline our position on this in detail in the guidance. Having a LTC or disability does not mean there is a risk to patient safety. Providing an adjustment that poses a risk to patient safety would not meet the threshold for an adjustment being reasonable so organisation should not provide it. BUT the risk to patient safety has to be evidenced, it cannot be theoretical.
12	Postgraduate providers were worried that the level of support available in the undergraduate setting may not be available in the postgraduate setting. They were also concerned that medical schools were making too many allowances, meaning graduates unlikely to progress through training enter the Foundation programme.	The revised guidance will include a stepwise approach that medical schools can follow to make decisions about support. Our <i>Outcomes for graduates</i> have a vital position in the new guidance, as the fundamental link between undergraduate and postgraduate training. Any student that can meet all the Outcomes* must be supported to do so.
13	Undergraduate and postgraduate providers voiced frustration with what they perceived to be an apparent lack of flexibility with course requirements and competences.	This is not only the remit of the GMC. In terms of what is within the GMC remit, we cannot provide additional flexibility in registration (in the form of a conditional or limited registration) or in the competence standards set in <i>Outcomes for graduates</i> and <i>Outcomes for provisionally registered doctors</i> . But we expect organisations to make adjustments to enable

		<p>learners to meet these standards. We are also implementing a <a href="#">programme of reforms</a> with other organisations to collectively make postgraduate curricula more flexible.</p>
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## Summary of roundtable events

- 1 We organised nine roundtable events across the UK as part of our health and disability work programme. Our aim was to hear directly from the people that will be affected by the revised *Gateways to the professions* guidance.
- 2 We invited attendees to register via an online questionnaire; we received 272 responses in total (as of 18 January 2018). We hosted the following sessions from September – December 2017:
  - a **Medical students:** London, 9 October 2017; Manchester, 11 October 2017
  - b **Undergraduate educators:** 12 October 2017
  - c **Doctors:** London, 5 October 2017; Manchester, 12 October 2017
  - d **Postgraduate educators and employers:** 18 September 2017
  - e **Mixed audiences:** Edinburgh, 23 October 2017; Cardiff, 11 December 2017; Belfast, 13 December 2017
- 3 Attendance ranged with between five and 20 attendees per session.
- 4 The themes highlighted in this document are drawn from the qualitative feedback in the above events. The content of this document represents qualitative findings and not GMC positions or recommendations. The findings will inform our updated guidance in this area.
- 5 Selected slides from a PowerPoint version of the summary are below, and the full summary can be found [here](#).



## Doctors: Suggestions

Supra-regional/national occupational health services	Accountability through overseeing organisation or expert advisory panels	Reasonable adjustments made in timely manner; highlight legal framework and responsibility of employers
Role of HR promoting appropriate expertise, recommending assessments, preventing bullying	All professional guidelines from medical education bodies to include a section on disability	Attitude of enablement, changing culture, 'you are welcome and you are valued' → GMC asked to take a stand on this
Treat as individuals and develop approaches in partnership, with tailored communication	Being more flexible with competences doctors have to meet, for example by placing conditions to practice and easier transfer between specialties	Repository of support provided and mentoring system of support

General  
Medical  
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## Medical students: Suggestions

More data available on support from schools: National rankings/annual appraisals/audit data with student experiences	Ability for students to voice their concerns directly in a safe space	More signposting to support; Schools picking up on cues to offer support
Adjudicator role: national association of disabled students	Official policies and documents, more succinct and accessible – clear statement about ability to study medicine with a health condition/disability	Forward planning and involving students in decisions, follow up to ensure helpful
More tailored adjustments depending on condition, not static and consider impact at particular time	Role models ('I've done it so you can too') and more information about clinical practice	Standardise exam format in terms of reasonable adjustments eg carry over adjustments made for OSCEs (as done for written exams)

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## Undergraduate provider discussions

Concern that the extent of support available for students will not be matched when they are practising as doctors; not sure if students fully appreciate this

Pressure on mental health services

Dealing with student fitness to practise issues when underlying health problems

Difficulty in implementing some recommendations from occupational health

Tensions between university and medical school

### SUGGESTIONS

- Guidance on selection
- Clear information for pre-applicants about course requirements
- Resilience and wellbeing in curriculum (eg wellbeing coaches)
- Tackle stigma, mental health initiatives, myth-busting
- Preparing students that they may need to disclose
- Student support cards and OSCE cards to use
- Encourage student-led awareness initiatives
- Medical courses delivered less than full time
- UK-wide independent service for medical students
- Data on effectiveness of support

General Medical Council



## Postgraduate provider discussions

Importance of sharing information and potential unintended consequences of not doing so

Hesitation to share information; doctors may prefer receiving support anonymously

Joint working between employers and support services

Variability in occupational health services

### SUGGESTIONS

- Encourage information-sharing
- Explain the role of the GMC in this area
- Empower individual
- Encourage sharing of more stories
- Put together easily accessible information for educational supervisors
- Signpost people and services to contact for support throughout training, including assessments
- More detailed health statements for declaring health issues
- More visual information such as social media, podcasts, videos rather than too much reading material

General Medical Council



## Mixed audiences: Additional suggestions

Named contact for students and doctors, to offer confidential support	Information transfer and continuity, to avoid students and doctors repeating details about their health	Sharing good practice via forum for employers, educators and individuals, regional or national networks
Guidance should say patient safety is paramount	Philosophy of expecting people to need support and having the appropriate services in place to provide it - without fear of consequences	Offer more flexibility in outcomes
Independent multidisciplinary team for prospective applicants/students	Having guidance for honest and frank conversations early in people's careers	Identify learners who are unlikely to progress and offer alternative options/career counselling

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## 6 – Health and disability work programme – revised guidance for public consultation

### 6 – Annex C

#### Annex C: Membership of external experts' steering group

- 1 Chair: Professor Bill Reid, Postgraduate Dean for South East Scotland and Chair of COPMeD

##### Undergraduate education

- 2 Clare Owen, Policy Adviser, Medical Schools Council
- 3 Dr Margaret Bunting, Senior Lecturer in Medical Education, University of East Anglia

##### *Medical students*

- 4 Gurdas Singh, Deputy Chair (Welfare), BMA Medical Students Committee
- 5 Dr Twishaa Sheth, Former Deputy Chair (Welfare), BMA Medical Students Committee

##### Postgraduate training

- 6 Dr Helen Johnson, Foundation School Director (EBH)
- 7 Dr Nick Spittle, Foundation School Director (Trent)
- 8 Professor Sheona MacLeod, Postgraduate Dean for East Midlands and Chair of COPMeD
- 9 Dr Claire Loughrey (from COGPED, nominated by the AoMRC as the JATF representative for this group)
- 10 Professor David Black, Joint Royal Colleges of Physicians Training Board Medical Director
- 11 Paul Deemer, Head of Diversity and Inclusion, NHS Employers

*Profession*

- 12** Dr Anthea Mowat, Chair, BMA Representative Body
- 13** Sally Brett, Head of Equality, Inclusion and Culture, BMA
- 14** Amanda Lee-Ajala, Senior Policy Adviser for Equality, Inclusion and Culture, BMA

**Occupational health**

- 15** Dr Blandina Blackburn, Consultant in Occupational Health Medicine and chair of Association of National Health Occupational Physicians (ANHOPS)
- 16** Dr Harjinder Kaul, Consultant in Occupational Health Medicine and representative of Higher Educational Occupational Physicians/Practitioners (HEOPS)
- 17** Professor Debbie Cohen, Director of Student Support, Cardiff School of Medicine and Consultant in Occupational Health Medicine