Disability equality in the medical profession

July 2007
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Equal Opportunities Committee

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BMA equal opportunities policy statement

The British Medical Association is committed to equality in the provision of its services to its members and stakeholders. This ensures that all members, those applying for membership, and other service users will receive the highest possible standards of service from the BMA, irrespective of race, ethnicity, gender, sexual orientation, marital status, age, disability, chronic illness, religion or beliefs.

Our equal opportunities policy has been developed to ensure that BMA members and staff are fully aware of our commitment to provide equality of opportunity in all of our functions. Furthermore, the BMA will monitor the implementation and application of our equal opportunities policy and ensure that it reflects and meets the requirements of the increasingly diverse membership, which we seek to serve.

BMA members may obtain further guidelines about equal opportunities from the BMA website at www.bma.org.uk or by contacting the Science and Education Department at info.science@bma.org.uk
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Abbreviations

AOMRC  Academy of Medical Royal Colleges
CCT    Certificate of Completion of Training
CEHR   Commission for Equality and Human Rights
CHMS   Council of Heads of Medical Schools
CMO    Chief Medical Officer
COGPED Committee for General Practice Education Directors
COPMeD Conference of Postgraduate Medical Deans
CPD    Continuing professional development
CRE    Commission for Racial Equality
DDA    Disability Discrimination Act
DDS    Disability and Dyslexia Service
DEA    Development Education Association
DEEL   Disability Equality and Etiquette Learning
DFES   Department for Education and Skills
DH     Department of Health
DRC    Disability Rights Commission
DSA    Disabled Students’ Allowance
ELB    Education and Library Boards
EOC    Equal Opportunities Commission
F1     Foundation year 1
F2     Foundation year 2
GMC    General Medical Council
GP     General practitioner
GPwSi  General practitioner with special interest
IWL    Improving working lives
JACS   Joint Academic Coding System
MMC    Modernising Medical Careers
MSC    Medical Schools Council
NCAS   National Clinical Assessment Service
NHS    National Health Service
PCT    Primary care trust
PCO    Primary care organisations
PMETB  Postgraduate Medical Education and Training Board
PRHO   Pre-registration house officer
QAA    Quality Assurance Agency for Higher Education
QABME  Quality Assurance in Basic Medical Education
SAAS   Student Awards Agency for Scotland
SHO    Senior house officer
SSTA   Study skills and technology assessments
UCAS   Universities and College Admissions Service
WHO    World Health Organisation
Foreword

I am pleased that the BMA invited me to provide a foreword to this report which I hope will become the basis for an improved relationship for disabled people working in the medical profession. I also believe this report will contribute to better satisfaction for all disabled people working in and using healthcare services.

Healthcare services are extremely important to disabled people as both employees and service users. There are around 11 million people covered by the definition of disability under the Disability Discrimination Act 1995 (as amended 2005). This includes people with physical and sensory impairments, people with mental health problems, people with learning disabilities and people with long-term health conditions such as cancer, HIV/AIDS and diabetes. Disabled people expect to use and work in the medical profession as equal citizens.

This report gives a powerful insight into the cultural challenges faced by healthcare service employees with impairments and/or long-term health conditions. It demonstrates how issues can be addressed by tackling traditional fears, attitudes and myths.

I strongly believe that a vital component of the relationship between the medical profession and disabled citizens is not just the treatment of disabled patients but how healthcare organisations treat disabled employees at all levels. Surveys indicate that most patients have no problem with being treated by disabled doctors; partly as a result of shared experiences and a greater understanding of patients’ needs. But this report outlines the negative attitudes which have prevented disabled doctors from pursuing a medical career.

Medical professionals are especially important not just for medical expertise, but also as the frontline of healthcare service and as gatekeepers supporting disabled citizens to lead ordinary lives as active members of communities. This wider role is not always well understood and has led to tension and mistrust in the relationship between the profession and disabled people. It is significant that the BMA has produced this important report which the DRC welcomes and hopes will contribute to improvements for disabled people working in healthcare services.

I also welcome the recent publication of the BMA ‘Disability equality within healthcare: the role of healthcare professionals’ report. It includes powerful recommendations to improve the responsiveness of medical services for disabled users and I commend the BMA for producing both these important reports aimed specifically at tackling inequality in healthcare service provision.

‘Disability equality in the medical profession’ highlights the legal imperative that employees receive support in the event of developing an impairment and/or long-term health condition. By welcoming more disabled medical students, and by retaining more disabled doctors in employment, the profession will improve its outward facing service and better reflect modern society.

The cultural change described in the report will not occur overnight but it is overdue. The substantial recommendations described need initiating now for implementation in full over a sustained period. I am pleased to commend its implementation and believe it illustrates the seriousness with which the BMA is taking disability – placing it as a mainstream priority concern.

Sir Bert Massie CBE, Chairman, Disability Rights Commission
Rationale

In 2006 the BMA annual representative meeting resolved:

'That this meeting believes that the BMA must engage with the Royal Colleges, PMETB and the GMC to ensure that:

(i) doctors are aware of their duties under the Disability Discrimination Act;

(ii) doctors have an understanding of the social model of disability as well as medical models;

(iii) individuals with disabilities have appropriate access to medical education;

(iv) doctors with disabilities are enabled to have fulfilling and rewarding medical careers.'

This report examines the provision of disability equality in the medical profession, looking specifically at the accessibility of medical careers to disabled people, and the support provided to disabled medical students and disabled doctors. Section one introduces the social model of disability, and provides general information about disability legislation and discrimination. Developing disability equality policies, the problem of under-reporting of impairment and the barriers faced by disabled doctors and disabled medical students are considered in section two.

Section three examines disability equality in access to studying medicine, looking specifically at the importance of promoting medical careers to disabled people, integrating disability equality in admission and selection processes, and the support and retention of disabled medical students. This section is of particular relevance to organisations with responsibility for undergraduate medical education.

The final section looks at what is required to enable disabled doctors to lead successful careers in the medical profession including the need for effective disability monitoring and the importance of providing disability equality in the recruitment and selection of doctors. This section also considers the support that should be provided for disabled doctors and individuals who acquire an impairment while studying, training and practising medicine. This section is of particular relevance to medical workforce managers and employers, postgraduate training providers, as well as regulatory bodies and the UK health departments.

The report contains recommendations for action and is aimed at policy makers; healthcare, academic, training and regulatory organisations that have strategic and operational responsibilities within the medical profession; the UK health departments; and medical workforce managers. It may also be of interest to medical students and doctors, and relevant stakeholder organisations.

This report has been published in conjunction with the 2007 BMA report Disability equality within healthcare: the role of healthcare professionals which discusses disability equality in healthcare service provision and considers the inequalities in access to healthcare and health outcomes experienced by disabled people. It also identifies ways in which healthcare professionals can help to break down disabling barriers, and highlights the need for consistent disability equality and etiquette training throughout medical education. The roles of healthcare organisations in promoting disability equality and supporting policy implementation are also discussed.
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Introduction

'We human beings are all different. We have different needs, and different qualifications, different strengths and different weaknesses. Therefore, the society in which we live should never be formed on the basis of special demands by the few. The society must be formed in such a way that it will suit all. The needs of disabled persons must influence the planning of our societies as much as the needs of non-disabled persons, not because we must pay special attention to the disabled, but because they are citizens of the society as everyone else. Therefore, their needs must be included in the building of the society as a matter of course.

This concept favours us, the non-disabled, partly because the needs of disabled people are the same as for many other groups and partly because we and our relatives through illness or accident may one day belong to the group of disabled persons ourselves. And then, we would, of course, wish that our daily life, ie our jobs, our homes, our social relations, our leisure time activities, as far as possible will continue as before. We do not wish that practical defects in planning of the society shall force us to limitations and changes which the disability itself does not make necessary.'

Disability in all its forms is a major facet of modern society with an estimated 11 million disabled adults in the UK – one in five of the total adult population – and 770,000 disabled children. Disability is therefore a mainstream subject, both for society in general and for the medical profession in particular. There are, however, several reports and studies indicating that healthcare professionals commonly fail to identify and tackle disability concerns. This manifests itself as unequal access to healthcare services, inequitable treatment and health outcomes for many disabled people, discrimination against disabled doctors, and barriers to careers in medicine. The causes of this inadequate engagement by the medical profession with disabled people are manifold and not easily identifiable. They are manifested in the poor record of treating disabled colleagues as equal within the profession; a lack of understanding of disability concerns; a lack of support for disabled doctors and disabled medical students, and those who acquire an impairment while studying, training or practising medicine; perceived environmental barriers; and the low numbers of disabled students who are admitted to medical school. The barriers to disability equality are at several levels including the individual, the attitudes of colleagues, the attitudes of employers and the culture within the profession.

There have been a number of encouraging developments in disability equality in recent years including the establishment of the Disability Rights Commission (DRC) in April 2000; the introduction of legislative changes that require employers, and service and education providers to actively promote disability equality; and the development of the social model of disability. This model recognises that an individual is disabled by society through attitudinal, environmental and organisational barriers and not as a result of their impairments or conditions. Progress on disability equality in the medical profession, however, has been limited and has relied mainly on the efforts of individual champions. Disability equality has failed to keep pace with the high-profile progress that has occurred in the medical profession in race and gender equality. The numbers of disabled people applying to study medicine remains low, and many that do apply are often prevented from studying medicine as a result of the competence standards regulatory framework. Disabled doctors and disabled medical students commonly fail to disclose information on an impairment through fear that it may

a For further discussion of the health and healthcare access inequalities of disabled people, see the BMA report Disability equality within healthcare: the role of healthcare professionals (2007).
lead to discrimination and limit their career progression.\textsuperscript{8,9} Progress has been further limited by a deficiency in information on the numbers of disabled doctors and disabled medical students.

The population of disabled people is highly diverse and includes people from all ages, ethnic communities and socioeconomic classes. It is vital that all doctors and medical students treat disabled colleagues equitably. Providing disability equality requires strong leadership and a strategic and coordinated approach to removing the barriers for disabled doctors and disabled medical students. It is essential that disabled people are provided with a level playing field and are fully integrated into the profession. This can only be achieved by providing an inclusive environment that actively encourages and enables disabled students to study medicine and disabled doctors to practise medicine.
Defining disability

The population of disabled people is highly diverse and includes people from all age groups and across the income and education spectrum. Impairments are diverse in their causes, nature, timing, pace and societal implications. Despite significant differences in impairment experienced by disabled people, there is a tendency to simplify the disability spectrum and assume all disabled people encounter similar barriers and experience the same difficulties. This ‘one size fits all’ approach is inappropriate as it is not possible to categorise impairments as is possible with ethnicity for example.

Disability is an extremely diverse topic, as not only are there a huge number of impairments and health conditions covered by the Disability Discrimination Act (DDA) as amended 2005, but the complexity is accentuated by the fact that impairments are very rarely consistent, with circumstances liable to change unpredictably. There is also a great deal of variation from person-to-person as to how an impairment can affect a person’s everyday life.

According to the DDA 1995 (as amended) ‘a person has a disability if he or she has a physical or mental impairment, which has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities’. If the impairment has substantially affected a disabled person’s ability to carry out normal day-to-day activities, but no longer does, it will still be counted as having that effect if it is likely to do so again. Where a disabled person has a progressive condition that will substantially affect their ability to carry out normal day-to-day activities in the future, they will be regarded as having an impairment which has a substantial adverse effect from the moment the condition has some effect on their ability to carry out normal day-to-day activities. In 1996, the British Medical Association’s (BMA) disabled doctor’s working party defined disability as ‘the end result of either physical, mental or sensory impairments (and people can be healthy with such impairments) or long term ill health (which can limit functional ability). Either case may result in a loss or limitation of opportunities’.

While there is no comprehensive list of impairments which constitute a person being disabled, examples of the types of impairment include sensory impairments; mobility difficulties and other physical impairments; learning difficulties and people who have a condition within the autistic spectrum; mental health problems; speech impairments; cognitive memory problems, such as dementia; and long-term conditions, such as epilepsy and dyslexia. It is important to note that the definition also covers illnesses and conditions which some people may not associate with disability, such as asthma, depression, heart disease or diabetes. People affected by these types of conditions may consider themselves to have an impairment or chronic illness, but not as disabled. Following the introduction of the DDA 2005, the definition of disability has been widened to include individuals, such as those with cancer, HIV infection and multiple sclerosis, from the point of diagnosis.

There are very few national data on the relative prevalence of different impairments within the population; a number of national household surveys do contain some disability data, but their ability to measure specific impairment prevalence reliably is limited. Approximations for the prevalence are available from charities and stakeholder organisations, although these tend to be specific for a single impairment, as such comparison is not necessarily informative.

b In this context long-term means it has lasted for 12 months, or is likely to last for more than 12 months or for the rest of the disabled person’s life.
The traditional models of disability
The traditional models of disability (including, among others, the ‘individual’ and ‘medical’ models) view disability as a result of a physical condition that is intrinsic to the individual, and that may reduce the individual’s quality of life (see figure 1). Under these models, disabled people are defined by their illness or medical condition, and medical diagnoses are used to regulate and control access to social benefits, housing, healthcare, education, leisure and employment. The traditional models view the individual disabled person’s impairment as the problem, and therefore see impairment and disability as synonymous. As a result, curing or managing an impairment involves identifying the illness, medical condition or loss of function, understanding it and learning to control it. For example, where an individual is unable to read information provided at an open day because they have a visual impairment, the traditional models see the disabled person as the problem because their impairment prevents them from doing so. The definition of disability in the DDA 1995 (as amended) views disability in the same way as it is viewed by the traditional models of disability.

The social model of disability
The social model of disability recognises that an individual is disabled by society through attitudinal, environmental and organisational barriers and not as an inevitable result of their impairment or medical condition (see figure 1). This model makes a clear distinction between impairment (i.e. the loss or abnormality of psychological, physiological or anatomical structure or function) and disability (i.e. discrimination on the grounds of impairment). While an impairment may produce a need for a different set of living requirements, it is not the impairment that is the problem, but the segregation imposed by society in the provision and inaccessibility of services that result in a general prejudice against an integrated community life for disabled people. This gives rise to the concept of disabilism where disabled people’s individual and collective disadvantage is due to a complex form of institutional discrimination, as is the case with sexism and racism. Under the social model, disability is preventable by removing attitudinal, environmental and organisational barriers to people who have an impairment. The social model of disability empowers disabled people to challenge society to remove these barriers. Considering the previous example where an individual is unable to read information provided at an open day because they have a visual impairment, the social model sees the organisation as the problem because they have not provided suitable material that can be read by someone who is visually impaired (e.g. Braille or large print documents).
Another model of disability is the biopsychosocial model; this is an integration of traditional and social models. This model is used by the World Health Organisation (WHO) in the International Classification of Functioning, Disability and Health (ICF), which provides a standard language and framework for the description of health and health-related states. The ICF goes some way towards recognising the highly diverse nature of disability, with these states being classified from body, individual and societal perspectives as well as the environmental factors that interact with these components. The emphasis of ICF is on health and functioning, rather than on impairment, and acknowledges that every human being can experience a decrement in health and thereby experience some impairment.
Disability discrimination legislation

The DDA 1995 (as amended) prohibits discrimination on the grounds of disability (see appendix 1), and makes it unlawful for employers and service providers to treat disabled people less favourably, without justification, for a reason that relates to their disability. It also requires them to make reasonable adjustments or accommodations to ensure that disabled people are not put at a substantial disadvantage. The DDA 2005 introduces a duty for employers and service providers to promote disability equality. The Equality Act 2006 establishes a Commission for Equality and Human Rights (CEHR) that will combine the Equal Opportunities Commission (EOC), the Commission for Racial Equality (CRE) and the DRC. The CEHR will encompass not only the areas previously covered by these bodies but also sexual orientation, religion, belief, age and human rights. Further information on disability legislation can be found in appendix 2.

The Government has published proposals for a Single Equality Bill, to simplify and improve existing legislation to modernise discrimination law. Discrimination law is currently contained in nine major pieces of legislation. It is believed that having a Single Equality Act will help prevent discrimination, by putting the law on equality and discrimination in one place, supported by clear practical guidance. The Discrimination Law Review will consider the opportunities for creating a clearer and simpler discrimination law framework which produces better outcomes for people who experience disadvantage. More information can be found at www.cehr.org.uk

Reasonable adjustments

All organisations with responsibility for disabled doctors and disabled medical students in areas such as their recruitment, teaching, training and employment, have a statutory duty under the DDA 1995 (as amended) to make reasonable adjustments. In supporting disabled doctors and disabled medical students it is important that organisations make reasonable adjustments in all areas for which they are responsible. These can include, but are not limited to: selection, admission and teaching of, and the provision of interviews, open days and taster sessions for medical students; as well as the training and employment of doctors.

There is considerable debate as to what constitutes a reasonable adjustment within the workplace. It should be remembered that many adjustments will directly benefit both employees and members of the public and clients. The level of adjustment deemed reasonable will vary according to the situation; however, areas which can be considered for reasonable adjustments include the physical environment (such as doorways, toilets, office furniture) and criteria or practices (for example, selection and interview procedures, the terms on which employment is offered, conditions of service). In many cases only small changes are necessary but these can make significant differences. The needs of people who have hearing, sight, or communication impairments, learning impairments or mental health conditions, as well as physical impairments, must also be met.
Some examples of reasonable adjustments that should be considered in the provision of
disability equality include:
- reconfiguring of tasks among a team
- altering a disabled person's working hours or training
- transferring a disabled person to a different place of work or training
- giving or arranging for training or mentoring
- allowing a disabled person to be absent during working or training hours for
  rehabilitation, assessment or treatment
- acquiring or modifying equipment (for example, providing voice-activated computer
  software for an employee with a visual impairment)
- modifying or adjusting disciplinary and grievance procedures
- adjusting redundancy selection criteria
- altering physical features of the building/office layout.

There are also adjustments specific to the medical profession such as the use of a simulated
patient lab which would allow an individual who lacks practical experience because of time
off due to illness to practise relevant practical procedures. It is important that while
reasonable adjustments can be made generally, due to the diverse nature of disability, a
case-by-case approach is necessary.

For further information on reasonable adjustments, please see www.drc.org.uk

The DDA 1995 (as amended) does not require the General Medical Council (GMC) to make
adjustments to their competency standards, although they must ensure that these standards
are proportionate and not discriminatory. The methods of assessing or demonstrating these
competencies can, however, be subject to reasonable adjustments. It should be noted that
the requirement to make reasonable adjustments does not imply a lessening of the
professional standards.

Recommendation
- Organisations with strategic and operational responsibility for doctors and medical students
  should ensure that all reasonable adjustments are made in accordance with the DDA 1995
  (as amended) to ensure that they are not put at a substantial disadvantage when studying,
  training, or practising medicine. In assessing the requirement for reasonable adjustments,
  expert advice should be sought from occupational health specialists or from the disability
  experts, as relevant. It is particularly important that the individual is fully involved in any
discussions relating to reasonable adjustments as they are best placed to assess the effect
of these adjustments.
Equal opportunities for disabled doctors and disabled medical students

Disabled doctors and disabled medical students are invaluable within the medical profession. In living with an impairment and/or disability discrimination, they are uniquely placed in terms of responding to the healthcare needs of disabled people and fostering a diverse and inclusive environment. There are numerous examples of disabled people with successful careers in the medical profession; yet, disabled doctors and disabled medical students are disproportionately undervalued. As a result, a medical career is often not supportive or enabling towards disabled doctors and disabled medical students. Significant difficulties are also faced in accessing the medical profession, as evident from the low numbers of disabled people applying to study medicine (see Monitoring disability in medical school admissions).

It is essential that disabled doctors, disabled medical students and any individual who acquires an impairment while studying, training or practising medicine have appropriate support and are provided with the same opportunities as their non-disabled colleagues. The amount and type of support available and the reasonable adjustments which are made for disabled doctors and disabled medical students is entirely dependent on the organisation involved, be that a medical school, Royal College, postgraduate deanship or general practitioner (GP) directorate.

Barriers to a career in medicine for disabled people

The lack of equality for disabled doctors and disabled medical students results from direct forms of disability discrimination (eg failure to make reasonable adjustments) and from more implicit forms of discrimination that can be attitudinal, assumptive, exclusionary or segregational. This implicit discrimination results from the culture in the medical profession where doctors are traditionally viewed as having to be flawless and fully fit. The historical culture behind medicine and medical training means the approach to disability has traditionally focused on finding a cure or providing care in accordance with the traditional models. One example of this is the GMC publication *Tomorrow’s doctors* (GMC, 2003)

which states that graduates must recognise the importance of ‘reducing or managing impairments, disabilities and handicaps’. Viewing disability in this way sees the individual disabled person’s impairment as the problem and ignores the social model of disability. It is likely that many doctors and medical students find it difficult to move away from this traditional mind-set. This is compounded by external pressures on how disability is viewed. For example, the definition of disability in the DDA 1995 (as amended) also corresponds to the traditional models of disability, where an individual’s impairment is seen as the problem. In its *Recommendations to Government July 2006* (DRC, 2006)

the DRC suggests changing the DDA definition to one consistent with the social model of disability.

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**Career barriers in medicine: doctor’s experiences** (BMA, 2004) identified a number of significant barriers for disabled doctors including:

- inflexible working patterns
- poor contingency cover
- unsympathetic colleagues, and those who are ‘sympathetic until it affects them’
- the stigma attached to disabled doctors or doctors with a chronic illness
- the small amount of data collected or collated for disabled doctors make it far more difficult to extract meaningful information from analysis, this is exacerbated by under-reporting.

These factors often ‘add guilt to an already difficult situation and leave doctors wondering whether they can continue working in a position that makes little allowance for their specific health needs.’
Some of the barriers I experienced have been in other people’s perceptions of disability, rather than the reality – General practitioner.

Under-reporting of impairment

Due to the culture within the medical profession, and the stigma attached to the term ‘disabled’, there is a great deal of under-reporting of impairment by doctors, particularly in the case of hidden impairments (e.g. mental health problems), as it is felt this may adversely affect career progression. Under-reporting of impairment is also probable among medical students and those applying to study medicine. The problem of under-reporting of impairment is however, not unique to medicine as it is generally acknowledged as being prevalent throughout the higher education sector and in the workplace. There are a number of potential reasons why individuals choose not to disclose information on their impairment, including:

• concerns about discrimination or being rejected by people with pre-set ideas about the effects of a particular impairment. The reluctance of doctors and medical students to declare their impairment most likely arises as a result of concern that an impairment may be considered by colleagues and employers to be a sign of weakness that limits professional competence
• concerns that it will give the employer or education provider the chance to label individuals by their impairment and make assumptions about what they can and cannot do on the basis of their impairment
• a reluctance to provide information on an impairment as this may not allow an individual to convey an accurate understanding of their impairment, or they may find it difficult to explain it in words
• the belief that their impairment will have no effect on their ability to do a job or undertake a course.

Under-reporting of impairment is not easily solvable. It necessitates a fundamental shift towards a culture and environment that encourages openness about impairment and views disability positively. It also requires a better understanding of the barriers to declaring impairments and targeted approaches to encourage doctors and medical students to declare information on their impairment. It is important to understand the extent to which impairments are under-reported, as well as the types of impairment that are most/least likely to be declared and the barriers to declaration in the medical profession.

One approach towards reducing under-reporting is to ask doctors and medical students to identify as disabled people using the social model i.e. asking them if they experience discrimination on the grounds of impairment, rather than if they are unable to carry out normal day-to-day activities. This would encourage more disabled people to self define, and encourage a culture where organisations and individuals recognise and deal with discrimination on grounds of impairment, and related matters. Using the application process for the Access to Work scheme, to allow employees the opportunity to disclose as disabled people for monitoring purposes, would provide a more accurate reflection of the number of disabled employees.
Disclosure of impairments

Personal and sensitive information, such as that relating to impairment, should be treated as confidential, and access to this information should be strictly regulated. Organisations that collect, store, monitor and analyse personal sensitive information are governed by eight principles set out in the Data Protection Act 1998, which ‘make sure that personal information is:

• fairly and lawfully processed
• processed for limited purposes
• adequate, relevant and not excessive
• accurate and up to date
• not kept for longer than is necessary
• processed in line with [the individual’s] rights
• secure
• not transferred to other countries without adequate protection’.

Personal sensitive information must only be obtained and held where consent has been given, and only then when it is of relevance to the provision of a service. Data must be safeguarded by technical and organisational measures, for example, password-protecting electronic information, and storing paper-based records in lockable cabinets or cupboards. It is important that data are accurate and be kept up to date, and should be disposed of following the elapse of a reasonable time. Experience shows that anonymous monitoring leads to a better response rate – because individuals are often concerned about disclosing personal information.

Where it is not possible to collect information on an anonymous basis, for example, when tracking the progress of individuals, confidentiality must be guaranteed and reports of such exercises should be anonymised so that individuals cannot be identified. It is important that personal information is only provided when necessary and only where appropriate. Documents such as application forms and CVs should not include sensitive information. Information such as disclosure of a specific impairment should be used by occupational health services to assess an applicant’s physical and mental ability to practise as a doctor, and not to influence the admission selection procedures regarding academic performance and personal qualities.

Developing disability equality

Disability equality must be a central component of all equal opportunities policies and strategies in the medical profession. This requires leadership from the GMC, as well as commitment at the most senior levels. There have been a number of recent initiatives aimed at improving disability equality within the National Health Service (NHS) such as Improving working lives (IWL) and positive action (see appendix 3). These initiatives are NHS-wide, however, and are not sufficiently focused on providing disability equality for doctors and medical students which may lead them to believe that these initiatives are not relevant to them.

It is important that equal opportunity policies are developed and kept up-to-date and that disabled people are consulted about, and involved in, their on-going development. This commitment must extend throughout all organisations with strategic and operational responsibility for doctors and medical students and cover all aspects of education, training and employment. It is important that all organisations clearly set out their equal opportunities policies with respect to disability, and that these policies are communicated to all members of staff. For more information on developing equal opportunities policies with respect to disability see appendix 4.

It is important to acknowledge that in addition to addressing disability equality among doctors and medical students, the required actions and adjustments relating to education, training and employment can have a significant impact upon service provision for disabled patients.
Improvements in patient care should result directly from the adjustments and policies put in place within healthcare organisations and also indirectly through having a workforce which supports and includes a greater number of people with impairments. In this way the workforce will better reflect the user population, meaning that it can relate to the needs of disabled patients and create a more responsive service. This is further discussed in the BMA publication *Disability equality within healthcare: the role of healthcare professionals* (BMA, 2007).

**Disability awareness and etiquette**

The inclusion of disabled doctors and disabled medical students requires the medical profession to approach disability with confidence and in ways that support disabled people. A lack of engagement with disabled people and a poor understanding of disability concerns can contribute to the discrimination, social exclusion and stigma experienced by disabled people within the profession. Research evidence suggests healthcare professionals often lack the appropriate knowledge and skills when working with disabled people. While doctors and medical students are primarily taught to interact and communicate with disabled patients as part of their training, they also have a responsibility to treat disabled colleagues equitably and with respect. In order to foster disability confidence and competence among medical professionals, disability awareness and etiquette training must be provided to medical students and doctors throughout their career. This will encourage disabled people to discuss their needs and help early identification of problems. It is vital that this training does not simply focus on the medical aspects of conditions and impairments but that the social model is used to inform learning related to communication and attitudes.

**Undergraduate and postgraduate training**

According to *Tomorrow’s doctors* (GMC, 2003), knowledge of disability and rehabilitation is one of the content areas in undergraduate medical education, and the importance of communication with patients and colleagues is also emphasised. ‘Graduates must be able to communicate clearly, sensitively and effectively with patients and their relatives, and colleagues from a variety of health and social care professions. Clear communication will help them carry out their various roles, including clinician, team member, team leader and teacher.’ They must also have some knowledge of different methods of communication, such as British Sign Language and be able to ‘communicate effectively with individuals regardless of their social, cultural or ethnic backgrounds, or their disabilities’. While disability is a recognised theme in the undergraduate medical curriculum, a review of the teaching of disability and rehabilitation in the UK found it to be patchy and sporadic and that it rarely had clearly defined aims and objectives. There have been a number of innovative projects aiming to develop curricula which engage students in the subject of disability, find ways of exploring the social model of disability and challenge students’ perceptions of disabled people. A common theme of such initiatives is that they involve disabled people directly, either as teachers, in curriculum development and/or through direct contact with disabled people’s lives.

It is vital that doctors regularly update their knowledge and skills relating to disability competence and that the theme of disability equality is present throughout postgraduate medical education and training. Modernising Medical Careers (MMC) states that all newly qualified doctors (Foundation years 1 and 2) are expected to demonstrate core competencies relating to communication skills and understanding the needs of disabled colleagues and patients. The GMC publication, *The new doctor* (GMC, 2005), states that junior doctors should ‘respect everyone they work with (including colleagues in medicine and other healthcare professions, allied

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*c Communication skills education for doctors: a discussion paper (BMA, 2004) assesses communication skills training at both undergraduate and postgraduate level, highlighting concerns about the benefits of improved communication and current communication skills training in medicine.*
health and social care workers and non-health professionals) whatever their professional qualifications, lifestyle, culture, religion, beliefs, ethnic background, sex, sexuality, disability, age, or social or economic status.  

**Continuing professional development**

It is important that doctors ‘keep themselves up to date in all areas of Good medical practice’ those being: good professional practice, maintaining good medical practice, relationships with patients, working with colleagues, teaching and training, probity, and health. The DRC has produced a supplement to Good medical practice (GMC, 2006) which outlines the importance of keeping up to date on matters of disability equality including legislation changes. Further information can be found at www.drc.org.uk. There are a number of organisations that offer Continuing Professional Development (CPD) courses (e.g. medical Royal Colleges and Faculties, specialist associations, management training organisations and universities). There are, however, a limited number of courses available which are aimed at developing disability awareness and equality within the medical profession.

**Universal disability awareness training**

Everyone working within the medical profession has a responsibility to support disabled colleagues and employees and provide an inclusive and enabling environment. In order to initiate a cultural shift, towards an environment where disabled people, doctors and patients alike, are treated with respect, it is important that all staff in an organisation, including senior management, receive an appropriate level of disability equality and etiquette training (see case study 1). This would help to dispel any negative attitudes or misconceptions they may hold about disabled people. Furthermore, the requirement for senior management to undertake such training will reinforce the importance of the process and reflect the priority given to disability equality. A disability awareness distance learning package, Welcoming patients with disabilities (NHS Executive, 1999; updated 2007), is intended to provide NHS staff with the skills needed to offer equal access to patient care, and is applicable to the workplace environment. The programme covers various topics including disability awareness, disability and law, and the do’s and don’ts of communicating with disabled people. Further information is available on the Department of Health (DH) website at www.dh.gov.uk. The DRC has developed a training package as part of its formal investigation into health inequalities which can be accessed at www.drc.org.uk.

**Case study 1 – NHS Fife disability awareness training**

NHS Fife provides disability awareness to all members of staff to provide them with a general understanding of disability and the main barriers faced by disabled people. The training focuses on several key areas including:

- the scope and requirements of the DDA
- an understanding of what disability is
- the need to involve users in their care
- how to work with an interpreter.

The national framework for Disability Equality and Etiquette Learning (DEEL) in health and social care that is currently being produced by the DRC will assist organisations in ensuring their staff have appropriate disability equality and awareness training. It is also important to consider providing specific awareness or other training to staff in response to the appointment of a disabled
colleague. To ensure confidence in disabled doctors, patients and the general public must be properly informed with respect to the competence of disabled doctors. This requires an understanding of patient attitudes towards, and the positive promotion of, disabled doctors. In the medical profession, approaching disability with confidence will not only enable disabled people to succeed in careers in medicine, but will also positively impact on the provision of healthcare to disabled people. Further details about the characteristics of effective DEEL in medicine and its role in improving patient care can be found in the *Disability equality within healthcare: the role of healthcare professionals* (BMA, 2007) or at [www.drc.org.uk](http://www.drc.org.uk).

**Recommendations**

- The GMC should take a lead role in promoting disability equality within the medical profession by working in partnership with the UK Health Departments and relevant stakeholder organisations to:
  - develop initiatives that promote disability equality among doctors and medical students. These should complement current and future NHS-wide initiatives
  - promote a positive image of disabled doctors and disabled medical students to patients and the general public.

- All organisations with strategic and operational responsibility for doctors and medical students should:
  - have a disability policy which is endorsed at the highest level and communicated to all employees. All of an organisation’s policies should consider disability-related matters and disabled people should be consulted and involved in the development of all equal opportunities policies. Appropriate measures must be in place to monitor and evaluate the effectiveness of these policies
  - ensure all employees undertake an appropriate level of disability equality and awareness training using the DEEL National Framework. This should be used to identify clear aims and objectives for training, and be built into individual staff members performance management review processes
  - use the application process for the Access to Work scheme, to give employees the opportunity to disclose as disabled people for monitoring purposes. Over time this should provide a more accurate reflection of the number of disabled employees.

- The GMC should work in partnership with the Postgraduate Medical Education and Training Board (PMETB), the Medical Schools Council (MSC)\(^d\) and the medical Royal Colleges and Faculties to ensure that disability equality is adequately taught at all stages of medical education and training, and that the teaching reflects the social model of disability.

- The medical Royal Colleges and Faculties should ensure that more CPD courses covering areas of diversity are made available, particularly those covering disability equality. These courses should reflect the social model of disability.

- Further research is required into the extent to which impairments are under-reported, the types of impairment that are most likely and least likely to be declared, and the barriers to declaration in the medical profession.

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\(d\) Medical Schools Council (MSC) was formerly known as the Council of Heads of Medical Schools (CHMS).
Disability equality in access to studying medicine

Many disabled people are eager to study, practise and succeed in the medical profession. Frequently, however, there are barriers preventing them from doing so in the form of discriminatory attitudes, structures, lack of adjustments and a lack of information and awareness. Equal access to education should be a fundamental right for every individual, regardless of their age, gender, sexual orientation, social class, ethnic or religious background or disability. Medical education should be no different from any other form of education in this respect and it is vital that steps are taken to tackle the barriers to accessing medicine.

Promoting medical careers to disabled people
Promoting disability equality allows the medical profession to attract, support and enable greater numbers of disabled students, and subsequently, establish a more responsive and diverse medical workforce. For disabled applicants, access to adequate information about medical schools, the learning materials on offer as well as physical access to buildings and premises, are all crucial requirements. In considering medicine as a possible career, disabled students are often unaware of the reasonable adjustments that can be made to allow them to study and practise medicine. There is also no national source of information as to whether a particular impairment will preclude a disabled person from studying and practising medicine. In promoting disability equality, the GMC has worked with Skill: National Bureau for Students with Disabilities in producing an information booklet, *Into medicine* (Skill: National Bureau for Students with Disabilities, 2007), aimed at encouraging disabled students into the medical profession. This booklet gives information about application to medical school, medical school admissions, funding availability, information about postgraduate courses and links to medical schools and a number of other useful organisations.

In accordance with the DDA 1995 (as amended), further and higher education institutions in the UK are required to publish disability statements that detail the provision of facilities for education made by the respective institutions in respect of disabled people. The GMC states in *Tomorrow’s doctors* (GMC, 2003) that medical schools should ‘publish information about the admission system, including guidance about the basis on which places at the medical school will be offered, and the selection process’. The MSC publication, *Guiding principles for the admission of medical students* (CHMS, 2004) indicates that ‘Medical Schools will make available to prospective applicants details of their admissions policies and explanations of the admissions process. Medical schools will be proactive in accordance with legislative requirements in reaching out to all sections of the community.’ Guidance from the Quality Assurance Agency for Higher Education (QAA) on academic quality and standards recommends that higher education institutions in the UK describe the opportunities for disabled students to participate and should consider implementing arrangements which ensure that:

- their disability statement provides clear and accurate information in accessible media on the physical environment, the human and technical support available and any costs that students will be expected to bear
- electronic information, including web sites, is accessible to disabled students
- information on placement opportunities, where relevant, is available at an early stage
- details of the designated contact(s) for disabled students are widely publicised
- responses to enquiries from disabled people are prompt and candid and include advice from experienced, specialist staff.

The 2002 report, *Pushing the boat out* (The Higher Education Academy, 2002), examined web-based information relating to the admission of disabled people to UK medical, dental and veterinary schools and found there to be significant inadequacies in the provision of
disability-related information to medical school applicants. This report was acknowledged as having several limitations, including that it only assessed the information available on the internet and only within a very narrow time-frame, and that there was little or no contact with staff in the relevant medical schools and universities. The report found very limited information to be provided on disability discrimination, the role of the GMC, the procedures for the assessment of disabled applicants, and what individual medical schools had undertaken with respect to providing equality of opportunity and widening participation in medicine. The follow-up survey The sequel to pushing the boat out (The Higher Education Academy, 2003), found there had been considerable improvement since the 2002 study in the number of medical schools providing adequate disability-related information, although negative attitudes to the admission of disabled students to medical schools persisted in a minority of cases.

A recent qualitative study aimed at facilitating discussion around the matter of disabled doctors and disabled medical students examined the views of different sections of society towards admitting disabled people onto undergraduate medical courses. A mix of individuals were selected from admissions staff, disabled medical students, non-disabled medical students, practising disabled doctors, disabled members of the general public, and non-disabled members of the general public. The study found an increasingly positive approach to the admission of disabled individuals to study medicine, and that many respondents felt it was time for the GMC to provide leadership in this important area. The study also showed however, that all groups questioned considered impairments which produce a major impact on observation and communication skills, such as hearing or visual impairments, incompatible with basic medical competencies.

**Personal perspective – Final year medical student**

Being visually impaired makes being a medical student that little bit harder than it is for everyone else, because of that, I need extra support, and have to be super-motivated, which I am most of the time. But there’s no way I could have achieved what I have without my family and friends’ help and consideration.

In the hospital setting I can’t do things like test someone’s urine as the writing on the bottles is too small, or check a drug vial myself which seem like insignificant things really, just a question of reading and not really much to do with my clinical competence. I can’t assess x-rays or work shifts and long hours as my vision gets worse when I’m tired and in artificial light. I’m not great at fundoscopy, but I’m hoping modern technology will invent some kind of USB ophthalmoscope to plug into a laptop – I’m getting a USB otoscope soon which is exciting. But when I’ve finished my hospital years and can go into a field where my sight isn’t so essential, all these things won’t matter.

My medical school have been very kind and helpful to me. The staff are usually told in advance about me and can be very supportive: allowing me to stick my head right up to screens in theatre, giving me PowerPoint notes etc.

With a bit of technology, a bag full of magnifiers, a good bunch of friends and a lot of determination, I think I can become just as good a doctor as any of my colleagues.

**Jemma Saville**
In the 2004 report *Sharing the challenge, sharing the benefits – equality and diversity in the medical workforce* (DH, 2004), the DH identified improving access for disabled people to medical education as one of the key challenges to providing equality and diversity in the medical workforce. This report was superseded by *Equal values: equal outcomes* (NHS Employers, 2005) which reinforced the commitments set out in *Sharing the challenge, sharing the benefits – equality and diversity in the medical workforce* (DH, 2004), and set out a number of commitments for NHS Employers and other stakeholders in relation to disabled students. In 2005, the GMC held a joint seminar with the DRC to outline the responsibilities of medical schools and professional bodies under the DDA 2005, and it is currently in the process of developing a discussion document on reasonable adjustments for the Quality Assurance in Basic Medical Education (QABME) process.

Recently, the GMC have joined force with 11 medical schools to initiate the ‘Gateways disability project’ which aims to develop advice for medical schools with regard to their disability equality schemes, to encourage the recruitment and retention of disabled people in the medical profession. While this project is still in the early stages, the GMC has ‘identified the negative attitudes and misunderstanding about disability and capability, including the assumption that it would be costly to support disabled doctors, and a lack of flexibility, as barriers to recruitment and retention of disabled people into the medical profession’. In response to the report *Gateways to the professions* (DfES, 2005) the Department for Education and Skills (DfES) have established a development fund of £6m over the next three years for a number of projects, including that managed by the GMC to tackle the problems faced by disabled people trying to enter the medical profession through higher education.

Disability equality in the medical profession necessitates the active promotion of medicine as a potential career for disabled people as well as the comprehensive provision of disability-related information on application procedures, admission and selection policies, and reasonable adjustment obligations. This must be considered a core activity and requires coordinated participation by individual medical schools and the MSC. In the absence of a central source of information on whether a particular impairment precludes entry into medicine, it is vital that information is provided to applicants on the implications of particular impairments and the type of reasonable adjustments that can be made to allow them to study and practise medicine. This approach has been adapted in the veterinary profession where the Royal College of Veterinary Surgeons (RCVS) has developed guidance explaining how different impairments may affect veterinary students (see case study 2). Similar guidance for medical students is essential. Under the DDA 2005, all public bodies will have a duty to promote equality of opportunity, promote positive attitudes to disabled people and encourage participation of disabled people.
Case study 2 – RCVS guidance on specific impairments and the admission of veterinary students

The RCVS Education Committee has published guidance on the admission of disabled veterinary students to assist veterinary schools in their selection procedures. The guidance recognises that students with a wide range of impairments or health conditions can achieve the required standards of knowledge and skills to enable them to practise as veterinary surgeons, but that each case is different and has to be viewed on its merits. The guidance provides information to veterinary applicants on the implications of particular conditions including dyslexia, sensory impairments, mental health problems, and physical impairments. In each case the guidance sets out how the different impairments may affect veterinary students and what support systems are available.

Source: Guidance on the admission of students with disabilities to the professional veterinary degree course (RCVS, 2003).

Actively promoting disability equality allows disabled applicants to make informed career choices and will encourage disabled people to apply to study medicine. A positive way to attract and enable disabled applicants would be to provide taster placements prior to application that would reduce any concerns about, or highlight potential difficulties in, studying medicine and practising as a doctor (see case study 3). Details about other similar taster courses can be found at www.medschoolonline.co.uk

Case study 3 – King’s College, London taster course ‘Tasting Medicine at King’s’

King’s College, London, organise a free five day course ‘Tasting medicine at King’s’ aimed at allowing year 12 students the opportunity to experience university life and studying medicine. This five day programme provides an insight into undergraduate medical training and the life of a medical student.

Attendees will meet basic medical science and clinical tutors and attend practical classes in dissection and clinical skills. As part of a group attendees will explore a clinical problem such as heart disease, which will be informed by the practical sessions throughout the week.

The Medical Admissions tutor will speak about the medical admissions process and there will also be opportunities to meet a number of current medical students.

While this event is not targeted specifically at disabled applicants, the University does provide support and access to disabled people wishing to take part in this course. Further information can be found on the King’s college website at www.kcl.ac.uk

Source: King’s college, London. www.kcl.ac.uk
Recommendations

- The GMC should work in partnership with the BMA, the MSC and the UK Health Departments to promote medicine as a potential career for disabled people.

- The MSC should work with medical schools to ensure that information on their websites and in student recruitment materials is appropriate for, and accessible to, all potential students, including disabled students. Medical schools should provide easily accessible disability-related information on application procedures, admission and selection policies, reasonable adjustment obligations, available support systems, and physical access considerations.

- The GMC should work with the MSC, the medical Royal Colleges and Faculties, and the PMETB to produce guidance on how specific impairments may affect the ability of disabled applicants to study and practise medicine. This should be readily available to potential students and include advice about what help and support is available.

- All medical schools should be aware of their responsibilities under the DDA 2005 to promote disability equality. Consideration should be given to providing disabled applicants with taster placements in medicine, in order to attract more disabled people to medicine and allow applicants to decide whether it is a suitable career choice for them.

Monitoring disability in medical school admissions

As highlighted in Career barriers in medicine: doctors’ experiences (BMA, 2004), the Universities and College Admissions Service (UCAS) collect data on medical school applicants and acceptances in the UK. Applicants are requested to voluntarily declare information on disability on the UCAS application form and are advised that they may choose only to inform the institutions to which they apply directly. This information is used to help universities and colleges to provide the appropriate support and facilities for disabled applicants, and to monitor progress in equal opportunities in higher education. UCAS carries out some limited analysis of the data collected during the application process, although this is mainly for institutional statistics and on request from various stakeholders. To encourage greater disability equality, UCAS works closely with Skill: National Bureau for Students with Disabilities, and provides guidance and information on how and why it is beneficial to fill in details relating to any impairment. From 2006, UCAS has included three new pieces of information in all application systems literature and websites with the aim of encouraging applicants to disclose impairment. These include:

- a series of case studies, supplied by Skill and written by disabled students in higher education, that relate to each of the disability codes on the application form
- information on how to access the contact details for disability officers at all higher education institutions
- information about the Disabled Students’ Allowance (DSA) (additional information about DSA can be found at www.direct.gov.uk).
Table 1 compares the number of medical school applicants and acceptances with the number of applicants and acceptances for all courses in the UK. The data in table 1 illustrate that the proportion of applicants who are accepted to study medicine with and without indicating disability is similar. There is, however, a significant difference in the number of disabled applicants who apply to study medicine compared to the number of non-disabled applicants. In 2005, of the 20,892 applicants to pre-clinical medicine, only 598 identified themselves as having an impairment, though this figure is disproportionately low, although this does not take into account the fact that the majority of people who acquire an impairment, do so at an older age. Data about the number of applicants and acceptances to higher education and medical school for specific types of impairment can be found in appendix 5. Analysis of these data shows that the proportion of acceptances per applicant is variable with respect to the type of impairment. It is important to consider the extent to which the disproportionately low numbers of disabled applicants results from perceived or actual barriers to the profession, or from the under-reporting of disability. A review of the medical workforce in Scotland found that disabled people have particularly low success rates in applying to study medicine, and therefore remain a largely untapped resource of potential doctors. Further research is required into why disabled people are deterred from applying to study medicine.

Table 1 – comparison between applicants and acceptances for medicine compared to all courses

<table>
<thead>
<tr>
<th>Medicine</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>With disability (applicants)</td>
<td>263</td>
<td>323</td>
<td>462</td>
<td>508</td>
<td>598</td>
</tr>
<tr>
<td>With disability (acceptances)</td>
<td>140</td>
<td>168</td>
<td>212</td>
<td>196</td>
<td>201</td>
</tr>
<tr>
<td>Acceptances as % of total applicants</td>
<td>53%</td>
<td>52%</td>
<td>46%</td>
<td>39%</td>
<td>34%</td>
</tr>
<tr>
<td>With no disability (applicants)</td>
<td>10,565</td>
<td>12,368</td>
<td>15,428</td>
<td>18,551</td>
<td>20,294</td>
</tr>
<tr>
<td>With no disability (acceptances)</td>
<td>6,100</td>
<td>6,791</td>
<td>7,455</td>
<td>7,759</td>
<td>7,620</td>
</tr>
<tr>
<td>Acceptances as % of total applicants</td>
<td>58%</td>
<td>55%</td>
<td>48%</td>
<td>42%</td>
<td>38%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All courses</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>With disability (applicants)</td>
<td>19,151</td>
<td>19,588</td>
<td>20,371</td>
<td>21,059</td>
<td>24,517</td>
</tr>
<tr>
<td>With disability (acceptances)</td>
<td>15,298</td>
<td>15,795</td>
<td>16,355</td>
<td>16,746</td>
<td>19,713</td>
</tr>
<tr>
<td>Acceptances as % of total applicants</td>
<td>80%</td>
<td>81%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>With no disability (applicants)</td>
<td>380,494</td>
<td>382,266</td>
<td>389,597</td>
<td>392,275</td>
<td>420,113</td>
</tr>
<tr>
<td>With no disability (acceptances)</td>
<td>310,174</td>
<td>315,930</td>
<td>317,587</td>
<td>317,549</td>
<td>340,531</td>
</tr>
<tr>
<td>Acceptances as % of total applicants</td>
<td>82%</td>
<td>83%</td>
<td>82%</td>
<td>81%</td>
<td>81%</td>
</tr>
</tbody>
</table>


UCAS define the term pre-clinical medicine (Joint Academic Coding System (JACS) code A1) as “Vocational science of preventing, diagnosing, alleviating or curing disease in homo sapiens. Includes such areas as Anatomy, Physiology, Pharmacy and Nutrition which can be specialisms in their own right’. Due to the fact that medical schools apply course codes, this group includes a number of courses with clinical elements.

This statement is made in the absence of any comparative data for the number of disabled people in the UK medical workforce and is based on the estimation that one in five of the UK adult population is disabled. Extrapolating this to the total number of applicants to pre-clinical medicine in 2005 (20,892) provides a figure of 4,178.
Table 2 compares the number of medical school applicants and acceptances with the number of applicants and acceptances for all courses in the UK in 2005 by specific disability category. The percentage of acceptances for applicants to all higher education courses with a specific impairment remains fairly constant compared to the percentage of acceptances for applicants with no impairment. There is, however, significant variation in the percentage of acceptances for applicants to pre-clinical medicine with a specific impairment compared to the percentage of acceptances for applicants with no impairment. While 38 per cent of applicants with no impairment were accepted to pre-clinical medicine in 2005, the percentage of acceptances for applicants who were categorised as having mental health difficulties or as having to use a wheelchair/have mobility difficulties were 25 per cent and 17 per cent respectively. None of the applicants categorised as having autistic disorder were accepted for pre-clinical medicine. As well as information about the relative proportions of disabled students entering medical courses, it is important to gather information on the number of students who give up study early or who leave the profession once qualified. It is also essential to find out how many do not apply for jobs within the NHS and how many take up positions in other countries.

**Table 2 – comparison between applicants and acceptances for pre-clinical medicine and all courses by specific category of disability for 2005**

<table>
<thead>
<tr>
<th>Disability category</th>
<th>Pre-clinical medicine</th>
<th>Higher Education</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of applicants</td>
<td>No. of acceptances</td>
</tr>
<tr>
<td>Learning difficulty*</td>
<td>280</td>
<td>95</td>
</tr>
<tr>
<td>Blind / partially sighted</td>
<td>19</td>
<td>9</td>
</tr>
<tr>
<td>Deaf / hard of hearing</td>
<td>27</td>
<td>11</td>
</tr>
<tr>
<td>Wheelchair / mobility difficulties</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Autistic disorder</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Mental health difficulties</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>Unseen disability**</td>
<td>122</td>
<td>43</td>
</tr>
<tr>
<td>2+ disabilities / special needs</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Other disabilities / special needs</td>
<td>108</td>
<td>33</td>
</tr>
<tr>
<td>No disability</td>
<td>20,294</td>
<td>7,620</td>
</tr>
</tbody>
</table>


* From 2003, the wording on the application form changed from ‘You have dyslexia’ to ‘You have a specific learning difficulty (for example, dyslexia’).

** The term ‘unseen disability’ refers to impairments such as diabetes, epilepsy, and asthma.
Recommendations

- Further research is required into:
  - the barriers that deter disabled people from applying to study medicine, including the extent to which this is dependent on the type of impairment
  - the number of disabled students entering medical courses, as well as information on the number of students who give up study early
  - the number of disabled medical students who do not apply for jobs within the NHS and how many take up positions in other countries.

Providing disability equality in selection and admission to medical school

Doctors are routinely responsible for the health and safety of others and are therefore required to have high levels of skill, concentration, competence and stamina. It is important that the selection procedure is rigorous and robust enough to ensure that only those with the appropriate qualities to make competent doctors are chosen. With careful selection and appropriate support, disabled students are able to succeed in a career in medicine. It is unclear where the responsibility for integrating disabled students into the medical profession ultimately lies. The GMC has a duty of care to protect patients, to ensure, through its accreditation of undergraduate medical courses, that graduates who are admitted to the medical register are ‘fit for purpose’. The GMC does not have statutory authority over the selection and admission of medical students, but it does require medical schools to ‘put in place valid, open, objective and fair selection procedures’ in admitting students to study medicine. Although the GMC considers selection procedures as part of the QABME process, this is only in relation to the requirements set out in Tomorrow’s doctors (GMC, 2003). It is therefore the responsibility of individual medical schools to determine the specific criteria and requirements for selection into medical school. The QAA guidelines on the selection and admission of students recommend that institutions should consider:
  - ensuring that criteria and procedures used for selecting students are relevant to the requirements of the programme, including any professional requirements, and do not unjustifiably disadvantage or debar disabled applicants
  - ensuring that appropriate support is offered and available for applicants attending interviews and other selection activities
  - where appropriate, offering disabled applicants the opportunity to demonstrate their ability to use alternative ways for meeting programme requirements.

An examination of admissions to UK medical schools for disabled applicants found a lack of parity in the way different medical schools evaluate whether there were particular circumstances that precluded a candidate being able to practise as a doctor. This variation occurred in the way admissions staff arrived at decisions, how occupational health services and disability services were included in the decision-making process, and the accessibility and availability of these services. The GMC has previously reviewed its involvement in the admissions process in a consultation on the strategic options for undergraduate medical education. Responses to the consultation showed some support for the development of guidance on admissions but not for a change in the GMC’s statutory powers. Respondents supporting the increased involvement of the GMC in this area felt its role should be limited to competence to practise considerations.

According to Guiding principles for the admission of medical students (CHMS, 2004), ‘Medical schools have agreed that the selection process for medical students must be transparent and involve procedures that respect obligations under relevant diversity and equality legislation’. This report also states ‘issues relating to a candidate’s health will not be
dealt with by an interview panel set up to assess personal qualities. Health matters will be separately considered by a “fitness to practise” committee informed by an occupational health assessment. This process would be run in parallel with the general selection process. The MSC guidance on the selection of medical students with specific learning difficulties indicates that:

- applicants to medical school should disclose information on specific learning difficulties on their UCAS application form
- medical schools should give equal consideration to applicants with learning difficulties with the relevant academic and personal qualities
- applicants with specific learning difficulties should provide evidence of this in the form of a full diagnostic assessment by an educational psychologist, specialist teacher or other appropriately qualified professional.

There is however a lack of similar guidance regarding other types of impairment.

The provision of equality of opportunity for disabled people requires a consistent approach to the assessment and selection of disabled students. The GMC needs to reassess its policy within this area, and clearly define the core skills and competences required to study and practise medicine, and ensure that this information is made available to applicants and taken into consideration in the assessment of disabled students. Consistent admissions procedures also require comprehensive and accurate recording of assessment and selection decisions and the reasons for them, and the sharing of this information within and between institutions. Further guidance is also required on the interpretation and implementation of competence standards.

The individuals involved in assessing whether an applicant is competent to study and practise medicine – including occupational health physicians, GPs and hospital consultants – may not have the experience or training in disability concerns, adjustments or the support relevant to training and employment. The ability to assess competence to enter medical school requires an in-depth understanding of the applicant’s impairment, how this affects their ability to function in their daily working lives, the requirements and demands of medical training and practising medicine, and the relevant aspects of anti-discrimination legislation. There are no data on the levels of occupational health provision to medical schools in the UK. An examination of the provision of occupational health services in all UK universities found significant variation in their practise and performance. Occupational health services were found commonly to be provided on a less than full time basis, covering large populations with limited numbers of staff, and were poorly represented on relevant university committees involved in policy making.

The GMC states in Tomorrow’s doctors (GMC, 2003) that ‘staff responsible for selecting students should include individuals with a range of expertise and knowledge. All those involved in selecting students should be trained to apply guidelines about entry requirements consistently and fairly. They must also follow current equal opportunities legislation.’ The QAA guidance on academic quality and guidance recommends that institutions should consider “providing disability awareness/equality guidance and training for all tutors and administrative staff involved in selection and admissions.” It is also important that the composition of the selection panels are monitored and regularly reviewed. The assessment of all disabled applicants must occur on an individual basis. Further information is required on the use and availability of occupational health services in medical schools and the training provided to individuals responsible for assessing disabled applicants. It is important to consider the role of disability officers who have expertise in this area and are well positioned
to provide advice on the needs of disabled applicants, as well as to assess the extent and suitability of reasonable adjustments. Further information on disability officers can be found on the National Association of Disability Officers (NADO) website at www.nado.org.uk

Personal perspective – 3rd year medical student

I am a medical student with a profound hearing loss. I personally found that having a hearing loss at medical school was much more challenging than I had ever envisaged. One of the problems was when I started my course I was on my own in sorting things out. Simple things like applying for a Disability Student Allowance to fund equipment such as a radio aid were fraught with difficulties due to the disorganisation within the NHS Student Grants unit. So I spent days and days on the phone trying to get through and my applications were repeatedly lost. I consequently went many months without the equipment I needed to help me hear. In the end my university were very helpful in lending me the money to buy the specialist equipment I required.

It is tricky on the wards because as there is sometimes teaching by humiliation, if I can’t follow what is being said, I can appear stupid. I also had a comment from a consultant when I didn’t hear on a ward round who said ‘your hearing aids not working, then?’

Overall, I think medical students with an impairment need as much support as they can get from their university. Regular update meetings and mentoring are essential. On an already stressful course, having a disability can easily become the final straw making students give up. I really want to do medicine, but it has been a fight. Without the support of my university I don’t think I would have succeeded.

Luci Richards

Recommendations

• The GMC should take a lead role in the admission and selection of disabled applicants by providing specific guidance to medical schools on the selection and assessment procedures for disabled students. This should provide clear guidance for medical schools on how to interpret the regulatory framework set out in Tomorrow’s doctors (GMC, 2003).

• The GMC should clearly define the core skills and competencies required to study and practise medicine. The GMC should ensure this information is made available to all potential students and should be taken into consideration by medical schools when assessing the suitability of disabled applicants.

• The GMC should work with the MSC to ensure that there are consistent admissions procedures in UK medical schools, and that there is a system by which information on assessment and selection decisions can be recorded and shared within and between institutions.
The GMC and MSC must work with medical schools to ensure that:

- any assessment of the suitability of a disabled applicant to enter medical school is based solely on academic performance and personal qualities, and be independent of any health assessment
- disclosure of a specific impairment is only used to inform any assessment of an applicants’ physical and mental ability to practise as a doctor and not to influence the admission selection procedures regarding academic performance and personal qualities
- any decision regarding a disabled applicant’s ability to study and practise medicine takes into account all reasonable adjustments that can be made
- any decision to decline an applicant a place at medical school on the basis of an impairment is based on expert advice on what effect an applicant’s impairment might have on their ability to study and practise medicine. Where this isn’t available, the GMC and the MSC must ensure that those making the decision are appropriately trained in making such decisions
- all individuals involved in the selection and assessment of medical school applicants have undertaken disability awareness training, and that those involved in making decisions with respect to a disabled applicant’s physical and mental ability to practise as a doctor have sufficient expertise in this area
- all UK medical schools have access to well-trained and adequately resourced occupational health services.

Medical schools should give consideration to the use of disability officers to assist in making decisions on a disabled applicant’s ability to practise as a doctor.

Further research is required into:

- the selection to medical education for disabled applicants, including the variation in assessment and selection procedures and policies within UK medical schools
- the provision of occupational health services in UK medical schools and how medical schools assess the competence to practise of disabled applicants.

Supporting and retaining disabled medical students

Disabled students’ support needs should be identified and assessed in an effective and appropriate way to ensure they are given the support to which they are entitled. There is no guidance provided to medical schools on the support that should be made available to disabled medical students, this means that the amount and type of support available, and the level of adjustment which is deemed reasonable are entirely dependent on individual medical schools. A 2004 survey of UK medical schools found there to be a variable amount of support for disabled medical students,9 this variation was found to be dependent on the type of impairment.9 All of the survey respondents indicated that they had the resources to accept students with learning difficulties; however, only two respondents indicated they had the resources to accept visually impaired students.9 Many medical schools do not provide support themselves, with it instead being provided by the generic student support services at the respective institution (see case study 4). Many of the barriers faced by disabled medical students are unique to medicine, and it would therefore be beneficial for medical schools to provide a disability officer with specialist knowledge in order to help disabled medical students overcome these barriers. In addition to support when entering medicine it is important that disabled medical students are given support throughout their course, as their impairment may develop or fluctuate over time.

9 For this study, responses were received from seven of the 29 medical schools that were surveyed.
The GMC is currently in the early stages of a matched funding project in collaboration with the DfES to develop information on reasonable adjustments for medical schools. In higher education, disabled students may be eligible for a DSA that can be used to pay for the cost of additional equipment, non-medical helpers or extra study support. This higher education government funding is provided by Local Authorities (LA) in England and Wales, Education and Library Boards (ELB) in Northern Ireland, and the Student Awards Agency for Scotland (SAAS) in Scotland. Further information on funding for disabled students in higher education is available on the Skill: National Bureau for Students with Disabilities website at www.skill.org.uk

Further research is required into the availability and type of support provided to disabled medical students. In providing equality of opportunity, it is important that medical schools receive guidance on the support services that should be provided to disabled medical students. This should include information on the appropriate support for specific impairments, and how medical schools should provide this support.

### Case study 4 – Disability & Dyslexia Service, Cardiff University

The Disability & Dyslexia Service (DDS) at Cardiff University provide confidential advice and support for disabled students. They offer a range of support services for disabled students including:

1. **Study skills and technology assessments (SSTA)** – these assessments identify the effects of disability, and provide students with a summary of ways the department can help
2. **Assisting with applications for the Disabled Students’ Allowance** – the SSTA report is sent to relevant funding bodies, who will decide whether or not to provide funding
3. **Provision of non-medical help, such as note-takers and communication support workers** – DDS staff assist disabled students in finding relevant support workers
4. **Dyslexia tuition** – qualified tutors are provided to help dyslexic students with aspects of their study
5. **Disability-related IT and study skills sessions** – DDS provide study skills, tuition and assistive technology
6. **Screening for dyslexia** – DDS has screening tools which can be used to find out if students show any indicators of dyslexia, and if appropriate refer them for a dyslexia assessment
7. **Loan equipment** – DDS has a small stock of equipment for loan to students on a short-term basis, including laptop computers, minidisks and spellcheckers
8. **Assisting in the application for alternative examination arrangements** – alternative examination arrangements can include: extra time, and/or use of a word-processor or amanuensis, and are available in circumstances including dyslexia, visual impairment, hearing impairment, physical impairment from writing a script or medical conditions.

Further information can be found at [www.cardiff.ac.uk](http://www.cardiff.ac.uk)
The QAA guidelines on the selection and admission of students recommend that higher education institutions should consider:

- drawing up agreements with individual disabled students and all concerned parties which specify details of support and other arrangements, including those for course examinations and assessments
- means for establishing early contact with disabled applicants, especially those with complex academic and/or daily living support needs, in order to identify appropriate sources or systems of support
- how best to ensure that all students who can benefit from the services available to them are aware of those services
- ensuring that they have effective means of delivering the particular specialist support needs identified for each student
- establishing regular and effective links with external statutory and voluntary agencies to provide appropriate support
- putting in place arrangements to ensure the quality of the specialist support provided
- regularly reviewing the support arrangements agreed with disabled applicants and students to ensure that these are being met and are responsive to their current needs.

Recommendations

- The MSC should work with all UK medical schools to ensure that they provide adequate support to all disabled medical students. Consideration should be given to the use of disability officers to assist in making decisions about the appropriate level of support.

- Medical schools should be aware of the QAA guidelines on the selection and admission of students and ensure that they take appropriate action to implement the recommended guidelines with respect to the support of disabled students.

- Further research is required into the type, quality and availability of support provided to medical students and the nature of coping strategies.
Enabling practising disabled doctors

Providing a supportive and inclusive environment enables disabled doctors to succeed in their chosen career and provide high quality healthcare services. This necessitates a clear understanding of the number of doctors affected by disability, the nature of their coping strategies, the type and availability of support systems, and the barriers to practising medicine. All organisations with operational responsibility for doctors must ensure they provide accessible, appropriate and non-discriminatory services, which are responsive to the individual circumstances of people’s lives.

Monitoring disability
An essential component of effective equal opportunities is monitoring. Unless an organisation is aware of the composition of its workforce, it is impossible to ensure that disabled employees are not unfairly disadvantaged or under-represented. The NHS is the largest single employer in the UK, yet, there are no reliable data on the number of disabled people in the workforce. By extrapolating statistics on the number of disabled people in the UK from the 2001 census, it is estimated there could be up to 174,000 disabled people working within the NHS. There is very limited information on the numbers of disabled doctors or their distribution among the different specialties, partly because of a lack of centrally collated data. There are currently no data collected on the number of disabled doctors working outside the NHS. Within the BMA, the 2006-07 committee monitoring exercise found that, of the 59 per cent of committee members who responded to the question about disability, 4.7 per cent identified themselves as having a disability. A 2006 Women in Academic Medicine (WAM) study found that 7.5 per cent of respondents (n=84) reported some form of disability, including:

- specific learning difficulties, eg dyslexia (5)
- deaf or hearing impaired (12)
- use of a wheelchair/mobility difficulties (9)
- autistic spectrum disorder or Asperger syndrome (1)
- mental health difficulties (10)
- unseen impairment ie diabetes, epilepsy or heart condition (18)
- multiple impairments (1)
- an impairment, special need or medical condition not listed above (22)
- undisclosed (6).

The deficiency in disability data represents a significant limitation in the provision of equal opportunities in the medical profession. Without reliable information on disability, it is impossible to adequately support and enable disabled doctors, and to ensure that equal opportunities policies and procedures do not disadvantage disabled doctors. There is an urgent need for research into, and data on, the number of disabled doctors; including how many enter and leave the profession, and how many do not apply for NHS jobs. Most NHS organisations already carry out regular disability monitoring of their workforce. However, occurs on an individual basis and there is significant variation in the categories used for data collection, and in whether the data are collected qualitatively or quantitatively. It is important that the collection of data on the number of disabled doctors is extended to include those doctors working outside the NHS.
In a 1998 survey of NHS Trusts in England\(^h\), 90 per cent of trusts were found to collect information on job applicants by disability, 88 per cent collected disability data on appointments and 80 per cent monitored for disability among short-listed candidates.\(^i\) The majority of trusts were found to collect monitoring data on the total workforce by disability, however, only a minority collected disability data on promotion, redundancies, dismissals or training.\(^j\) In terms of data collection and analysis, a quarter of trusts stated this was carried out ‘very well’, 63 percent stated it was carried out ‘moderately well’, six per cent said it was carried out ‘well’, and one per cent that it was conducted ‘badly’.\(^k\) Nearly two-thirds of trusts reported the monitoring data to the trust board.\(^l\) When asked whether they had taken specific steps to ensure their organisation complied with the provisions of the DDA 1995 (as amended), 97 per cent of trusts indicated they were reviewing their recruitment and selection procedures, and nearly three-quarters provided training to managers on the requirements to provide reasonable adjustments.\(^m\)

NHS employers have been collecting data about the number of disabled doctors in the NHS in England since December 2005 (see appendix 6). The data collected represent a small fraction of the entire workforce and are heavily reliant on doctors’ willingness to disclose such information. Since December 2005 there has been a slight increase in the proportion of doctors reported as being disabled. It is hoped that continuing the collection of these data will allow for a greater understanding of the situation and more accurate results. A report jointly commissioned between the DH and NHS employers, *Creating a disability equality scheme: a practical guide for the NHS* (DH, 2007),\(^n\) has been published in order to develop and promote good practice guidance for NHS organisations on disability monitoring in their roles as employers. The report explains the processes and actions required to produce and implement a Disability Equality Scheme, including steps the organisation must take to meet the Disability Equality Duty. It also includes a series of resources including advice on carrying out an impact assessment and other processes, and links to other sources of support.\(^o\)

Disability monitoring allows an organisation to analyse its equal opportunities policies, and ensure equality with respect to disability, as well as track the progress of its policy. This confers a certain amount of legal protection against challenges on the grounds of discrimination. As well as data collection, monitoring must include analysis, from which any barriers or failures that are found must be followed up and tackled, and any subsequent actions should also be impact assessed. Disability monitoring should be consistent and standardised, and the results computerised to allow cross-referencing. Further information about disability monitoring can be found in appendix 7.

Further leadership and guidance is required to ensure disability monitoring is effectively implemented throughout the medical profession, both locally and centrally. There needs to be a system by which monitoring data are collected and analysed centrally, and by which organisations are encouraged to share data and liaise when commissioning new data collection.

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\(^h\) The survey of 425 NHS Trusts in England was conducted via a postal questionnaire sent to trust chief executives. A total of 420 out of the 425 trusts responded (corresponding to a 98.9% response rate).
Recommendations

• The UK Health Departments need to work in partnership with relevant stakeholder organisations, to ensure that data on the number of disabled doctors are collected throughout the UK. They should:
  • develop guidance on disability monitoring for all organisations with strategic and operational responsibility for doctors
  • develop a system by which disability monitoring is collected and analysed centrally, and which allows cross-referencing with other equality strands
  • consider how monitoring should extend to doctors outside the NHS.

• All organisations with strategic and operational responsibility for doctors should ensure that they monitor disability and are compliant with UK disability legislation. This monitoring should be done in accordance with the code of practice issued by the DRC and cover all aspects of employment. A commitment to undertake disability monitoring should be made at the most senior levels in the organisation.

• Disability monitoring data should be:
  • fully analysed and any barriers or failures that become apparent should be tackled and consequent actions assessed for their impact
  • be collected in such a way as to allow cross-referencing and comparison against other information such as the other equality strands and between different medical specialties.

Providing disability equality in the recruitment and selection of doctors

Disability equality in the recruitment and selection of doctors is essential to ensure that disabled doctors are not discriminated against when applying for jobs in the medical profession. Looking beyond labels: widening the employment opportunities for disabled people in the new NHS (DH, 2000), identifies a number of areas in the recruitment process where disability equality is of particular significance. These include:

• job descriptions and person specifications – these need to avoid unnecessary and marginal requirements and consider how the job, and its conditions, can be adapted so that it may become more suitable for disabled people. The essential criteria for the post should be clearly set out in the person specification and ranked in such a way that clearly distinguishes them from desirable criteria. Person specifications should only stipulate certain educational standards and the requirement for particular work experience, skills and qualities where they are essential for the role

• application forms and recruitment literature – consideration needs to be given to the language and format of application forms and recruitment literature so that they promote a positive image of disability. Provisions need to be in place to allow applicants to receive and return information in a variety of ways (eg large print format)

• asking about impairment – information on an applicant’s impairment should only be sought under limited circumstances, where it is relevant to the person’s ability to do the job. As disabled applicants are often cautious about declaring an impairment at this stage, any questions should be worded sensitively and appropriately, and represent the social model of disability. It should be clearly stated that applicants will not be discriminated against on the basis of any impairment and full consideration will be given to the provision of reasonable adjustments

• advertising – all vacancies should be advertised as widely as possible, and positive action should be taken to make contact with disabled people (eg ensuring job advertisements are sent to local DEAs, specialist disability employment organisations and agencies, and
specialist disability publications). The advertisement should be clear, concise, and worded in a way that positively promotes disabled employees (eg advertising full-time career grade posts in such a way that disabled candidates, unable to work full time, are able to apply)

- **interviews** – candidates should be asked if they have any specific requirements to enable them to attend and take part in the interview (eg an induction loop system) in all application forms and invitation letters. Clear information should be provided on the accessibility of the interview venue and the interview format. During the interview, questions relating to a candidate’s impairment or medical condition should be avoided and interviewers must focus on the candidate’s skills and experience

- **health assessment** – medical questionnaires and health screenings should not be requested until after a conditional job offer has been made, even when there are medical requirements for a job. Any pre-employment health assessment should be conducted by an occupational health specialist, and must ensure that any decisions relate specifically to the particular job being done by that person, and take into account reasonable adjustments.

The DH has published specific guidance on the employment of people with mental health difficulties in its publication *Mental health and employment in the NHS* (DH, 2002). This provides specific information on the role of occupational health services, health and risk assessment in pre-employment health screening, entry into training and management of healthcare professionals with mental health difficulties, and guidance to employers on advertising posts, recruitment and interviewing.

In ensuring that disabled doctors are not unfairly disadvantaged during the recruitment process, it is essential that all interviewers and staff involved in the process have undertaken appropriate disability awareness training (see case study 5). It is also important to consider the composition of interview panels to ensure there is fair representation of disabled people.

### Case study 5 – management training in recruiting and retaining disabled people

Hertfordshire Partnership NHS Trust offers specialist management training in recruiting and retaining disabled staff. The training is delivered annually by the Trust’s human resources team and is one of several initiatives reinforcing a broader commitment to supporting disabled people both inside and outside the workforce.

Source: *Positive action in the NHS* (NHS Employers, 2005)

### Recommendations

- All organisations with strategic and operational responsibility for doctors should ensure that their recruitment and selection procedures do not discriminate against disabled applicants, in accordance with guidance from the DH and the DRC.

- All individuals involved in the recruitment and selection process must have undertaken appropriate disability awareness training, and the composition of interview panels must be monitored and regularly reviewed to ensure there is fair representation of disabled people.
Supporting doctors who are newly impaired

It is difficult to quantify how many doctors are affected by illnesses or impairments after they qualify, as such, data are not centrally collected. As 70 per cent of disabled people will acquire their illness or impairment during their adult life or while in work, it is reasonable to suggest that a substantial proportion of doctors will acquire an impairment at some point during their career. With continued progress in disability equality and further advances in technology, doctors who acquire an impairment have a much better chance of remaining within the medical profession provided there is adequate support available. It is therefore important to consider the provisions for doctors who have become disabled after they have entered the profession to ensure that every opportunity is provided to allow them to continue in their chosen career. Doctors who acquire an impairment or chronic illness at some point during their medical career need special consideration; while they are entitled to the same system of support and reasonable adjustment as doctors who have had their illness or impairment since before qualification. Many of these doctors do not know what support is available to them, and may feel uncomfortable seeking help. In addition to coming to terms with their illness or impairment, these individuals may be faced with the daunting prospect of a career change, either within medicine or to a career outside medicine.
Personal perspective – General practitioner

My diagnosis of MS presented abruptly with an episode of transverse myelitis during December 2002, whilst I was on duty for our local GP cooperative.

I was five months into a new GP principal post at a well respected training and teaching practice having been a GP principal for 12 years previously at a different practice. When initially diagnosed a colleague of mine commented that I should be ‘vague’ about the diagnosis to my GP colleagues.

However, on return to work I explained the nature of my illness and the impact I felt it may have on my work. As my new practice was several miles away it seemed wise at the time to look for alternative work nearer home. Having been an established GP principal locally, finding a different job was feasible, and in May 2003, with the help of the Flexible Careers Scheme, I commenced sessions at a different training practice. In addition, in view of my experience of a very fragmented MS service locally I commenced negotiations with the primary care trust (PCT) / acute trust for training as a general practitioner with special interest (GPwSI) in neurology, specifically in MS. A new clinic set up was commenced in December 2003 and in 2005 we received a national award from the MS Society for services to MS patients.

Following my diagnosis I was surprised that attitudes to a doctor with MS seemed as unpredictable as the disease. These are in general three main groups:

• firstly some are honest about their own reaction to and ignorance of this chronic and incurable disease but sympathise and are supportive
• the second group feel uneasy with a professional with an impairment having concerns that they may be unable to fulfil their duties
• the third group exclude the colleague completely from any contact and would not employ a doctor with an impairment. This last group represent a large minority and the distress caused probably accounts for the incidences of non-disclosure by healthcare professionals.

In my work as a GPwSI and writing articles in the BMJ and GP magazines I have had correspondences from colleagues with MS. Several from GPs who have not told their work partners of their diagnosis for fear of a reaction, and a few from consultants who feel that their respective trusts may not sympathise. Most sad was a note from a newly qualified GP who was unable to obtain a post because of her honesty on her CV. Being an established and respected GP principal before my diagnosis certainly helped me personally.

I believe that there is a positive aspect to the healthcare professional with a chronic illness, as seen in the achievements of our local MS clinic over the past four years. As a fellow doctor with MS once said to me “we are doubly qualified, first as a patient and second as a doctor” – sometimes, however, I would not mind having just the professional qualification!!

Dr Neale Pimenta
Where a doctor has a newly acquired impairment, they are referred for an occupational health review to identify the necessary support or alternative arrangements that may be required. This should always be considered outside the disciplinary procedures system. Further occupational health reviews may be necessary if there is any change in an individual's physical or mental condition.

‘when I discovered my hearing loss, it was very difficult finding information about whether I am fit to practise and how to practise medicine with a hearing loss. I found no occupational health support and minimal contact with any other health professionals with hearing loss in the UK so couldn’t learn from others’ – General practitioner.

Under certain circumstances, doctors who acquire an impairment during their careers may be reluctant to notify their employer about their impairment or admit that it is affecting their professional competence. It is, therefore, essential that an organisation's policy on retaining disabled doctors is communicated to all doctors. Good medical practice (GMC, 2006) requires doctors to take responsibility for their own health in the interest of public safety. Accordingly, if a doctor knows that their judgement or performance could be significantly affected by an impairment, they must take and follow advice from a consultant in occupational health or from another suitably qualified doctor on whether, and in what ways, their clinical contact with patients should be adapted. They may also want to consult with their medical defence organisation for advice. Disabled doctors, like all doctors, will be required to participate in the appraisal and recertification/re-licensing system in order to retain their license to practise and to demonstrate on a regular basis that they are up to date and competent to practise; and have been practising in line with the guidance set out in Good medical practice (GMC, 2006). It will be important to consider how newly disabled doctors are assessed following the proposed changes to medical regulation in the UK.
Personal perspective – General practitioner

I was diagnosed with colorectal adenocarcinoma whilst working as a gastroenterology pre-registration house officer (PRHO) at the Hull royal infirmary, and so my initial colonoscopy and investigations were done on the ward where I was working. It made life potentially embarrassing for me, but the ward staff and my colleagues were fantastic – everybody really drew together and helped me through a very difficult part of my life.

We live in a climate where the NHS is getting badmouthed on a daily basis, and sometimes I feel that we really are a nation of moaners. When situation demands, the system needs to work well, and by god it does. Within a week of diagnosis, I had seen the gastroenterologist, colorectal surgeon, radiologist, pathologist, oncologist, clinical psychologist, and had started my pre-operative chemo- & radiotherapy.

I ended up having my operation at the colorectal ward where I subsequently became a surgical PRHO, and so again this was set to be very awkward. However, fortunately for me, I do not really have an embarrassment threshold, and the staff were again amazing - they never gave me any stress (other than the standard stress a surgical houseman gets!) and a few of them knew that I was having the adjuvant post-operative chemotherapy through a Hickman line.

However, I intentionally only told the consultant who I was working for and his secretary about my problems as I didn’t want people to make a big deal about it. I was working at my own decision, and sometimes I was so neutropenic I should not have been there, but I persevered and never took a day off sick. I was working with another houseman however (who didn’t know about my illness) who took two weeks off with mouth ulcers, it was then that it dawned on me how different even people within the medical profession’s work ethic and pain thresholds are.

I like to keep my personal life just that and so do not start a job and tell everybody about my illness. I usually tell my educational supervisor just in case I have to take time off at short notice. I tend to suffer with intestinal hurry and a very irritable colonic lining, but I have learned to cope with it, and have seen how differently things could have ended up from my clinical experience as a doctor. I guess what I am trying to say is that you become very grateful for what you have rather than pity yourself for what you had.

My family have been phenomenal throughout the whole time, and this is indispensable in a recovery from any form of illness. I do not think that my clinical practice has changed in a tangible way since the illness, but I guess I can relate to patients’ experiences much easier now and probably give them a lot more time than many of my colleagues.

Dr Anupam Banerjee
**Recommendations**

- Organisations with strategic and operational responsibility for doctors should ensure that:
  - any newly impaired doctor is offered appropriate support and access to occupational health services
  - their organisational policies on retaining disabled doctors are communicated to all doctors to encourage newly impaired doctors to notify their employer.

- All doctors must take responsibility for their own health in accordance with guidelines set out in *Good medical practice* (GMC 2006). If a doctor knows that their judgement or performance could be significantly affected by an impairment, they should take and follow advice from an occupational health advisor or another suitably qualified doctor on whether, and in what ways, their clinical contact with patients should be adapted.

**Supporting and retaining disabled doctors**

In a supportive and appropriately adapted workplace, disabled doctors are able to offer the same range of skills, abilities and personal qualities as their non-disabled peers. Disabled doctors’ support needs should be identified and assessed in an effective and appropriate way to ensure that they are given the support to which they are entitled. There are concerns as to how far disabled doctors are supported and retained because of a lack of knowledge within NHS organisations about how to support these staff and what disabled doctors are and are not capable of. There has been very little research on disabled doctors in the NHS and much of the progress has been driven by doctors themselves. Research commissioned by the Disabled Doctors Action Group into sources of help and enablement for disabled doctors in the NHS found there to be:

- a wide range of publications on disabled doctors in the form of reports and opinions rather than systematic reviews or randomised controlled research studies
- a lack of guidance in effectively supporting and enabling disabled doctors
- a great deal of information about mental health – and in particular, the depression, stress and anxiety commonly associated with the workload and nature of the doctor’s job – but very little information on other types of impairment.
Personal perspective – Consultant in public health medicine

After experiencing juvenile chronic arthritis, I tried to ignore the familiar feeling of painful stiff joints I experienced in my second year as a consultant in public health medicine. I was then diagnosed as having rheumatoid arthritis, which rapidly deteriorated.

I became disabled before the DDA was passed. My boss was supportive, saying I could have whatever equipment I needed, but I didn’t know what was available. Neither did my occupational therapist or occupational health service. I struggled until I met a disabled person who used voice-recognition software; he told me how to get this funded through Access to Work. As a result of an Access to Work assessment, I was supplied with the software, and other equipment such as arm and leg rests.

I had problems getting to CPD events because I cannot drive for long distances and there are lots of barriers for disabled people using public transport. More recently, I had to withdraw from a national training course because the hours were excessive. I’ve no problem working full-time, but a course that has 16-hour days is a problem.

In terms of staying in work, I’ve had most help from other disabled people – none of them doctors. They introduced me to the social model of disability, which locates disability in society, not individuals. Addressing disability means tackling the barriers in society that exclude disabled people, be they environmental, attitudinal, or physical barriers.

If my condition deteriorates, I’ll explore funding for a personal assistant at work to carry things and drive my car. This funding is available to disabled people but many health professionals are not aware of it; this means they could advise people to give up work, not knowing that many barriers to employment can be overcome.

Dr Joyce Carter

The Disability Doctors Action Group report also highlighted significant gaps in research within this area, with a lack of information on the nature of coping strategies of disabled doctors currently at work or excluded from work in the NHS, and the type and quality of support provided in the NHS compared with other organisations. Further research is required into the type and quality of support provided to disabled doctors. A report from the National Clinical Assessment Service (NCAS), *Understanding performance difficulties in doctors* (NCAS, 2004), examined the factors that can affect a doctor’s performance including physical health and disability. The report found that:

- doctors are often reluctant to seek help about their own health
- there is only a small body of research into the physical health of doctors and its effect on their performance
- problems can occur if the workplace is not suitably adapted for disabled doctors, or if attitudes make practice difficult
- a full occupational health assessment is required in cases of chronic illness.
It is important that all organisations responsible for the training or employment of doctors adopt good employment practices like flexible working; individual development programmes and effective communication strategies to promote disability equality in the medical profession (see case studies 6-8).

**Case study 6 – Disability support within Sunderland teaching PCT**

Sunderland teaching PCT has set up a disability sub-group as part of its equality and diversity steering group to advise on matters such as support for disabled staff and staff requiring adjustments to working practices. In developing its disability action plan the group also consulted with representative voluntary organisations. Initiatives in place or under consideration include:

- supporting disabled staff with training opportunities
- raising awareness about disability across the organisation
- working with local colleges and Re-employ to support work placements for disabled people.

*Source: Positive action in the NHS (NHS Employers, 2005)*

**Case study 7 – good practice in the employment of people with mental health problems**

The South West London and St George’s mental health NHS trust operates a supported user employment programme for people who have experienced mental health problems, allowing them to gain and maintain employment. Where an individual is offered employment by the trust on a supported basis, this is agreed between the potential employee, their manager and the user employment programme at the time when the offer of a job is made. The supported status of an employee is kept confidential and it is entirely at the supported employee's discretion whether they tell their colleagues about their mental health problems or not. A written support plan is agreed between each individual employee and a user employment programme support worker, in consultation with the individual’s manager where necessary. The plan specifies the ongoing support that will be provided for the individual, help to be provided in the event of difficulties arising and contact that will be maintained with the person’s manager to ensure that all is going well. Support plans are reviewed with the supported employee at least once every three months or more regularly where required.

*Source: Mental health and employment in the NHS (DH, 2002)*

Doctors with conditions which fall under the requirements outlined in the DDA 1995 (as amended) and DDA 2005 should be protected from discrimination. There is, however, anecdotal evidence to suggest this is not always the case. Many of these conditions are unpredictable, with exacerbations and remissions, sometimes requiring long spells of treatment, possibly in hospital, followed by long spells of relatively good health. Other conditions may necessitate frequent treatment sessions requiring time off work. All this may impact on the doctor’s attendance at work and temporarily affect their ability to do their job.
It is important to note that there is no ‘one-size-fits-all’ approach to doctors with impairments and illnesses as the conditions they are affected with are wide-ranging and varied. The overwhelming anecdotal evidence from disabled doctors is that support is variable and depends on many factors, including the condition they have and the specialty they are working in; whether or not they have a supportive medical Royal College, deanery, supervisor and colleagues; the availability of occupational health services; the availability of funding for reasonable adjustments; and access to career advice.

**The compatibility of condition or impairment and specialty**

The safety of patients is paramount and in some specialties, acquiring or developing a particular condition can mean that it is no longer safe for a doctor to continue practising in that specialty. For example, if a surgeon develops macular degeneration and their vision becomes impaired, they may not be able to practise surgery for safety reasons. They may, however, be able to switch to a specialty that does not rely on such high visual acuity. In most cases, however, the doctor should be able to continue in their chosen specialty with adequate support and reasonable adjustments as long as patient safety is not at risk. There are no set guidelines about what doctors with particular impairments are ‘allowed’ to do, and so they are frequently implicitly discriminated against. In some cases it is the ability of a doctor to be able to continue in that specialty even with reasonable adjustments, which is the main factor. For example, if a surgeon develops inflammatory bowel disease meaning they cannot operate for long periods of time without having to rush to the toilet, it may mean that he or she may have to switch to a surgical specialty with short operations. Some conditions, for example hearing impairments, have hi-tech solutions allowing doctors to use tools and equipment effectively and to interact with their patients. Conditions, such as cancer or myocardial infarction, may mean that a doctor has to be off work for considerable periods of time, but then be able to return to their specialty after a period of recovery. If the doctor is still in training, returning to training will require the support of their deanery. The NCAS publication *Back on track* provides principles and framework guidance for return to work programmes.

**Supportive medical Royal College**

Disabled doctors and doctors who acquire impairments often approach their medical Royal College for information and career support (see case study 8). According to research conducted by the BMA, the information and support available to doctors in this situation is variable. Some medical Royal Colleges and Faculties do not have specific information for disabled doctors and they also vary in what support they give to candidates sitting their exams. *Examining equality: a survey of Royal College examinations* (BMA, 2006), found that disabled candidates are dealt with on a case-by-case basis, and that a number of colleges had developed recommendations for the provision of services for disabled candidates.
Case study 8 – Support for disabled doctors from the Royal College of Obstetricians and Gynaecologists (RCOG)

To support disabled doctors, the RCOG:
- has a mentoring system for doctors who may need extra support
- provides specific advice on returning to work after absence
- provides extra support for disabled doctors on a case-by-case basis
- attempts to provide as much assistance as is practicable if it has received a specific request from an examination candidate. For example, in the past the College has given extra time in examinations to candidates with dyslexia, has permitted the use of a keyboard to a candidate with a hand injury, has provided a separate examination room to a candidate suffering from a nervous condition, and has made special provision for those who are hearing impaired.

The College states that as a general rule, it aims to be as compassionate and supportive as possible within the bounds of feasibility.

Source: Personal correspondence from Emily Symington, Royal College of Obstetrics and Gynaecology, 29 March 2007.

Supportive deanery

Anecdotal evidence suggests that some deaneries are more supportive of disabled doctors than others. There is no standard inter-deanery practice for supporting disabled doctors. It would appear that deaneries have different interpretations of the DDA 1995 (as amended), GMC guidance and Generic standards of training (PMETB, 2006) (see case study 9). The new doctor (GMC, 2005) and Generic standards for training (PMETB, 2006) require those responsible for training to provide appropriately modified training programmes to ensure disabled doctors are able to meet the necessary outcomes.

The new doctor (GMC, 2005) states that ‘we need to encourage those responsible for training to design original and individual training programmes to help PRHOs with disabilities to meet the outcomes set out in this guidance. Those responsible for training must make sure they meet the DDA 1995 (as amended) and other relevant legislation, and good practice in designing, putting into practice and assessing individual training programmes. Outcomes should be assessed to the same standard, but reasonable adjustments may need to be made to the method of education and assessment while protecting patient safety. Each person’s situation is different and so has to be considered individually by those responsible for training, with the employing trusts’. In facilitating disabled doctors to complete training, the GMC is able to approve training programmes under Section 10(4) of the Medical Act 1983 that are not able to meet the current legislative requirements that otherwise apply. This requires the respective university and postgraduate dean to apply to the GMC education committee for approval of the altered programme. Generic standards for training (PMETB, 2006) states that ‘deaneries must take all reasonable steps to ensure that programmes can be adjusted for trainees with well-founded individual reasons for being unable to work full time to work flexibly within the requirements of PMETB Standards’ Rules’.

Flexible training options, which are often appropriate for disabled doctors, are not available in some deaneries due to lack of funding. It is also important to consider the role of MMC. One of the principles of MMC is that training should be customised, for example, to suit disabled
doctors. In an interview in 2003 with Aidan Halligan, the deputy Chief Medical Officer (CMO) for England who was responsible for overseeing MMC, he said: ‘We need to carefully think through what the PRHO requirements are for someone who is disabled. Being disabled shouldn’t mean that you are disqualified from medicine because we have a system that is 55 years old. Compromised motor skills can be customised for and streamlined which is what we are all about. We need to make disabled people feel welcome and that they are able to achieve an objective that is more than passing exams.’

### Case study 9 – Supporting disabled doctors at the Cardiff postgraduate deanery

Cardiff postgraduate deanery is a good example of a deanery that is very supportive of disabled doctors. As part of their role, the associate dean must identify the issues relevant to the disabled doctor, and the job, and to help solve any problems that may be interfering with the doctors training by modifying the training programme accordingly. Heather Payne, the associate dean says:

‘Depending on the disability, we may call on the help of assessments from specialists including occupational health, psychiatry, occupational psychology, management, human resources, and speech and language specialists.’

‘The modification is usually common sense, for example, if shift work precipitates mental illness in a trainee, then the trainee will need a supernumery post with no on-call for a period. Someone with severe asthma might not be able to work in pathology (all the chemical fumes). A doctor with epilepsy who cannot drive would require a taxi to outlying clinics.’


### Supportive supervisor

Doctors who have finished their postgraduate training often have to rely on a senior colleague, or supervisor, for support. Anecdotal evidence suggests that this support is extremely variable. The consultant handbook (BMA, 2005) outlines the role and responsibilities of consultants including their role as team leader. It is important that in this supervisory role, consultants have a professional obligation to contribute to the education and training of their colleagues including the provision of advice and support for their disabled colleagues.

### Supportive colleagues

The prevalent culture in medicine, in which doctors see themselves as having to be flawless and fully fit, means that many doctors feel guilty about being off work due to illness, or not being able to perform certain duties due to their condition. It often falls to their colleagues to perform these duties, and anecdotal evidence suggests that while many are happy to do so some are not so willing.

### Availability of occupational health services

The occupational health system can be a good source of support for disabled doctors and doctors with newly diagnosed impairments. Some doctors, however, view occupational health with suspicion and are reluctant to self-refer, or to ask their supervisor if they can be referred to occupational health. If the supervisor refers the doctor to occupational health, they can only do so with the doctor’s consent. Occupational health is best placed to make
recommendations about reasonable adjustments and employers are obliged to implement these recommendations. The relationship between the occupational health physician and the referred doctor is confidential – a point that many doctors are unaware of.

The provision of occupational health services are dependent on the organisations involved, and can therefore be patchy and inconsistent. It is important that the role of occupational health services is clear and that their primary duty lies with the needs of the doctor, rather than their employer. It is important that there is adequate access to occupational health services and that the individuals required to assess the necessary support and alternative arrangements have sufficient knowledge and expertise in this area. It is also important that occupational health services are sufficiently staffed and resourced as there is anecdotal evidence that this is rarely the case. Support from occupational health services should also be made available to doctors working in general practice and to those working outside the NHS.

**Availability of funding for reasonable adjustments**

Organisations including deaneries have many competing priorities for funding, and there is no ring-fencing of funds for reasonable adjustments for disabled doctors. Some doctors may therefore be better supported than others, depending on where they work. Occupational health services should be aware of the sources of funding available, such as the Access to Work scheme, which may be able to help with some of the reasonable technical adjustments. Funding for a supernumerary post while recovering from a major illness, for example, is often at the discretion of the deanery.

**Career advice**

Disabled doctors may not have received the same postgraduate educational and training opportunities as their non-disabled colleagues and there is a deficiency in the provision of career advice for chronically ill and disabled doctors. It is, therefore, important that disabled doctors have full access to educational and training opportunities, and that these opportunities are widely advertised and accessible. Consideration also needs to be given to the provision of career advice for disabled doctors and the use of mentoring schemes. The availability of career advice from medical Royal Colleges and Faculties, and deaneries is variable and at present there is no central place where doctors with newly diagnosed impairments can receive independent advice about their career options. *Career management: an approach for medical schools, deaneries, royal colleges and trusts* (MMC, 2005) evaluates the delivery of career management initiatives for doctors, and gives regard to the need for these systems to be developed to meet doctors’ specific needs, including those of ‘female doctors, any doctor who may need to train flexibly or work part time, doctors with disabilities or significant illness, or doctors with issues related to sexual orientation’. This publication proposes a number of initiatives for career management support, including forums, conferences, designated advisers, peer groups and a career handbook/resource containing information to back up existing local resources. The BMA careers service offers information, careers workshops and counselling to doctors and medical students. This service is planned to be extended nationwide in the near future. Under consideration is a proposal that the service will offer advice and support to disabled doctors and disabled medical students as well as tailored guidance to those that acquire an impairment while studying, training or practising medicine. For more information visit [www.bma.org.uk/careerservices](http://www.bma.org.uk/careerservices)
**Recommendations**

- Organisations with strategic and operational responsibility for doctors should ensure that:
  - appropriate and accessible support systems are in place to support disabled doctors. These support systems should be regularly reviewed and widely advertised to all staff.
  - occupational health services are adequately provided and resourced.
  - all disabled doctors and newly impaired doctors are offered the support they are entitled to whatever their specialty, condition, or place of work.

- The UK health departments should work in partnership with relevant stakeholder organisations to produce guidance for all organisations with responsibility for doctors on the support that should be provided to disabled doctors.

- Further research is required into the type, quality and availability of support provided to disabled doctors and the nature of coping strategies.

- The Academy of Medical Royal Colleges (AOMRC) should work with all medical Royal Colleges and Faculties to ensure there is adequate provision of support for disabled doctors.

- The GMC and the PMETB should work with the Conference of Postgraduate Medical Deans (COPMeD) and the Committee for General Practice Education Directors (COGPED) to ensure the requirements set out in *The new doctor* (GMC, 2005) and *Generic standards for training* (PMETB, 2006) with respect to disability are effectively and consistently implemented by postgraduate deaneries to ensure that all doctors receive the same standard of support, and reasonable adjustments and that this is adequately funded and resourced.

- The BMA should work in partnership with the medical Royal Colleges and Faculties, and the postgraduate deaneries and GP directors to ensure that there is adequate provision of career advice for disabled doctors and newly impaired doctors.
Sources of further information

Sources of information on support organisations for disabled doctors and disabled medical students can be found on the BMA website.

**UK healthcare organisations and bodies**

**Committee for General Practice Education Directors (COGPED)**
www.cogped.org.uk

**Conference of Postgraduate Medical Deans (COPMeD)**
www.copmed.org.uk

**Department of Health (DH)**
www.dh.gov.uk

**General Medical Council (GMC)**
www.gmc-uk.org

**Medical Schools Council (MSC)**
www.chms.ac.uk

**National Clinical Assessment Service (NCAS)**
www.ncas.nhs.uk

**NHS Careers**
www.nhscareers.nhs.uk

**NHS Employers**
www.nhsemployers.org

**NHS Modernising Medical Careers (MMC)**
www.mmc.nhs.uk/pages/home

**Northern Ireland Health, Social Services and Public Safety**
www.dhsspsni.gov.uk

**Postgraduate Medical Education and Training Board (PMETB)**
www.pmetb.org.uk

**Scottish Executive Health Department (SEHD)**
www.sehd.scot.nhs.uk/hdl.asp

**Welsh Assembly Government Health and Social Care**
http://new.wales.gov.uk/topics/health/?lang=en
Other UK organisations

Commission for Racial Equality (CRE)
www.cre.gov.uk

Commission for Equality and Human Rights (CEHR)
www.cehr.org.uk

Disability Rights Commission (DRC)
www.drc.org.uk

Equal Opportunities Commission (EOC)
www.eoc.org.uk

Equality Commission for Northern Ireland (ECNI)
www.equalityni.org

Quality Assurance Agency for Higher Education (QAA)
www.qaa.ac.uk

Universities and Colleges Admissions Service (UCAS)
www.ucas.ac.uk
Appendix 1: Types of disability discrimination

Under the DDA 1995 (as amended), unlike the other anti-discrimination legislation, indirect discrimination is not dealt with explicitly. Rather, it is addressed by the combined effect of the direct discrimination provisions and the duty to make reasonable adjustments. Under the DDA 1995 (as amended) there are four types of discrimination:

1. **Direct discrimination** – this is where someone is less favourably treated because of their impairment. This may happen when:
   - an employer's treatment of a disabled person is because of that person's impairment
   - the employer treats a disabled person less well than they would treat a comparator – that is, a non-disabled person or a person not having that particular impairment ('less favourable treatment')
   - the relevant circumstances – and abilities – of the comparator are pretty much the same (in ways that count) as those of a disabled person.

2. **Failure to make reasonable adjustments** – if an adjustment is deemed reasonable but the employer or service provider fails to make the adjustment; this failure cannot be defended or justified.

3. **Disability-related discrimination** – this occurs when an employer's treatment of the disabled person is:
   - for a reason related to their impairment
   - and
   - is less favourable than the way in which others, to whom that disability-related reason does not apply, are or would be, treated
   - and
   - which the employer is unable to justify and/or
   - when the employer has failed to make a reasonable adjustment, which would have made a difference to the reason the employer has given justifying its less favourable treatment.

4. **Victimisation** – this is the negative treatment (eg being refused time off) of an individual because they have complained or intend to complain about discrimination, or because they have supported or given evidence for another individual who has done so.

The DDA 1995 (as amended) also makes it unlawful for employers to subject disabled employees to harassment. Harassment is any action or comment, deemed unreasonable, unwelcome or offensive, which causes the recipient to feel threatened, humiliated or embarrassed. It also includes avoiding an individual so that they are made to feel unwanted or isolated, and excluding an individual from particular activities. Harassment can be deliberate or may not be intended to be malicious.
Appendix 2: Disability legislation

England, Wales and Scotland
In Great Britain, the DDA 1995 (as amended) prohibits direct discrimination on the grounds of disability. The DDA 1995 makes it unlawful for employers and service providers to treat disabled people less favourably, without justification, for a reason that relates to their disability; and, requires them to make reasonable adjustments or accommodations to ensure that disabled people are not put at a substantial disadvantage. Under Part IV of the DDA 1995 amended by the Special Educational Needs and Disability Act (SENDA), education providers – including schools, colleges, universities, and providers of adult education and youth services – are required to ensure that they do not discriminate against disabled people. Since September 2005, further and higher education institutions have been required to make reasonable adjustments to physical features of premises where these put disabled people at a substantial disadvantage. The DRC was established as an independent non-departmental public body following the introduction of the Disability Rights Commission Act 1999. Under this Act, the DRC has a statutory duty to work to eliminate discrimination against disabled people, promote equal opportunities for disabled people, encourage good practice in the treatment of disabled people, and advise the Government on the working of disability legislation. The DRC also has a major strategic role in enforcing the law in the public interest, and is able to provide support for individual cases and conduct formal investigations for any purpose connected with the performance of its duties. Further information is available from the DRC website at www.drc.org.uk

The DDA 2005 further amends the DDA 1995 to place a general duty on all public bodies to promote equality of opportunity for disabled people. The duty to promote disability equality means that when carrying out their functions, public authorities must give due regard to the need to:
- eliminate unlawful discrimination
- eliminate disability-related harassment
- promote equal opportunities
- promote positive attitudes towards disabled persons
- encourage participation by disabled persons in public life.

The new duty reflects the social model of disability and focuses on how organisations can remove the barriers that disabled individuals’ experience by taking active steps to promote equality for disabled people. Under the DDA 2005, most public bodies – including all health authorities – will be subject to specific duties to support them in achieving the outcomes required by the general duty. All public authorities covered by the specific duties must:
- publish a disability equality scheme (DES) that includes an action plan
- involve disabled people in producing the scheme and action plan
- demonstrate they have taken actions in the scheme and achieved appropriate outcomes
- report on progress
- review and revise the scheme.

Northern Ireland

While the DDA 1995 extends to the whole of the United Kingdom, separate secondary legislation and Codes of Practice are required for Northern Ireland, as set out in Schedule 8 of the Act. In Northern Ireland, the DDA 1995 is amended by the DDA 1995 (Amendment) Regulations (Northern Ireland) 2004, the Disability Discrimination (Northern Ireland) Order 2006, the Special Educational Needs and Disability (Northern Ireland) Order 2005 and the Special Educational Needs and Disability (Northern Ireland) Order 2005 (Amendment) (Further and Higher Education) Regulations (Northern Ireland) 2006. The DDA 2005 does not extend to Northern Ireland since disability discrimination and transport are ‘transferred matters’ under the Northern Ireland Act 1998. The Equality Commission for Northern Ireland (ECNI) was established as an independent public body under the Northern Ireland Act 1998 to work towards the elimination of discrimination, promote equality of opportunity, and review relevant legislation. The duties and powers of the ECNI were extended in relation to disability matters following the introduction of the Equality (Disability, etc) (Northern Ireland) Order 2000 (EDO). This requires the ECNI to:

- work towards the elimination of discrimination against disabled people
- promote the equalisation of opportunities for disabled people
- take steps to encourage good practice in the treatment of disabled people
- keep the DDA 1995 and Part II of the EDO under review
- assist disabled people by offering information, advice and support in taking cases forward
- provide information and advice to employers and service providers
- undertake formal investigations
- prepare statutory codes of practice providing practical guidance on how to comply with the law
- arrange independent conciliation between service providers and disabled people in the area of access to goods, facilities and services.

Further information is available from the ECNI website at www.equalityni.org

Section 75 of the Northern Ireland Act 1998 requires public authorities to have due regard to the need to promote equality of opportunity between persons with a disability and persons without. Any public authority is duty bound to produce an equality scheme stating how it proposes to fulfil its duties, and is required to carry out an equality impact assessment and publish the results. Public authorities must also undertake a consultation process that is inclusive of any individuals likely to be affected by the equal opportunities policy. The ECNI is responsible for ensuring and monitoring effective implementation of the statutory duties of Section 75 of the Northern Ireland Act 1998.
Commission for Equality and Human Rights

The Equality Act 2006 establishes a CEHR that will bring together existing equality commissions for sex, race and disability and cover new areas of discrimination law including sexual orientation, religion and belief, and age. The duties of the new commission will include:

- encouraging awareness and good practice on equality and diversity
- promoting awareness and understanding of human rights
- promoting equality of opportunity
- working towards eliminating unlawful discrimination and harassment
- promoting good relations between different communities
- keeping discrimination and human rights legislation under review
- being a source of expertise on equality and human rights.

The CEHR is expected to become fully operational in October 2007 and will cover England, Scotland and Wales. It will bring together the work of the three existing Commissions, the CRE, the EOC and the DRC. It will also have new powers to enforce legislation more effectively and promote equality for all. The introduction of a single commission will provide a number of benefits, including:

- bringing together equality experts and providing a single source of information and advice
- providing a single point of contact for individuals, businesses and the voluntary and public sectors
- tackling discrimination on multiple levels.

Further information is available on the CEHR website at www.cehr.org.uk
Appendix 3: Current NHS equality initiatives

As part of the NHS human resources programme, Working Together, the DH launched an equalities framework, The Vital Connection (DH, 2000), to help secure the mainstreaming of equality and diversity within the NHS. The Vital Connection (DH, 2000) set out a national target for the NHS on disability that required all local employers to meet the criteria to use the Employment Services Disability Symbol by April 2001. The IWL standard introduced by the NHS Plan (DH, 2000) set out the commitment expected from NHS employers to create well-managed, flexible and supportive working environments, and reinforced the target set out in The Vital Connection (DH, 2000). All NHS employers were expected to be accredited as putting the IWL standard into practice by April 2003. The commitment to disability equality is further supported by the Positively Diverse programme which sets out a strategic approach to manage and improve equality of opportunity for all staff.

The DH outlined its strategy for the employment of disabled people in its publication Looking beyond labels: widening the employment opportunities for disabled people in the new NHS (DH, 2000). This provided guidance on recruiting and retaining disabled people, and highlighted areas of best practice in the employment of disabled people. Equal values: equal outcomes (NHS Employers, 2005) provides an action plan to address equality and diversity matters specific to doctors and dentists. The action plan focuses on partnership working, constructive dialogue and finding effective solutions to the needs of both the medical and dental workforce and NHS organisations. It identifies seven key work areas including:

- removing barriers to medical and dental education and continuing to increase access opportunities for all
- promoting best practice in equalities monitoring by deaneries, medical and dental schools, strategic health authorities and trusts
- promoting the principles of IWL throughout the whole medical and dental workforce, including independent contractors
- identifying how the NHS can best support international medical and dental graduates in finding employment in the UK and making progress in their careers
- ensuring continuing openness and transparency in clinical excellence awards and other recognition processes
- creating fair and expeditious systems for identifying and dealing with clinical negligence and other competence issues for medical and dental staff
- supporting a zero-tolerance approach to bullying and harassment in the medical and dental workforce.

NHS Employers has worked with a range of NHS organisations’ to promote positive action on equality and diversity in the NHS workforce in England. Positive action can be defined as ‘a range of lawful actions which seek to address an imbalance in employment opportunities among targeted groups which have previously experienced disadvantage, or which have been subject to discriminatory policies and practices, or which are under-represented in the workforce’. The report, Positive action in the NHS (NHS Employers, 2005), provides information on the rationale behind positive action, practical guidance in setting up such schemes and presents some useful examples of positive action currently delivering benefits to the NHS.

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i NHS Employers invited NHS trusts in England to submit examples of workforce-focused positive action initiatives currently being implemented in their organisations. A total of 20 organisations responded, providing over 70 examples of positive action for consideration.
Employment Services Disability Symbol

Employers are able to work with their local disability employment adviser to qualify to use the Employment Services Disability Symbol (or ‘Two Ticks’ symbol). The symbol has been developed so those employers can show their commitment to good practice in employing disabled people. Once eligible, employers can use the symbol on recruitment literature, letterheads and stationary, internal magazines and on publicity materials. Employers who use the symbol make these five commitments:

1. To interview all disabled job applicants who meet the minimum criteria for a job vacancy, and consider them on their abilities
2. To ask disabled employees, at least once a year, what can be done to make sure they can develop and use their abilities at work
3. To make every effort to keep staff in their jobs should they become disabled
4. To ensure that key employees develop the awareness needed to make the commitments work
5. To review these commitments annually, to plan improvement and to tell all employees about achievement and future plans.

Source: Looking beyond labels: widening the employment opportunities for disabled people in the new NHS (DH, 2000)

In Scotland, the 1998 report Towards a new way of working: the plan for managing people in the NHS (Scottish Office, 1998) sets out the requirement for Trusts and where appropriate, Health Boards, to develop action plans to attain the Employment Services Disability Symbol by April 2000.  The Fair for all – disability initiative has been established by the Scottish Executive Health Department (SEHD) and the DRC to support NHS Boards in meeting the provisions of the DDA 1995. A survey of NHS Boards in Scotland found there to be confusion regarding the key policy and legal drivers which ensure disability matters are addressed in the NHS. Despite a positive commitment to mainstream disability equality in policy and planning work, there was no consistent approach to achieving this across the NHS Boards. The survey also found that only 12 of the 23 NHS Boards in Scotland had named disability advisors. The subsequent report recommended that the SEHD ‘seek commitment at individual board level to either a designated advisor post or an identified lead officer’.
When an organisation is developing a new policy, practice or provision or revising an existing one, it is important that they conduct a disability impact assessment. An impact assessment is a method by which an organisation can examine their activities and services to ensure there is no potential for discrimination against a particular group (e.g., disabled people). In conducting a disability impact assessment, it is important to ensure that disabled people with a range of perspectives are involved. The first stage in conducting a disability impact assessment requires mapping of all formal and informal policies, practices, procedures, and criteria to establish who is responsible for implementing them and what relevance they have to disabled people and disability equality. Data are then collected and assessed on each policy, practice, procedure or criterion to determine whether there is any positive or adverse impact. Measures are then taken to reduce or eliminate any adverse impact.

**DRC guidance on including disability with an organisation’s equal opportunities policies and practices**

The DRC has produced guidance on how to take account of disability in the development of equal opportunities policies through a series of steps, which include:

- agreeing, in principle, what needs to be included in policies and getting commitment at senior levels
- drafting new policies or changing existing policies as an interim measure, and disseminating these within the organisation or business
- letting managers and supervisors know how they should deal with disability concerns when these arise, and making sure procedures are in place to support this
- nominating someone to be responsible for developing and reviewing disability policies
- conducting a disability audit by looking at existing systems, procedures, and working practices to identify where changes are needed
- producing an action plan that identifies and prioritises actions, allocates responsibilities, identifies costs, and allocates resources, develops a timetable with target dates, and sets out methods to review the plan and identify progress
- drafting the new policy, with involvement from a wide range of employees. The policy is likely to include: a supporting statement from a senior manager, a clear policy statement, guidance on the law and how the policy relates to this, details of what the policy aims to do, why and how
- circulating the new policy and ensuring that it is implemented effectively by letting everyone know about its development and purpose, providing timely and accessible support for employees, and including disability awareness training and guidance for key staff, especially supervisors and line managers.


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The BMA Equal Opportunities Committee is currently developing internal guidelines for staff on disability impact assessment methods.
Appendix 5: UCAS data: Number of applicants and acceptances to higher education and pre-clinical medicine by disability

Applicants to higher education by disability 2000-2005*

<table>
<thead>
<tr>
<th>Disability</th>
<th>2000</th>
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<th>2002</th>
<th>2003</th>
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<td>No disability</td>
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<td>380,494</td>
<td>382,266</td>
<td>389,597</td>
<td>392,275</td>
<td>420,113</td>
</tr>
<tr>
<td></td>
<td>96.01%</td>
<td>95.21%</td>
<td>95.13%</td>
<td>95.03%</td>
<td>94.91%</td>
<td>94.49%</td>
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<tr>
<td>Dyslexia**</td>
<td>7,110</td>
<td>9,336</td>
<td>10,044</td>
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<td>-</td>
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<td></td>
<td>1.83%</td>
<td>2.34%</td>
<td>2.50%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning difficulty</td>
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<td>-</td>
<td>10,930</td>
<td>11,427</td>
<td>13,137</td>
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<td>2.76%</td>
<td>2.95%</td>
</tr>
<tr>
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<td>602</td>
<td>641</td>
<td>604</td>
<td>707</td>
</tr>
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<td></td>
<td>0.12%</td>
<td>0.15%</td>
<td>0.15%</td>
<td>0.16%</td>
<td>0.15%</td>
<td>0.16%</td>
</tr>
<tr>
<td>Deaf / hard of hearing</td>
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<td>875</td>
<td>900</td>
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* The figures in brackets show the percentage for each respective category.
** From 2003, the wording on the application form changed from ‘You have dyslexia’ to ‘You have a specific learning difficulty (for example, dyslexia)’.
*** From 2003, the ‘Need personal care support’ category was removed from the application form; an additional category of ‘You have Autistic Spectrum Disorder/Asperger Syndrome’ was introduced.
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<th>2005</th>
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</tbody>
</table>


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* The figures in brackets show the percentage for each respective category.
** From 2003, the wording on the application form changed from ‘You have dyslexia’ to ‘You have a specific learning difficulty (for example, dyslexia)’.  
*** From 2003, the ‘Need personal care support’ category was removed from the application form; an additional category of ‘You have Autistic Spectrum Disorder/Asperger Syndrome’ was introduced.
### Applicants to pre-clinical medicine, by disability 2000-2005*

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<th>Disability</th>
<th>2000</th>
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<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
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</tbody>
</table>

* The figures in brackets show the percentage for each respective category.
** From 2003, the wording on the application form changed from 'You have dyslexia' to 'You have a specific learning difficulty (for example, dyslexia)'.
*** From 2003, the 'Need personal care support' category was removed from the application form; an additional category of 'You have Autistic Spectrum Disorder/Asperger Syndrome' was introduced, but no medical applicants/accepted applicants indicated they had this impairment in 2003.

## Accepted applicants to pre-clinical medicine, by disability, 2000-2005*

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<th>2003</th>
<th>2004</th>
<th>2005</th>
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<td>0.42%</td>
<td>0.44%</td>
<td>0.42%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>5,714</td>
<td>6,240</td>
<td>6,959</td>
<td>7,667</td>
<td>7,955</td>
<td>7,821</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

* The figures in brackets show the percentage for each respective category.

** From 2003, the wording on the application form changed from ‘You have dyslexia’ to ‘You have a specific learning difficulty (for example, dyslexia)’.

*** From 2003, the ‘Need personal care support’ category was removed from the application form; an additional category of ‘You have Autistic Spectrum Disorder/Asperger Syndrome’ was introduced, but no medical applicants/accepted applicants indicated they had this impairment in 2003.

Appendix 6: NHS employers’ data on disability

**Proportion of disabled doctors within the NHS**

<table>
<thead>
<tr>
<th></th>
<th>Dec-05</th>
<th>Jan-06</th>
<th>Feb-06</th>
<th>Mar-06</th>
<th>Apr-06</th>
<th>May-06</th>
<th>Jun-06</th>
<th>Jul-06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total surveyed</td>
<td>6,090</td>
<td>4,392</td>
<td>4,601</td>
<td>9,337</td>
<td>14,747</td>
<td>20,469</td>
<td>13,636</td>
<td>10,034</td>
</tr>
<tr>
<td>Disabled</td>
<td>16</td>
<td>22</td>
<td>36</td>
<td>59</td>
<td>71</td>
<td>128</td>
<td>109</td>
<td>112</td>
</tr>
<tr>
<td>Not disabled</td>
<td>6,058</td>
<td>4,367</td>
<td>4,560</td>
<td>9,266</td>
<td>14,647</td>
<td>20,317</td>
<td>13,515</td>
<td>9,905</td>
</tr>
<tr>
<td>Undisclosed</td>
<td>16</td>
<td>3</td>
<td>5</td>
<td>12</td>
<td>29</td>
<td>24</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>Total disclosed</td>
<td>6,074</td>
<td>4,389</td>
<td>4,596</td>
<td>9,325</td>
<td>14,718</td>
<td>20,445</td>
<td>13,624</td>
<td>10,017</td>
</tr>
<tr>
<td>% Disabled</td>
<td>0.26%</td>
<td>0.50%</td>
<td>0.78%</td>
<td>0.63%</td>
<td>0.48%</td>
<td>0.63%</td>
<td>0.80%</td>
<td>1.12%</td>
</tr>
<tr>
<td>% Not Disabled</td>
<td>99.47%</td>
<td>99.43%</td>
<td>99.11%</td>
<td>99.24%</td>
<td>99.32%</td>
<td>99.26%</td>
<td>99.11%</td>
<td>98.71%</td>
</tr>
<tr>
<td>% Undisclosed</td>
<td>0.26%</td>
<td>0.07%</td>
<td>0.11%</td>
<td>0.13%</td>
<td>0.20%</td>
<td>0.12%</td>
<td>0.09%</td>
<td>0.17%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Aug-06</th>
<th>Sep-06</th>
<th>Oct-06</th>
<th>Nov-06</th>
<th>Dec-06</th>
<th>Jan-07</th>
<th>Feb-07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total surveyed</td>
<td>6,329</td>
<td>12,220</td>
<td>20,406</td>
<td>16,582</td>
<td>13,125</td>
<td>12,311</td>
<td>4,958</td>
</tr>
<tr>
<td>Disabled</td>
<td>63</td>
<td>77</td>
<td>135</td>
<td>93</td>
<td>64</td>
<td>111</td>
<td>28</td>
</tr>
<tr>
<td>Not disabled</td>
<td>6,261</td>
<td>12,122</td>
<td>20,259</td>
<td>16,474</td>
<td>12,988</td>
<td>12,121</td>
<td>4,837</td>
</tr>
<tr>
<td>Undisclosed</td>
<td>15</td>
<td>21</td>
<td>12</td>
<td>17</td>
<td>73</td>
<td>79</td>
<td>95</td>
</tr>
<tr>
<td>Total disclosed</td>
<td>6,314</td>
<td>12,199</td>
<td>20,394</td>
<td>16,567</td>
<td>13,052</td>
<td>12,232</td>
<td>4,865</td>
</tr>
<tr>
<td>% Disabled</td>
<td>0.84%</td>
<td>0.63%</td>
<td>0.66%</td>
<td>0.56%</td>
<td>0.49%</td>
<td>0.90%</td>
<td>0.56%</td>
</tr>
<tr>
<td>% Not Disabled</td>
<td>98.93%</td>
<td>99.20%</td>
<td>99.28%</td>
<td>99.35%</td>
<td>98.96%</td>
<td>98.46%</td>
<td>97.56%</td>
</tr>
<tr>
<td>% Undisclosed</td>
<td>0.24%</td>
<td>0.17%</td>
<td>0.06%</td>
<td>0.10%</td>
<td>0.56%</td>
<td>0.64%</td>
<td>1.92%</td>
</tr>
</tbody>
</table>

Appendix 7: Monitoring disability

The purpose of disability monitoring is to enable an organisation to establish its current position, identify barriers to aspects of equality, accommodate for the needs of all, remove any unfairness or disadvantage, plan future action to address any inequalities, and assess progress over time. Disability monitoring and the ability to demonstrate the proactive and effective implementation of equal opportunities policies is necessary to protect an organisation from any legal challenge on the grounds of discrimination. All employees should be monitored, including those at senior management level. The most important areas for disability monitoring are:

- recruitment
- promotion
- transfers
- training
- terms and conditions of employment
- grievances and disciplinary procedures
- resignations
- redundancies
- dismissals.

Monitoring is more than just data collection. Monitoring data must be systematically analysed and questioned. Any barriers or failures highlighted must be followed up and tackled, and any subsequent actions taken should also be monitored to assess their impact. Effective monitoring requires board-level commitment. Information gained from monitoring exercises, and planned further action, should be communicated to the Board and senior management on a regular basis, and through organisational literature such as the Annual Report.

Ideally, disability monitoring should be performed in a consistent, standardised manner, with results computerised so that cross-referencing and comparison with other data-sets can be undertaken. It is important to consider the full diversity of disabled people in terms of different forms of impairment as well as other equality strands such as ethnicity, age, gender, sexual orientation, and religion or belief. Data should be collected and analysed in such a way that recognises the potential for inequality to extend between categories and, where appropriate, monitoring procedures should be able to identify multiple disadvantage (eg discrimination faced by disabled women). In collecting disability data, the DRC recommends using non-anonymous monitoring to provide a more sophisticated representation of disability in the workplace. It is important, however, that this is conducted sensitively and that employees are informed that any information given will be treated, subject to statutory requirements, confidentially. Reassurance should also be provided as to why the information is being sought and how it will be used. All monitoring forms or methods should use appropriate disability etiquette and be accessible as regards their format, content and implementation. Further guidance on disability monitoring can be found on the DRC website at www.drc.org.uk
References


34 Personal correspondence from Ms Paula Robblee, General Medical Council, 15 August 2006.


36 Royal College of Veterinary Surgeons (2003) Guidance on the admission of students with disabilities to the professional veterinary degree course. London: Royal College of Veterinary Surgeons.


38 Personal correspondence from Ms Janet Pearce, Head of External Relations and Development, Universities and Colleges Admissions Service (UCAS), 16 October 2006.


50 Unpublished data from WAM/Asset2006 survey.


Equal Opportunities Committee’s publications

2007
• Disability equality within healthcare: the role of healthcare professionals
• Disability equality in the medical profession

2006
• Examining Equality: Royal Colleges Report
• Equal Opportunities Committee leaflet

2005
• Sexual Orientation in the workplace
• Religion and belief: best practice for arranging meetings
• A guide to mentoring for BMA committee members
• Guide to effective communication non-discriminatory language

2004
• Career Barriers in Medicine: doctor’s experiences
• Dealing with discrimination: guidelines for BMA members (revised July 2004)
• Valuing Diversity: BMA equal opportunities guidelines

2003
• Getting involved in BMA committees: guidelines for BMA members

Copies of these and other reports can be obtained from:
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