General Medical Council

Regulating doctors
Ensuring good medical practice

Report of the group leading the review of health and disability in medical education and training

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Executive summary

1. Many disabled doctors are practising successfully in the medical profession alongside non-disabled colleagues. Indeed, patients often say they identify closely with disabled medical professionals who can offer a particular personal insight and sensitivity. Medical schools told us for the year 2011/2012 that around 6.5% of students declared a disability[1]. In the National Training Survey for 2012 2% (1019) of trainees told us their day-to-day activities are limited a lot or a little because of a health problem or disability which has lasted, or is expected to last, at least 12 months[2].

2. However, the journey through the medical education and training system is not always an easy one. In some cases, even with reasonable adjustments, it may not be possible for every disabled medical student to successfully and safely undertake all stages of medical education and training.

3. Equally, medical schools and postgraduate deaneries (and in future local education and training boards[3]) face challenges in determining the level of support which disabled students and trainees may need during their education and training. In making decisions about the progression of a student or trainee, they have to balance the rights and expectations of the individual against the overriding requirement to maintain standards and protect the safety of patients.

4. As the regulator, now with responsibility for all stages of education and training, it is appropriate and timely that the GMC should review the overall position to see where there might be scope to promote greater clarity and consistency in the type and level of support which may be available. Against this background, in February 2012, Council established the Health and Disability in Medical Education and Training Group to undertake the first phase of a comprehensive review. Some issues will be for the GMC to address, but others will require work with partners. The heightened awareness of disability issues prompted by the London 2012 Paralympic Games makes this a particularly pertinent time to be exploring the issues.

5. This report details the initial findings of the group and suggests possible areas for action which Council may feel should be explored as part of further work in 2013. It follows an examination of a wide range of issues, including the implications of relevant legislation, the existing processes in place to support disabled students and trainees, and takes account of the viewpoint and experience of key interests following a series of helpful engagement activities.

6. The group identified that a number of the areas for possible action would undoubtedly be of benefit to all disabled doctors.

[1] www.gmc-uk.org/education/medical_school_reports.asp

[2] www.gmc-uk.org/education/surveys.asp

[3] It is expected deaneries' functions will be incorporated within local education and training boards when they come into effect in April 2013. For ease of reference we refer to deaneries in this report.

7. The group proposes that if the areas for possible action outlined in this report are taken forward, these should lead to the following outcomes:

a. A revised version of *Gateways* reflecting the findings of this report.

b. A review of the competencies, including the practical procedures, in *Tomorrow's Doctors, The Trainee Doctor* and the Foundation Programme.

c. Quality assurance arrangements that promote good practice in reasonable adjustments, occupational health, and transition.

d. Sharing of good practice on provision of reasonable adjustments.

e. The National Training Survey and, if introduced, an annual student survey including questions around disability that can be monitored year by year.

f. An improved understanding of the GMC's role among students and trainees.

Outcomes with partners

a. Named expert in schools and deaneries who can ensure that disabled students and trainees have access to careers advice and occupational health services.

b. Greater consistency in the quality of occupational health assessment/advice for disabled students and trainees.

c. Better support for transition of disabled students from medical school to the Foundation Programme.

d. Improved sharing of information to support disabled students and trainees.

Background

Reasons for the review

8. The *Education Strategy 2011-2013* [4] makes the commitment that: 'By 2013 we will also examine the challenges that doctors with disabilities face at all stages of education and training and any implications for the regulatory framework.

9. This commitment was made in the light of a number of factors.

   a. The opportunity to take stock, following the merger of PMETB with the GMC, of disability issues across the continuum of medical education and training, taking into account the earlier publication of *Gateways to the Professions - Advising medical schools: encouraging disabled students* [5]**.**

   b. The desirability of clarifying the legal implications of the Equality Act 2010[6] (the Act).

   c. Our strategic aim to promote and support equality and diversity.

10. Last autumn, the Undergraduate and Postgraduate Boards considered the legal advice received about the extent of the GMC's duties and powers under the Act.

11. In relation to disabled students and doctors, the legal advice said the requirements set out in our standards for undergraduate and postgraduate medical education (*Tomorrow's Doctors* [7] and *The Trainee Doctor* [8] respectively) are 'competence standards' for the purposes of the Act.

12. The effect is that the GMC is under no duty to require reasonable adjustments that would alter or lower the standard of competence – which exists to protect patients – that is required. The advice is covered in more detail at Appendix A.

13. Following consideration of the legal advice and noting the views expressed by the Boards, in February 2012, Council established the Health and Disability in Medical Education and Training Group (referred to in this report as the Health and Disability Group) to lead a review of the current position.

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[4] *Education Strategy 2011-2013* - GMC, 2010 www.gmc-uk.org/Education_strategy.pdf_39254208.pdf

[5] *Gateways to the Professions - Advising medical schools: encouraging disabled students* - GMC, 2008 revised 2010 www.gmc-uk.org/education/undergraduate/gateways_guidance.asp

[6] Equality Act 2010, HMSO www.legislation.gov.uk/ukpga/2010/15/contents

[7] *Tomorrow's Doctors* - GMC, 2009 www.gmc-uk.org/static/documents/content/GMC_TD_09__1.11.11.pdf

[8] *The Trainee Doctor* – GMC, 2010 www.gmc-uk.org/Trainee_Doctor.pdf_39274940.pdf

Scope of the review

14. Council set up the review to develop a comprehensive picture of the issues which face medical students and trainees at all stages of their education. The review was also to consider the challenges faced by those with transient and long-term health issues. The work was to have regard to students and trainees who have physical and sensory disabilities, mental health issues and learning disabilities.

15. Council agreed that the following questions and issues should be addressed:

a. How can we promote effective support and clearer transitions which enable students and trainees to progress?

b. How should reasonable adjustments work in practice and is there equity in the way these are administered across the UK?

c. What has been the impact of the *Gateways* guidance including on selection into medical school, and will it be possible for all disabled students to complete Foundation and specialty training?

d. How do we ensure that an appropriate balance is struck between protecting the rights and expectations of students and trainees whilst maintaining standards and protecting patient safety?

e. What has been the experience of students and trainees (including those with longstanding disabilities and those who become disabled during their education and training) in accessing advice, occupational health services and other support?

f. Mental health issues amongst medical students, and how they can be supported. (The GMC has commissioned research in this area and it will inform our wider work on health and disability.)

16. Council also agreed that the review should examine the emerging debate about whether there should be some form of restricted registration and exemptions that would restrict the scope of trainees according to particular disabilities.

Governance and accountability

17. The Health and Disability Group was chaired by Sally Hawkins and was asked to report to Council by December 2012.

18. The membership reflects a broad range of knowledge and expertise from across the sector as can be seen from the terms of reference at Appendix B.

19. The group met on three occasions: 15 May 2012, 18 September 2012 and 8 November 2012.

Engagement and communication

20. The group's discussions have been informed by a series of engagement and communication activities.

Disability Roundtable and Reference Group

21. In February 2012, the GMC held a roundtable meeting with disabled medical students and doctors. Issues raised included the need for guidance to help disabled doctors early in their career, peer support networks, and concerns about the role of occupational health. The discussion helped shape the work programme for the rest of the review. Several of those who attended participated in some short films sharing their experiences as disabled students and doctors which are available on the GMC website[9].

22. On 16 October 2012 a meeting was held with key interests, including disabled students and trainees, acting as a reference group, to seek views and test ideas emerging from the main Health and Disability Group[10].

Statement on health and disability in medical education and training

23. In May 2012, a statement was published summarising the legal advice the GMC had received about the implications of the Equality Act 2010**.** The statement also provides details of the practical advice produced by the Higher Education Occupational Physicians/Practitioners (HEOPS) and, more generally, our review of health and disability.

The regulatory framework

24. Although the legal advice which the GMC received had been helpful, the Health and Disability Group was conscious of the wider debate about the current legal framework and whether more flexibility could be built in to support disabled medical students and trainees.

25. There is currently no provision within the Medical Act to restrict the grant of provisional or full registration. Doctors are never given restricted or conditional registration on registering with the GMC. Where an individual is already registered, and their fitness to practise is found to be impaired, they may be permitted to remain in practice subject to their compliance with certain conditions. The conditions will be designed to protect patients and the public and, on occasions, the doctor and enable the doctor to remediate their practice in the hope that they can be returned to unrestricted practice in due course.

[9] The Disability Roundtable report and short films are at http://www.gmc-uk.org/education/12680.asp.
[10] The Health and Disability Reference Group report is at http://www.gmc-uk.org/education/12680.asp.

Advantages/disadvantages

26. The potential advantages and disadvantages of greater flexibility with the legal framework were explored by the group and with key interests – particularly the feasibility of granting restricted registration and exemptions from certain competencies that would restrict the scope of trainees' practice according to particular disabilities.

27. In discussions, it was recognised that a form of restricted registration and exemptions from competence standards not required in an individual's ultimate career destination might allow more disabled people to be part of the medical profession. Allowing more disabled people to enter and complete training might widen the pool of applicants and also help to deliver training that is, and seen to be, supportive of disabled people.

28. However, it was felt that the debate needed to be viewed in the context of wider changes which have taken place in medical education over the last 15 years and the profession's drive for more consistency through minimum standards of proficiency and safety. This period has seen major developments including the Foundation Programme, strengthened standards and curricula and a clearer articulation about the role of the doctor[11].

29. The group's view, overwhelmingly supported at the various engagement events including the Reference Group, was that restricted registration could undermine the progress already made. In particular, it was felt that the understanding of what it means to be 'a doctor' could be completely changed.

30. Council took a similar position in response to the recent consultation by the Law Commission – *Regulation of health care professionals; regulation of social care professions in England* [12]. The Commission made the provisional recommendation that:

> 'The regulators will be required to register applicants on a full, conditional or temporary basis. In addition, the regulators will be given powers to introduce provisional registration if they wish to do so.'

31. In the GMC's response it was argued that if some applicants are to be granted a conditional or restricted form of registration, it is possible to say that they will not need to have completed the full programme of education and training normally required of prospective registrants. Disaggregating education and training in this way could have profound implications for what it means to be a doctor.

[11] *The Consensus Statement on the Role of the Doctor* - AoMRC, UK University Hospitals, BMA, COPMeD, DH www.medschools.ac.uk/AboutUs/Projects/Documents/Role%20of%20Doctor%20Consensus%20Statement.pdf

[12] *Regulation of health care professionals; regulation of social care professionals in England* - Law Commission, 2012 lawcommission.justice.gov.uk/consultations/healthcare.htm

32. In respect of the wider discussions on the question of introducing more flexibility, there was concern that the potentially wide variety and many permutations of restrictions/exemptions could lead to confusion in a pressurised service environment, especially during on call shifts.

33. It was also argued that regulatory change could have unintended consequences with disabled students and trainees feeling/being stigmatised by a system that exempts them from meeting the same competence standards as others. Granting restricted registration could provide unhelpful labels and make individuals – given they have a health condition or disability – more readily identifiable.

34. It was particularly striking that the vast majority of disabled students and trainees at the various engagement events were not in favour of the introduction of restricted registration/exemptions. Instead, they expressed a strong view that they did not want to be judged by different standards.

Flexibility in respect of cardio-pulmonary resuscitation

35. Although not directly related to the conclusions on restricted registration, the group noted the flexibility which had been introduced in relation to the competence standard requirements for cardio-pulmonary resuscitation (CPR). Students and trainees are required to demonstrate that they both understand the principles of CPR and can direct others to perform the procedure. The flexibility, which is reflected in GMC standards, does not constitute a reasonable adjustment, since it is part of the competence itself and applies to all students and F1 trainees. However, the flexibility to understand the principle and be able to direct others is not available with any other competencies except ‘moving and handling’ people or objects.

36. As part of the review of practical procedures referred to later in this report, the issue of consistency and alignment of requirements for procedures across the different stages of education and training will be taken into account.

Conclusions

37. The emerging consensus from all of the discussions is that changes should not be sought to the Medical Act to allow restricted registration and exemptions.

38. For the reasons discussed, the group’s view is that the GMC should continue to require students and trainees to meet all of the competence requirements prescribed in its standards and outcomes for all stages of the medical education continuum, including the curricula it approves for postgraduate education.

39. The group felt that this would provide continuity and assurance that everybody is being assessed against the same requirements, subject of course to the duty to provide reasonable adjustments to help students and trainees meet those requirements. In that sense, the group agreed that the *Standards of medical fitness to train* guidance[13] developed by the Higher Education Occupational Physicians/Practitioners (HEOPS) is a helpful aid to occupational health (OH) staff when they assess whether an individual is likely to meet GMC standards and outcomes for undergraduate education.

40. Maintaining the current legal (and regulatory) position would also be broadly consistent with our response to the Law Commission's consultation.

41. Although the group did not favour seeking to introduce restricted registration and exemptions, members were very conscious of other work already in train or in development which could potentially address many of the issues identified in the discussions with key interests. These are outlined in the areas for possible action below.

Areas for possible action

42. The group recommends that Council agree not to seek to introduce restricted registration and exemptions at the present time, in light of the group's findings and conclusions.

43. Council may also wish to consider the following areas for possible action as part of further work in 2013.

Review of standards and practical procedures

44. There was general agreement that the GMC should review the competence standards it sets in *Tomorrow's Doctors* and the *Trainee Doctor*. This includes the practical procedures that these documents set out for students and provisionally registered doctors respectively. Ideally, this should be done alongside a review of the Foundation Programme.

45. Such a review would examine whether the practical procedures remain relevant and fit for purpose and whether they are helping doctors demonstrate the more generic skills needed for the modern health service, for example, performance under pressure and judgment. In particular, the group acknowledged that increased emphasis on team working may affect the requirements for specific practical skills.

46. Work to assess the impact of *Tomorrow's Doctors* will take place from 2013, subject to the agreement of Council, with the expectation that a review of standards across all stages of medical education and training would then follow at a later stage. It is expected that the review would be an opportunity to consider the issue of practical procedures.

[13] *Medical Students - Standards of medical fitness to train* – HEOPS
www.heops.org.uk/HEOPS_Medical_Students_fitness_standards_2011_v7.pdf

Specialty curricula

47. There was discussion about the desirability of greater flexibility in the way that core requirements for postgraduate speciality curricula are applied. On the one hand, earlier specialisation might allow more disabled trainees to progress to their preferred specialty by enabling them to bypass practical skills that may not be required in that specialty. On the other hand, there may be advantages to trainees remaining generalist for longer so that they are better able to make appropriate specialty choices and to meet the needs of the service. It was agreed that this could not be resolved in the short term as part of the review. However, it was agreed that the Shape of Training review[14] will provide an opportunity to explore these issues.

Reasonable adjustments and occupational health

48. There was universal agreement that more must be done to promote and strengthen greater consistency in the provision of reasonable adjustments and the quality of occupational health services. These areas are covered in the following sections of the report.

Guidance and advice

49. One of the common themes running throughout discussions included the desire for more guidance to assist medical schools, deaneries, students and trainees. In particular, it was argued that the *Gateways* advisory guidance should be reviewed and updated.

50. There was also a clear signal from students and trainees that the current level of careers advice was insufficient and a high priority issue for further consideration.

51. Both *Gateways* and careers advice are covered later in this report.

Reasonable adjustments

52. One of the themes which came out strongly at the Disability Roundtable and the Reference Group, as well as at the Health and Disability Group, was that students and trainees feel that more needs to be done to improve provision of reasonable adjustments.

53. While it was suggested that medical schools in particular seem more ready than in the past to provide reasonable adjustments, the picture is still mixed across and within medical schools, deaneries and local education providers.

54. Individual medical school staff or doctors have often been instrumental in encouraging and helping disabled students and trainees to overcome challenges. Student and trainees say they are often acting in an unofficial capacity which exacerbates inconsistency. A lack of formal arrangements, and reliance on goodwill which may not always be available, makes it more likely that disabled people will be denied reasonable adjustments and so discriminated against.

[14] www.shapeoftraining.co.uk/

55. It was also suggested that it is easier to access reasonable adjustments for relatively stable conditions as opposed to conditions which may fluctuate (such as mental health conditions) or are progressive (such as MS or progressive sensory loss).

56. The range of people involved in providing reasonable adjustments is wide and varied. Disabled students and trainees say that sometimes there appears to be no identifiable, central point of contact for them to discuss reasonable adjustments.

What the law says

57. The Equality Act 2010 (the Act) imposes the duty to make reasonable adjustments – a reasonable step taken to prevent a disabled person suffering a substantial disadvantage compared with people who are not disabled.

58. The duty requires that reasonable adjustments be provided in relation to three broad categories:

a. A provision, criterion or practice.

b. A physical feature.

c. An auxiliary aid.

59. A failure to comply with the duty is discriminatory. However, the Act does not define what is reasonable. Ultimately what is reasonable in a particular case can only finally be judged in a court or tribunal.

60. The GMC is subject to the duty to provide reasonable adjustments as a qualifications body, but, as mentioned earlier, the GMC is under no duty to require reasonable adjustments that would alter or lower the standards it sets.

61. In turn those organising and delivering medical education and training, that is medical schools, deaneries and local education providers, are also subject to the duty.

What the GMC's standards and guidance say

62. The GMC's standards for the delivery of undergraduate and postgraduate education and training, *Tomorrow's Doctors* and *The Trainee Doctor* respectively, reflect the duty to provide reasonable adjustments.

63. In addition, the *Gateways* advisory guidance includes examples of reasonable adjustments that can be made for medical students and trainees. These are a mix of potential adjustments and actual adjustments reported to us by medical schools.

64. *Gateways* is primarily aimed at medical schools, as it was first developed before the GMC took on responsibility for postgraduate education. However, it does include a section on postgraduate training and so we would expect *Gateways* to also be of help to deaneries and local education providers involved in postgraduate medical training. We also had intended that *Gateways* would additionally be helpful to students and prospective students.

What we know about what is happening on the ground

65. The GMC does not have data on the total number of reasonable adjustments made or the total number of medical students for whom they are made. We do know from the Medical Schools Annual Return (MSAR) for the 2011/2012 year that 27 out of 33 medical schools made new (for them at least) reasonable adjustments. The majority of these were of an organisational nature, with a significant minority relating to auxiliary aids, and a much smaller number relating to physical features.

66. Medical schools reported only seven instances of refusing an adjustment as unreasonable (and for one of these the student was, after appeal, allowed to resit the examination to which the adjustment related). If there is one theme that stands out from such a limited number, it may be that there was, in these cases, a mismatch between the need of the training to simulate clinical practice and the adjustments requested.

67. This theme fits with correspondence received by the GMC and discussions at the Reference Group. Both seem to suggest that there are differing expectations, at least among students though possibly among medical schools, around provision of reasonable adjustments to Objective Structured Clinical Exams (OSCEs). The issue appears to centre on the extent to which the timed nature of OSCE stations reflects clinical requirements to complete a procedure within a set time, meaning that adjustments might not be considered reasonable. Some schools feel able to allow extra reading time for dyslexic students, while others do not.

68. In terms of trainees, the National Training Survey for 2012 provides some understanding of the total number of reasonable adjustments provided.

a. 2% (1,019) of 50,274 trainees said their day to day activities were limited because of a health problem or disability.

b. Of these, 36.2% (369) said they needed adjustments in post to carry out their work.

c. Of these, 8.1% (30) said the adjustments they needed had not been made.

69. The survey free text responses to ‘Please insert any comments you have about the adjustments you require’ paint a picture of significant qualitative variation in the experiences of different trainees. One said: ‘Hospital staffing/rota have been very supportive, as have occupational health and every team I have worked with.’

70. Another said: ‘It’s a tough call. Asking for adjustments, so I could pursue my career have lead (sic) to a grudge in my employer which has resulted in prejudiced behaviour making my time in training difficult to sustain. In spite of problems I want to train, but the biased attitude makes me disillusioned.’

71. And even the same trainee can have different experiences from one post to the next: ‘This post has been very helpful in implementing all of the suggestions from my access to work assessment other previous posts have been less helpful.’

72. The free text responses also illustrate the range of people involved with providing reasonable adjustments for trainee doctors, including the trainee’s team, occupational health service, human resources etc.

Conclusions

73. The Health and Disability Group found reasonable adjustments to be one of the main areas of concern for students and trainees. Members felt the GMC must, together with key interests, promote greater consistency and fairness in access to reasonable adjustments.

Areas for possible action

74. The group felt that the GMC, as the regulator and given our commitment to fairness, is well placed to promote consistent good practice on reasonable adjustments by:

a. Gathering data on reasonable adjustments.

b. Reflecting good practice and other learning back to those delivering medical education and training.

75. The GMC will continue to collect data on reasonable adjustments through the MSAR and National Training Survey.

76. The GMC is due to consider in 2013 whether to start to survey all medical students annually. The GMC could consider the potential for using such a survey to gather data on reasonable adjustments at the undergraduate level (as we already do at the postgraduate level through the National Training Survey).

77. The GMC could review arrangements for reasonable adjustments at medical schools and deaneries as part of its quality assurance activity.

78. There was general agreement that *Gateways* should be revised and that the revision could address the following:

a. The desirability of students and trainees having a named contact within a medical school or deanery that has responsibility for oversight of the provision of reasonable adjustments.

b. The desirability for greater clarity around reasonable adjustments provided for OSCEs.

c. Further examples of reasonable adjustments collected through the MSAR.

d. Examples of reasonable adjustments collected through the National Training Survey.

e. The desirability of more explicitly targeting as an audience those delivering postgraduate medical education and training.

79. It was also felt that the GMC should explore additional means of sharing good practice and other learning (especially gathered annually through the National Training Survey) with deaneries, occupational health services and local education providers, beyond published guidance.

Occupational health

80. The Health and Disability Group heard of particular concerns, through the Disability Roundtable and Reference Group, about the perceived variability in the quality of assessments and support provided by occupational health (OH) services.

81. The main concerns were as follows:

a. That OH assessments and advice provided by practitioners who understand the requirements of medical education and training should be offered to prospective disabled students prior to applying to study medicine. There should be one assessment rather than an assessment in relation to each medical school they might apply to. This would enable individuals to make informed choices when deciding whether to apply and help identify reasonable adjustments which may be required.

b. Disabled students, trainees, and doctors said that OH practitioners can sometimes appear unhelpful with a poor understanding of applicants' disabilities. Some said that OH staff did not always demonstrate respect for applicants' ability to manage their own conditions. Comments included a proposal that OH professionals should be trained to 'focus more on actual functionality and not anticipated lack of functionality or a diagnostic label.'

c. Having to see a different OH practitioner for each clinical placement can be frustrating and create anxiety for disabled students and trainees; for example 'what if this is the one who won't let me continue?' It was also felt that duplication of assessments should be avoided where possible.

d. There need to be more OH practitioners with a specific knowledge and understanding of the needs of medical students and trainees.

The role of occupational health services

82. OH have a role at all stages of medical education and training, advising employers and medical schools as well as students and trainees.

83. OH services are pivotal in assessing medical students and trainees with chronic medical conditions and disabilities who require adjustments. In making assessments, OH must consider the ability of a student or trainee to meet the core competence requirements of the standards set in *Tomorrow's Doctors* and *The Trainee Doctor*, and of the Foundation Programme curriculum[15].

84. In practical terms, OH is involved in a number of areas including the following:

a. Assessment of fitness for study and future fitness to work/practise at various stages from pre-entry into medical school, prior to clinical placement and prior to starting postgraduate training. OH advise on adjustments to accommodate impairments arising out of ill health or disability.

b. Undertaking assessments following referrals from management. Issues prompting referral include sickness absence, impaired performance, a health concern and fitness to practise concerns on medical grounds. The purpose of the OH assessment in this situation is to assess and advise the trainee and manager on the impact of health on fitness for work, work performance and adjustments to accommodate ongoing study and ability to practise/work.

c. Review and follow up of students and trainees with health and disability who have adjustments already in place to ensure they remain fit for work/fit to practise on an ongoing basis.

d. Screening/clearance for blood borne viruses (BBVs) and infectious diseases. Advising on fitness for exposure prone procedures. Providing vaccinations for clinical work in line with national guidance, undertaking post-exposure to BBV assessment and provision of post-exposure prophylaxis and follow up of BBV exposures.

e. General support, including assessment, advice and signposting/referral for treatment.

f. Contributing to clinical governance through leadership activities such as policy development, membership of various committees, and clinical leadership in the full remit of OH services.

[15] www.foundationprogramme.nhs.uk/pages/home/curriculum-and-assessment/curriculum2012

Key organisations

85. The key organisations involved in OH include the following:

a. The Faculty of Occupational Medicine (The Faculty) is the body concerned with promoting and supporting health at work and providing support to members to raise the standard of OH practice.

b. The Higher Education Occupational Physicians/Practitioners (HEOPS) is a professional association for all OH professionals working in the UK higher education (HE) sector. HEOPS' purpose is to develop and promote best practice in the provision of OH services to the higher education sector.

c. The Association of National Health Occupational Physicians (ANHOPS) is composed of a group of 250 occupational physicians providing OH services to the NHS across the UK. It has the overall aim to improve the standards of professional practice of occupational medicine within the health service.

Availability of OH support

86. Historically, there has been national variability in the level of available and experienced OH professional support in universities and medical schools. A survey of OH provision in all UK universities in 2007 (which is the latest available data) documented that 50% of UK universities had in house services, 32% used a contractor and 9% had no OH service at all.

87. In its document, *Recommendations on occupational health provision in UK universities* [16], HEOPS recommend that all universities have access to at least one accredited specialist in occupational medicine. A small university focusing on teaching may find that occasional sessional work by an external accredited specialist contractor is adequate for its needs. For larger research-intensive universities, one or more in-house posts may be appropriate. HEOPS also recommends that all universities have access to at least one specialist in OH nursing.

In-house and contracted out services

88. The group heard that whether a school's or trust's OH service is in-house or contracted out to another OH service provider can have a major effect on OH involvement in policy, planning and procedure. Contracted out services may lead to reduced communication, impaired transfer of information and difficulties with continuity of care.

[16] *Recommendations on occupational health provision in UK universities* – HEOPS, 2009 www.heops.org.uk/HEOPS_Guidance_2009_101209.pdf

Referrals

89. In terms of referrals to OH, some, but not all, medical schools have the facility for ‘self referral’. This self referral will be on a confidential basis for a medical student to seek advice from OH about their health or disability. The group supports the Faculty’s suggestion that it is important that this self referral facility is available in all medical schools and that medical students are aware of how to access expert occupational health advice at an early stage should their health status change.

90. A student may also be referred to OH by a tutor or fitness to practise committee. If referred, an assessment will be undertaken with their consent and a report provided to the referrer answering any specific questions. If appropriate, further information will be obtained from the student’s GP or specialist with their consent. On occasion, if the local arrangements allow, referral for further specialist advice / opinion is arranged for example from an independent consultant psychiatrist. This will then result in an occupational health report and recommendations being given to the medical school on fitness and adjustments. The student should be offered a copy of the report before it is sent to management in line with GMC guidance.

Enhanced competencies

91. The group also heard about an initiative by the Faculty and ANHOPS to develop enhanced competencies for occupational physicians advising doctors with health and disability issues.

92. As doctors advance in their career, their attitudes and behaviours may become more complex. This may include behaviours such as self diagnosis, self investigation, self prescribing and a number of other behaviours which are well documented. This is where the enhanced competencies for occupational physicians can be beneficial in assessment and management of doctors experiencing difficulties.

93. This further training for occupational physicians has commenced with one cohort of occupational physicians completing the programme so far. There are plans to roll out the programme to further cohorts of occupational physicians working in the NHS. This is taking place in parallel to similar enhanced competencies for GPs and psychiatrists caring for doctors under guidance developed by their respective royal colleges.

94. The group agreed that this is a positive development. However, members recognised that OH assessments need to involve a range of qualified staff across the multi disciplinary team working together to deliver effective services and that the team as a whole require the right competencies.

Shared information

95. One of the emerging ideas which the group felt has some merit was the concept of a ‘passport’. The group also recognised it would require much further work to make it a reality and that there are areas of concern, for example, content, confidentiality and practical implementation which would need to be addressed. These sentiments were echoed at the Disability Roundtable and Reference Group. Even the term ‘passport’ (which we are using as a working title) is far from ideal and this would have to be looked at carefully. All students and trainees would have such a ‘passport’ – whether or not they are disabled – and it would serve as a record of the required checks for BBV they had undergone and any reasonable adjustments they required to enable them to undertake their education and training.

96. The ‘passport’ would be held by the individual as they progressed through the different stages of their education and training. The individual would make it available to OH and those responsible for their training and employment to demonstrate the BBV checks they had undergone and any reasonable adjustments they require.

97. The group felt that this has the potential, for some but not all students and trainees and in some but not all situations, to reduce the need for repetition of OH assessments each time a student or trainee moved around, for example to a new clinical placement at undergraduate level or training position at postgraduate level. This would require appropriate screening, for example for BBV, taking place to the departments of health standards at an early stage of a student’s education.

98. There have been previous attempts to introduce ‘smartcards’ with a similar objective, but these were not successful. However the group felt that the idea of a ‘passport’ is an area which has some merit and should be explored further.

Transfer of information

99. The group felt that, in principle, there needs to be a process which enables the adequate transfer of information between the various institutions delivering medical education and training to reduce repetition and ensure continuity of care for disabled students and trainees. This reinforces the need for robust follow up arrangements with good transfer of information between OH services in different schools and trusts. A central ‘passport’ approach may prevent this repetition to some extent.

100. While databases exist, particularly within postgraduate deaneries for tracking and supporting individuals, there was some concern within the group about whether the checks and balances were sufficiently robust to ensure student and trainee confidentiality. One option would be to introduce protocols which require trainees to be made aware of any information which exists about their disability and how that information will be used.

Conclusion

101. The group recognised that access to quality OH services is crucial for disabled medical students and trainees and that this is currently inconsistent. However, the group was encouraged by the creative approaches being developed by the bodies involved in the delivery of OH services.

102. The group noted also that a more consistently high quality of assessment and support provided by OH services would be of benefit to all doctors, not just students and trainees. It was also felt that an overreliance on contracted out OH services should be avoided as it may lead to reduced communication, impaired transfer of information and difficulties with continuity of care.

103. Members were attracted to the idea of a 'passport', while recognising it would require much further work to make it a reality and that there are areas of concern such as confidentiality which would need to be addressed. This also had considerable support, with similar caveats, from key interests.

104. Members also welcomed the work currently underway by the Faculty and ANHOPS on developing enhanced competencies. This may go some way to addressing concerns about the current scarcity of appropriately qualified staff with an understanding of doctors.

105. In addition, the group supports the view that the GMC should set standards for medical schools and deaneries to have arrangements in place for quality OH services to support students and trainees.

Areas for possible action

106. Many of the areas for possible action identified for OH in this review naturally sit with bodies other than the GMC, for example, deaneries and employers, medical schools and the Faculty. The GMC may be well placed to convene a working group including these bodies to explore what can be done, including the idea of a 'passport', to improve the current situation.

107. The review of health and disability has highlighted more generally the opportunities for further development, but also the role which the GMC can play in both coordinating views and opinion and in promoting good practice.

108. Council may feel that, as part of further work on health and disability, the GMC should continue to monitor and explore developments with the Faculty and the Medical Schools Council (MSC). If Council decides that *Gateways* should be revised, this would provide an opportunity to promote some of the practical solutions outlined in this section.

Transition into the Foundation Programme

109. Another area of particular concern noted by the Health and Disability Group was the transition from medical school to the Foundation Programme.

110. The Foundation Programme (FP) is a two year generic training programme which forms the bridge between medical school and specialist or general practice training.

111. The concern came to light early on at the Disability Roundtable that disabled students and trainees feel that the transition can be a difficult one for any student and that having a disability can make it more difficult. The following specific points were noted.

a. Some felt the application process to the FP did not take sufficient account of applicants' disabilities and the implications for the relative suitability of different placements.

b. While disabled applicants should do their own research into the relative suitability of different placements, some felt that the application process does not support the early access to expert advice and information which would help them to work out which placements are likely to be suitable for them.

c. The Transfer of Information (TOI) form is perceived to not work well. First, the questions are felt to discourage disabled students from answering fully. Second, it was suggested that sometimes the completed forms do not reach the deanery until after allocations have been made, so the information they do contain is not factored into decisions on the allocation of placements.

d. Disabled students often fear applying for provisional registration with the GMC because of the health component of fitness to practise.

112. The transition has several aspects, for example recruitment, transfer of information and applying for provisional registration with the GMC, which mean it is quite complicated. We have attempted to set out in Appendix C an overview of the transition for students starting on the FP or Academic Foundation Programme (AFP) in 2013.

Situational judgement test

113. The Situational Judgement Test (SJT) is new for the 2013 application process, having been piloted during the 2012 process as part of the Improving Selection to the Foundation Programme Project. Applicants needed to request reasonable adjustments to the SJT by 21 September 2012.

Foundation Programme application form

114. The FP application form, which is completed via the Foundation Programme Application System (FPAS), asked all applicants the following as part of the 2012 application process.

> 'We recommend that you disclose disabilities and personal health issues, such as blood borne virus infections, in the disability declaration on the application form. This information will be held in confidence and only authorised foundation school staff members and the HR department of your employing healthcare organisation will be able to access this information.
>
> If you do not wish to disclose this information on the application form, it is essential that you inform your allocated foundation school, in confidence, by no later than 28 February 2013 as your specific programme allocation may be affected. For example, you may need to avoid exposure prone procedures. Arrangements will be made for you to meet up with a foundation school staff member to discuss your training.
>
> If you have a disability, do you have any special requirements relating to that disability? [Yes/No]
>
> If so, please give details of your disability and any special requirements.'

115. The guidance and questions give applicants a choice either, to disclose information about their disabilities in the application form – in 2012 2% of applicants – or at a later date to contact the Foundation School (FS) to which they are allocated. This means the data on disability collected through the application form is likely to be incomplete.

Transfer of information

116. The GMC requires in *Tomorrow's Doctors* that:

> '…medical schools should also make arrangements so that graduates' areas of relative weakness are fed into their Foundation Programme portfolios so they can be reviewed by the educational supervisor. This information should draw on assessments in relation to the outcomes and include graduating transcripts.'

117. Although the above does not mention health, the TOI form, produced by the Medical Schools Council (MSC) in collaboration with the UK Foundation Programme Office (UKFPO), includes a section titled 'Information related to welfare and health'.

118. The TOI form, including the section on welfare and health, has been revised for the 2013 application process.

119. The new questions are perhaps more specific than those used in 2012, which asked for details of any absences. It will be interesting to see if disabled students feel the new questions are more helpful.

120. For the 2013 application process the intention is that medical schools will forward completed TOI forms to FSs before they know which final year students have successfully graduated, that is by no later than 31 May 2013. This should allow FSs more time to review and consider adjustments that could reasonably be made to support those who will be joining them as F1s.

121. Also for the 2013 application process, medical schools will reserve the right to add additional, supportive and relevant information regarding the welfare and health and educational progress on behalf of students. This will only be required where a medical school considers a student has not been fully engaged in the supportive nature of TOI and would benefit from additional information being transferred.

Applying for provisional registration

122. FP/AFP applicants must have provisional registration and a licence to practise with the GMC before they start work in August 2013.

123. This is a separate application process to the FP/AFP application process and the GMC advises that applications are made in May 2013.

124. Applicants for provisional registration have to complete a fitness to practise declaration. This includes the following question in relation to the health component of fitness to practise.

> 'Are you aware of anything about your physical and/or mental health that might raise a question about your fitness to practise as a doctor in the UK?'

125. Where an applicant answers yes – in 2012 126 (1.75%) of applicants – they are asked to respond to supplementary questions. In 2012 only 4 (0.05%) of applicants were refused registration and of these none were refused solely because of health issues. We have historically only refused one applicant solely on health grounds (in 2010). A number of disabled students and trainees said they felt ‘terrified’ of the GMC, especially in relation to the application for provisional registration. Yet the figures show that applicants are exceptionally rarely refused provisional registration solely on health grounds. Making disabled students aware of these figures may go some way to addressing this fear of the process.

126. There also appears to be some confusion as to what needs and what does not need to be declared. Many people do not appear to know that a health condition or disability alone does not mean that fitness to practise is impaired. Such concerns only arise where the condition or disability is preventing an applicant from meeting their obligations under *Good Medical Practice* [17]. You can be disabled with no fitness to practise health issues; and you can have fitness to practise health issues without being disabled. With this in mind, the GMC is already working with occupational health practitioners to consider how we might improve applicants' understanding of what needs to be declared and to identify whether the current arrangements ensure that those who should declare matters are doing so. The GMC will also be looking at how to address concerns about confidentiality.

The impact of the Gateways advisory guidance

127. The group was asked to consider whether all disabled medical students will be able to complete Foundation and specialty training. This was in the context of understanding whether *Gateways* may have encouraged some disabled people to study medicine, who will be unable to complete Foundation and specialty training.

128. The group considered data from the Medical Schools Annual Return and noted that there appears to be no discernable increase in the numbers of disabled students, entering medical school after *Gateways* was published.

129. However, since the GMC does not collect data on the types of disability, the group felt unable to reach any firm conclusions as to whether all disabled students will be able to complete Foundation and specialty training. For example, *Gateways* could have altered the profile of disabled students in terms of disability type and this could impact on whether all disabled students will be able to complete Foundation and specialty training. At the moment, we do not know.

130. The group noted that, in terms of awareness of *Gateways*, at the Disability Roundtable participants – including disabled medical students and trainees – suggested that awareness among disabled applicants to medical schools varies.

131. Members of the group with a medical school perspective felt that although those delivering medical education may be aware that *Gateways* exists few outside of admissions teams will have read it and considered its implications.

132. It was suggested that there is almost no awareness of *Gateways* at the postgraduate level, which perhaps reflects the fact it was primarily targeted at medical schools.

Conclusions

133. The transition from medical school to the FP is quite complicated, perhaps even more so for disabled students, and much of it within the remit of other organisations rather than the GMC.

[17] *Good Medical Practice* – GMC, 2006 updated 2009 www.gmc-uk.org/guidance/good_medical_practice.asp

134. The group felt that, as the regulator for all stages of medical education and training, the GMC has an interest in working with key interests towards a transition that protects patients and promotes and supports disabled students as they become trainee doctors. In particular, two issues stood out:

a. The need to make sure disabled students have early access to the information and expert advice they need when considering different FS and later applying to the FP/AFP and for provisional registration.

b. The need for supportive information about the reasonable adjustments individuals will need to reach FSs in good time so it can be acted on.

135. The group agreed that no firm conclusions could be drawn on the basis of current data as to whether it will be possible for all disabled students to complete Foundation and specialty training. We do not have sufficient data about disability types and this is something the GMC should address, as well as seeking further discussion with medical schools.

136. The group also felt that a revised *Gateways* needs to be made relevant and accessible to a wider group of people delivering medical education. Consideration should also be given as to how to raise awareness among disabled students, prospective students, and Foundation and specialty trainees.

Areas for possible action

137. As part of any further work, Council may wish to consider the GMC working with the MSC, UKFPO and the BMA to develop a joint web resource for use by disabled students preparing to apply to the FP. This could be part of a wider web resource on access to medicine.

138. The GMC could also consider whether to require medical schools to provide a timely transfer of information to FSs that is relevant to each student undertaking the FP. The information, provided with students' consent, would include, among other things, reasonable adjustments they are likely to require.

139. Students acknowledged the helpful work undertaken by the GMC registration functions to support applicants for provisional registration. However, there was general agreement that the GMC should undertake further work to clarify for students the purpose of the health component of the fitness to practise declaration they are asked to complete when applying for provisional registration. The intention would be to remove any unnecessary anxieties.

140. The GMC may also wish to monitor, and explore with the MSC and UKFPO, whether the new TOI form and process for the 2013 cycle has improved the quality and timeliness of information exchange.

141. As mentioned earlier in the report, the group is suggesting that *Gateways* be revised as part of further work next year. This revision should take into account the conclusions above about its impact.

Mental health

142. The Health and Disability Group has been mindful and been kept up to date about the joint project between the GMC and the Medical Schools Council (MSC) on student mental health and support services. The project is being overseen by the Medical Student Mental Health Operational Group chaired by Stephen Whittle.

143. The issue of mental health among doctors was highlighted in the GMC's *State of medical education and practice, 2012*.[18] It noted that doctors may be more vulnerable to mental health problems than the general population.

144. There are three strands to the project:

a. Research into what medical schools currently do to support students with mental health concerns, identifying best practice.

b. Development of a tool for medical schools to use to identify problems in their own support systems for students. This tool will also allow schools to identify issues that are increasing the pressure on their students.

c. Development of guidance for medical schools on how to best support medical students.

145. The research into what medical schools currently do to support their students with mental health concerns is now well underway. The team undertaking the project is a joint team from Cardiff Medical School, Peninsula Medical School and Prepare to Share Ltd, led by Dr Andrew Grant.

146. Development of the tool for medical schools to use in assessing their own support systems is also underway. Led by Dr Debbie Cohen, a survey has been developed and has been tested successfully at Cardiff and Leicester medical schools. The team is now in the process of validating the results by testing the survey at a further five medical schools. These schools have been selected to provide a representative sample of schools across the UK in terms of their size, geographical location and the type of curricula they use. Once the validation process has been completed the team will assess whether any changes need to be made to the survey.

147. The operational group agreed that the best way forward is for the GMC, with the MSC, to produce guidance for medical schools based on the findings of the research.

Conclusions

148. The group felt that Council should take into account the conclusions and recommendations of the operational group as part of any further work next year.

[18] *State of medical education and practice, 2012* (page 71), General Medical Council http://www.gmc-uk.org/publications/13887.asp

149. It was also suggested that the operational group should consider how its conclusions and recommendations can be applied to the postgraduate level.

Areas for possible action

150. Once the guidance for medical schools is published in 2013 the GMC plans to develop a communications plan to support the guidance, focusing on students.

151. Often students have misconceptions about the impact that their mental health will have on their studies and future careers. It is important that the GMC, MSC and others address these concerns as this will encourage students to come forward and get help. As part of this, the GMC may consider setting up a web based resource for students about mental health and how to promote this through student engagement and social media activities.

Careers advice

152. From the engagement events it is clear that students and trainees consider the current position on careers advice to be unsatisfactory.

153. Some reported receiving no careers advice at any stage of their education and training. A few, who had since gone on to progress, cited examples where attempts had been made to actively deter them with the suggestion that, by virtue of their disability, they would not be able to cope in medical practice.

154. These negative perceptions were in line with earlier testimony the GMC had received when developing *Gateways*. Some examples are below:

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

b. ‘There has been virtually no support...I have sought careers guidance myself and again have found this very difficult to obtain. It has made my training a very difficult and disappointing time for me as I have been left feeling very isolated and unsupported. I tend to have had very little in terms of postgraduate options.’

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

155. In an already competitive environment, it was argued that it is particularly important for disabled students and trainees to have access to expert careers advice through a clearly identified resource within medical schools or deaneries.

What GMC standards and guidance covers

156. The GMC’s standards and guidance set out expectations for good practice in careers advice.

Education standards

157. In *Tomorrow's Doctors* the GMC says the following:

a. Section 125:

'Students will have access to careers advice, and opportunities to explore different careers in medicine. Appropriate alternative qualification pathways will be available to those who decide to leave medicine.'

b. Section 134:

'Schools must have a careers guidance strategy. Generic resources should include an outline of career paths in medicine and the postgraduate specialties, as well as guidance on application forms and processes. Specific guidance should be provided for personalised career planning. The careers strategy should be developed and updated with the local postgraduate deanery.'

c. Section 135:

'A small number of students may discover that they have made a wrong career choice. Medical schools must make sure that these students, whose academic and non-academic performance is not in question, are able to gain an alternative degree or to transfer to another degree course.'

158. In *The Trainee Doctor*, Domain 6 – Support and development of trainees, trainers and local faculty, the GMC says the following:

a. Mandatory requirement 6.9:

'Trainees must have relevant, up-to-date, and ready access to career advice and support.'

b. Mandatory requirement 6.27:

'Trainees who believe that their particular skills and aptitudes are well-suited to an academic career, and are inclined to pursue it, should receive guidance in that endeavour.'

c. Mandatory requirement 6.31:

'Trainers must regularly:

(e) advise on career progression'.

Gateways advisory guidance

159. *Gateways* does not impose additional standards but highlights the importance of careers advice for every medical student and junior doctor, whether disabled or not.

a. Section 14.3 on careers guidance explains that anyone providing careers advice should be able to do so for all students:

'Officers should know to communicate with a range of disabled people using many formats and understand issues of exclusion and how to promote inclusion.'

b. Section 3.3 on the implications of the GMC guidance for careers in medicine says:

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

Conclusions

160. The Health and Disability Group considered that careers advice should be available:

a. To prospective students before entry to medical school.

b. As students and trainees progress through their education and training.

c. And for those who become disabled during the course of their education and training.

Areas for possible action

161. Drawing on earlier discussions and the testimony from the events, there are a number of areas which the group felt would benefit from further exploration and possible action.

Access to careers advice resources

162. There should be a clearly identifiable individual in each school and deanery who students and trainees can refer to for expert careers advice. This should be available to students and trainees at pre-application, undergraduate and postgraduate levels.

163. It was recognised that expertise does not usually reside in one person. Instead, schools or deaneries may need to arrange for several people to be involved, for example medical school staff and practising doctors with disabilities.

164. It was agreed that occupational health has an important part to play in providing specialist careers advice.

165. It was also felt that the GMC should explore the possibility of providing a web resource for organisations and individuals, signposting how careers advice can be accessed and the processes involved. This could be part of an improved GMC web resource for all potential applicants to medical school.

166. It was also recognised there is considerable pressure on medical schools to widen participation in medicine from across society. In this context, it will be important that suitable mechanisms are in place to inform those with a disability to know if they will be likely to be able to have a career in medicine.

Sharing expertise

167. The group felt that the GMC could do more to promote the sharing of expertise between medical schools and deaneries in relation to careers advice. To this end, the GMC could work jointly with the Medical Schools Council to explore possible approaches. The BMA would also have an important role to play in this respect.

168. It was felt that the GMC should also publicise examples of good practice and target not only those who are responsible for careers advice, but also students and trainees.

169. The group acknowledged that the area of encouraging prospective students with disabilities is particularly difficult. However, the use of schools careers adviser networks might offer a route into this. The group felt that careers advice should be made available to school students as early as possible, perhaps at 13 or 14 years of age. This is a crucial time for many in formulating ideas about possible career choices. Careers advice which promoted positive role models of disabled medical students and trainees could help inform their choices.

Alternative careers

170. Where a student has been unable to continue with their medical education after all reasonable adjustments have been made - because of the extent of their disability - it was felt that universities are best placed to provide advice on possible alternative career pathways.

Perceptions

171. Throughout the review, the Health and Disability Group has been keen to understand whether and to what extent the perceptions of colleagues and others are having an impact on disabled students and trainees.

172. The group also looked at some of the negative perceptions of the GMC reported by students and trainees at the engagement events and what action the organisation might take to improve the current view.

Perceptions of students and trainees

173. The general message from the events was that disabled doctors are viewed positively by patients and that there is often a strong sense of empathy between both parties.

174. Clearly, it is important that colleagues do not treat disabled students and trainees as patients. However, it was reported that this is sometimes what happens and that colleagues can display negative attitudes in subtle ways. Reasonable adjustments may lead to resentment among colleagues if it is perceived that they create extra work for others in the team.

175. As the group has explored earlier in the report, there are several process-related issues which might benefit from a further examination to ensure greater fairness and equity.

Perceptions of the GMC

176. Whilst education forms one of the key elements of the GMC's business, it was clear from the events that there remains a lack of knowledge about the organisation's role.

177. The language used underlined a sense of anxiety from students and trainees who are reluctant to disclose information to the GMC about their health or disability as they feel it could lead to fitness to practise action. There were particular concerns about the transition from medical school to the Foundation Programme and the fear individuals have about the application process for provisional registration - in particular the question which asks individuals to declare any health issues. The wording was described as daunting and positioned unhelpfully close to the section seeking information about criminal convictions. It was suggested the GMC could do more to reassure students and trainees and to differentiate health from other kinds of fitness to practise concerns.

Conclusions

178. In order to increase confidence, the group believes that there is a need to explore how the GMC can improve the perceptions of the organisation among medical students and trainees.

179. To this end, there should be a clearer articulation of the GMC's role in seeking improvements in medical education for students and trainees – particularly through standards and quality assurance and the active position it is taking on issues such as heath and disability.

180. The group is also concerned to ensure that the GMC's fitness to practise process is de-mystified and better explained. It is important that reassurance is given

about its purpose and scope and that is not seen as a device to disadvantage disabled doctors – which it clearly is not.

181. Therefore the group believe that it is important to show that the GMC has a role which goes far wider than fitness to practice, as important as that is.

Areas for possible action

182. There were several interesting suggestions arising from the events about how some of the concerns might be addressed.

Guidance and reassurance

183. It was felt that improvements should be made to the fitness to practise declaration form – specifically, the guidance regarding confidentiality, the phrasing of the questions and that it should provide the opportunity for individuals to attach further information.

184. The language used by the GMC when people are trying to declare health issues which may impact on fitness to practise needs to be improved. In particular, reassurance should be given to trainees about disclosing mental health problems on the form.

185. It was also suggested that the GMC should explain how confidential information is used at the GMC, for example, who sees it.

Communications

186. It was felt that the GMC should review the advice and tone adopted in its correspondence.

187. The GMC should re-think the way the GMC initially interacts with students. There should be greater engagement with disabled students and trainees, for example through a dedicated web resource and the use of social media.

188. It would be helpful to use anonymised case base scenarios in any resources.

189. There should be more use of images of people with disabilities in GMC publications.

190. *GMC Student News*[19] could be used to raise the profile of these issues.

[19] www.gmc-uk.org/information_for_you/student_gmc_news.asp

Summary of conclusions and areas for possible action

191. In delivering its findings, the group has highlighted areas for possible action. Members recognised that there are some areas where the GMC can deliver change – where its remit allows – and others where it is more appropriate to work with key interests who have a lead role. What is clear is that many of the issues highlighted are relevant to all disabled doctors and not only those in education and training.

192. The group proposes that if the areas for possible action outlined in this report are taken forward, these should lead to the following outcomes:

a. A revised version of *Gateways* reflecting the findings of this report.

b. A review of the competencies, including the practical procedures, in *Tomorrow's Doctors, The Trainee Doctor* and the Foundation Programme.

c. Quality assurance arrangements that promote good practice in reasonable adjustments, occupational health and transition.

d. Sharing of good practice on provision of reasonable adjustments.

e. The National Training Survey and, if introduced, an annual student survey including questions around disability that can be monitored year by year.

f. An improved understanding of the GMC's role among students and trainees.

Outcomes with partners:

a. Named expert in schools and deaneries who can ensure that disabled students and trainees have access to careers advice and occupational health services.

b. Greater consistency in the quality of occupational health assessment/advice for disabled students and trainees.

c. Better support for transition of disabled students from medical school to the Foundation Programme.

d. Improved sharing of information to support disabled students and trainees.

Report of the group leading the review of health and disability in medical education and training - Appendix A

Summary of the legal advice

The Equality Act 2010 and the GMC

1. The Health and Disability Group initially reviewed the legal advice about the extent of the GMC's responsibilities in relation to the Equality Act 2010 (the Act) and, in turn, the implications for those delivering education and training.

2. In addition to being listed in the Act as a public authority, the GMC is also a qualifications body - that is, 'an authority or body which can confer a relevant qualification'.

3. Under the Act a competence standard is defined as 'an academic, medical or other standard applied for the purposes of determining whether or not a person has a particular level of competence or ability'.

4. There are a number of provisions in the Act concerning disability discrimination. This includes the duty to make reasonable adjustments where a provision, criterion or practice, or a physical feature, puts a disabled person at a substantial disadvantage. The duty to make reasonable adjustments applies to a qualifications body. However, section 53 provides that:

> 'The application by a qualifications body of a competence standard to a disabled person is not disability discrimination unless it is discrimination by virtue of section 19 (that is, unless it is indirect discrimination).'

Undergraduate education

5. *Tomorrow's Doctors* sets out the standards for the delivery of undergraduate medical education and specifies the outcomes that all students must achieve by the time they graduate. This includes the requirement to undertake a range of practical diagnostic and therapeutic procedures detailed in the document.

6. Counsel advised that the outcomes and practical procedures in *Tomorrow's Doctors* would be regarded by a court as competence standards for the purposes of the Act and as such the GMC is under no duty to require adjustments that would alter the standard of competence required.

7. Counsel also stated that reasonable adjustments may be made to modes of assessment of those outcomes and procedures (except where the method of performance is part of the competency to be attained). Medical schools and/or deaneries which organise the delivery of medical education are responsible for putting those arrangements in place.

8. In 2008, the GMC published *Gateways to the Professions – Advising medical schools: encouraging disabled students*. Updated in 2010 to reflect the requirements of the Act, the appendix to this advisory guidance gives some helpful examples of reasonable adjustments.

9. Counsel also drew a distinction between the situation of a medical student seeking access to the profession and that of a qualified doctor. A qualified doctor may choose a medical career that does not require them to demonstrate competency in all of the practical procedures listed in *Tomorrow's Doctors*. However, the GMC is entitled to set competence standards that all medical students are required to meet at the point of graduation in order to ensure that:

a. All medical students who graduate will practise in a way that maintains patient safety.

b. Those who graduate have sufficient competencies and skills to meet employers' service needs.

c. Those intending to enter the medical profession know in advance with reasonable certainty the core practical requirements of medical practice in circumstances, where they lack the knowledge and/or experience to take decisions as to later career specialisation, and given that the GMC has no power to grant any form of restricted registration.

Postgraduate education

10. The standards for postgraduate medical education and training (including Foundation and specialty) are set out in The *Trainee Doctor*. This includes the core clinical and procedural skills which provisionally registered doctors are required to undertake.

11. Counsel's advice on postgraduate education was similar to that the GMC had received for undergraduate education. The standards in *The Trainee Doctor* and specialty curricula are considered to be competence standards in respect of the Act. The fact that there is no facility for a disabled trainee to obtain an exemption from demonstrating competencies in postgraduate medical education and training is unlikely to amount to discrimination.

12. Counsel also provided advice on section 10A(2)(f) of the Medical Act 1983[1] which states that the GMC may determine arrangements for disabled doctors in the first year of the Foundation Programme[2].

[1] www.gmc-uk.org/about/legislation/medical_act.asp#10

‘[A]rrangements for a person with a disability not to be disadvantaged unfairly by the disability while participating in a programme for provisionally registered doctors’.

13. Counsel advised that this does not require us to alter or lower the substantive requirements of the Foundation Programme or to grant exemptions from meeting its requirements. It merely empowers us to make arrangements that will make it easier or possible disabled trainees to participate in the Foundation Programme, for example by determining that a trainee should undertake placements in particular specialties.

[2] www.gmc-uk.org/education/postgraduate/foundation_programme.asp

General Medical Council

Regulating doctors
Ensuring good medical practice

Report of the group leading the review of health and disability in medical education and training - Appendix B

Health and Disability in Medical Education and Training Group

Terms of reference

Background

1. The *Education Strategy 2011-2013* makes the commitment that:

   'By 2013 we will also examine the challenges that doctors with disabilities face at all stages of education and training and any implications for the regulatory framework.'

2. This commitment was made in the light of a number of factors including:

   a. The opportunity to take stock, following the merger of PMETB with the GMC, of disability issues across the continuum of medical education and training, taking into account the successful earlier *Gateways* project on disability at the undergraduate stage.

   b. Suggestions from some in the sector that further clarification of the legal position would be helpful, especially in the light of the Equality Act 2010.

   c. Our strategic aim to promote and support equality and diversity.

3. In light of the above and relevant advice received from Counsel on the extent of our duties under the Equality Act, Council agreed that a review of the overall position of health and disability in relation to the continuum of medical education and training is timely.

4. These terms of reference specify the arrangements for the establishment, remit and operation of the expert working group which will lead the review.

Purpose

5. The purpose of the review will be to develop a comprehensive picture of the issues which face medical students and trainees with disabilities at all stages of their education. The review will also consider the challenges faced by those with transient and long-term health issues. The work will have regard to students and trainees who have physical, sensory, psychological and learning disabilities.

Key tasks

6. The task for the working group will be to address the following key areas:

a. How can we promote effective support and clearer transitions which enable students and trainees to progress?

b. How should reasonable adjustments work in practice and is there equity in the way these are administered across the UK?

c. What has been the impact of the *Gateways* guidance including on selection into medical school, and will it be possible for all medical students with disabilities to complete Foundation and specialty training?

d. How do we ensure that an appropriate balance is struck between protecting the rights and expectations of students and trainees whilst maintaining standards and protecting patient safety?

e. What has been the experience of students and trainees (including those with longstanding disabilities and those who become disabled during their education and training) in accessing advice, occupational health services and other support?

f. Mental health issues amongst medical students, and how they can be supported. (We will shortly be commissioning research in this area and it will inform our wider work on health and disability.)

7. The group will also examine the suggestion, put forward by some, that there should be different categories of registration that would restrict the scope of trainees according to particular disabilities.

Outputs

8. The working group will, by December 2012, provide a written report setting out conclusions and recommendations in respect of each of the key areas identified above.

9. The group's recommendations will represent the first phase of the review of health and disability. There will be a second phase of work which will be carried forward by Council. As it is likely that Council will be reconstituted at the end of 2012, it will be for the reconstituted Council to decide any further work to be undertaken. Thus, the group will be disbanded in December 2012.

Working group – membership and competences

Membership

10. The membership of the working group will include at least three Council members, at least one of whom will be a lay member, together with:

a. A medical school nominee.

b. A nominee from the Royal College of General Practitioners.

c. A medical Royal College nominee (reflecting secondary care).

d. A nominee from the Faculty of Occupational Medicine.

e. An NHS Trust Chief Executive or Medical Director.

f. A Postgraduate Deanery nominee.

g. A medical student with a disability.

h. A postgraduate trainee with a disability.

11. The group will be chaired by a GMC Council member.

Competences

12. All members should have the following competences:

a. An understanding of the issues facing disabled medical students or trainees including barriers to progression and the use of reasonable adjustments.

b. A working knowledge of the Equality Act 2010 and its implications for the GMC's duties and standards in medical education and training.

13. Additionally the Chair should have:

a. Credibility with key interests in health and disability policy in medical education and training.

b. Experience of supporting or supervising disabled medical students or trainees.

Working methods

14. To be determined by the review group.

Accountability

15. The working group will report to Council.

General Medical Council

Regulating doctors
Ensuring good medical practice

Report of the group leading the review of health and disability in medical education and training - Appendix C

Overview of the transition for students starting on the Foundation Programme (FP) or Academic Foundation Programme (AFP) in 2013

What happens	Timing	Organisations involved
Student ID checks at all medical schools. Includes presentation on the process for applying for provisional registration, explanation of how FtP matters dealt with and encouragement to apply early if have FtP issues to declare. Also, a chance for discussion with students and contact details given out for future discussions.	Mar 2012 onwards	GMC
Applicants research which foundation schools (FSs) they want to attend.	Pre Oct 2012	
Deadline for requesting reasonable adjustments for the situational judgement test (SJT).	21 Sep 2012	Medical schools, UKFPO
Deadline for submission of Special circumstances form.	14 Dec 2012	Medical schools, UKFPO
Applicants register on the Foundation Programme Application System (FPAS).	1 Oct 2012	UKFPO
Applicants complete the online application form.	8 to 19 Oct 2012	UKFPO
Applicants attend the SJT.	7 Dec 2012 and 7 Jan 2013	Medical schools, UKFPO
AFP offers are issued.	25 Jan to 13	UKFPO, FSs

	Feb 2013	
FP applicants are allocated to FSs (unless they are not immediately allocated a place and instead put on the reserve list).	25 Feb 2013	UKFPO
Local processes match FP applicants to particular foundation programmes.	Feb to Apr 2013	FSs
Pre-employment checks undertaken and contracts issued. Employers need to agree to reasonable adjustments.	Apr to Jul 2013	FSs, employers
Applicants apply for provisional registration with the GMC.	May 2013 to August 2013	GMC
UK medical schools forward TOI forms of students who have passed finals to their FS. (Non-UK grads and UK grads from pre Aug 2012 forward their own forms.)	By 31 May 2013	Medical schools, FSs
FP/AFP starts.	Aug 2013	FSs, employers