

Health and disability work programme

Summary of roundtable discussions 2017

Roundtable events

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.

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:

- **Medical students:** London, 9 October 2017; Manchester, 11 October 2017
- **Undergraduate educators:** 12 October 2017
- **Doctors:** London, 5 October 2017; Manchester, 12 October 2017
- **Postgraduate educators and employers:** 18 September 2017
- **Mixed audiences:** Edinburgh, 23 October 2017; Cardiff, 11 December 2017; Belfast, 13 December 2017

Attendance ranged with between five and 20 attendees per session.

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.

If you have any questions or would like more information about getting involved in our work programme, please email quality@gmc-uk.org

Structure of the discussions (2 hour sessions)

- Introduction and warm up (30 minutes)
- General discussion (30 minutes)
 - Open discussion about reflections on support received by medical students and doctors
 - Attendees shared their experiences and challenges encountered
- Table discussions (35 minutes)
 - Allocated topics – tailored for each respondent group
 - Feedback to full group from each table
- Brainstorming possible solutions and recommendations for revised guidance (25 minutes)

Medical students

Reflection on the issues

- 'Bland' statements about admissions – information missing about help available and impact on studying medicine.
- Impression that medical schools use the 'guise' of being competent to disguise discrimination
- Limited knowledge about what will happen after graduation and concern about GMC registration
- Difficulties accessing support and requests for support dismissed, no route to take if unhappy with support provided
- Sense that students are 'in trouble' and have their fitness to practise automatically questioned if they request support
- Assumptions and ethos that medical students cannot be suffering from ill health
- Gatekeeper person is key and can influence ongoing relationship between student and services
- Support in clinical placements described as 'non-existent' by some students
- A lot of issues described in the perceived attitude of the medical schools

Reflections on schools' attitudes

- 'We are not afforded the same empathy that we are taught to show our patients'
- 'It's just guidelines'
- 'It's going to take a lot of effort'

Some students commented on the attitude of the schools:

- Lack of sensitivity
- Not proactive; onus is on the student to know what is appropriate for them
- 'We're here to help you' as a formality
- No cross-communication, no systematic way to raise concerns
- Dismissive of students' opinions
- Role complete once adjustments made, there is no follow up
- More focus on academic excellence than support
- A lot of staff do care but some approaches feel like 'tick-box' eg lecture at start of term when GMC visit was coming up

Support in placements was described as 'non-existent' by some students:

- Services at main campus away from placement, only open 9-5
- Services only open at term-time, but medical students have longer term times

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)

Doctors

Reflections on the issues

- Expertise and role of occupational health: variability across regions, huge impact of service provider
- Hesitation to share health information because of misconceptions around health conditions and disability (fear of being labelled)
- Sense that individuals are making subjective judgments about practice and training pathways ('you can't be a doctor')
- Lack of collaborative/joint care plans compared to what taught to do with patients
- Arrangements for support are sometimes left to individual
- Doctors expected to know what adjustments they need despite not having experience in specific settings
- Fragmented information: information does not follow trainee, deanery does not have adequate details for decision-making
- Enough difficulty being a doctor without having to have additional fight for support
- Pressure on NHS service, stress of system gets transferred to the person with a health condition/disability

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

Undergraduate providers

Reflections on the issues

- 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

Postgraduate providers

Reflections on the issues

- 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

Mixed audiences

Additional reflections

- Reiterated variability in occupational health services and difficulty in getting appropriate information
- Need for authoritative guidance and consistency in how it is interpreted
- Difficult to strike a balance between consistency and being too rigid – there is no ‘one size fits all’ approach
- Advance planning can help nurture a culture of inclusivity where students and doctors feel supported
- System should enable students and doctors to take control but not leave them on their own to drive the process
- From a patient perspective, patients want to know that their doctors are competent to perform their role
- There are benefits to having a diverse medical profession that reflects the community
- Sharing information about health conditions and disabilities benefits students and doctors
- More help is needed in transitions, for example from student to Foundation doctor
- More research is needed to build an evidence base in this area
- Students and doctors with long-term health conditions and disabilities can feel isolated
- Support programme must take into account possible exacerbation periods of health conditions

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