General Medical Council

the **RTK**

Identifying unmet needs from the *Gateways to the Professions* guidance

February 2018

Contents

Abstract

The General Medical Council (GMC) commissioned this research to inform revisions to the *Gateways to the Professions* guidance (*The Guidance*). *The Guidance* supports medical education providers to ensure that disabled students and doctors in training (disabled learners) do not face unnecessary barriers to successful medical careers. Through interviews and surveys; we consulted with medical schools, HEE Local Teams, deaneries, and employers on their use of the current guidance and good practice. We also interviewed medical students to better understand their experiences of admissions procedures and the support they were able to access during their period of study. Both medical schools and postgraduate providers perceived a need for a revised version of *The Guidance* to reflect good practice and provide more specific advice to them as well as to leaners. It was evident that the provision for disabled learners is varied and that there is no single established model of support; however, the interviews revealed some key principles of good practice and innovative suggestions for future provision.

Keywords

Disabilities; Medical Education; Equal opportunity (Education); Educational guidance.

Acknowledgements

Key highlights

- Current practice in the areas of providing support for disabled medical students and doctors in training is variable;

- Some disabled students continue to report issues that impact negatively on their experiences of medical education including perceived discriminatory attitudes, a high-pressured environment that appears to be unaccepting of difference, and the physical inaccessibility of medical environments;

- All of the students we spoke to felt strongly that any form of revised guidance should be made available to them;

- Over 80% of medical school staff surveyed report using *The Guidance* to inform their practice in some way but few use it regularly;

- Despite perceiving a need for advice in this area, *The Guidance* is currently used in far fewer postgraduate training settings;

- Over three quarters (76%) of the providers surveyed, across the training spectrum perceived a need for *The Guidance* to be revised;

- It would be useful for revisions to reflect elements of good practice highlighted during the research, including:
  - Effective communication across all key stakeholders;
  - Proactive provision of support for students;
  - Early contact with disabled students with pre-existing conditions; and
  - Training for staff on supporting students and doctors.

- Providers suggest the revised guidance could provide a clear explanation of the process and procedures they should go through when considering how best to support disabled students and doctors;

- Providers would also like:

  - Localised peer support networks to share good practice and advice;
  - Co-production of the revised guidance with education providers, students, doctors in training and other key partners;
  - Information on how to manage perceived tensions with issues of fitness to practise; and
  - An online or telephone support service for providers

Executive summary

The aim of this research was to gather evidence to inform the revised *Gateways to the Professions* guidance for the General Medical Council. To do that, the research team used online surveys and interviews with medical schools, providers of postgraduate medical education (HEE local teams and deaneries) and employers to explore the challenges posed when using the existing *Guidance,* and examples of what they consider to be good practice in this area. They also spoke to medical students about their experiences of admissions procedures, and the support available during their period of study.

The research team conducted face to face and telephone interviews with 46 stakeholders across providers of medical education, including: Foundation School Directors, Postgraduate Deans, Heads of Medical Schools, and university/medical school Disability and Welfare Officers. They interviewed 26 disabled medical students from across seven university sites with a range of impairments. A survey was also conducted with staff from undergraduate and postgraduate medical education providers.

The GMC specified three sets of questions to be put to key groups of stakeholders (full details are included in appendix B). The key aims were to explore:

a) how *The Guidance* is currently used, good practice examples, key challenges posed by *The Guidance* and suggestions for the revised *Guidance*; and
b) The views of undergraduate medical students concerning their experiences of admissions procedures, and the support available during their period of study.

The context of medical education is complex:

- A large number of stakeholders are involved in the medical education journey;
- All participants agreed that it can be characterised by high levels of pressure; and
- The culture of the profession as a whole and within specific organisations can heavily shape practices and individual experiences.

Interviews with students revealed that:

- Student views on the quality of support offered by medical schools were generally positive; however,
- They have significant worries about disclosing impairments or medical conditions;
- They do not have a comprehensive understanding of their legal rights;
- They would like to be better informed and have access to any revised guidance;
- They continue to face barriers to accessing education including communication, physical, financial and cultural or attitudinal barriers; and
- Perceptions of good practice were influenced by having consistent, tailored support provided by teams that work closely with them and with one another.

Good practice of medical education providers is characterised by:

- Key principles of practice that can be applied across both undergraduate and postgraduate levels which include: fostering a positive culture, having clear and established processes, supporting early disclosure, offering tailored support and effective communication, moving towards a universally accessible environment and delivering regular monitoring and training;
- Where appropriate, providing disabled students with a personal advisor, who in turn has access to a network of support; and
- Making good use of expertise, particularly using independent occupational health specialists to enable employers and medical schools to identify needs and develop appropriate support.

Current Usage of the Guidance:

The survey of medical education providers established that:

- 88 per cent of undergraduate education providers surveyed were familiar with *The Guidance* but far fewer use it regularly;
- Less than half (46%) of the postgraduate education providers surveyed were familiar with the guidance;
- Currently *The Guidance* is most commonly used by the organisations surveyed to establish their responsibilities; and
- 76 per cent of those surveyed think *The Guidance* should be updated.

Interviews with medical school staff and postgraduate deans suggest that:

- They make decisions on a case by case basis but that the processes for how this is achieved varied between organisations;
- Those who reported finding *The Guidance* unhelpful wanted to use it as a 'how to' guide;
- Despite considerable thought and in many cases considerable expertise in this area, some providers continue to find deciding what is 'reasonable' in a given situation challenging; and
- Foundation School directors were especially concerned about the financial implications of sustaining 'reasonable adjustments' introduced by medical schools.

Suggestions for developing *The Guidance* include:

- Establishing a clearer consensus on the definitions of disability and which individuals require support;
- Providing more accessible information for disabled students on the support available to them as well as potential issues they will face in the working environment; and
- Including advice on legal issues around what constitutes 'reasonable adjustments'.

The report highlights several other important issues for the GMC to consider:

- The GMC may have a role in establishing and supporting localised peer group networks;
- Working with key stakeholders to co-produce revised guidance could help engage education providers, students and others; and
- Communicating *The Guidance* to students and developing specific resources for this audience.

Chapter 1: Background and research methods

1.1 Context

A research report published by the Higher Education Academy in 2005 highlighted issues concerning the admission of disabled students to the study of medicine[1]. The General Medical Council (GMC), responsible for overseeing doctors' education and training, responded by investing in research that produced *The Gateways to the Professions* guidance in 2008, updated in 2012-13 as part of a health and disability review. *The Guidance*, which is purely advisory, offers medical schools practical suggestions to help ensure disabled students and doctors in training (disabled learners) have equality of access to successful medical careers.

More recently, medical education providers at both undergraduate and postgraduate levels have suggested through the Medical schools Annual Return (MSAR) that despite the existing guidance, they believe more could be done to improve the support they offer to disabled learners.

To facilitate such further improvement, the GMC commissioned this research to gather evidence that could inform updated guidance. Specifically, the current project set out to collect:

a) evidence from medical schools, providers of postgraduate medical education (HEE local teams and deaneries) and employers on how they currently use *The Guidance*, examples of what they consider to be good practice, any challenges posed by the existing *Guidance* and suggestions about what would be useful in the revised guidance; and
b) the views of medical students concerning their experiences of admissions procedures, and the support available during their period of study.

The GMC specified that the project would best meet its requirements by putting questions to three key groups of stakeholders, using a mixed methods approach. The full research questions appear in appendix B.
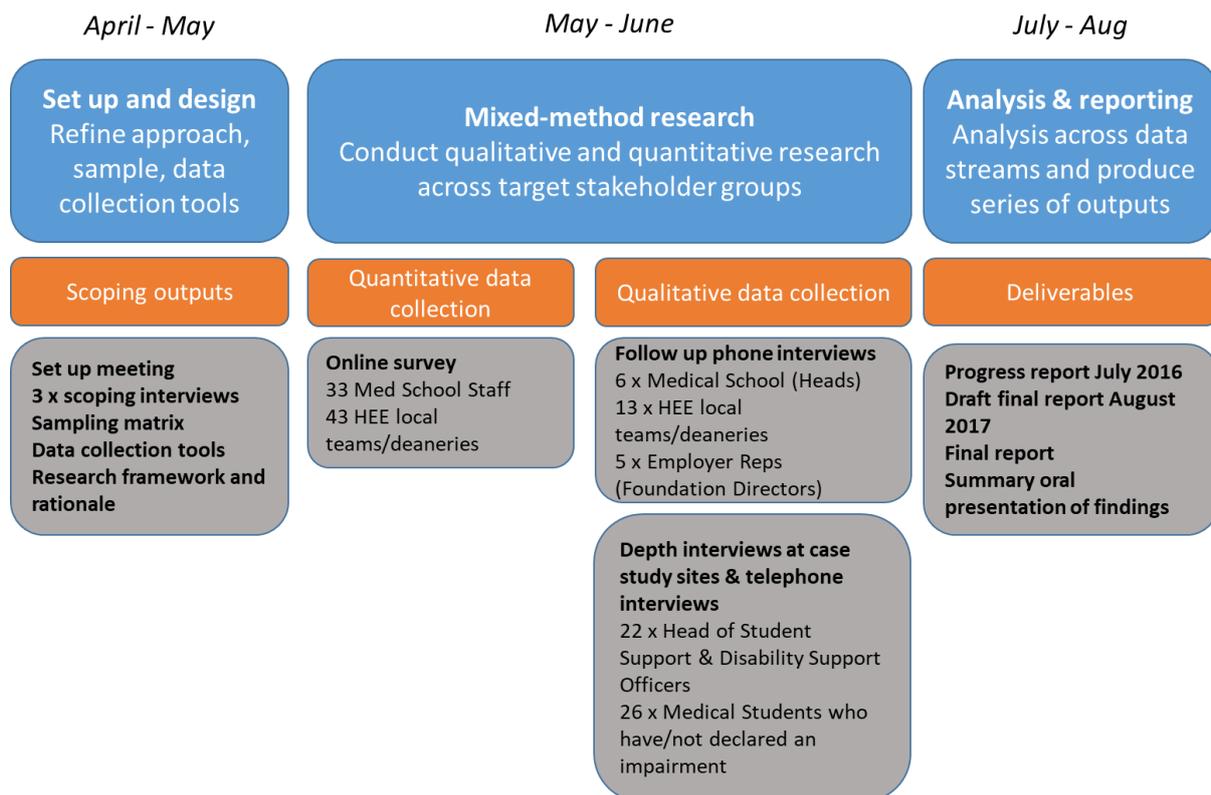
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[1] Roberts TE, Butler A and Boursicot KAM (2005). Disabled students, disabled doctors – time for a change? A study of different societal views of disabled people's inclusion to the study and practice of medicine. *The Higher Education Academy*. **Special Report 4**.

1.2 Approach

We delivered the research over three phases. Figure 1 summarises the key components of each phase.

Figure 1. Overview of research methodology and delivery timetable

April - May	*May - June*		*July - Aug*
Set up and design Refine approach, sample, data collection tools	**Mixed-method research** Conduct qualitative and quantitative research across target stakeholder groups		**Analysis & reporting** Analysis across data streams and produce series of outputs
Scoping outputs	Quantitative data collection	Qualitative data collection	Deliverables
Set up meeting 3 x scoping interviews Sampling matrix Data collection tools Research framework and rationale	**Online survey** 33 Med School Staff 43 HEE local teams/deaneries	**Follow up phone interviews** 6 x Medical School (Heads) 13 x HEE local teams/deaneries 5 x Employer Reps (Foundation Directors)	**Progress report July 2016 Draft final report August 2017 Final report Summary oral presentation of findings**
		Depth interviews at case study sites & telephone interviews 22 x Head of Student Support & Disability Support Officers 26 x Medical Students who have/not declared an impairment	

Phase 1

The scoping phase included an initial set up meeting with the GMC, to discuss the research brief in more detail, gather relevant documentation and understand the audiences for the final report. We also conducted three scoping interviews with key strategic stakeholders including:

1) a postgraduate dean based in Scotland;
2) a senior lecturer in medical education; and
3) the Assistant Director of Education at the GMC.

We submitted a one-page document with headline findings from the three scoping interviews to the GMC and used these insights to refine the fieldwork tools. The fieldwork tools included:

- An online survey for undergraduate and postgraduate respondents.
- Qualitative interview topic guides for:
  - Medical students

- o Heads of medical schools, HEE local teams/deaneries and employer representatives
- o Head of Disability or Student Support roles
- An ethical statement which set out a brief overview of the research and our ethical position, data handling and confidentiality, which we shared with all medical schools invited to take part in the research.

We used the data from MSAR (Medical Schools Annual Return) 2013-2015 to inform our sampling strategy. We ranked medical schools by the size of the student population, and then split them into three categories – small, medium and large. We then further categorised the schools according to geographical location. We selected our sample based on schools which had higher numbers of declared disabled students but also reflected the different locations and the various sizes of the institutions.

Phase 2

During this stage, we completed the following:

- We launched the online survey for undergraduate and postgraduate stakeholders, responses were not limited to specific job titles and included anyone who has a role in this area.
- We invited the 10 medical schools in our sample to partake in 'case study' fieldwork. We conducted depth interviews with: 6 Heads of Medical Schools, 22 Heads of Student Support or disability officers and 26 medical students.
- We invited all HEE local teams and deaneries to take part in the research and completed 13 depth interviews with senior stakeholders across 8 sites.
- We undertook five further depth interviews with employer representatives (Foundation School directors).

In total, we conducted face to face and telephone interviews with 46 stakeholders across providers of medical education, including Foundation School Directors, Heads of Deaneries and Medical Schools, and Disability and Welfare Officers from both the Medical School and wider university. We also spoke to 26 disabled medical students (including two student representatives) from across seven university sites with a range of impairments, including students who had not declared an impairment.

Phase 3

The research team met for an analysis workshop, debating the key themes and trends from across the stakeholder groups. This was used to inform a shared analysis framework, to manage data and facilitate robust thematic analysis.

Chapter 2: Understanding disability and medical education

My health has given me valuable experiences and the best doctor I have ever had was a wheelchair user, so I think that medicine should be representative.

Student interviewee

2.1 Models of disability

Our research has been shaped by the social model of disability, the key principles of which are reflected in the current version of *The Guidance:*

> *This is the thinking behind recent developments in disability legislation and informs the language and advice used in this guidance. (p.40)*

The social model was developed as a challenge to what is now known as the medical or individual model of disability. The medical model is embodied in the World Health Organisation's International Classification of Impairment, Disability and Handicap (ICIDH). It defines a disabled person as having an impairment considered to cause disadvantage encountered and thus resulting in dependence on others for support. The implication was that since disability cannot be cured, disabled people required care to enable them to participate in society. In the latter half of the twentieth century, disability activists were critical of this model for reinforcing the endemic discrimination experienced by disabled people in most developed countries.

The social model of disability distinguishes between the terms impairment and disability; this will be reflected in the language used in this report[2]. Whilst impairment refers to a physical or psychological attribute or condition, disability refers to the range of social, economic and physical barriers experienced by people with impairments. A person may have an impairment, but it is social disadvantage and discrimination that prevents their full participation in society, and which thus 'disables' them[3]. We have included a more detailed description of the social model of disability in appendix C.

Since the 1980s, the social model has become the *de facto* definition of disability, and was adopted by organisations including the UK Council for Disabled People, the Disability Rights Commission, the World Health Organisation[4], and by the Labour government's Life Chances for Disabled People report[5]. It is important to also note that a number of other models of disability have been developed.

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[2] Barnes, C. (2009). Understanding the Social Model of Disability. http://www.hso.se/Global/Projekt/Fr%C3%A5n%20forskningsobjekt/Forskning/Anteckningar%20Colin%20Barnes%20091118.pdf last accessed July 12th 2017.

[3] Oliver, M. (2004). The Social Model in Action: If I had a hammer?. In, C. Barnes & G. Mercer (Eds.) *Implementing Social Models of Disability: Theory and Research*. Leeds: The Disability Press, 18-32.

[4] WHO, 2001: **Rethinking Care from Disabled People's Perspectives,** Geneva: World Health Organisation. http://www.independentliving.org/docs6/barnes200106.pdf last accessed August 8th 2017.

[5] http://webarchive.nationalarchives.gov.uk/+/http://www.cabinetoffice.gov.uk/media/cabinetoffice/strategy/assets/disability.pdf last accessed August 30th 2017.

The biopsychosocial model[6] has become a prevalent alternative that represents a balance between the medical and social models. This approach takes into consideration the personal and psychological dimension of an impairment alongside the biological condition and social context.

2.2 Provision of support for disabled learners in medical education

One of the key challenges for developing effective practical guidance is the variety and diversity in medical education provision. It was evident that there is no single model for provision of support to disabled learners.

We interviewed medical school staff with responsibility for providing support for disabled students. Job titles varied across medical schools; from Heads of schools, to dedicated disability support officers (DSOs) or disability liaison officers (DLOs). Additionally, there were a number of people whose primary role was not to support disabled medical students, for instance lecturers or administrative staff, but who nevertheless provided a level of pastoral support. When asked about their role in relation to supporting disabled students, most identified oversight of support processes, and sitting on panels responsible for making decisions concerning the provision of 'reasonable adjustments'. Our interviews suggested that in postgraduate settings, there is no individual with a job role comparable to a DSO or DLO; all staff have a role in supporting disabled doctors in training, and ultimately the responsibility for coordinating support lies with the postgraduate dean.

At undergraduate level, our research revealed that although there is no one process followed by all medical schools, there are some similarities across settings. For instance, the majority of medical schools ask students about any medical conditions or impairments prior to starting the course. They then refer students to the university-wide disability support service (DSS) who undertake a needs assessment and agree proposed adjustments. The medical school then considers whether these adjustments are suitable within the context of studying for a medical degree. This means ensuring that they are feasible as well as adequate to ensure accessibility in both clinical settings and the academic environment.

A key difference across settings is at the stage when the medical school receives information from the DSS. Some medical schools have clear processes whereby they may also make a referral to occupational health, assign individual caseworkers, complete further needs assessments, engage panels of experts in the decision making processes and complete regular monitoring. Other medical schools may only have one or two members of staff whose role it is to make these decisions and the processes are seemingly less robust and more ad hoc. Another key difference is that whilst some medical schools work in close partnership with university-wide services, others do to a much lesser extent meaning the student's experience is more disjointed.

At postgraduate level, our research revealed that the processes for disabled doctors in training are less standardised. Amongst the sample of HEE local teams and deaneries that we interviewed, it was evident that there was no individual who held a role dedicated to supporting disabled doctors in training. There were a small number of the postgraduate deans we spoke to who are usually heavily

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[6] Engel GL. (1980). The clinical application of the biopsychosocial model. *American Journal of Psychiatry.* 137: p535-805.

involved in all of these cases, but the majority explained that only the most complex cases would come to their attention. As we only spoke to postgraduate deans, it should be noted that they are often not involved in the intricacies of all decision making processes and this may limit the validity of some of the findings from this group. Commonly however, the perception was that most of these decisions are made informally on a local level and are then implemented by the Trust/Board in a straightforward manner; therefore not requiring much input from postgraduate deans. The key people who are involved in decision making at postgraduate level were described as the head of Foundation School, the training programme manager, occupational health, representatives from the Trust/Board and specialist careers advisors. However, the level of involvement and the timing of each professional's involvement seems to vary across providers. The use of panels in decision-making was described as much less common than at undergraduate level. When panels are used they seem to be less formal and structured; however, they signify a recognition of the importance of agreeing support and adjustments with occupational health practitioners and representatives from the Trust. Some providers also described having (or being in the process of developing) separate professional support units, these offer holistic and varied support for any doctor in training wishing to access it.

The majority of staff and students we spoke to drew attention to the high pressure and stress associated with medical education courses. Interviewees perceived stress to result from the high levels of competition to gain access to courses, and having to manage a high volume of varied work. Many staff associated these stresses with their perception of an increase or exacerbation of mental health conditions. The perceived high prevalence of mental health conditions was also reflected in the results of the survey with 92% and 90% of undergraduate and postgraduate respondents respectively, reporting that these were in the top three most common conditions they experienced among students and doctors in training.

> *"Mental health problems are on the rise generally but particularly for medical students. Medicine is stressful"- Placement Provider (medical school)*

Another issue frequently raised by staff concerned the challenges of providing support given the complex journey of medical education. Clearly the training is inherently intellectually challenging, but this is further intensified by the fact that training is delivered using a number of methods, in various buildings, locations, contexts and spaces. Trying to coordinate the delivery of effective support across such a range of environments is seldom straightforward. This is further complicated by the sheer numbers of stakeholders involved; particularly at postgraduate level as the doctors in training are employed by the NHS trust rather than the postgraduate provider. As one postgraduate dean noted:

> *"At the postgraduate setting, it is a complex relationship with the trainee, the training programme and employers as they are learning whilst working." – Postgraduate Dean*

2.3 Attitudes towards disability in medical education

Our research revealed that there is very little consistency in the ways that providers approach the issue of disability in terms of attitudes and the culture of the organisation. The interviews with staff from postgraduate and undergraduate providers as well as medical students reflected a range of

knowledge and understanding when it comes to disability. However, it was a common response across all interviewees (students and staff) to view a condition or impairment as a challenge to be overcome. This perspective appears to be more closely aligned with the medical model of disability.

Respondents rarely expressed highly negative attitudes or a complete lack of understanding. However, three issues were key:

- First, a lack of understanding about who is considered 'disabled,' particularly when this involved long-term medical conditions or less visible conditions.
- Second, some people expressed a view that it can be difficult to find the time and resource needed to provide support for disability in an already resource deprived NHS.
- Third was the view of some interviewees that students sometimes use a diagnosis to benefit themselves; this was linked in particular with perceptions concerning the timing of disclosure either just prior to exams or following exam failures. Such attitudes, when directly or indirectly communicated, have implications for disabled students not only in terms of their own self-worth but also in terms of how likely they may be to disclose impairments and access support.

Commonly, there was a view among students and staff that whilst it is possible to create an inclusive, open and supportive culture within undergraduate medical education, this cannot always be replicated within the workplace. Staff involved at both undergraduate and postgraduate levels frequently spoke about the pressured culture of the workplace and felt this could directly impact on the levels of support doctors in training could access. Students also spoke about how their perception of workplace culture from placements is one that is less supportive than in medical schools. Whilst some medical schools were taking steps to alter the environment to make it more accessible; they often held the view that within the workplace, individuals must instead be the ones to adapt to the environment.

> *'I haven't experienced anything specific but in the profession as a whole it just isn't an open supportive culture, but the university is really supportive' – Student*

There were also many progressive attitudes that created positive cultures and environments within institutions at undergraduate and postgraduate levels. Staff noted that whilst the current landscape may be far from optimum, it is changing. Furthermore, some staff members were clear that the culture within workplaces needs to change. Many felt it is up to providers to make these changes by fostering a supportive environment within education. As one DLO commented:

> *"[The] culture is changing slowly and people are becoming more open. The culture of equality makes it apparent that we want doctors to be a diverse group."- DLO*

Chapter 3: The experience of students

We interviewed disabled medical students, most of whom had declared their impairment, and some of whom had not. As well as wanting to explore their experiences, our questions focused specifically on the support they were able to access, and the extent to which they had been made aware of medical schools' duties and responsibilities. The students were at different stages of their medical courses. This is a self-selecting sample, so it should be noted that the students who were interested in responding may be more likely to hold strong views on the matter. The students' understanding of disability, their experiences of disclosing impairments, their understandings of their legal rights and the barriers they have faced are detailed below.

3.1 Students' understanding of disability

Many of the students we spoke to saw "disability" as a loaded term; many didn't view themselves as being 'disabled.' Some suggested this was because of the negative associations of the term and society's restricted view of disability. For example, the widespread use of a wheelchair logo to represent disabled services only applies to a small proportion of disabled people as a whole. This was particularly apparent for those who had less visible impairments, such as mental health conditions.

> *"I don't feel I need to be under that disability umbrella, I can be ok for months, not like someone who is affected everyday like a wheelchair user and didn't want to feel I was taking away from them. It is confusing on forms as I don't know what box to tick. It is long term but it doesn't affect me every single day."* - Student

> *"I don't view myself as disabled, it is something I have only recently come to understand, that mental health problems are considered a disability… I have only developed these problems while studying."* – Student

3.2 Disclosure

A significant proportion of the students we spoke to did not disclose their medical condition or impairment until they experienced significant problems that created barriers to them in terms of accessing and progressing in the course. Generally, students were aware of support services but were unaware of the specifics of what medical schools could offer; this could be a deterrent for them disclosing their impairment:

> *"I didn't feel encouraged to disclose. I didn't know what options were available and I know it needs to be tailored to individuals and that is why they ask you what you need, but I am newly diagnosed and I didn't know much about my condition or what was available."* – Student

However, the biggest concern that students voiced in relation to disclosure was their perception that it could have a direct impact on their ability to access courses or, moreover, to access the profession in the future.

> *"My fear has always been occupational health telling me I can't be a doctor." - Student*

> *"I was concerned about confidentiality, whether it would impact on future job applications, whether it would go in my medical notes, that kind of thing, particularly with mental health - you feel judged." – Student*

Interestingly, these comments came from students whose concerns were at least somewhat if not entirely allayed once they had disclosed their conditions to the medical school as demonstrated in the following quote:

> *"You don't see many disabled doctors and it isn't discussed a lot, I used to be worried about talking about it because of this but now I feel I can tell people because I have had more positive reactions"– Student*

However, many students remained concerned about their health status having implications for fitness to practise in their future careers, particularly if their condition or impairment was changeable. In this sense, some students viewed disclosure not as a positive process to enable access to support, but as a requirement that could sometimes carry a perceived threat of punitive sanctions.

Conversely, students also told us of examples where medical schools make an active effort to support disclosure. Most commonly these were medical schools that already have an embedded culture of openness. Certainly, the most positive outcomes for students (having their needs met early, efficiently and consistently) were achieved when they were encouraged to disclose their impairment or medical condition early to their medical school.

> *"Certainly the medical school are always sending emails and telling you how you can disclose and what support is available and it is mentioned in lectures" – Student*

In sum, students generally have concerns about disclosing to the medical school because they are unsure or unaware that they would be considered disabled, they are unsure about what support could be offered, or they are worried about fitness to practise implications. In medical schools where students are encouraged to disclose, they seem more likely to at an earlier stage and are less worried about the implications of doing so.

3.3 Students' understanding of legal responsibilities towards them

Some students were totally unaware of the legal responsibilities towards them at any stage of education or employment. Others had some idea of the notion of 'reasonable adjustments' but did not have any detailed knowledge of the subject. A significant proportion of students held the view that

whilst there may be legislation to protect their rights, that these may not always be strongly upheld because of underlying discriminatory views that persist throughout society, as demonstrated by the quotes below:

> *"It is whether the guidance is adhered to before applying. I spoke to a retired admissions tutor who told me not to disclose that I have [condition X] as a few universities routinely do not offer places to people with [condition X]. I know this is illegal but it happens." - Student*

Only two of the students we interviewed were aware of *The Guidance*. Despite this, all the students we spoke to felt strongly that any form of revised guidance should be made available to them. They explained that this would inform students of their rights and would therefore be likely to encourage future students to disclose their impairment or medical condition and get the support they need.

Students were clear that this information should be made available and brought to their attention, prior to the application stage. This is interesting given that the students generally did not consider issues of support and accessibility as an essential factor when deciding whether and where they would study medicine. This was commonly because this wasn't a relevant issue for them at the time of application as they had only been diagnosed with a condition during their period of university study. Other students described how they did not prioritise this consideration because they assumed the support would be there as it had been through their time at school. Even so, students felt that it would be reassuring for them to have access to *The Guidance* prior to application stage to understand the GMC's position with regards to how disabled students and doctors should be supported.

3.4 Barriers faced by students

The main barriers faced by the students fell into five categories:

- communication/information barriers;
- physical barriers;
- financial barriers;
- cultural barriers; and
- experiences of overt discrimination.

This is not to suggest that there are no other barriers faced by students, but these are the key ones they highlighted consistently.

3.4.1 Communication/Information barriers

It was evident from interviews with students that they encountered problems where communication broke down or was ineffective between the different stakeholders; including the medical school staff, the placement provider and the student themselves. Whilst students valued confidentiality in terms of the details of their specific condition, they recognised the importance of effective information sharing to ensure that their accessibility needs were met. There were some situations where students simply did not know who to contact and who to speak to, often when they were on placement. In situations where

communication broke down; students seldom felt empowered and well informed enough to know who to contact in each situation, or indeed have the time to take control of this information sharing themselves.

> " Lots of adjustments were agreed like having a stool for dissection but usually when I got there I had to fetch my own and was accused of being lazy because lecturers didn't know….. I intercalated for a year because I found placement so inaccessible" – Student

> " I am on placement now, I have no information on who to go to for support and I am based far from the medical school so it isn't practical to go there, I don't feel supported, I have a new personal tutor but they haven't been in contact" - Student

3.4.2 Physical barriers

The interviews revealed that physical access needs for students are usually met for students within the university. The vast majority are able to access lectures with relative ease, their accommodation, disabled parking facilities and other activities around the campus. However, problems could arise for students trying to access placements in a number of areas. Travel to the placements could be challenging; either in terms of distance, which could cause considerable fatigue and also would mean being further away from their support and physician; or in terms of the practicalities, for instance having to use multiple methods of public transport or having difficulty with parking. Additionally, a few students described how sometimes the physical environment of the placement itself was inaccessible. For those with impairments which impacted upon mobility, large hospitals requiring long walks between departments could be challenging and sometimes there was not enough physical space to manoeuvre mobility aids such as wheelchairs. Equally, for those with hearing impairments, loud background noise in busy environments could pose a barrier and situations where doctors wear masks, such as in theatre would impede their ability to lip read.

> " I missed out on learning opportunities on placement because my wheelchair didn't always fit on the ward. A doctor took students to another part of the hospital and left me at the top of the stairs, when I found a lift to where I needed to be the door was locked and I didn't have the code so I missed out on that opportunity" – Student

3.4.3 Financial barriers

A small minority of students we interviewed mentioned that they experienced financial barriers to receiving the support they needed. This included being unable to access the financial means to pay for equipment as well as a lack of resources in terms of staffing being unavailable or overstretched. Though this was an issue raised by only a few of the students, the consequences for them were far reaching. Often in cases where students were not currently experiencing any financial barriers, there was a tendency to believe that this would be likely to change once they were in the workplace, given the current financial constraints within the NHS.

> "For the equipment I need, I have to pay for it and the university reimburses me but I don't have that kind of money so I haven't got it" – Student

3.4.4 Cultural barriers

As noted in the previous chapter, the culture of medical education can have a significant impact on the students' experiences. Typically, we found that a positive ethos and supportive culture towards disability was becoming more commonplace in medical schools. Despite this, significant cultural barriers still exist when it comes to disability and medicine. A commonly held view was that although medical school was supportive, they would not expect this level of care and consideration from the profession as a whole. The students linked this perception to the current pressures on the NHS meaning practitioners would not have the time to make adjustments but also many made reference to what, by their own admission, were stereotypes about the level of empathy in certain specialties.

> *"There are stereotypes of certain specialties like Cardiology or Surgery wouldn't be very sympathetic" - Student*

Interestingly, a key cultural barrier students described was one in which they also acknowledged that they had a role in perpetuating; a culture of perfectionism. Students believed that this developed from the high levels of competition to access the course and to achieve within the profession. This was compounded by the fact that in their opinion, the medical schools encouraged them to put pressure on themselves. This was more keenly felt by those with mental health conditions, with clear implications for their symptoms.

> *"There is a view that you have to be superhuman and can't get as much as a cold, got to always be 100%, attitude from my peers that I must be stupid because I look 'normal'" - Student*

3.4.5 Experiences of discrimination

In a small number of cases students described how negative encounters with one individual could dissuade them from seeking support in the future, or could shape their view of the whole department or even the whole profession. Although it was rare, some students did talk about some specific experiences of overt discrimination when they were on placement. For example, students described how some of the doctors who were supervising them voiced opinions about how disabled people could not work as doctors or certainly could not work in certain areas within the profession. A small number of students described how their supervising doctors made derogatory comments, particularly about mental health conditions or about psychiatry as a specialty to students whom, unbeknownst to them, had diagnoses of mental health conditions.

> *"Lots of conversations like this – 'how will you be a doctor in a wheelchair, what's the point in you doing the course when you aren't going to be able to be a doctor' that was a doctor but other students are equally as bad but that's not everyone, the odd person will go out of their way for you"- Student*

3.5 Students' views on good practice

The most commonly referenced indicator of good practice from the student interviews were positive interpersonal relationships with supportive staff members at the university. In fact, students seemed to value a 'listening ear' and an empathetic individual or group of individuals at the medical school, over practical supports. This is exemplified by the quote below:

> *'It is having individuals who honestly care about you that makes all the difference, not in a medical way just a normal human way, it is centralised and they all know what they are talking about and what support is available, one of them isn't medically qualified but she has decades of experience"* – Student

Students recognised and valued the need for individualised, tailored support and the importance of having a level of flexibility to account for their changing needs and changing course requirements. This was particularly important for students who were newly diagnosed, or where their prognosis was uncertain and unpredictable. This highly personalised support seemed to be most effective when students had access to 1:1 time with case-workers, providing clear communication channels and consistency. Good communication and a personalised approach seemed to be associated with a holistic consideration of the student needs, especially for things they may not have considered themselves.

> "*They considered finances, accommodation, accessing lectures, placements, parking and they are also just there for me to talk to"* - Student

These positive interpersonal relationships allowed students the opportunity to be empowered to take a proactive role in the decision-making about how medical educators might best meet their needs. The medical students themselves have the best understanding of the barriers they face and therefore make invaluable contributions to this process. As one student described:

> "*I explained my condition and they explained what would be expected in the course, we identified barriers and solutions together, it was collaborative"* – Student

Students also wanted to participate in other ways. For instance, some students had set up student bodies specifically to support other disabled students. Others mentioned buddy systems where older students supported younger students. Students generally seemed to have invested in these activities and felt comforted that others had similar experiences.

In sum, students' experiences were variable but there are indications of ongoing issues that can impact negatively on their experiences of medical education. Experiences of actual or perceived negative and discriminatory attitudes, a high pressured environment which is sometimes perceived to be unaccepting of difference, and the physical inaccessibility of medical environments, are some of the barriers highlighted by students interviewed. However, those who have had positive experiences articulated that good working relationships and effective communication were vital components in overcoming barriers to medical education.

Chapter 4: Good practice

After what happened I didn't think I would still be on the course but I went up 70 rankings from 1ˢᵗ to 2ⁿᵈ year so that just shows what a bit of support can do support can do' - Student interviewee

We sought the views of students, medical education providers and employers when it came to identifying good practice. Despite the changing nature of medical education at undergraduate through to postgraduate level, the key elements of good practice remained largely consistent. Furthermore, what is very clear is that these elements are echoed by providers and students alike. Good practice starts with fostering positive attitudes towards disability and establishing clear processes; this encourages early disclosure and facilitates the provision of effective, tailored support. More insight into how each of the discussed principles are translated into practice at either undergraduate or postgraduate levels are provided within Appendix A as case studies.

4.1 Fostering a positive culture towards disability

Just as students recognised the importance of good relationships, so too did providers. Providers made reference to the importance of creating a supportive culture in which students and doctors in training feel able be open about seeking out support. This was a view held by staff at all stages of medical education. These are some of the views expressed in interviews:

> *"There is definitely a willingness and a good team…... This is good as these people have got through medical school and dealt with many challenges. We have a 'can do' attitude." – Postgraduate Dean*

> *"We have a reputation for being supportive, we have an open-door policy. We are open and available and set up an environment where students are able to approach us." – Placement provider (undergraduate)*

4.2 Established and clear processes

In general, providers that fostered a supportive culture had used *The Guidance* to shape their ethos on disability and to design their internal procedures. Providers who had clear processes were confident in their use and the outcomes of following them, including what should be considered 'reasonable'. They were assured that they had considered a range of possible options, consulted with experts such as occupational health and had held discussions with the student or the doctor in training. Usually the results of these processes meant that all stakeholders were satisfied and in instances where this was not the case, there were procedures for this to be renegotiated.

> *"Occupational health are pretty clued up about what is reasonable, I have never seen anything I would consider to be unreasonable so we follow the recommendations" - DLO*

> *"We have very close links between the school of medicine support and the university support services. Close communication with the experts in the DDS [Disability and Dyslexia Service] are essential to ensure the correct adjustments are provided."* Head of Student Support

Critical to this is the level of importance that medical education providers place on meeting the needs of disabled learners. This is in terms of funding and capacity to ensure that panels and teams can make fully informed and carefully considered decisions. Some medical schools fund whole support units within the medical school as an additional resource to that provided by the wider university. It was evident in these cases that significant thought, as well as financial resource had been committed to this area. Conversely, there were some medical schools where these decisions were made by only one individual. In these situations, despite their best efforts, they felt that that the process and provision of support could not be as robust without investment across the whole medical school.

4.3 Supporting early disclosure

Overwhelmingly, providers at undergraduate and postgraduate levels described how early disclosure (preferably receiving this information prior to the individual starting the programme of study) allows for a proactive and planned response to individual needs. This was imperative particularly at postgraduate level where doctors in training are required to begin posts in Trusts immediately and this information is required to ensure that the placements are accessible. At undergraduate level there is a longer induction and more time spent on campus at the beginning of the course.

Encouraging early disclosure at undergraduate level meant sending out leaflets and information about support services at an early stage and reiterating this at induction and throughout the course. At postgraduate level, the transfer of information (TOI) form is considered to be critical to ensuring a smooth transition. Some HEE local teams and deaneries have good relationships with medical schools and make effective use of the transfer of information (TOI) form, as well as holding meetings with the medical school and the doctor in training. Understanding what was helpful at undergraduate level and transferring this support where possible to postgraduate level seems to be an effective approach. As a result, fostering a supportive culture and providing information at an early stage also seems to be good practice for encouraging disclosure at postgraduate level.

> *"We have started having regular meetings with the medical school to talk about readiness for foundation and good relationships with local schools for transfer of information and some good relationships with employers."* – Postgraduate Dean

> *"I had email contact with the university before I started, I sent over my report of the assessment that I had had from an independent disability assist service after finishing my a-levels, they agreed to implement everything on my needs assessment"* – Student

4.4 Tailored support

Providers noted tailored support that was student or doctor focussed was a hallmark of good practice. This commonly resulted from a comprehensive assessment process undertaken by a personal adviser which considered solutions to a number of barriers. At undergraduate level this involved consideration of adjustments to enable access to all aspects of the course including lectures, exams and clinical placements. At postgraduate level this meant choosing placements carefully to ensure the environments were accessible and learning opportunities were available for the individual to meet the required competencies; but also individual careers advice about choosing or changing specialties. At all levels of medical education it was acknowledged that this was holistic support and was not limited to practical support.

Specific examples of providing tailored support include designing assessment and adjustment packs to ensure that every aspect of support is considered and matched to the needs of the learner. For instance providing extra time, rather than rest breaks for students with dyslexia. Key to this was a flexible approach to support and keeping the individual at the centre of decision making. For example, some medical schools are starting to conduct observations of students practicing clinical skills with adjustments early in the course, in order to identify the adjustments which could prove to be useful.

> *"We have started to do functional assessments early on to test whether students are going to manage clinical skills. This is important as students don't know what may be helpful adjustments until they try it. We have developed our own reasonable adjustments pack, this means it is holistic and covers everything so that the student doesn't have to come up with it themselves." – DLO*

> *"The standardised case management approach works well but with the personalised approach to outcomes"- Student*

4.5 Universal adjustments

An interesting feature of good practice discussed was the move towards universal 'adjustments'; that is changing the environment for everyone so that it is accessible to all. This approach embodies the practical application of the social model. This was only mentioned by undergraduate providers; a possible explanation for this could be that postgraduate providers have less control over the environment in which they operate. Nevertheless, there is evidence of innovative approaches at undergraduate level:

> *"We have a philosophy of changing the environment to make it accessible for everyone so changing paper and font etc. We are moving to being more inclusive it is about being proactive and not reactive" - Disability Lead*

4.6 Effective communication across stakeholder groups

As identified by student participants, effective communication between all parties was considered vital. Communication within organisations and with the individual concerned seemed to be straightforward in the majority of cases. This was particularly successful in situations where medical schools actively sought close collaboration to foster mutual understanding and good relationships with occupational health departments and the university-wide disability service.

Postgraduate education providers were accustomed to liaising with employers and, providing they had sufficient information from doctors in training, they reported that they were able to communicate effectively with employers. However, medical school staff highlighted that communicating with placement providers could be problematic. A balance needed to be struck between confidentiality and sharing information on a need-to-know basis. Students echoed this concern. An effective solution that providers shared as a good practice example was to work with the student to write a statement about their circumstances that they would be happy to share:

> *"We give them a blue card to give to the placement providers we develop the wording with the student to choose what they want to disclose but it may say something like, 'this student has a recognised medical condition and should be allowed to access the toilet as requested"- DLO*

> *"I have about 6 people I can email for support and one person I can text…. It is the little things like I get emails just checking in with me to check I am ok"- Student*

4.7 Training and workshops

The providers who prioritised issues of disability were also keen to continue to develop these services to ensure they were fit for purpose. Interviewees felt it was important that their organisations adopted a culture of learning. Many interviewees spoke about the importance of staff training and highlighted the opportunity for more peer to peer training or information sharing workshops about disability in order to raise the standards of support. Specifically, they highlighted the importance of this to continue to develop their understanding about classifications and models of disability. Furthermore, these sessions were viewed as a forum to discuss complex case studies to begin to develop a consensus about process and decisions about what is 'reasonable.' Indeed, there was a recognition amongst interviewees that these issues are too complex to be incorporated within guidance alone and in fact attempting to do so in a 'how to' guide could restrict development of shared thinking and innovative ideas.

4.8 Monitoring and Review

Regular monitoring and review was perceived to be a vital component of good practice due to the changing requirements of the course and the changing nature of conditions. Many undergraduate education providers had procedures in place to complete reviews, typically on an annual basis. However at postgraduate level, progress reviews (i.e. Annual Review of Competence Progression) are

completed annually with all doctors in training and these often provide the forum for such issues to be discussed. Most providers pointed out that if they established a culture of openness, good interpersonal relationships and channels of communication, then students will contact the relevant support staff for an updated assessment. Providers also pay close attention to indications that the student or doctor may be experiencing problems such as non-attendance or poor performance and contact them to remedy the situation:

> *"We do yearly reviews. We also keep an eye on all students' progress, it is usually a red flag if a high achiever starts failing suddenly, that can be a sign of mental health problems, so we speak to them" – Head of Medical School.*

Chapter 5: Current use of *The Guidance*

This chapter is concerned with how medical schools, deaneries and HEE local teams are currently using *The Guidance.*

The responses to our online survey reveal that awareness of *The Guidance* was far more common among undergraduate medical education providers (88%) than among postgraduate education providers (48%). This may reflect the fact that *The Guidance* was originally produced primarily for medical schools; indeed postgraduate deans pointed out in interviews that even the full title includes the phrase, 'advising medical schools' and therefore suggests it is less applicable for postgraduate providers.

For those that were aware of it, the results of the survey indicate that *The Guidance* is not currently used on a regular basis or referred to directly for individual student cases. In the case of medical school staff; only 9% of those surveyed are using *The Guidance* regularly (3% referring to it in the case of every disabled student), while over half (52%) use *The Guidance* just a few times a year. Frequency of use was even lower within the postgraduate medical education providers surveyed, with just 2% of those who are aware of *The Guidance* using it regularly.

We asked respondents to select the types of support that they use *The Guidance* for. The six most common things that medical schools use *The Guidance* for are[7]:

1) Understanding responsibilities of the medical school (82%)

2) Considering requests for reasonable adjustments (73%)

3) Informing internal procedures - student welfare and support (63%)

4) Informing students of the support that can be provided to them (59%)

5) Reviewing provisions, criteria or practices, including in assessments (59%)

6) Encouraging students to disclose an impairment (59%)

Responses from postgraduate education providers indicate that they find *The Guidance* most useful in similar areas:

1) Understanding responsibilities of the organisation (83%)

2) Informing doctors in training of the support that can be provided to them (67%)

3) Providing technical assistance and equipment for the disabled doctors in training (67%)

4) Considering requests for reasonable adjustments (50%)

5) Meeting the communication needs of doctors in training (50%)

6) Encouraging doctors in training to disclose an impairment (50%)

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[7] NB. Valid percentages are reported here as those who indicated they were unaware of the guidance were routed away from this question.

These results as well as evidence from the interviews suggest that for both undergraduate and postgraduate medical education providers, *The Guidance* is used primarily to understand the responsibilities of the organisation towards the disabled learners. Additionally, it is used as a backdrop to set the tone and processes within an organisation. It is used more occasionally for specific issues such as considering individual requests for reasonable adjustments and encouraging disabled learners to disclose their impairment.

5.1 Challenges of using *The Guidance*

During the interviews we explored why people might not be using *The Guidance* to a greater extent. It would appear likely that a key issue may be a disconnect between the purpose for which the GMC produced *The Guidance*, and the expectations of medical education providers.

While some medical education providers use *The Guidance* to help them understand their legal duties and responsibilities, others look to it to provide insight into dealing with specific problems such as what might constitute reasonable adjustments. The interviews and the results from the survey are consistent in suggesting that medical educators find *The Guidance* most useful as an overview of how to approach supporting disabled students; however, it may have limited practical value to deal with specific issues on a day-to-day basis. For example, one DLO commented that:

> *"We use it daily in that it has set the tone of our work, we apply the ethos and principles so in that sense we use it daily as it shapes our practice but we don't flick through it or refer it to specifically."- DLO*

Among those who looked to *The Guidance* for specific assistance in identifying and making decisions about reasonable adjustments, a key criticism was that it lacks clarity. On the whole, interviewees accepted that the GMC cannot provide a tick box approach essentially matching reasonable adjustments to specific needs. However, they were concerned that without some clarification about what reasonable adjustments can be offered and to what extent, the result is inconsistency between providers. Specifically, the providers wanted clear instruction on the parameters of adjustments, for example whether or not to provide extra time in OSCEs and how much extra time is sufficient. Others explained how the examples in the current version do not aid decision making because they lack details of context. Many interviewees at both undergraduate and postgraduate levels were concerned about legal challenge and felt that *The Guidance* was not robust and clear-cut enough to support them if cases were taken to court.

> *"[It's] pretty unhelpful, it passes the buck and suggests everyone can be a doctor with little regard for the physical demands, skills and intensity. I'm not sure this is fair to give this impression as the workplace is not sufficiently designed so that anyone can do anything." Head of Medical School*

> *"We don't offer extra time for OSCEs but this is inconsistent with other medical schools and so I worry about students coming to me and challenging it because*

> *they have heard that other medical schools do. Equally, if we offer extra time,*
> *we don't offer rest breaks as well but again this varies between schools." - DLO*

A particular concern raised by postgraduate interviewees with using *The Guidance* is that they do not perceive it to be as relevant to them. This was in part because they felt, as highlighted previously, that the wording used in *The Guidance* suggests that it was not developed for postgraduate education providers. Specifically though, they felt that in medical school there can be more focus solely on the individual student's learning; but as the student progresses to a doctor, patient safety must always take precedence. Postgraduate deans reflected in interviews that they do not feel *The Guidance* adequately reflects this shift in focus. There was also a perception among a few of the interviewees that a person's impairment, or indeed the adjustments provided for a disabled doctor in training could have a detrimental impact on patient safety. Examples that they referenced include situations whereby doctors were required to work alone with patients but could experience a seizure as part of their condition; or mobility problems which could impact on the speed of response for patients. They discussed that the complex balance between the rights of doctors in training, the aims of the programme, the working environment of the trust/board and the need to provide an effective and safe service is not sufficiently dealt with. As one postgraduate dean described:

> *"It is different getting a degree to being a doctor, and that is where there is a*
> *disconnect…. we have to consider patient safety."- Postgraduate Dean*

Therefore, although *The Guidance* is explicit in its function in the introduction to help education providers understand their obligations; many of the frustrations expressed in the interviews seem to reflect different sets of expectations about the practical applicability of *The Guidance* to assist with specific situations and (especially at postgraduate level) to address the complexities of the clinical environment more thoroughly.

5.2 Challenges in supporting disabled learners

In addition to the specific challenges faced when using *The Guidance*, providers also discussed challenges more generally in this area. Issues included difficulty in implementing support and adjustments, frustrations about a perceived lack of flexibility in course requirements, a concern about '*setting students up* to fail', tensions between different departments, and not knowing what to do when a student has been supported but cannot complete the course.

5.2.1 Difficulty in implementing support

This was more commonly a problem at postgraduate level because doctors in training are employed by the NHS trust or board, and it is therefore for them to organise the adjustments. This could pose a challenge in terms of communication between the HEE local teams or deanery and the trust/board, particularly considering the number of rotations that are required at foundation level. Additionally, there were also concerns that sometimes the trust, or individuals in the trust, are reluctant to make adjustments. As one postgraduate dean describes:

> *"There is an advocacy role because sometimes placements are unhelpful and will not manage the environment, we can't force them to take doctors in training but we have to advocate making the adjustments, particularly small trusts who haven't come across these issues before are reluctant so you get to know people in trusts who are more helpful."*- Postgraduate Dean

This could also be problematic at undergraduate level; for example in ensuring adjustments are adequate on placement. This is particularly challenging in situations where a medical condition or impairment is less visible and the need for adjustments may not be immediately obvious; in these situations DLOs need to liaise with all the lecturers and staff involved in the delivery of the course to ensure that support continues to be met. This can also raise issues of confidentiality because staff may need to be reminded about adjustments or may enquire about why they are necessary which can be challenging to do in a discreet way. The DLOs explained their preferred approach is to focus on the adjustment or support whilst maintaining the confidentiality of the individual in terms of details of their specific impairment. Even within the medical school itself this can be challenging as there are numerous stakeholders involved, for instance spaces such as carparks may be privately owned and having to co-ordinate support with so many stakeholders can make the adjustments difficult to achieve.

Another challenge to implementing support was limited resources. Generally, there was a view from both undergraduate and postgraduate providers that this was more of a pressing concern at postgraduate level given the current financial pressures within the NHS. Employer representatives also confirmed that some more costly adjustments, such as one to one support, may not be feasible due to resource constraints. As one postgraduate dean described:

> *"NHS is under extreme financial pressure, it hasn't happened yet but we could get to a point where universities are providing things that employers cannot afford to"*- Postgraduate Dean

5.2.2 Students being 'set up to fail'

A commonly referenced concern was a perceived paradox that by providing support and adjustments, medical educators could in fact be setting students up to fail in the long term. Their concern was that they could be providing support that may be unavailable in the workplace either because of lack of resources or because of busy working environments that could not offer similar levels of flexibility. Worse still, they worried that they were encouraging students to continue into a profession inherently high pressured, which could be detrimental to their health. This concern was most commonly voiced in relation to those students with diagnoses of mental health conditions.

> *"The huge risk is whether we are creating an environment that is overprotective and one that cannot be replicated in employment. We all have to recognise the high rate of junior doctor suicide and we should be careful about putting people in a situation that increases their vulnerability."*- Head of Medical School

"...concern that providing adjustments creates an environment where a student can manage, but then in practice, the workplace cannot be adjusted so that this is feasible. Are we therefore setting students up to fail? OR do we need to influence the culture of the workplace. If we can't change the workplace we need to be giving advice about alternative careers and pathways early on."- DLO

5.2.3 Fitness to Practise concerns

Setting students up to fail was not only a concern in terms of risking investment of time and money when they were unlikely to progress, but was also associated with fitness to practise concerns. Some postgraduate deans expressed a view that medical schools were making far too many allowances due to fear of legal challenge resulting in students unlikely to progress starting foundation. This was particularly in relation to students taking what they considered to be an excessive amount of time to finish their degree and the impact that could have on their learning. There was a view that where these students could be identified earlier, discussions could take place about possible alternative programmes of study. However, this is not to say that medical schools did not share these concerns, as one Head of Medical School described:

"We have failed if there is a scenario where we refer a trainee to GMC on fitness to practise grounds due to ill health and there have been ongoing problems for ages and when we trace it back you can see they weren't going to progress"- Head of Medical School

5.2.4 Lack of flexibility in course requirements

Some providers voiced frustration with what they perceived to be an apparent lack of flexibility with course requirements. This was commented on at both undergraduate and postgraduate levels with specific reference to clinical competencies. Despite a GMC position statement which addresses this issue[8]; some interviewees still described a perceived contradiction or tension between the GMC's aims to be inclusive and provide adjustments, and having to meet rigid requirements.

"There are other cases where people cannot fulfil a specific competence for foundation but within their specialty they would never have to use that again" – Postgraduate Dean

"[it] Bothers me that there is no flexibility in competencies, it means we miss out on good doctors because of the strict regulations on clinical skills, of course it needs to be safe but a lot of public money has gone into training them, it feels like indirect discrimination. When I was training I trained with a disabled doctor who could access the profession because back then there was some flexibility in competencies." – DLO

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[8] GMC Review of Health and Disability in Medical Education and Training May 2013 http://www.gmc-uk.org/H_26D_review_statement___May_13.pdf_56450036.pdf

5.2.5 Tensions between departments

At undergraduate level, tensions between departments were typically due to either the university-wide disability service or occupational health making recommendations which, in the view of the medical school, were not applicable to medical training. Such tensions seemed to arise in medical schools where they had not fostered good working relationships with these external departments. Similar issues were noted at postgraduate level with the added complication of the relationship between the trust/board and the education provider negotiating adjustments and support.

> *"Sometimes occupational health can make suggestions which just are not conducive with the training. For instance, one where they said the person could not undergo any assessments and I had to go back and explain this isn't possible. Very occasionally people have unrealistic expectations."-Postgraduate Dean*

5.2.6 Poor communication during transitions

A common concern raised by postgraduate deans and employer representatives was that the Transfer of Information (TOI) process is not happening efficiently. Some postgraduate providers were generally not aware of the widespread use of the TOI form, though they recognised it as a crucial aspect of a smooth transition for learners. Many of the postgraduate deans we spoke to explained that they do not receive the information at all from the medical school. The postgraduate providers that do use the TOI process consistently explained that this is bolstered by their working relationships with the local medical school; they highlighted that TOI forms from outside of the local area were still rarely received. The interviewees explained that commonly the doctors in training disclose the information themselves once they have begun the programme, though there was a concern that individuals seem particularly hesitant to share information relating to mental health and may only do so once they are experiencing more severe symptoms.

> *"Supposed to have transfer of information from the medical school but in reality that is breathtakingly rare and so the individual trainee informs us but they may be reluctant for whatever reason so we don't get to know until they start the course and by then it is too late to design a bespoke course. For example you may have them in a busy A&E and they may have mental health issues and that is unsuitable for them"- Postgraduate Dean*

There were also concerns raised that when TOI documents are received they do not contain adequate information about the needs of individuals. There was a perception amongst the interviewees that this was particularly the case for those with diagnoses of mental health conditions. Some postgraduate providers expressed a frustration with this lack of detail as it would hinder their ability to adequately prepare. For example, interviewees described situations where they had organised placements, only to find that when an individual started the programme, the placement was totally inappropriate to meet their needs. Many also described how they would not be informed that it had taken a student many additional years to complete the medical degree due to periods of absence, which may indicate they will require a range of support.

Whilst the TOI process is recognised as being vital, the concern is that it is not being used effectively across the board. However, it is vital to note that within this research we only spoke to postgraduate deans as representatives from postgraduate providers so it may well be the case that this limits the validity of the findings.

5.2.7 Withdrawal from the programme

Both undergraduate and postgraduate providers were keen to point out that non-completion of a course or programme on medical grounds was extremely rare. In fact, when this did happen it was usually due to a number of compounding factors of which a student or doctors' health status was only one. Nevertheless, these rare circumstances still led to a considerable amount of worry for providers. It was evident from the interviews that these decisions were painstaking and for the most part, providers agonised over whether there was anything further they could offer in terms of support. Providers clearly found these situations extremely challenging. Across the board, interviewees recognised that a medical degree was no small undertaking and that there is considerable investment made in terms of time, finances and emotion to becoming a doctor. Interviewees at both undergraduate and postgraduate levels felt that withdrawal was more common for those with diagnoses of mental health conditions compared with other health conditions; they suggested that this was perhaps due to the gradual increase of pressure and the unpredictability and changeable nature of mental health conditions.

> *"Once you have offered all the support you can, you then need to treat them the same as any other student, it is most commonly students with mental health conditions who don't complete but it is hard to extrapolate whether this is academic or health"* – Head of Medical School

> *"Very rare and odd occasion is usually due to deteriorating mental health and only when they lack insight does this become a problem"*- Postgraduate dean

Chapter 6: What do medical education providers and students want from *The Guidance*?

A key objective for the research has been to identify and explore suggestions stakeholders had regarding how *The Guidance* or related resources could be developed or supplemented. It is clear from the survey data that the majority of both undergraduate (82 per cent) and postgraduate (67 per cent) medical education providers surveyed feel that the current guidance needs to be updated. As to what they would like to see in an update, again the survey provides some indications that were explored in more detail during the interviews. The suggestions outlined in this chapter also reflect the challenges and current good practice previously discussed.

6.1 A clearer consensus on disability

The providers interviewed felt that the revised guidance should establish a clearer consensus on definitions of disability and which individuals require support. Whilst a definition of disability is already provided in the current version of the guidance, there were a few instances where interviewees were still unsure about legal definitions and who the GMC would expect organisations to provide additional support to. Many providers expressed a view that there is a need for a shared understanding and for this to be reiterated in the revised guidance, possibly with examples.

6.2 Specifics about reasonable adjustments

As previously stated, providers were realistic that the GMC is not in a position to provide tick-box solutions to the issue of reasonable adjustments. However, they expressed a desire for parameters about what is and is not considered 'reasonable'; in effect they wanted benchmarking data to assess whether their practices are justifiable on the basis of precedent. Providers explained that they would feel better able to advocate for adjustments if this was clearly defined by the GMC. Furthermore, there was a wish for consistency across education providers, particularly in relation to whether extra time should be offered in clinical exams and how much extra time should be granted. Some medical schools are wary of the threat posed by possible judicial review should students be able to establish that other medical schools provide levels of adjustment and support that exceed the provision in their own setting.

6.3 Assurance in decision-making processes

Many providers are worried about legal challenge. In their view, it would be helpful for the revised Guidance to offer a level of clarity that could stand up to legal scrutiny. Other participants recognised that it is not possible for the guidance to cover every circumstance, but it can offer advice about processes; including who should be involved in decisions, how to maximise the expertise of occupational health, and processes to follow for review or challenges to decisions. Additionally, there was a desire for advice on information sharing and how this should be balanced with individual

confidentiality, this includes TOI and negotiations with placement providers. As one Head of a Medical School described:

> *"Some sort of framework of questions to ask to interrogate your processes and to evaluate and improve the process. We can't have a one size fits all approach but we could have a best practice process which we can all aim for."- Head of Medical School*

6.4 Shaping students expectations for the future

Interviewees felt that *The Guidance* did not give enough information to enable providers to create an inclusive environment for disabled learners across all aspects of the curriculum. Furthermore, they also wanted guidance around how to approach the rare cases where students or doctors are unlikely to progress despite all possible support being offered and advice about how to start and shape these conversations. This would particularly be guidance about changing to different programmes of study or considering different specialities. This is a reflection of the concerns about '*setting students up to fail'* as described in the previous chapter; providers perceive that there are situations when it might be more appropriate to suggest alternatives earlier in the course. However, there seemed to be reluctance on the part of providers to take that route because of the risks of legal challenge or because they lacked a framework to assist them to address such a sensitive topic. As one DLO noted:

> *"Guidance about those conversations when a student can't meet the competencies with all the support but desperately want to be a doctor, whether these decisions can be made earlier to avoid unnecessary debt"- DLO*

Providers also wanted more clarification from the GMC about 'fitness to practise' in this context. Several providers found it difficult to balance the rights of students or doctors in training, the demands of the curriculum, the concerns of employers and patient safety issues.

6.5 Informing students

All students were clear that they wanted access to *The Guidance* so that they could best understand their rights; a view echoed by providers. Providers and employers felt that *The Guidance* should be available at the pre-application stage. It should be clear about the realities of the workplace so that prospective students can make informed decisions. In a similar way, many interviewees suggested it would be useful to provide practical advice to students about what to expect at Foundation level and to inform decision making about different specialties. However, they were concerned that this could result in an increased risk of legal challenge if it is open to interpretation.

> *"Students need to have access to is for transparency and also lots of students don't know they would be considered disabled so it needs to be made clear"- DLO*

"I know they have examples of disabled people doing very well and that is great but also need a realistic and truthful account about what is possible. Truthful like hours, time spent on feet, limited breaks etc."- DLO

6.6 Format suggestions for the revised guidance

We asked people, through the survey and in interviews, for their thoughts on possible formats for a revised version of *The Guidance*. They came up with several innovative suggestions including:

- **Having an online version supported by an app for hand-held devices.** There was a perception across all interviewees that this would encourage students to us it.

- **Interactive video.** Many interviewees, particularly the students were unaware of the existing resource Experiences Shared but were interested in this once they were informed about it. Providers thought that interactive video could be an appropriate medium to discuss more complex elements of decision making.

- **A quick guide version with simple flow charts.** To enable busy professionals to refer to it quickly including when they are with students and doctors in training.

- **More use of infographics.** To present the information in a different way and to consolidate the information.

- **Ensuring an accessible format** (e.g. larger font). It was seen as particularly pertinent to consider the accessibility requirements of the potential audience.

6.7 Supplementary initiatives alongside the revised guidance

To supplement *The Guidance*, providers suggested the following:

- **Localised peer group networks.** For example, launching any revised guidance at local round-table events could be one way of creating an opportunity for medical education providers to identify suitable peers with whom they could exchange information and support. Indeed, providers did suggest they would appreciate the opportunity to share good practice.

- **Training.** Providers recognised that it would be impossible to cover all possibilities through guidance and therefore inspiring and encouraging good practice may be best done through training.

- **An online or telephone support service** for providers would be desirable for some cases.

Chapter 7: Conclusions

The research has highlighted several key issues for the GMC to consider when revising *The Guidance*.

- Medical schools tend to have varied approaches to the way in which they provide support for disabled students. We did not find evidence of any single model of across the board good practice applied consistently. Rather, our research suggests providers fall into three broad categories,

    a) Those who have a good understanding of the key principles as outlined in the current guidance and deliver good practice informed by those principles;

    b) Those who have a good understanding of the key principles but face challenges in consistently delivering what they know to be good practice; and

    c) Those who are working towards developing good practice principles to reliably and robustly inform practice in their institutions.

    There was a sense that these categories were also reflected in the postgraduate education providers we spoke to, though we did not get as rounded a view of postgraduate providers to make such a clear distinction.

- Providers delivering good practice find *The Guidance* a useful source of information about their responsibilities to disabled learners and of advice on effective internal procedures, including welfare and support. Those working towards developing capacity to deal effectively with supporting disabled learners were more likely to hope the revised guidance would provide specific advice on reasonable adjustments. Should the GMC determine it will not be practicable for revised guidance to offer that, managing the expectations of what is a significant proportion of providers, is likely to be critical.

- The GMC might wish to consider whether through the revised Guidance or associated resources, it could provide information for prospective students about what to expect from a career in medicine, including different specialties. This will allow prospective students to make more informed choices. *The Guidance* should also include practical advice to students such as how to access support and signposting to other information.

- The findings suggest that the many of the interviewees, including staff and students, appear to still be heavily influenced by the medical model of disability which is very much ingrained within society. This was evident in comments made about impairments as imperfections, deficits or individual limitations.

- It is crucial to build on the inclusive ethos which is already laid out in the existing guidance and use this to promote an asset based approach. That is, an approach that focuses on strengths and what an individual is able to do as opposed to focussing upon barriers. For instance, many students were unaware of *Experiences Shared* but were very interested after

they had been informed as they wanted to see examples of doctors thriving within the profession.

- It is important for the GMC to continue and build on its level of co-production for the revised guidance in a way that will engage education providers, wider stakeholders and disabled students and doctors in particular. It is possible that doing so will also assist with effectively disseminating the revised Guidance.

Providers and students clearly find this to be an important and valued area of research and development. Although the current version of *The Guidance* is not widely used in peoples' day to day roles, there is a clear desire for an updated version across all stakeholders. The current version has provided a backdrop for providers to design their internal processes and has set the tone and ethos for supporting disabled learners. However, both providers and students express that there remain significant challenges for ensuring that the needs of disabled learners are met in an effective and timely way. The research has identified important examples of good practice and innovative suggestions for future development and knowledge sharing in this area.

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Appendices

Appendix A: Good practice case studies in the provision of medical education

Undergraduate medical education

We have taken one example (anonymised) of a medical school to illustrate the key features of good practice in the provision of undergraduate medical education.

Participants:

Head of School
Student support team leader
Director of student support within the medical school
7 Students

Processes:

The Head of School has oversight of the processes for supporting disabled students and is the final adjudicator in the rare situations where there are disputes.

Four key services are involved in the processes designed to support disabled students, these are: the University-wide Disability and Dyslexia Service (DDS), University-wide occupational health, the University-wide Counselling Service, and a Student Support Service within the school dedicated specifically to medical students.

There is a wealth of expertise concentrated within the Student Support Service in the Medical School. For example, the Director is a senior academic with a background in occupational health. Within this unit there are case managers with backgrounds either as GPs or as occupational health specialists as well as a Speech and Language Therapist and some highly trained administrators. The unit offers holistic support based on a bio-psychosocial model of intervention to all medical students experiencing any kind of difficulty.

Professionals do not work in isolation. Rather, they liaise closely with the other services detailed above. Staff at School A clearly value the expertise of occupation health and recognise the need for this independent assessment, similarly, they were complimentary about the DDS service and their understanding of the specifics of medical courses. Whichever service the student is referred to or indeed self refers to, they will share information as appropriate with the other services. This is working well:

"Self- referrals to [Student Support in the medical school] have quadrupled since started, I think people are becoming more confident. Once they understand it is not going to stop them qualifying, they come forward. We need to create a culture where it is ok to ask for help"

Students are asked about their support needs prior to starting the course and reasonable adjustments are organised by DDS and a referral is made to Student Support within the Medical School. The student is then assigned a case manager. This case manager will meet with the student and offer them direct support; but also signpost to other services, ensure reasonable adjustments are implemented, advocate for any more adjustments, liaise with placement providers and provide a listening ear. The case manager will agree with the student how often to meet and this can vary based on the changing needs of the individual.

Enablers of good and noticeable practice within the school:

1. The Student Support Service use a traffic light system in the database to indicate the level of need and the corresponding level of contact required:

    "If we haven't heard from students in a while we will check in with them, but also they can contact us in multiple ways at any time" – Student support team leader

    Students described how this works in practice:

    "I see the case manager periodically, it depends how I am doing, if I am well, I will just email them if I am struggling but if I am going through a phase of being unwell I see them more often. I am always able to seek support when I need it , they can make time for you really quickly."- Student

    "well supported but good balance as also left to be independent."- Student

    "I have a case manager who is also the director but she works so closely with the rest of the team that in the event that she is unavailable the rest of the team are able to pick it up. They are always my first port of call, they are holistic and impartial"- Student

2. There is a focus upon the expertise offered by certain professionals, particularly occupational health. This means that this medical school offers a wide range of adjustments which are not necessarily available at all schools, based on the advice from occupational health. For example, they offer extra time in clinical exams. Students also valued the specific expertise and impartiality of the support services:

    "I now see occupational health as more supportive rather than punitive."- Student

"It is all confidential and they are better able to advocate for you."- Student

3.   In complex cases a collaborative approach is employed, whereby all the support services detailed above along with the Head of the Medical School and the student themselves come together to discuss barriers and solutions. Similarly, for clinical tasks, a student may be observed by the panel practising a task with the agreed adjustments to assess whether they need more support and what further could be offered.

> *"It was fantastic. I explained my condition and we looked at the challenges and solutions, it was collaborative. They considered everything mobility, accessible parking, I don't have to attend everything and don't have to fill out the form every time I have time off I just send an email"* - Student

4.   Staff felt that the biggest strength was that they had an effective process in place but this did not detract from a highly individualised service. They described having a clear process which draws upon a wealth of expertise and considers a student's holistic experience. In the interests of transparency everything is recorded and shared and there is a clear appeals and complaints process. Staff were confident in this approach and took the view that:

> *"whether an adjustment is reasonable or not is for a tribunal to decide but we take the approach that if we can then we will. We have a clear audit trail for decisions"*- Director of student support

> *"I can't fault the support, always someone to talk to, even a 24-hour nightline for any student needing support. I was surprised how helpful my year 1 director was. Everyone has been really nice and all the support is really useful."* – Student

5.   Staff highlighted the importance of early and effective careers advice in situations where with support, students were unable to fulfil the requirements. One interviewee described:

> "*There are certain things doctors have to be able to do and it's one thing completing the degree and another being an independent medical provider, there are people who are extremely bright but may not be able to do the things required even with support and adjustments and reviewing those adjustments this is the difference between competence and capability.*" – Director of student support

However, staff were clear that these situations are very rare but that effective careers advice and good communication with the student were key to agreeing best outcomes.

6.   The school had invested heavily in this area and clearly valued it. They have a culture of learning and of sharing good practice, as described by one interviewee:

> *"We share good practice. I think there needs to be more of this and less competition between medical schools"* – Director of student support

Students were also aware of the value placed on this area and the resulting quality of service:

> *"Open day was brilliant, they provided an accessible parking space and there was a large section on support and so I felt quite confident, I went in year 10 I was eager. I declared on my UCAS for but this was a separate declaration to the main application, I like that, I wanted to go in as me without any pre judgement."* - Student

7. The staff have developed a project called 'One Act of Kindness' in order to promote good mental health throughout the school. This is a universal provision for all students which raises awareness of mental health issues and also encourages peer support and self-care. The school also uses a buddy system for new students as another universal provision:

> *"There was a buddy system where older students showed us round they were really supportive and I am still in touch with them now."* - Student

8. The school has developed a passport system whereby they work with the student to write a statement which they would be happy to share with a placement provider with as much information as the student feels comfortable sharing. This can then be used by the student when on placement to hand to their supervisor to detail support needs. Students valued this as they often pointed to the difficulty in having a confidential discussion with a supervisor, finding the time to do so and having the confidence to speak to a someone they had no previous relationship with about a personal matter.

Postgraduate medical education provision

We attempted to develop a single good practice case study for postgraduate provision. However, we found that as the research design had not offered the same '360 view' for postgraduate education as for undergraduate education, we were unable to triangulate the data. Furthermore, there was no single example that stood out across all areas of provision. For that reason, rather than provide a single case study, we report here a summary of the processes that senior staff associated with good practice at post-graduate level and the key factors which signify good practice based on a sample of our interviews.

Processes:

- Postgraduate Deans described their role as overseeing the training of postgraduate doctors in training through foundation and through to CCT level (specialist registered consultant). This varied slightly between each provider as some covered all specialities, whereas others covered only secondary care or only certain specialities. However, all of them covered foundation.

- In relation to disabled doctors in training, postgraduate deans saw their role as being responsible for oversight of the process, key things for them to consider would be whether the individual is likely to fulfil the requirements of the training programme with support, patient safety, reasonable adjustments and appropriate placements

- The process is commonly reliant on an individual declaring an impairment or medical condition either on an occupational health form during application, upon starting the programme or during the programme if they are newly diagnosed with a condition during this time. A commonly held view was that it is the responsibility of the individual to share this information. However, the importance of transfer of information was also highlighted.

- Once an individual declares an impairment or medical condition the process varies depending on the providers, in many cases reasonable adjustments are dealt with on a local level with the employers, in other cases this decision is made with the head of school and the training programme manager.

- As each individual trust/board is the employer, they will usually make the decision about reasonable adjustments

- Only in more complex cases, do the postgraduate deans become involved. On some occasions there is a panel that will come together to assist in decisions but this varies between providers. Sometimes the post graduate deans have an advocacy role to remind the trust of their duties and encourage them to be flexible in adapting the working environment.

- Though post graduate deans accepted that the process could be improved, only a very small minority could think of any doctors in training who had left the programme because the environment could not be sufficiently altered to allow for an individual to keep training.

Enablers of good and noticeable practice:

1   A 'Can do' attitude was cited by many of the postgraduate providers as being the most important enabler of good practice. As some Postgraduate Deans described:

> *"It is dangerous to apply boundaries or limits of what is reasonable. What we need is a culture change, it is unhelpful to say some things are unreasonable as it is the wrong mind set."- Postgraduate dean*

> *"You can make almost anything happen if you are trainee centred, you can offer bespoke programmes"- Postgraduate dean*

2   The providers who expressed this attitude also had a pragmatic approach to finding solutions. For instance, some providers would complete a gap analysis of the curriculum and find solutions to remove barriers. For instance, one postgraduate dean explained:

> *"Nightshifts were a problem for one trainee so they couldn't do nightshifts as it would interfere with their medications and impact on her health. So I thought what is this testing? It is testing emergency response with limited supervision, so we set up those scenarios just not at night and in a way that didn't impact on her peers."- Postgraduate dean*

> *" If it is something I haven't dealt with or I am unsure about I will contact other trusts and see what they have done, we need a culture of sharing and of learning"- Postgraduate dean*

3   Key to implementing this successfully was good communication and early disclosure. As highlighted in the main report, it remains the case that most providers rely on the individual to disclose to them and in reality the Transfer of Information form is rarely used. However, where it is used it is proving to be effective.

> *"If we receive the information early, we can consider the placements and can design a bespoke programme for them"- Postgraduate dean*

> *"We get informed by the Transfer of Information, this is usually really good and it is just a smooth transition"- Postgraduate dean*

4   The importance of concentrating expertise and making effective use of colleagues who have knowledge of arranging adjustments was recognised. For example, some providers would ensure that there was a separate occupational health report for each training setting for the individual to take account of individual needs, the requirements of the training programme and the specifics of the training environment. Others would have panels of experts for complex decisions. The importance of occupational health was described by postgraduate deans below:

> *"Sometimes I need to speak to occupational health and get more information. For instance, I had to get voice recognition software but had to speak to them to*

identify some which recognised medical terminology. so sometimes about fine, where do I get that from and how do I do it."- Postgraduate dean

"I am a doctor but I am not their physician, so it is not ethical for me to make those decisions, it is for occupational health to make that assessment"- Postgraduate dean

5   Another common feature was the recognition of the impact of experiencing barriers or indeed of receiving a new diagnosis during the training programme and the need therefore of holistic support packages. For instance, some of the providers had Professional Support Units which offered a wide range of support including coaching, tuition and signposting to other sources of support.

6   Viewing disabled doctors in training as a key resource, as opposed to users of resources enabled innovative practices to evolve as evidenced below:

"We had one doctor in training who had dyslexia, not only did we provide appropriate adjustments but they went on to develop a programme to train other doctors and to educate others about understanding the diagnosis and response"- Postgraduate dean

"Often it is key to speak to the doctor in training, they know what worked for them at medical school so often have a good idea of what support they require"- Postgraduate dean

7   Postgraduate deans recognised that there were some extreme cases whereby the environment could not be sufficiently adjusted to allow for the individual to access the programme, in these cases a degree of flexibility and effective and timely careers advice enabled the best outcomes. One solution was that some of the learning from a specialty should be transferable on a points basis to a different specialty, so that an individual was not forced to reapply and start from scratch in a specialty:

"We have two postgraduate deans who are committed to transfers to different specialties. Also need to develop stronger links with medical schools to look at careers outside of medicine".- Postgraduate dean

Appendix B: Research questions

(please note that during the course of the research Local Education Training Boards or LETBs changed to HEE local teams and are referred to as such within the main text)

Set 1 – questions for medical schools (providers of undergraduate medical education), deaneries and Local Education and Training Boards (LETBs) (postgraduate education) and employers:

1) What challenges and/or areas of uncertainty do medical schools, LETBs, deaneries, and employers encounter when/if using our *Gateways to the Professions* guidance or related resources?

2) What challenges and/or areas of uncertainty do medical schools, LETBs, deaneries, and employers encounter when supporting disabled students or trainees more generally?

3) What conditions do students and doctors most commonly present with in the experience of medical schools, LETBs, deaneries, and employers?

4) Are medical schools, LETBs, deaneries, and employers able to identify examples of notable practice in supporting disabled students or trainees (ideally, evaluated but if not, perceived)?

5) Do medical schools, LETBs, deaneries and employers have any suggestions regarding how the *Gateways* guidance or related resources could usefully be developed or supplemented?

Set 2 – questions for medical students:

6) How would disabled medical students who have recently been through admissions processes to medical school assess their experience of those processes and the support they have been offered during their studies?

7) To what extent are prospective and current disabled medical students (including long-term health conditions) aware of the medical schools' duties and responsibilities to them, at the different stages of access to medical education (i.e. application, admission, during studies)?

Set 3 – questions for medical schools:

8) What types of adjustments or specific adjustments are considered 'standard'?

9) What types of adjustments or specific adjustments are considered 'complex' or 'non-standard'?

10) How do the medical schools make the differentiation between the categories identified at 8) and 9)? What criteria do they use?

11) Once reasonable adjustments are in place, to what extent is monitoring undertaken?

- What, if any, types of monitoring (eg meetings, documentation, staff present in assessments etc.)?
- How are schools satisfied that the adjustments are implemented?
- How are schools satisfied that these adjustments have had the desired effect in terms of supporting the student?
- What is done if the monitoring shows the outcome has not been as desired / expected?

12) Once reasonable adjustments are in place, to what extent is the student's level of satisfaction assessed?

- In what ways/using what types of methods?
- What happens if students state they are dissatisfied with the support put in place for them?

Appendix C: The social model of disability

The latter half of the twentieth century saw the development of what commentators have called disabled activism. It grew out of the endemic discrimination, social, economic and physical, experienced by disabled people in most developed countries. The key element of that movement was the challenge mounted to what are now known as medical or individual models of disability.

Embodied in the World Health Organisation's International Classification of Impairment, Disability and Handicap (ICIDH), the medical model defined a disabled person as having an impairment, which was considered to be the cause of the disadvantage encountered, and thus resulted in dependence on others for support. The implication was that since disability cannot be cured, disabled people required care to enable them to participate in society. Disability activists were quick to point out that this individualistic or medical model simply served to reinforce the assumed inadequacy and dependence of disabled people.

That challenge led to a reinterpretation that people have since labelled the social model of disability[9]. Key here is the distinction between the terms impairment and disability. While impairment refers to a physical or psychological attribute or condition, disability refers to the range of social, economic and physical barriers experienced by people with impairments. In this understanding, a person may have an impairment, but it is social disadvantage and discrimination that prevents their full participation in society, and which thus 'disables' them.

To clarify, it is worth citing the following key characteristics of the social model[10]:

1) A social model perspective does not deny the importance or value of appropriate, individual interventions in the lives of disabled people, whether on medical, rehabilitative, educational or employment grounds, but draws attention to their limitations in terms of furthering their empowerment and inclusion in a society constructed by "non-disabled" people for "disabled" people.

2) By contrast with the conventional individual medical model of disability, it is a deliberate attempt to switch the focus away from the functional limitations of impaired individuals and on to the problems caused by disabling environments, barriers and cultures.

3) It is an holistic approach that explains specific problems experienced by disabled people in terms of the totality of disabling environments and cultures. These include inaccessible education, information and communication systems, working environments, inadequate disability benefits, discriminatory health and social support services, inaccessible transport, houses and public buildings and amenities, and the devaluing of disabled people through negative images in the media – films, television and newspapers.

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[9] Barnes, C. (2009). Understanding the Social Model of Disability. http://www.hso.se/Global/Projekt/Fr%C3%A5n%20forskningsobjekt/Forskning/Anteckningar%20Colin%20Barnes%20091118.pdf last accessed July 12th 2017.
[10] Oliver, M. (2004). The Social Model in Action: If I had a hammer?. In, C. Barnes & G. Mercer (Eds.) *Implementing Social Models of Disability: Theory and Research*. Leeds: The Disability Press, 18-32.

Since the 1980s, the social model has become the *de facto* definition of disability, and was adopted by organisations including the UK Council for Disabled People, the Disability Rights Commission, the World Health Organisation[11], and by the Labour government's Life Chances for Disabled People report[12].

The principles reflected in the social model of disability run throughout the current version of the GMC's *Gateways to the Professions* guidance. Indeed, as *The Guidance* explicitly states:

> *This is the thinking behind recent developments in disability legislation and informs the language and advice used in this guidance. (p.40)*

[11] WHO, 2001: ***Rethinking Care from Disabled People's Perspectives,*** Geneva: World Health Organisation. http://www.independentliving.org/docs6/barnes200106.pdf last accessed August 8th 2017.
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