

A photograph of two young adults, a woman with long dark hair and a man with short dark hair, both smiling and looking towards the right. They appear to be in a classroom or computer lab setting. The woman is wearing a black and orange striped sweater, and the man is wearing a grey and white striped sweater. The background is blurred, showing other people and what looks like a computer monitor.

**Welcomed and valued:
Supporting disabled learners in medical
education and training**

**General
Medical
Council**

Welcomed and valued: Supporting disabled learners in medical education and training

Overall summary

About this guidance

The guidance is advisory, to help organisations consider how best to support medical students and doctors in training. It does not lay down new requirements, quality assurance standards or policies from the GMC or any of the other organisations involved. The guidance refers to statutory requirements for medical schools and organisations involved in postgraduate training, and provides practical suggestions for organisations to consider.

This guidance is also underpinned in our standards for doctors, medical students, and medical education and training. This means that patient safety is the first priority. Patient safety is inseparable from a good learning environment and culture that values and supports learners and educators.

This guidance may be useful for:

- medical education providers and organisers
- medical school staff
- deaneries and Health Education England (HEE) local teams, referred to as postgraduate training organisations
- local education providers
- employers
- royal colleges and faculties.

It will also be useful for individuals, including medical students (both prospective and current) and doctors with long-term health conditions* and disabilities.

* A long-term health condition is a condition that cannot, at present, be cured but is controlled by medication and/or other treatments or therapies. For example: diabetes, chronic obstructive pulmonary disease, arthritis and hypertension.

Local education providers should read this guidance to understand their role in supporting medical schools and postgraduate training organisations to meet their obligations to students and doctors in training while in the work environment. They should also be aware of the options available for supporting students and doctors in training. Employers should always keep in mind the provisions and potential sanctions covered under the *Equality Act 2010* and, in Northern Ireland, the *Disability Discrimination Act 1995* and *Special Educational Needs and Disability (Northern Ireland) Order 2005*.

We hope people who are thinking of applying to medical school, medical students and doctors will use this guidance to understand the support they can expect to receive while going through their undergraduate and postgraduate training.

This document replaces *Gateways to the professions*. It reaffirms the principles from *Gateways to the professions* and aims to give more practical advice for the day-to-day aspects of medical education and training.

Throughout this document, when we refer to:

- **Disabled learners or disabled doctors = we mean medical students and doctors in training with disabilities, including long-term health conditions.**
- **Doctors in training = Doctors in training are those who:**
 - are in foundation year two
 - are in a GMC approved training programme
 - have a fixed term specialty training appointment (FTSTA), or
 - have a locum appointment for training (LAT).

The BMA also has a helpful document explaining doctors' titles.*

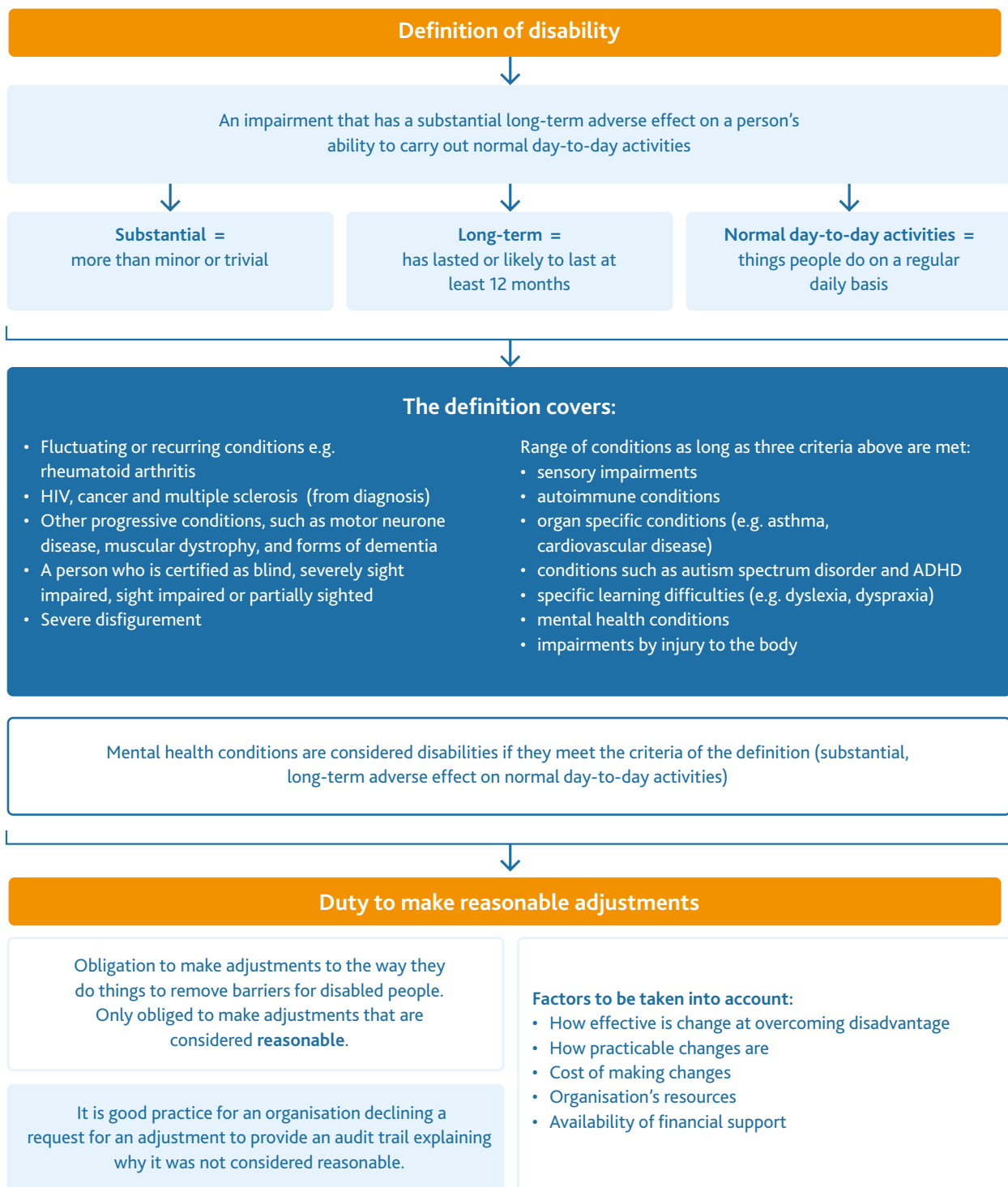
- **Support = we mean a range of support measures including reasonable adjustments.**
- **Organisations = we mean organisations responsible for educating and training medical students and doctors in training in the UK.**
- **Employers = we mean organisations employing doctors in training.**

* BMA Resources. Doctors' titles: explained. Available to download online from:
<https://www.bma.org.uk/collective-voice/committees/patient-liaison-group/resources>

Key messages from chapter 1:

Health and disability in medicine

- As the professional regulator, we firmly believe disabled people should be welcomed to the profession and valued for their contribution to patient care.
- Doctors, like any other professional group, can experience ill health or disability. This may occur at any point in their studies or professional career, or long before they become interested in medicine.
- No health condition or disability by virtue of its diagnosis automatically prohibits an individual from studying or practising medicine.
- Having a health condition or disability alone is not a fitness to practise concern. We look at the impact a health condition is having on the person's ability to practise medicine safely, which will be unique for each case.
- Medical students and doctors have acquired a degree of specialised knowledge and skills which should be utilised and retained within the profession as much as possible.
- A diverse population is better served by a diverse workforce that has had similar experiences and understands their needs.
- Legally, disability is defined as an 'impairment that has a substantial, long-term adverse effect on a person's ability to carry out normal day-to-day activities'. This covers a range of conditions, including mental health conditions if they meet the criteria of the definition.
- Organisations must make reasonable adjustments for disabled people, in line with equality legislation. Making reasonable adjustments means making changes to the way things are done to remove the barriers individuals face because of their disability.
- Organisations must consider all requests for adjustments, but only have the obligation to make the adjustments which are reasonable.

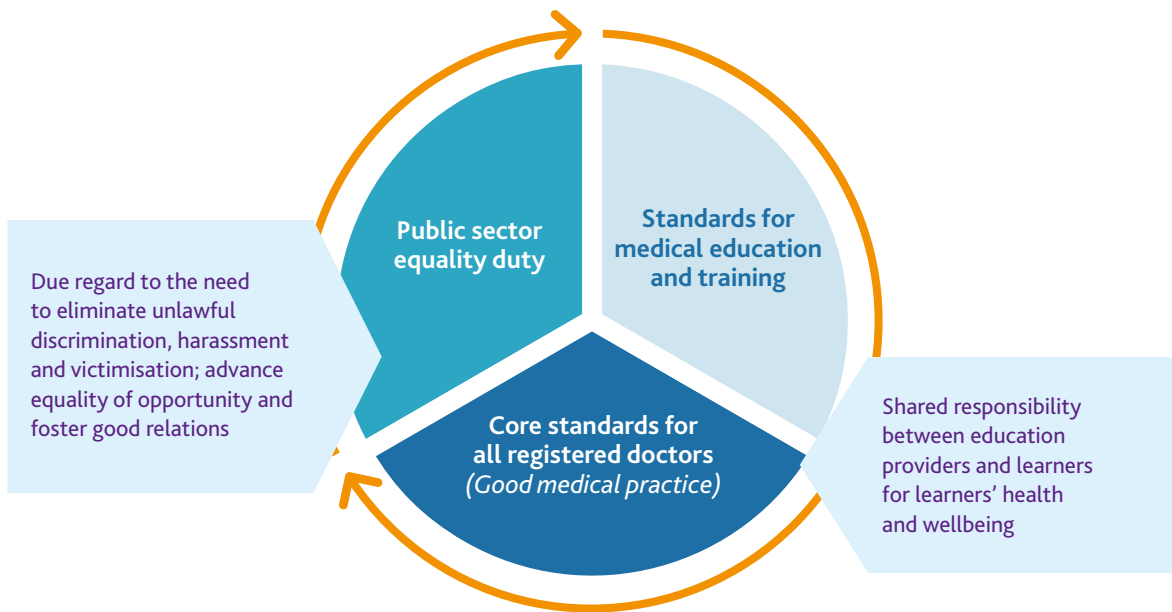


Key messages from chapter 2:

Our involvement as a professional regulator

- We are bound by the public sector equality duty, to promote equality and eliminate discrimination.
- We have a statutory remit to promote high standards of medical education and coordinate all stages of medical education. We do this through producing standards for medical education and training that organisations involved in medical education have to follow. Our standards say that these organisations must support disabled learners, including by making reasonable adjustments.
- All medical students and doctors in training, regardless of whether they have a disability (including long-term health conditions), need to meet the competences set out for different stages of their education and training in order to ensure patient safety. These are the absolute requirements for medical students and doctors in training in order to progress in their studies and practice. This includes the *Outcomes for provisionally registered doctors* at the end of the first year of the Foundation Programme and the learning outcomes of their curricula through training.
- We have a remit over organisations responsible for designing, managing, and delivering the training of doctors. These are medical schools, postgraduate training organisations and colleges / faculties, and local education providers.
- We do not have a remit over organisations employing doctors (e.g. NHS trusts / boards). However, organisations involved in training doctors and organisations employing doctors work very closely as doctors train in their working environment. For that reason, we hope the guidance will be seen as aspirational beyond education and training, and that all organisations employing doctors will follow the principles outlined in this document.
- We do not have a remit over admissions, but do set the level of knowledge and skill to be awarded a primary medical qualification via *Outcomes for graduates*.
- Learners and organisations have a shared responsibility for looking after wellbeing (*Good medical practice* and *Achieving good medical practice*).
- Any student can graduate as long as: they are well enough to complete the course; they have no student fitness to practise concerns; they have met all the *Outcomes for graduates*, with adjustments to the mode of assessment as needed.
- We ask for health information to provisionally register doctors but that is not a barrier to registration. We rarely need or ask for health information after full registration.
- Every licensed doctor who practises medicine must revalidate. Our requirements for revalidation are high level and not prescriptive. This allows flexibility for our requirements to be adapted to individual doctors' circumstances.

- Having a health condition or disability does not mean a doctor’s fitness to practise is impaired. Having a health condition or disability also does not mean there is an inherent risk to patient safety. A reasonable adjustment or support measure requested for a doctor with a health condition or disability is not inherently a risk to patients.



Admission

- We don’t have a remit over admissions, but we determine the outcomes every UK medical graduate has to meet

Studying and graduating

- We quality assure all medical schools to make sure they meet our standards
- To graduate, a student has to: be well enough to study; meet all the course requirements; not have SFTP concerns; meet all the outcomes for graduates (with reasonable adjustments if needed)

Registration

- All applicants complete health declaration. The questions are not about the condition but about the effect it is having on the applicant’s ability to practise and care for patients
- We cannot grant restricted or conditional registration

Continuing training

- Most of the time, doctors do not need to tell us about a health condition or disability
- A doctor’s fitness to practise is not impaired just because they are ill, even if the illness is serious.

Key messages from chapter 3:

What is expected of medical education organisations and employers?

There are two overriding expectations for all medical education organisations in the UK with respect to disability. This applies to medical schools at the undergraduate level and postgraduate training organisations.

Firstly, organisations must comply with UK equality legislation. Secondly, organisations must meet our standards and requirements for medical education and training in the UK.

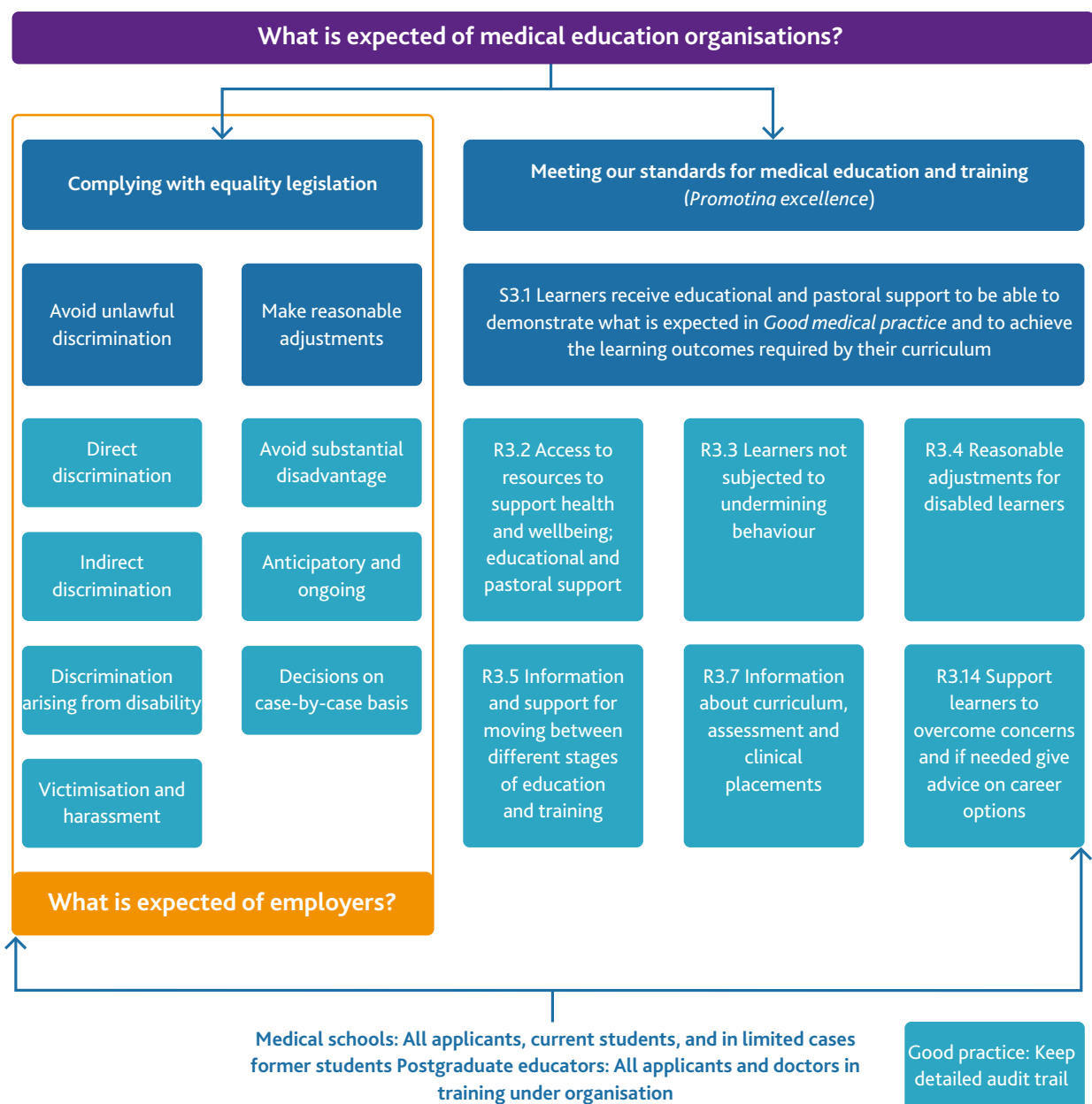
Complying with equality legislation means:

- Not treating a student or doctor worse than another learner because of their disability. This is called direct discrimination.
- Recognising a disabled learner can be treated more favourably. It is not direct discrimination against a non-disabled learner to do this.
- Making sure learners with a disability are not particularly disadvantaged by the way an organisation does things, unless this is a 'proportionate way' to achieve a 'legitimate aim' of the organisation, e.g. maintaining education standards or health and safety. Disadvantaging learners this way is called indirect discrimination.
- Not treating a learner badly because of something connected with their disability. This is called discrimination arising from a disability.
- Avoiding victimisation and harassment.
- Making reasonable adjustments: Organisations must take positive steps to make sure disabled learners can fully take part in education and other benefits, facilities and services. This includes:
 - Expecting the needs of disabled learners.
 - Avoiding substantial disadvantage for disabled learners from way things are done, a physical feature, or the absence of an auxiliary aid.
 - Thinking again if an adjustment has not been effective.
 - Considering support on a case by case basis and deciding what adjustment(s) would be 'reasonable' for each person's circumstances and the barriers they are experiencing.
- Organisations might like to keep an audit trail to demonstrate they have considered whether an adjustment is reasonable, including how they assessed and balanced different factors for each case.
- Medical schools owe this duty to applicants, existing students, and, in limited circumstances, to disabled former students. Postgraduate education organisations owe this duty to all applicants and doctors in training under their organisation, and in limited circumstances to former doctors in training.

The GMC cannot define what adjustments are reasonable in medicine.

Meeting [our standards for medical education and training](#) means following the requirements for supporting disabled learners set out in Theme 3 (R3.2 – R3.5, R3.14, R3.16).

- Medical schools must use the competence standards set out in *Outcomes for graduates* to decide if a student can be supported through the course or not.
- Employers have the same legal responsibilities and educational organisations in terms of avoiding direct, indirect and other forms of discrimination,* and making reasonable adjustments. Employers only have to make adjustments where they are aware – or should reasonably be aware – that an employee or an applicant has a disability.



* More information on the forms of discrimination can be found in the Appendix of the guidance.

Key messages from chapter 4:

How can medical schools apply their duties?

- Medical schools should continuously promote health and wellbeing for their students. Students should be empowered to look after their health and wellbeing through activities by the school.
- Medical schools must support disabled learners. Part of this is making the course as inclusive and welcoming as possible. This includes the accessibility of the physical environment, equipment that can help students, and how things are done at the school to make sure disabled learners are not disadvantaged. Schools have a duty to expect the needs of disabled learners, even if there are no disabled students on the course at the time.
- Medical schools can consider the support structures and processes for specific elements of the course such as clinical placements and assessments.
 - Clinical placements are often delivered away from the medical school services, so schools can think about what support will be available to their students while they are there.
 - Assessment is one of the educational components subject to the *Equality Act's* requirements. All assessments must be based on defined competence standards, and reasonable adjustments should be made in the way a student can meet those standards.
- Medical schools can use a health clearance form and occupational health services to identify students needing support. It is good practice to involve occupational health services with access to an accredited specialist physician, with current or recent experience in physician health.
- A school should make it possible for a student to share information about disabilities (including long-term health conditions) if they wish to do so. Once they have shared this information, the medical school must address the student's requirements for support as soon as reasonably possible.
- It is a matter for each school or university to assess how they approach each individual case. It is important to have a process for balanced and fair decision making that will apply across all cases. One approach we encourage medical schools to consider as good practice is the case management model. Schools can use a stepwise process to develop an action plan for supporting each student.
 - **Step 1:** Form support group for the student
 - **Step 2:** Decide on key contact(s)
 - **Step 3:** Agree confidentiality arrangements
 - **Step 4:** Reach a shared decision about how the student would be affected by the demands of the course.
 - **Step 5:** Decide whether the student can be supported to meet the competence standards set out in *Outcomes for graduates*. If the student can be supported to meet the outcomes, the school

must help them in doing so. If the school decides that the student cannot be supported in meeting the outcomes, it must encourage the student to consider alternative options, including gaining an alternative degree and other career advice.

- **Step 6:** Forming an action plan. The action plan may elaborate on support in each component of the course, as well as care arrangements for the student.
- **Step 7:** Implementation, monitoring and review. Implementing the action plan is a shared responsibility between the medical school and the student.
- Schools can assess the effectiveness of the support given to students, for example through regular 'check-ins' or reviews on a termly or annual basis.
- Schools must be prepared to respond to evolving needs of their students.

On ongoing or regular basis for the medical school

✓ Promote health and wellbeing among students

✓ Consider support structures and processes for specific course components e.g. clinical placements and assessments

✓ Make the course inclusive by:

- ✓ Reviewing accessibility of university premises
- ✓ Putting equipment in place that students may need to access the course
- ✓ Looking at how things are done to make sure practices do not disadvantage disabled learners

For each student with potential support needs

1 Student accepted

- ✓ Consider using health clearance form and occupational health services to identify students needing support
- ✓ Give opportunities for students to share information on support needs during induction
- ✓ Give information on contacts and on financial support available

2 Student support needs raised

- ✓ Initiate support arrangements
 - Step 1: Form support group
 - Step 2: Decide key contact(s)
 - Step 3: Confidentiality arrangements
 - Step 4: Reach shared decision on student needs for the course across different components (e.g. lectures, labs, clinical placements, assessments)
 - Step 5: Decide whether student can be supported to meet *Outcomes for graduates*
 - Step 6: Form action plan
 - Step 7: Implementation, monitoring and review

3 Support in place

- ✓ Assess effectiveness of support (e.g. through regular checking in with the student and termly /annual review)
- ✓ Respond to evolving needs and significant changes

Process map for supporting disabled medical students

This process gives an overview of what can be done; not all steps will be appropriate for all students, but it can be adapted to each individual case at the discretion of the medical school



Key messages from chapter 5:

Transition from medical school to Foundation training

- Medical schools must only graduate medical students that meet all of the outcomes for graduates and are deemed fit to practise.
- There are two processes that disabled learners, medical schools and foundation schools can use to make sure incoming foundation doctors are allocated to an appropriate post for their training. These are the Transfer of Information (TOI) process and the Special Circumstances pre-allocation process.
 - The TOI process communicates information to the foundation school (via the TOI form) to put support and reasonable adjustments in place.
 - Pre-allocation on the grounds of Special circumstances is a separate process to allocate graduates to a specific location for their foundation post.
- Postgraduate educators and doctors in training have a shared responsibility to make sure the right information is known about a doctor's health.
- Less than full time training may help disabled doctors. Postgraduate educators can inform disabled doctors about the possibility of less than full time training, and direct them towards relevant information and guidance.

Key messages from Chapter 6:

How can postgraduate training organisations apply their duties?

- Disabled doctors in training must be supported to participate in clinical practice, education and training.
- All doctors in training should have access to occupational health advice. Doctors may acquire a condition or disability at any stage of their career. If a doctor in training has a long-term health condition or disability, they may need specialist occupational health advice through an accredited occupational health physician, to make decisions about training and working
- It is a matter for postgraduate educators and employers to assess how they approach each individual case. One approach we encourage to consider as good practice is the case management model. Postgraduate educators and employers can use a stepwise process to develop an action plan for supporting each doctor in training. This process gives an overview of what can be done – not all steps will be appropriate for all doctors in training, but it can be adapted to each individual case at the organisations' discretion.
 - **Step 1:** Sharing information - Doctors in training share information about how their condition or disability affects them with their deanery / HEE local team and employer.
 - **Step 2:** Postgraduate dean as gatekeeper - Postgraduate dean or nominated representative to arrange the consideration for what support is needed.
 - **Step 3:** Form doctor's support network. Depending on decision by postgraduate dean or nominated representative, they can gather individuals to provide advice on how the doctor in training can be supported
 - **Step 4:** Decide key contact(s)
 - **Step 5:** Further confidentiality arrangements.
 - **Step 6:** Occupational health assessment. It may be helpful for a disabled doctor in training to have an occupational health assessment.
 - **Step 7:** Case conference / joint meeting. The support network may discuss any recommendations from the occupational health assessment, to form an action plan on how the doctor in training will be supported going forward.
 - **Step 8:** Action plan. The action plan could address a number of areas where the doctor in training can be supported. The purpose of any support implemented is to help the doctor achieve the level of competence required by the Foundation Programme curriculum or the specialty curricula – and not to alter or reduce the standard required. It is good practice for the action plan to be developed in collaboration with the doctor in training as much as possible.

- **Step 9:** Monitoring and review. There is a shared responsibility for implementing the action plan between the employer, deanery or HEE local team and the doctor in training.
- The educational review process can help monitor the support a doctor in training is receiving, record any relevant conversations in the educational portfolio or escalate concerns to the support network as needed.
- The preparation and evidence submitted by disabled doctors in training for the Annual Review of Competence Progression (ARCP) can be an opportunity to raise something about the support they are receiving and the environment in which they are training. The ARCP process is also a way to decide whether a doctor in training can be supported to meet the competence standards at their stage of training.
- Colleges and faculties should remove or revise any redundant aspects of the curriculum, not crucial to meeting the required standard that may disadvantage disabled doctors.
- Organisations designing assessments have a duty to anticipate the needs of disabled candidates.
- All doctors in training must have an educational supervisor who should provide, through constructive and regular dialogue, feedback on performance and assistance in career progression.

Process map for supporting doctors in training

This process gives an overview of what can be done; not all steps will be appropriate for all doctors in training, but it can be adapted to each individual case at the discretion of the postgraduate deanery / HEE local team and the doctor's employer. All doctors should have access to occupational health advice. Doctors may acquire a condition or disability at any stage of their career. If a doctor has a long-term health condition or disability, they may need specialist occupational health advice through an accredited occupational health physician, to make decisions about training and working.



How should I read this guidance?

If you are:

	Chapter 1: Health and disability in medicine	Chapter 2: Our involvement as a professional regulator	Chapter 3: What is expected of medical education organisations and employers?	Chapter 4: How can medical schools apply their duties?	Chapter 5: Transition from medical school to Foundation training	Chapter 6: How can postgraduate training organisations apply their duties?
	<p>Welcomes disabled people in medicine.</p> <p>Explains legal definitions of disability and reasonable adjustments.</p>	<p>Discusses our considerations as a professional regulator for each stage of medical education.</p>	<p>This chapter is for anyone who works in an organisation providing medical education and training. It explains the requirements from the law and our standards. Medical students and doctors in training can also read this chapter to learn more about the support available to them.</p>	<p>How medical schools might meet their duties. Medical students can also read this chapter to learn more about the support available to them.</p>	<p>Discusses preparation from the medical school, working with foundation schools and existing processes to help the transition (Transfer of Information, Special Circumstances)</p>	<p>How postgraduate training organisations might meet their duties. Doctors in training can also read this chapter to learn more about the support available to them.</p>
Supporting medical students	✓	✓	✓	✓	✓	
Supporting doctors in training	✓	✓	✓		✓	✓
A medical student	✓	✓		✓	✓	
A doctor in training	✓	✓				✓

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Welcomed and valued:

Supporting disabled learners
in medical education and training

Chapter 1:

Health and disability in medicine

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Key messages from this chapter

- As the professional regulator, we firmly believe disabled people should be welcomed to the profession and valued for their contribution to patient care.
- Doctors, like any other professional group, can experience ill health or disability. This may occur at any point in their studies or professional career, or long before they become interested in medicine.
- No health condition or disability by virtue of its diagnosis automatically prohibits an individual from studying or practising medicine.
- Having a health condition or disability alone is not a fitness to practise concern. We look at the impact a health condition is having on the person's ability to practise medicine safely, which will be unique for each case.
- Medical students and doctors have acquired a degree of specialised knowledge and skills. We should utilise and retain this within the profession as much as possible.
- A diverse population is better served by a diverse workforce that has had similar experiences and understands their needs.
- Legally, disability is defined as an 'impairment that has a substantial, long-term adverse effect on a person's ability to carry out normal day-to-day activities'. This covers a range of conditions, including mental health conditions if they meet the criteria of the definition.
- Organisations must make reasonable adjustments for disabled people, in line with equality legislation. Making reasonable adjustments means making changes to the way things are done to remove the barriers individuals face because of their disability.
- Organisations must consider all requests for adjustments, but only have the obligation to make the adjustments which are reasonable.

Does this guidance only deal with disability?

No. We also give advice for medical students and doctors in training who need other kinds of support not expressly covered by the demands of legislation.

Promoting excellence makes it clear that we want organisations involved in all levels of medical education and training to provide comprehensive and tailored support to the medical students and doctors in training who need it.

The importance of inclusion in medicine

As the professional regulator, we firmly believe disabled people should be welcomed to the profession and valued for their contribution to patient care.

Doctors, like any other professional group, can experience ill health or disability. This may occur at any point in their studies or professional career, or long before they become interested in medicine.

The very qualities that make a good doctor, such as empathy and attention to detail, can also make medical students and doctors more vulnerable to stress, burnout and other health problems ([Managing your health](#)).

Medical students and doctors have acquired a degree of specialised knowledge and skills. We should utilise and retain this within the profession as much as possible. It is an expensive and avoidable loss to the profession if an individual gives up their medical career as a result of disability or long-term ill health when, with the correct support, they can continue for many years.

A diverse population is better served by a diverse workforce that has had similar experiences and understands their needs. Patients often identify closely with medical professionals with lived experience of ill health or disability, who can offer insight and sensitivity about how a recent diagnosis and ongoing impairment can affect patients. Such experience is invaluable to the medical profession as a whole, and illustrates the importance of attracting and retaining disabled learners.

Panel 1:

What disabled people bring to the profession – in their own words

'Each person has things to offer and in a team can contribute to excellent patient care. For example, because I was less able to walk the wards and do cannulations etc, I took responsibility for the majority of discharge summary management, drug chart management, lab result signing and general office tasks. This rapidly upskilled me in undertaking these tasks effectively and freed other colleagues to gain more complex clinical experience without an administrative burden. On the other hand, I think my experiences as a patient as well as a doctor improved my skills in the doctor-patient relationship such as outpatient clinics and history taking.'

'I am using my experience of being a vulnerable patient to become a better doctor. I understand how lonely and scary being in hospital can be, and how you can be made to feel more like a bed number than a human being. Having empathy, asking a patient about their concerns, and good communication can go a long way.'

'Patients seem to really appreciate that I am a doctor and a wheelchair user, some have opened up to me about health concerns or practical struggles. They instinctively know I have an insight into their side of the bed.'

'As a patient, I experienced and appreciated first-hand the care and sensitivity required for medicine. I want to be able to give back this care I received and more to the healthcare service that had significantly changed my life. My personal experiences as a patient have become the foundation of my career in practicing medicine and will shape me into a better doctor.'

Practising medicine with a long-term health condition or disability

There are many medical students and doctors in training with a long-term health condition or disability. Therefore, it is vital to have policies in place to support these individuals throughout their careers.

Many medical students with long-term health conditions and disabilities successfully complete their degrees and go on to practise medicine. Equally, many doctors in training who develop a long-term health condition or disability during their careers continue to work in medicine for many years. No long-term health condition or disability by virtue of its diagnosis automatically prohibits an individual from studying or practising medicine.

There are times when a health condition or disability might prevent someone from continuing their studies or career in medicine. These cases are very rare. There is more advice within this guidance about how educators and managers can support students and doctors in training finding themselves in this situation.

All medical students and doctors, regardless of whether they have a long-term health condition or a disability, need to meet the competences set out for different stages of their education and training. Organisations must make reasonable adjustments to help learners meet the competences required of them. Medical schools are responsible for arranging reasonable adjustments for medical students. Employers are responsible for arranging reasonable adjustments in place for doctors in training in the workplace. Postgraduate training organisations work closely with the employers to make decisions on reasonable adjustments to support doctors in training.

Who is a disabled person?

In this guidance we talk about disabilities, including long-term health conditions.

Disability is legally defined in the UK.

Focusing on support

We are including information about who is a disabled person, as people told us they would like to see it in this guidance.

Deciding whether someone is covered by the definition of disability as provided in equality legislation can be complex and time consuming. Any process that focuses on 'entitlement' to support, as opposed to the best method of support for someone, is unlikely to meet our expectations when it comes to [supporting learners](#), as described in [Promoting excellence](#).

The legal definition of disability

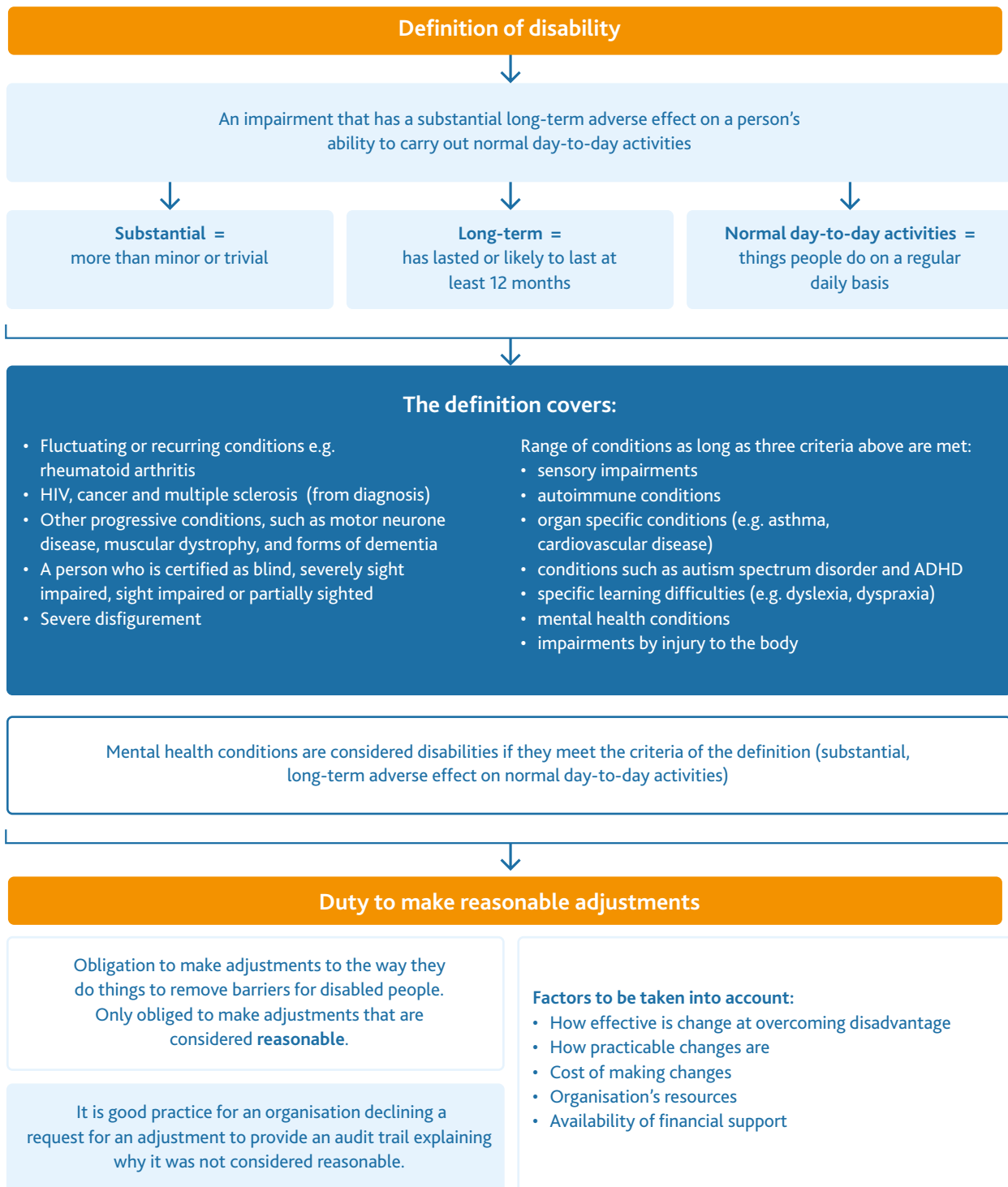
The *Equality Act 2010* ('the Act') and *Disability Discrimination Act 1995* ('DDA') define a disabled person:*

- 1 'A person has a disability if:
 - a They have a physical or mental impairment, and
 - b the impairment has a substantial and long-term adverse effect on the person's ability to carry out normal day-to-day activities.'

Disability affects a great amount of people. There are nearly 13.3 million disabled people in the UK, nearly one in five of the population.†

* *Equality Act 2010*, Schedule 1. Available online at: www.legislation.gov.uk/ukpga/2010/15/schedule/1

† Scope, Disability facts and figures. Available online at: www.scope.org.uk/media/disability-facts-figures



Breaking down the components of the definition

- It may not always be possible (or necessary) to categorise a condition as either a physical or a mental impairment. It is not necessary to consider the cause of an impairment.
- 'Substantial' – more than minor or trivial.
- 'Long-term' – the effect of an impairment is long-term if:
 - it has lasted for at least 12 months
 - it is likely to last for at least 12 months or
 - it is likely to last for the rest of the life of the person affected.

Disability includes situations where an impairment stops having a substantial adverse effect on a person's ability to carry out normal day-to-day activities, but the effect is likely to reoccur.

The *Disability Discrimination Act 1995* defines 'normal day-to-day activity'.* The *Equality Act 2010* does not define this. However, the guidance† published alongside the Act gives some advice (pages 34–35).

Organisations must consider all of the factors above when deciding whether a person is disabled. We expect organisations to approach the issue in an open, supportive way.

If there is doubt about whether an individual will be covered, an organisation can choose to focus on identifying reasonable adjustments and support measures that will assist them. A court or a tribunal ultimately decide if there is a dispute on whether someone meets the legal definition.

What does the definition cover?

The definition covers a range of conditions that may not be immediately obvious from reading it. Many people who are covered by the definition of a disabled person do not describe themselves as disabled and so may not think of asking for support or reasonable adjustments.

For example, the definition may cover:

- **Fluctuating or recurring** conditions such as rheumatoid arthritis, myalgic encephalitis (ME), chronic fatigue syndrome (CFS), fibromyalgia, depression and epilepsy, even if the person is not currently experiencing any adverse effects.
- People with **HIV, cancer and multiple sclerosis** are deemed as disabled as soon as they are diagnosed.
- Other **progressive conditions**, such as motor neurone disease, muscular dystrophy, and forms of dementia.
- A person who is **certified as blind, severely sight impaired, sight impaired or partially sighted** by a consultant ophthalmologist is deemed to have a disability.

* Schedule 1, paragraph 4. Available online at: <http://www.legislation.gov.uk/ukpga/1995/50/schedule/1>

† Office for Disability Issues, *Equality Act 2010* Guidance. Available online at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/570382/Equality_Act_2010-disability_definition.pdf

- **Severe disfigurement** is treated as a disability.
- A **range of conditions** are treated as a disability, as long as the other factors from the definition are met, in terms of having substantial and long-term impact on the ability to do normal day to day activities:
 - Sensory impairments, such as those affecting sight or hearing.
 - Auto-immune conditions such as systemic lupus erythematosus (SLE).
 - Organ specific conditions, including respiratory conditions such as asthma, and cardiovascular diseases, including thrombosis, stroke and heart disease.
 - Conditions such as autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD)
 - Specific learning difficulties, such as dyslexia and dyspraxia.
 - Mental health conditions with symptoms such as anxiety, low mood, panic attacks, phobias; eating disorders; bipolar affective disorders; obsessive compulsive disorders; personality disorders; post-traumatic stress disorder, and some self-harming behaviour.
 - Mental illnesses, such as depression and schizophrenia.
 - Impairments produced by injury to the body, including to the brain.
- Someone who is no longer disabled, but who met the requirements of the definition in the past, will still be covered by the Act (for example, someone who is in remission from a chronic condition).*
- Someone who continues to experience debilitating effects as a result of treatment for a past disability could also be protected (for example, someone experiencing effects from past chemotherapy treatment).

The guidance produced for the Act and DDA says it cannot give an exhaustive list of conditions that qualify as impairments. There are exclusions from the definition, such as substance addiction or dependency, or tendency to set fires, steal, and abuse of other persons, which can be found in the guidance published along the Act[†] (Section A12, page 11).

* Equality and Human Rights Commission, Disability discrimination. Available online at: www.equalityhumanrights.com/en/advice-and-guidance/disability-discrimination

† Office for Disability Issues, Equality Act 2010 Guidance. Available online at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/570382/Equality_Act_2010-disability_definition.pdf

Mental health and disability

A mental health condition can be considered to be a disability according to the definition. But not every mental health condition will be considered as a disability.

For a mental health condition to be considered a disability, it has to meet the criteria in the definition; to have a substantial and long-term adverse effect on normal day-to-day activity. Examples are given in the guidance published alongside the Act.

Reasonable adjustments

In this guidance, we talk about reasonable adjustments as part of the support for medical students and doctors in training.

What are reasonable adjustments?

The duty to make reasonable adjustments for medical education organisations and employers is that they must take positive steps to remove barriers that place individuals at a substantial disadvantage because of their disability. This is to make sure they receive the same services, as far as this is possible, as someone who is not disabled.

Organisations must adjust the way they do things to try to remove barriers or disadvantages to disabled people. Organisations **always have to consider** requests for adjustments, but they only have to **make** the adjustments which are reasonable. If an organisation considers an adjustment but decides it is not reasonable, they may wish to consider keeping an audit trail which explains their decision.

The Act provides that a disabled person should never be asked to pay for the adjustments.

Welcomed and valued:

Supporting disabled learners
in medical education and training

Chapter 2:

Our involvement as a professional regulator

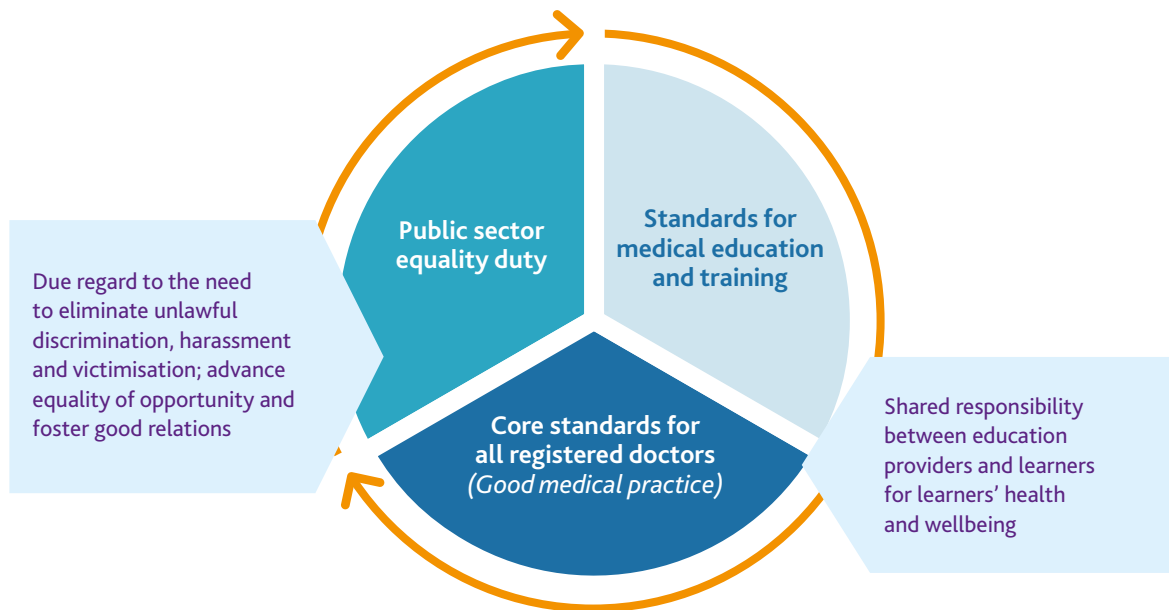
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Key messages from this chapter

- We are bound by the public sector equality duty, to promote equality and eliminate discrimination.
- We have a statutory remit to promote high standards of medical education and coordinate all stages of medical education. We do this through producing standards for medical education and training that organisations involved in medical education have to follow. Our standards say that these organisations must support disabled learners, including through making reasonable adjustments.
- All medical students and doctors in training, regardless of whether they have a disability (including long-term health conditions), need to meet the competences set out for different stages of their education and training. These are the absolute requirements for medical students and doctors in training in order to progress in their studies and practice. This includes the *Outcomes for provisionally registered doctors* at the end of the first year of the Foundation Programme and the learning outcomes of their curricula through training.
- We have a remit over organisations responsible for designing, managing, and delivering the training of doctors. These are medical schools, postgraduate training organisations and colleges / faculties, and local education providers.
- We do not have a remit over organisations employing doctors (e.g. NHS trusts / boards). However, organisations involved in training doctors and organisations employing doctors work very closely as doctors train in their working environment. For that reason, we hope the guidance will be seen as aspirational beyond education and training, and that all organisations employing doctors will follow the principles outlined in this document.
- We do not have a remit over admissions, but do set the level of knowledge and skill to be awarded a primary medical qualification via *Outcomes for graduates*.
- Learners and organisations have a shared responsibility for looking after wellbeing (*Good medical practice* and *Achieving good medical practice*).
- Any student can graduate as long as: they are well enough to complete the course; they have no student fitness to practise concerns; they have met all the *Outcomes for graduates*, with adjustments to the mode of assessment as needed.
- We ask for health information to provisionally register doctors but that is not a barrier to registration. We rarely need or ask for health information after full registration.
- Every licensed doctor who practises medicine must revalidate. Our requirements for revalidation are high level and not prescriptive. This allows flexibility for our requirements to be adapted to individual doctors' circumstances.
- Having a health condition or disability does not mean a doctor's fitness to practise is impaired. Having a health or disability also does not mean there is an inherent risk to patient safety. A reasonable adjustment or support measure requested for a doctor with a health condition or disability is not inherently a risk to patients.

An overview of our considerations as a professional regulator



Admission

- We don't have a remit over admissions, but we determine the outcomes every UK medical graduate has to meet

Studying and graduating

- We quality assure all medical schools to make sure they meet our standards
- To graduate, a student has to: be well enough to study; meet all the course requirements; not have SFTP concerns; meet all the outcomes for graduates (with reasonable adjustments if needed)

Registration

- All applicants complete health declaration. The questions are not about the condition but about the effect it is having on the applicant's ability to practise and care for patients
- We cannot grant restricted or conditional registration

Continuing training

- Most of the time, doctors do not need to tell us about a health condition or disability
- A doctor's fitness to practise is not impaired just because they are ill, even if the illness is serious.



As a public body and the professional regulator of doctors, the General Medical Council has several duties and considerations in this area. We explain our considerations in the next few sections, starting with our overall considerations and then following the different stages of medical education and training.

Overall considerations

- 1 As a public organisation, we are subject to the **Public Sector Equality Duty**.^{*} This requires us to have regard for the need to eliminate unlawful discrimination and advance equality of opportunity. We share this with universities and their medical schools, postgraduate training organisations and employers.[†]
- 2 Our **standards** for all stages of medical education and training, *Promoting excellence*, also set specific requirements for education providers in relation to supporting learners with disabilities.

One of the fundamental standards in *Promoting excellence* is that organisations must support learners to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum. This includes: making reasonable adjustments for learners; learners having access to information about reasonable adjustments with named contacts; and learners having access to educational support and resources to support their health and wellbeing.

We quality assure organisations against our *Promoting excellence* standards, as part of our role in overseeing all stages of medical education and training. Therefore, if we become aware of organisations not fulfilling their obligations towards learners through these requirements, we will take proportionate action.

* Equality and Human Rights Commission, Public sector equality duty. Available online at: www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equality-duty

† Section 49A of the Disability Discrimination Act 1995 defines the duty having due regard to the need to: (a) promote positive attitudes towards disabled persons, and (b) the need to encourage participation by disabled persons in public life.



Undergraduate



Postgraduate



All stages



Panel 2:

What do we do if we are concerned about organisations not meeting our standards?

We visit medical schools, postgraduate training organisations, and local education providers. We do this to check they are meeting our standards for undergraduate and postgraduate medical education. We focus our visits on areas of risk, which means we look at our evidence and decide which areas of education are most likely to be of concern. We also promote areas of excellence.

We have [exploratory questions](#) mapped to our standards, which we adapt for each visit based on evidence we have about the organisation (see pages 37–38 for the questions on supporting disabled learners).

We cannot intervene on individual cases, but if we receive concerns from disabled learners we ask for documentation so we can triangulate with other evidence we have on an organisation.

For more information, you can read about [how we quality assure medical education organisations](#).

3 There is **shared responsibility between the medical education organisation and the learner in terms of their wellbeing**. Organisations have a substantial role to play in offering comprehensive support. Learners equally have to take responsibility for looking after their own health and wellbeing.

It is inevitable that some medical students and doctors will experience ill health at different points of their studies and career. It is also inevitable that some people will join the profession with a disability, or acquire a disability at some point during their studies and career. As this guidance makes unequivocally clear, disabled learners are welcomed in to the profession and should be valued for their contributions. The aspect of taking responsibility for their own health does not relate to having a health condition or a disability, it relates to the expectations laid out in the standards for all registered doctors in the UK, [Good medical practice \(paragraphs 28-30\)](#), and the equivalent for medical students, [Achieving good medical practice \(paragraphs 31, 35, 38 and 40\)](#).

4 Meeting competence standards

All medical students and doctors, regardless of whether they have a long-term health condition or a disability, **need to meet the competences set out for different stages of their education and training**. These are the absolute requirements for medical students and doctors in training in order to progress in their studies and practice. They include:

- [Outcomes for graduates](#) for medical students, setting out the knowledge, skills and behaviours that new UK medical graduates must be able to show. By the end of their course, medical students must meet all of the outcomes to graduate.
- Medical schools can make reasonable adjustments to the modes of assessment of those outcomes, except where the method is part of the competence that needs to be attained.



Undergraduate



Postgraduate



All stages



- An example of adjusting the modes of assessment would be a student with a hearing impairment using an electronic stethoscope to perform part of a physical exam. The student still meets the outcome of performing a full physical exam, but with a slightly different method than for another student.
- An example where the method is part of the competence that needs to be attained is carrying out procedures requiring a specific method, for example venepuncture, intravenous cannulation or an ECG. The student has to perform the specific method to meet the outcome, but reasonable adjustments could be made to other aspects. For example, an adapted chair if the student needs to sit down while carrying out the procedure.
- Medical schools should agree reasonable adjustments in collaboration with the student, and put these in place. (see Chapter 4: 'How can medical schools apply their duties?').
- [Outcomes for provisionally registered doctors](#) for newly qualified doctors in their first year of training.
 - Doctors with provisional registration with a licence to practise in the first year of the Foundation Programme (F1 doctors) must demonstrate the *Outcomes for provisionally registered doctors* to be eligible to apply for full registration. This includes core clinical skills and procedures, which provisionally registered doctors are required to undertake.
 - *Outcomes for provisionally registered doctors* are competence standards for the purposes of the Act. Therefore, provisionally registered doctors must meet all of these outcomes to progress to the second year of the Foundation Programme (F2). Reasonable adjustments can be made to the modes of assessment of these outcomes.
 - These outcomes must be demonstrated on different occasions and in different clinical settings as a professional in the workplace demonstrating a progression from the competence required of a medical student. *The Outcomes for provisionally registered doctors* include a section on doctor's health.
- The learning outcomes in the [Foundation Programme curriculum](#) developed by The Academy of Medical Royal Colleges and the [specialty curricula for different training programmes](#) developed by royal colleges and faculties.
 - We approve all postgraduate curricula in line with our standards for postgraduate curricula and assessments ([Excellence by design](#)).
 - Reasonable adjustments can be made to the modes of assessment of these outcomes. In addition to the responsibilities of employers and postgraduate training organisations, royal colleges and faculties are responsible for making reasonable adjustments for postgraduate assessments.

You can find more information on competence standards in our position statement from May 2013.



Undergraduate



Postgraduate



All stages



Admission to medical school

We do not have a direct remit over selection into medical school. Decisions on admissions are ultimately up to each medical school. Because of this, the guidance does not cover admission processes.

We have one main consideration affecting the admissions stage. We are responsible for determining the knowledge and skill needed to award a medical degree in the UK, a primary medical qualification (the Medical Act (S.5(2)(a))). When considering applications from disabled people, medical schools may find it helpful to consider the [Outcomes for graduates](#) with applicants, as the competence standards they will need to demonstrate over their studies.

Medical Schools Council guidance

The representative body of UK medical schools (Medical Schools Council) is developing guidance for medical school admission teams to support and encourage disabled applicants. In addition to meeting the outcomes with reasonable adjustments, the Medical Schools Council's guidance advises:

- Being prepared to answer queries from prospective applicants with a disability.
 - considering setting up a dedicated email address or phone number so that potential applicants with a disability are able to ask advice
 - Helpful interventions such as a visit to the skills lab, talking to past and present students and virtual simulation.
- Making clear to applicants that talking about their disability in personal statements means that people involved in the selection process will know about it, but this knowledge will not impact on the decisions they make about that applicant.
- Ensuring that relevant experience requirements for selection do not negatively impact on disabled applicants
- Ensuring the decision on whether the applicant is able to meet the outcomes is separate from the decision to select the student.
 - Providing reasonable adjustments for interviews.
 - Ensuring interviewers understand they must not take the applicant's disability into account when scoring an applicant.
 - As far as possible interviewers should not know about a candidate's disability. This may be unavoidable.
 - Ensuring that they are satisfied that aptitude test providers understand their responsibilities under equality legislation, including having a process for candidates to raise concerns about the fairness of aptitude tests.



Undergraduate



Postgraduate



All stages



- Making a conditional offer based on the individual achieving the academic requirements of the course. Once an offer is accepted, then medical schools can get in touch to discuss the needs of disabled applicants.
- There will be rare situations where the medical school has concerns that the nature of the disability may make it impossible for the individual to meet the outcomes for graduates even with adjustments. In these situations medical schools should seek the advice from a range of professionals including an occupational health practitioner with expertise in working with medical students.
- At the point of making an offer, flagging that:
 - Although they hope that they will go on to become doctors working in the NHS they are not obliged to, and that GMC registration will only be given to students who meet all the outcomes and are fit to practise at the point of graduation
 - There may be circumstances where adjustments medical schools can provide will not be available to them in the NHS.

Studying medicine and graduating with a primary medical qualification

Our role includes overseeing undergraduate medical education.

Anyone can graduate as long as: they are well enough to study, are fit to practise, meet all academic requirements of their course and all of the *Outcomes for graduates*.

Being well enough to study: It is important to consider whether a student is well enough to participate and engage with their course. There is more information on considering fitness to study in Chapter 4 ('How can medical schools apply their duties?').

Meeting all academic requirements: All medical students need to meet the academic requirements of their course. Medical schools manage this, and a student cannot complete their degree otherwise.

Not having any student fitness to practise concerns: All graduates of UK medical schools must be fit to practise at the point of graduation. Medical schools manage professionalism and student fitness to practise concerns that arise in the duration of the course, and make sure these concerns are addressed by the time the student graduates. Medical schools must only graduate students who are deemed fit to practise at the time of graduation. Graduating a student means that the medical school is confident that the student is fit to practise.



Undergraduate



Postgraduate



All stages



- There are limited circumstances where a student's fitness to practise might be questioned in relation to their health. These do not relate to the health condition itself, but to the individual's behaviour as a response.
- As long as the student demonstrates insight into their condition and follows appropriate medical advice and treatment plans, it is unlikely there will be concerns about their fitness to practise.
- In exceptional circumstances, students failing to meet the Outcomes for graduates after reasonable adjustments and support have been put in place could be referred to student fitness to practise. In such cases, it's helpful for the school to demonstrate that it has made every effort to support the student to complete the course, including seeking appropriate advice from an accredited specialist in occupational medicine and other specialist services. We have more advice for [students who might not meet our published outcomes for graduates](#).

Panel 3:

Can disabled learners complete their medical course part time?

We do not object to students completing a medical course in a part time / less than full time mode as a potential reasonable adjustment, as long as the medical school is assured the above requirements. This would be a decision for the medical school to take for an individual student.

There are no part time medical courses in the UK at the moment. Any part time course would need to go through our [approval process for new programmes](#).



Registering with us for a license to practise

Registration with conditions or restrictions

We cannot grant registration with restrictions or conditions.

At the point of registration our decision is binary – to either grant registration or not, without a potential for additional registration categories. This is different to a registered doctor, who can have conditions placed on their practice during their career.



Undergraduate



Postgraduate



All stages



Applying for provisional and full registration

The next step after completing an undergraduate medical degree is to undertake an acceptable programme for provisionally registered doctors. In the UK, this is the first year of the Foundation Programme (F1). On successful completion of F1, doctors fully register with us and continue to the second year of the Foundation Programme (F2).

To gain registration, medical graduates have to apply with us. All applicants are asked to complete a [declaration about their health](#) as part of the application process.

This declaration asks specific questions about the applicant's health, but not all health conditions or disabilities need to be declared. We don't provide a list of health conditions that need to be declared. Applicants can read through the questions and decide if they should declare anything. We only need to know about an issue that may affect the applicant's ability to practice or care for their patients. The effect a condition has on an individual, and any potential effect on their practice, will vary from person to person.

If an applicant answers yes to one of the declaration questions, we'll ask them to give further information on their application. The applicant can tell us more about their health condition, any relevant dates of occurrences and treatment, how they are managing it, and how this has affected them, their practice or studies. In a small number of cases, we may then ask for more information from a third party if they have the applicant's consent, for example from an occupational health physician.

Just because a student or a doctor is unwell, even if the illness is serious, it does not mean that their fitness to practise is impaired. Even if an applicant answers yes to one of the questions, if they can show that they are managing their health and that it will not affect patient safety, it is unlikely there will be an impact on the outcome of their application. You can [find full guidance on the registration application process on our website](#).

Panel 4: How often do we refuse registration?

Extremely rarely. We have refused provisional registration in a very small number of cases; 39 cases in 2010–18, compared to around 58,000 applications received in the same period. Of these graduates, a substantial number re-applied in the following years and were granted provisional registration.



Undergraduate



Postgraduate



All stages



Postgraduate training

As the professional regulator, we rarely need information about a doctor's health conditions or disabilities while they are practising. Doctors practise with short- or long-term health conditions and disabilities all the time, as in any other profession. Most of the time, a doctor's health or disability is not a concern for us.

On a system-wide level, the *Promoting excellence* standards place requirements on organisations responsible for postgraduate training to support their learners. To make sure this is happening, we take proportionate action if concerns are raised to us that our standards are not being met.

Revalidation

Every licensed doctor who practises medicine must revalidate. Most doctors have a connection to a designated body, including locum doctors, and the responsible officer must support doctors in accessing appraisal and the systems for collecting supporting information. This includes putting specific arrangements in place for a disabled doctor to undertake their appraisal. We expect designated bodies to integrate equality and diversity considerations into all of their medical revalidation process, as set out in our [Effective governance to support revalidation handbook](#).

Our requirements for revalidation are high level and not prescriptive. This allows flexibility for our requirements to be adapted to individual doctors' circumstances. For example, our [protocol for Responsible Officers](#) says that a doctor does not need to have completed five appraisals to revalidate successfully, as they could have missed an appraisal due to ill health.

We can also give additional time in the revalidation process by guiding Responsible Officers to make a recommendation to defer for doctors who have been unable to meet all of the requirements by their revalidation date and again there are reasonable circumstances to account for this (see a [case study on deferring a doctor's revalidation date](#)).

We know that there are a small number of doctors who may not have a designated body and have to access their own independent appraiser. A doctor with a disability may find this challenging and in these circumstances we will help support them in meeting the requirements for their revalidation. Doctors who wish to discuss this or other revalidation queries can contact us at revalidation-support@gmc-uk.org.



Undergraduate



Postgraduate



All stages



Panel 5: Examples of revalidation support

A doctor had double vision as a result of a stroke and had not submitted his annual return.

The doctor advised they were struggling to complete this online. We offered to provide a hard copy in large print for the doctor.

A doctor was unable to attend the revalidation assessment in Manchester as they were unable to travel due to their disability. We undertook an assessment of what the doctor required. We arranged for the doctor to undertake the assessment in our London office instead and allowed additional time for them to complete the paper.

A doctor was struggling with all the requirements for their revalidation as they had dyslexia. We gave the doctor more time to meet the requirements and helped them in establishing if they had a connection to a designated body.

Sharing information at a local level

While we rarely need information about a doctor's health conditions or disabilities, we do encourage doctors to share this information at a local level with occupational health services, their educational supervisor or their line manager. This is to make sure the appropriate support is put in place for them locally, in their day-to-day practice settings.

Sharing information with us

The only time where we would like to receive more information about individual doctors' health is when the doctor themselves or someone else is concerned about how it is affecting their practice. This happens rarely.

As with our registration processes, we cannot provide a list of health conditions or disabilities doctors should share information on. This is because **health conditions or disabilities are not, in and of themselves, a reason for questioning a doctor's fitness to practise**. Our involvement is not about the condition itself, but about impact it is having on an individual's ability to practise medicine safely. This is unique for each case so it has to be considered on an individual basis. There is specific information on this in our dedicated online guidance, [Managing your health](#).



Undergraduate



Postgraduate



All stages



Panel 6:

Health and fitness to practise; addressing the perceived risk to patient safety

Having a health condition or disability does not automatically mean a doctor's fitness to practise is impaired. Having a health or disability also does not mean there is an inherent risk to patient safety. A reasonable adjustment or support measure requested for a doctor with a health condition or disability is not inherently a risk to patients. This diagram explains how a doctor's health, fitness to practise, and patient safety are related to each other according to our guidance.



Undergraduate



Postgraduate



All stages

Welcomed and valued:

Supporting disabled learners
in medical education and training

Chapter 3:

What is expected
of medical education
organisations and
employers?

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This chapter is for: Medical schools, postgraduate deans and their teams, including foundation schools, local education providers. Doctors' employers may also find this chapter helpful.

Key messages from this chapter

There are two overriding expectations for all medical education organisations in the UK with respect to disability. This applies to medical schools at the undergraduate level and deaneries or Health Education England (HEE) local teams at the postgraduate level.

Firstly, organisations must comply with UK equality legislation. Secondly, organisations must meet our standards and requirements for medical education and training in the UK.

Complying with equality legislation means:

- Not treating a student or doctor worse than another learner because of their disability. This is called direct discrimination.
- Recognising a disabled learner can be treated more favourably. It is not direct discrimination against a non-disabled learner to do this.
- Making sure learners with a disability are not particularly disadvantaged by the way an organisation does things, unless this is a 'proportionate way' to achieve a 'legitimate aim' of the organisation, e.g. maintaining education standards or health and safety. Disadvantaging learners this way is called indirect discrimination.
- Not treating a learner badly because of something connected with their disability. This is called discrimination arising from a disability.
- Avoiding victimisation and harassment.
- Making reasonable adjustments: Organisations must take positive steps to make sure disabled learners can fully take part in education and other benefits, facilities and services. This includes:
 - Expecting the needs of disabled learners.
 - Avoiding substantial disadvantage for disabled learners from way things are done, a physical feature, or the absence of an auxiliary aid.
 - Thinking again if an adjustment has not been effective.
 - Considering support on a case by case basis and deciding what adjustment(s) would be 'reasonable' for each person's circumstances and the barriers they are experiencing.
- Organisations might like to keep an audit trail to demonstrate they have considered whether an adjustment is reasonable, including how they assessed and balanced different factors for each case.

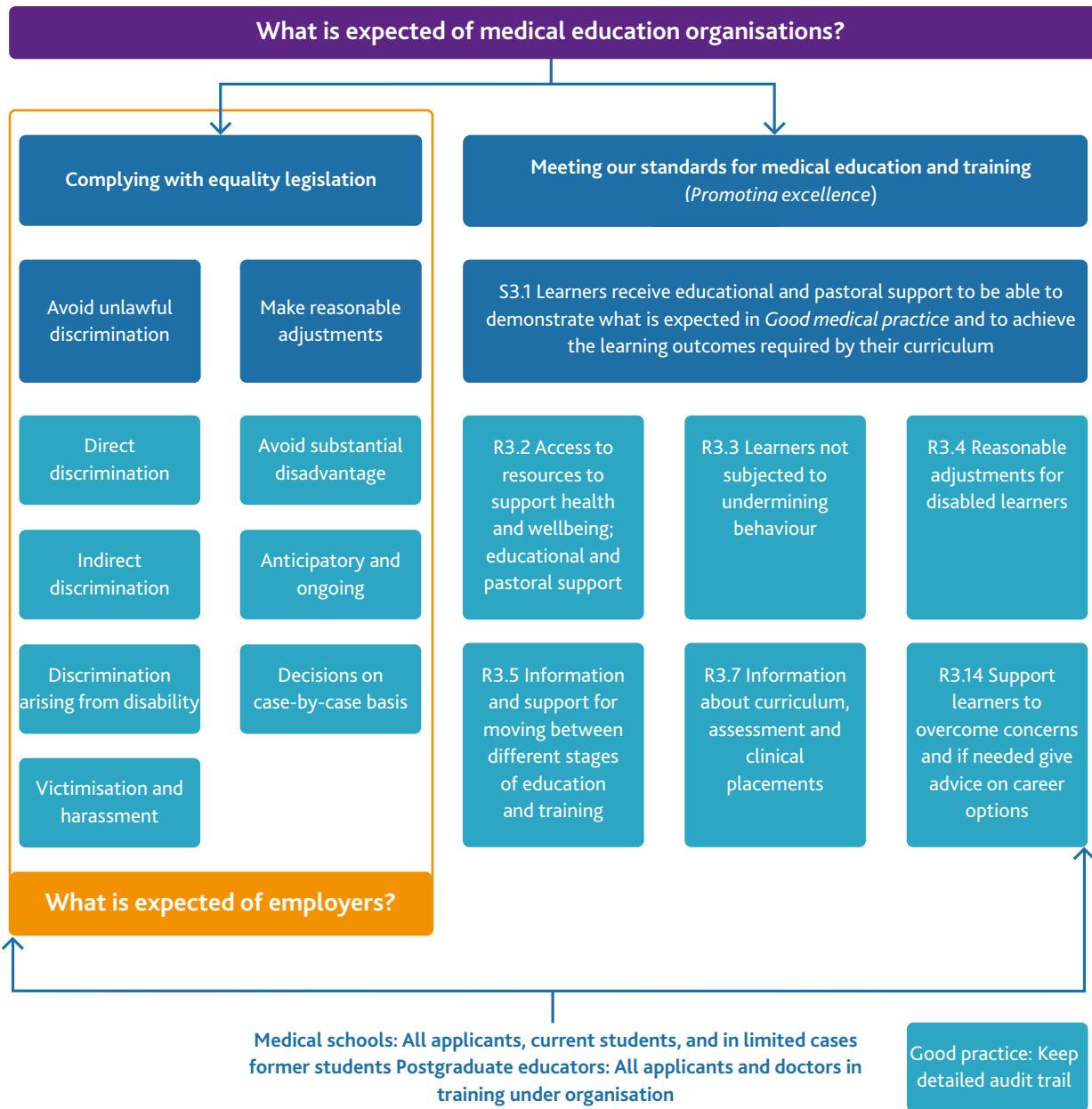
- Medical schools owe this duty to applicants, existing students, and, in limited circumstances, to disabled former students. Postgraduate education organisations owe this duty to all applicants and doctors in training under their organisation, and in limited circumstances to former doctors in training.

The GMC cannot define what adjustments are reasonable in medicine.

Meeting [our standards for medical education and training](#) means following the requirements for supporting disabled learners set out in Theme 3 (R3.2 – R3.5, R3.14, R3.16).

Medical schools must use the competence standards set out in *Outcomes for graduates* to decide if a student can be supported through the course or not.

Employers have the same legal responsibilities as education organisations, in terms of avoiding discrimination and making reasonable adjustments. Employers only have to make adjustments where they are aware – or should reasonably be aware – that an employee has a disability.



Overriding expectations

Medical education organisations in the UK have two overriding expectations in regards to disability.

- 1 Following equality legislation – the *Equality Act 2010* in England, Scotland and Wales, and the *Disability Discrimination Act 1995* and the *Special Educational Needs and Disabilities Order 2005* in Northern Ireland.
- 2 Meeting our standards and requirements for medical education and training in the UK – in *Promoting excellence* (2015).

Equality legislation

In undergraduate medical education, the governing body of the university has overall responsibility for complying with equality legislation. In postgraduate training, the postgraduate deaneries and HEE local teams have overall responsibility.

What do medical education organisations have to do to comply with equality legislation?

The duties from existing equality legislation are:

- 1 Organisations have to avoid unlawful discrimination against disabled learners (for the purposes of this guidance, more generally also against other protected characteristics). This includes specific types of discrimination, which are explained in more detail in the appendix of this guide: direct discrimination, indirect discrimination, discrimination arising from a disability, harassment and victimisation.
- 2 Organisations have a duty to make reasonable adjustments, in order to avoid putting disabled learners at a substantial disadvantage.

The duty to make reasonable adjustments

The duty* requires organisations to take positive steps to make sure disabled learners can fully participate in the education and other benefits, facilities and services provided for them.

This means organisations must take reasonable steps when a learner is at a substantial disadvantage because of:

- The way the organisation does things.
- For example, additional provisions or allowances for disabled learners, including extensions to deadlines, permitted periods of absence to attend medical appointments, breaks in teaching sessions, additional regular 1:1 tutorial support or provision of study skills support.

* Equality and Human Rights Commission: What are reasonable adjustments? Available online at www.equalityhumanrights.com/en/advice-and-guidance/what-are-reasonable-adjustments

- A physical feature. This could include removing the physical feature, altering it or providing a reasonable means of avoiding it.
 - For example, if locations and physical features are not accessible for learners, then these can be altered through installing ramps, automatic doors, accessible lifts and lift buttons, accessible external paths and landscaping.
- Not providing an auxiliary aid.
 - For example, equipment to help learners follow teaching activities or facilitate clinical practice, such as laptops or handheld devices to take notes or a note-taker to attend lectures, spell checkers, screen readers, an amplified stethoscope, supportive furniture or cushion or lumbar support and adjustable height chairs.

Key things to know about reasonable adjustments

Organisations must expect the needs of disabled learners. It is the organisation's responsibility to consider support on a case by case basis and decide what adjustments would be 'reasonable' for each individual. It is good practice to keep an audit trail of their decision making.

A request for an adjustment can be declined if it is not deemed 'reasonable', but it is unlawful not to consider reasonable adjustments at all. If the reasonable adjustments provided have not been effective, the organisation may need to consider alternatives. It is good practice to create an inclusive learning environment with adjustments that could help everyone.

1 What does reasonable mean?

There is no set definition of what 'reasonable' means.

What is 'reasonable' can only be decided on a case-by-case basis, and will always depend on the individual person and their circumstances.

The Equality and Human Rights Commission advises that whether an adjustment is reasonable depends upon all the circumstances including:^{*}

- if and how effective the change will be in overcoming the disadvantage the disabled person would otherwise experience
- how practicable the changes are
- the cost of making the changes
- the organisation's size and resources
- the availability of financial support.

The Commission has published guidance setting out factors for organisations to consider in assessing whether an adjustment is reasonable.[†] It suggests the following:

- You can treat disabled people better or 'more favourably' than non-disabled people and sometimes this may be part of the solution.
- The adjustment must be effective in helping to remove or reduce any disadvantage the disabled student is facing. If it doesn't have any impact then there is no point.
- It may take several different adjustments to deal with that disadvantage but each change must contribute towards this.
- You can consider whether an adjustment is practical. The easier an adjustment is, the more likely it is to be reasonable. However, just because something is difficult doesn't mean it can't also be reasonable.
- If an adjustment costs little or nothing and is not disruptive, it would be reasonable unless some other factor (such as impracticality or lack of effectiveness) made it unreasonable.
- What is reasonable in one situation may be different from what is reasonable in another situation.
- If advice or support is available then this is more likely to make the adjustment reasonable.
- If you think that making a particular adjustment would increase the risks to the health and safety of anybody then you can consider this when making a decision about whether that particular adjustment or solution is reasonable. But your decision must be based on a proper, documented assessment of the potential risks, rather than any assumptions.

^{*} Equality and Human Rights Commission, Commonly used terms in equal rights. Available online at: www.equalityhumanrights.com/en/advice-and-guidance/commonly-used-terms-equal-rights

[†] Equality and Human Rights Commission, What is reasonable? Available online at: www.equalityhumanrights.com/en/multipage-guide/what-do-we-mean-reasonable. Although this guidance is given in the context of employers considering what reasonable adjustments to provide, the principles may also be helpful for education institutions to consider.

If the decision of an organisation is challenged, the issue is whether or not the adjustment is 'reasonable' is ultimately a question for the courts to determine. The Equality and Human Rights Commission says that: 'The test of what is reasonable is ultimately an objective test and not simply a matter of what you may personally think is reasonable.'*

2 How can an organisation expect the needs of disabled learners?

Every organisation should plan ahead and expect the needs of disabled learners and the adjustments that might be made for them. This is regardless of whether they know that a particular person is disabled or whether they currently support any disabled students or doctors.

But it does not mean organisations have to expect the needs of every prospective student or incoming doctor in training. They must think about and take reasonable and proportionate steps to overcome any barriers, for example:

- Adapt the physical environment to help disabled learners
- Give auxiliary aids to learners
- Speak with employers and local education providers to make sure the physical environment would help disabled students and doctors in training, and auxiliary aids can be made available.
- Examine internal policies to see if anything could put disabled people at a disadvantage.
- Consider the impact of changes to the way the organisation does things impact on disabled learners, for example the impact of changes to the course format or curriculum content.
- An example from the Equality and Human Rights Commission[†] is that it may be appropriate for the university to install a hearing loop in lecture theatres to anticipate the needs of students with hearing impairments, but they would not be expected to have a British Sign Language (BSL) interpreter on the payroll.
- An example for postgraduate training organisations is to liaise with the local education providers where they place doctors to make sure locations are accessible. However, postgraduate training organisations would not be expected to have a piece of equipment required for an individual doctor's specific circumstances, before they are aware of this doctor's needs.

* Equality and Human Rights Commission, What is reasonable?
Available online at: www.equalityhumanrights.com/en/multipage-guide/what-do-we-mean-reasonable. Although this guidance is given in the context of employers considering what reasonable adjustments to provide, the principles may also be helpful for education institutions to consider.

† Equality and Human Rights Commission: What are reasonable adjustments?
Available online at www.equalityhumanrights.com/en/advice-and-guidance/what-are-reasonable-adjustments

3 Which learners does this duty apply to?

Medical schools owe this duty to applicants, existing students, and, in limited circumstances, to disabled former students. This relates to making reasonable adjustments in respect of qualifications awarded by a further or higher education institution. For example, if a former student needs a certificate in a different format as a result of a disability.

Postgraduate training organisations owe this duty to all applicants and doctors in training under their organisation, and, in limited circumstances, to former doctors in training.

4 How long does the duty apply for?

The duty is ongoing. If an adjustment has been made and it is not effective in overcoming the disadvantage, then the education body may need to think again – they cannot just assume that, having made one adjustment, their duty is completed.

5 Can the organisation not make reasonable adjustments for disabled learners?

An organisation must always show it has considered adjustments. But it can decide not to make an adjustment if it is not 'reasonable' (see Panel 12 in Chapter 4: How can medical schools apply their duties?). If after consideration, an organisation decides not to provide an adjustment on the grounds it is not reasonable, they should consider whether there are any alternative reasonable adjustments that might meet the person's needs.

6 Does the organisation need to consider each learner individually?

Yes. Reasonable adjustments must be considered on a case by case basis, taking into account the individual's circumstances and the specific barriers. This is because the impact of a disability or condition will be unique to each individual. Even if two people have the same disability, it might affect them differently, so each may need a different set of adjustments.

7 Are there adjustments that will frequently be considered reasonable?

Yes. There will be some adjustments that will be seen as reasonable for a number of students in the context of education and training. For example, extra time for someone with dyslexia when taking an examination after considering each case individually. But there is no prescriptive list. It is good practice for organisations to create an inclusive learning environment that could help all their students and doctors, which may include:

- printing documents on coloured paper
- providing plans, summaries, notes, and handouts in advance of lectures and other teaching activities in electronic format
- providing subtitled or transcribed video material
- reserved areas in all teaching and learning locations, including the library
- ensuring availability of coaching and mentoring.

Panel 5:

Can the GMC provide a list of adjustments that are reasonable in medicine?

The GMC cannot specify what adjustments are reasonable in medicine. We do not have the authority to do this as an organisation.

Because of all the factors taken into account when deciding what is reasonable, it is not possible to give general instructions on whether an adjustment is or is not reasonable in a medical setting. The medical school or employer (in collaboration with postgraduate training organisations) must exercise their judgment to assess and balance these factors. It will not necessarily be easy, but it may be made easier by consulting the individual about their need.*

An adjustment will not be reasonable if:

- It is not effective in removing or reducing any disadvantage
- If the adjustment alters or reduces the competency required of the learner at the specific stage of training
- If the adjustment poses an unacceptable risk to the safety of the learner or others. This has to be based on an objective assessment of the risk.

* Equality and Human Rights Commission: What are reasonable adjustments?
Available online at www.equalityhumanrights.com/en/advice-and-guidance/what-are-reasonable-adjustments

What is considered reasonable depends on the individual and their particular circumstances, so the same adjustment could be considered reasonable under one set of circumstances, but not reasonable under another. For example:

- A doctor in training requests an adaptation to the physical environment so they can work in a trust. The cost of the adaptation could be prohibitive to one organisation, while it could be proportionally lower for another organisation. The first organisation could say the adjustment is not reasonable due to cost, while the second could say it is reasonable (if in line with the other factors considered).
- Two medical students with diagnosed learning disabilities request additional time to complete an assessment. In one student case, this is supported by an expert report recommending additional time as an effective adjustment for the student. In another student case, additional time is not recommended for their particular form of learning disability. The medical school could say the adjustment is reasonable in the first case (if in line with the other factors considered), but not in the second case, if additional time would not be effective in helping the student.

These examples are illustrative. Often situations are more complex than the illustrative examples, so decisions always need to be made on an individual basis.

Panel 6:

Am I disadvantaging or discriminating against others by supporting disabled learners?

No.

The *Equality Act 2010* says it is not direct discrimination against a non-disabled person to treat a disabled person more favourably.

The law allows an organisation to treat a disabled person more favourably if it removes a barrier or disadvantage that the person is experiencing. For example, guaranteeing a placement or training post in a particular location because it is the one closest to the disabled learner's home or where they receive care.

A disabled learner may be at a disadvantage compared to their non-disabled peers before reasonable adjustments are made for them. The reasonable adjustments should aim to remove that disadvantage and bring the disabled person to an 'equal standing' with their peers. It does not give them an unfair advantage over others.

Some illustrative examples are below. Often situations are more complex than the illustrative examples, so decisions always need to be made on an individual basis.

- A student with diabetes is at a disadvantage in a usual exam environment, they may not be able to complete the exam without taking their medication or eating to regulate their sugar levels. By putting a reasonable adjustment in place to allow this student to take breaks from the exam to eat, to rest or to take medication, the medical school can allow them to perform at an equal level with other students who do not have diabetes.

- A doctor with chronic depression needs to attend regular medical appointments with their treating specialist. These cannot always be fitted around their rota. Therefore, the doctor is at a disadvantage compared to their peers, as they might suffer from the effects of their depression, which may interfere with their training and progression. By putting a reasonable adjustment in place to allow time off for attending clinical appointments, or adjusting their rota to attend certain shifts, the employer with the postgraduate training organisation can allow the doctor to overcome that barrier.

Meeting *Promoting excellence* standards for medical education and training

We have specific standards and requirements within *Promoting excellence* about supporting learners overall, and supporting learners with disabilities (including long term health conditions) in particular.

What does Promoting excellence say about supporting disabled learners?

Promoting excellence makes it clear that the purpose of providing effective support to students and doctors is for them to demonstrate what is expected in *Good medical practice* and achieve the learning outcomes required by their curriculum.

We require organisations to:

- give learners access to resources to support their health and wellbeing, and to educational and pastoral support, including (R3.2) confidential counselling services, careers advice and support, and occupational health services.
- make sure learners are not subjected to behaviour that undermines their professional confidence, performance or self-esteem (R3.3)
- make reasonable adjustments for disabled learners, and to make sure learners have access to information about reasonable adjustments, with named contacts (R3.4)
- give learners information and support to help them move between different stages of education and training. The needs of disabled learners must be considered, especially when they are moving from medical school to postgraduate training, and on clinical placements (R3.5)
- give learners timely and accurate information about their curriculum, assessment and clinical placements (R3.7). This is particularly relevant for disabled learners, as having this information in advance will help put any reasonable adjustments or other arrangements (eg travel arrangements for placements that are further away) required in place
- support, where reasonable, learners whose progress, performance, health or conduct gives rise to concerns to overcome these and, if needed, given advice on alternative career options (R3.14).

Medical schools also have responsibilities towards the very small number of medical students who may not be able to meet the competences in *Outcomes for graduates*, after they have exhausted the options for support.

Promoting excellence makes it clear that students must not progress if they fail to meet the required learning outcomes for graduates. In these cases, medical schools are required to give advice on alternative career options, including pathways to gain a qualification if this is appropriate. Doctors in training who are not able to complete their training pathway should also be given career advice (R3.16).

Panel 7:

Is there any type of support for a student that is not compatible with clinical practice in the future?

Medical schools must make reasonable adjustments for students with a disability to allow them to demonstrate they have achieved the *Outcomes for graduates*.

There may be times where an adjustment is both unreasonable on a course of study and in the workplace. If a certain level of support or an adjustment may not be available in a specific workplace environment, it does not necessarily mean that a medical school is not obliged to provide it. Ultimately, decisions on reasonable adjustments are matters for medical schools to be taken on the facts of the particular case.

When considering support for a student, the key thing to consider is whether providing a particular form of support or reasonable adjustment would enable a student to demonstrate a relevant competence standard – in this case the *Outcomes for graduates*. We recommend this approach because:

- Outcomes for graduates is an objective set of criteria which every medical student needs to demonstrate, developed with a range of experts in medical education
- there is a risk of making subjective judgments about the student's future abilities as a doctor and the setting where they will practise
- clinical environments vary hugely, and postgraduate educators are responsible for allocating a doctor in training appropriately. This includes finding a post where appropriate support will be available
- It cannot be predicted how someone's health condition or disability will affect them in the future.

Responsibilities of employers

Employers have the same legal responsibilities as education organisations, in terms of avoiding discrimination and making reasonable adjustments.

The main difference to the education provisions of the Act is that employers do not have to make adjustments to their premises or working practices until they are actually needed by a disabled employee or applicant.

Employers must, however, take reasonable steps to find out if an employee or applicant is a disabled person.

Employment law

With the contract of employment, different legal provisions come into play. Under Part 5 of the *Equality Act 2010*, discrimination is outlawed in all aspects of employment and occupation including recruitment and selection, including advertising jobs; retention of employees; promotion and training.

- direct discrimination (which includes treating someone less favourably directly because of their disability) is unlawful
- discrimination arising from disability (treating someone less favourably than others for a reason relating to their disability) is unlawful
- reasonable adjustments are expected in all aspects of employment, so must be made to working conditions, job descriptions, training, progression and the workplace environment to enable or help disabled people to do their job
- harassment at work is discriminatory
- an employer must not victimise or treat unfavourably someone disabled or not, because they have made allegations of discrimination or brought a complaint or any action under the Act. A complaint of discrimination may be presented to an Employment Tribunal (Industrial Tribunal in Northern Ireland).

Welcomed and valued:

Supporting disabled learners
in medical education and training

Chapter 4:

How can medical schools apply their duties?

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This chapter is for: Medical schools

Key messages from this chapter

- Medical schools should continuously promote health and wellbeing for their students. Students should be empowered to look after their health and wellbeing through activities by the school.
- Medical schools must support disabled learners. Part of this is making the course as inclusive and welcoming as possible. This includes the accessibility of the physical environment, equipment that can help students, and how things are done at the school to make sure disabled learners are not disadvantaged. Schools have a duty to expect the needs of disabled learners, even if there are no disabled students on the course at the time.
- Medical schools can consider the support structures and processes for specific elements of the course such as clinical placements and assessments.
 - Clinical placements are often delivered away from the medical school services, so schools can think about what support will be available to their students while they are there.
 - Assessment is one of the educational components subject to the Equality Act's requirements. All assessments must be based on defined competence standards, and reasonable adjustments should be made in the way a student can meet those standards.
- Medical schools can use a health clearance form and occupational health services to identify students needing support. It is good practice to involve occupational health services with access to an accredited specialist physician, with current or recent experience in physician health.
- A school should make it possible for a student to share information about disabilities (including long-term health conditions) if they wish to do so. Once they have shared this information, the medical school must address the student's requirements for support as soon as reasonably possible.
- It is a matter for each school or university to assess how they approach each individual case. It is important to have a process for balanced and fair decision making that will apply across all cases. One approach we encourage medical schools to consider as good practice is the case management model. Schools can use a stepwise process to develop an action plan for supporting each student.
 - **Step 1:** Form support group for the student
 - **Step 2:** Decide on key contact(s)
 - **Step 3:** Agree confidentiality arrangements
 - **Step 4:** Reach a shared decision about how the student would be affected by the demands of the course.
 - **Step 5:** Deciding whether the student can be supported to meet the competence standards set out in *Outcomes for graduates*. If the student can be supported to meet the outcomes, the school must support them in doing so. If the school decides that the student cannot be supported in

meeting the outcomes, it must encourage the student to consider alternative options, including gaining an alternative degree and other career advice.

- **Step 6:** Forming an action plan. The action plan may elaborate on support in each component of the course, as well as care arrangements for the student.
- **Step 7:** Implementation, monitoring and review. There is a shared responsibility for implementing the action plan between the medical school and the student.
- Schools can assess the effectiveness of the support given to students, for example through regular 'check-ins' or reviews on a termly or annual basis.
- Schools must be prepared to respond to evolving needs of their students.

On ongoing or regular basis for the medical school

- ✓ Promote health and wellbeing among students

- ✓ Consider support structures and processes for specific course components e.g. clinical placements and assessments

- ✓ Make the course inclusive by:
 - ✓ Reviewing accessibility of university premises
 - ✓ Putting equipment in place that students may need to access the course
 - ✓ Looking at how things are done to make sure practices do not disadvantage disabled learners

For each student with potential support needs

1 Student accepted

- ✓ Consider using health clearance form and occupational health services to identify students needing support
- ✓ Give opportunities for students to share information on support needs during induction
- ✓ Give information on contacts and on financial support available

2 Student support needs raised

- ✓ Initiate support arrangements
 - Step 1: Form support group
 - Step 2: Decide key contact(s)
 - Step 3: Confidentiality arrangements
 - Step 4: Reach shared decision on student needs for the course across different components (e.g. lectures, labs, clinical placements, assessments)
 - Step 5: Decide whether student can be supported to meet *Outcomes for graduates*
 - Step 6: Form action plan
 - Step 7: Implementation, monitoring and review

3 Support in place

- ✓ Assess effectiveness of support (e.g. through regular checking in with the student and termly /annual review)
- ✓ Respond to evolving needs and significant changes

Overall support structures: what does good look like?

Medical schools must support disabled learners to participate in education and training. This includes making reasonable adjustments. Every medical school will have individual systems and structures on how to do this.

We [commissioned research](#) to understand what helps provide successful support to students across medical schools. The research highlights principles of good practice that medical schools can adapt to their ways of working:*

- Fostering a positive culture towards health conditions and disability
- Supporting students in sharing information early
- Having established and clear processes for supporting disabled learners
- Effective communication
- Individualised tailored support
- Inclusive learning environment
- Investing in staff training and workshops
- Monitoring and review.

On ongoing or regular basis

Admissions

The Medical Schools Council will publish dedicated guidance with advice on the admissions processes for welcoming applicants with long term health conditions and disabilities.†

Promote health and wellbeing

Medical schools should continuously promote health and wellbeing for their students.

Medicine is a demanding and stressful course and students should be empowered to look after their health and wellbeing through activities by the school.

Some examples of student wellbeing campaigns are in the appendix (panel A7).


Make the course inclusive and welcoming

Before any new student arrives, medical schools should give serious consideration to ensuring the course is inclusive and welcoming for disabled learners. Schools have a duty to anticipate the needs of disabled learners, even if there are no disabled students on the course at a given time.

* More details on what students told us as part of the research are in the appendix of the document (panels A1-A2).

† You can see the key messages from the Medical Schools Council guidance to medical school admission teams in Chapter 2 of this document.

This covers the physical environment, auxiliary aids, and ways of doing things (provisions, criteria or practices).

	The physical environment	Auxilliary aids	Provisions criteria or practices (the 'way things are done')
This means...	<ul style="list-style-type: none"> • Accessible buildings (whether owned, rented or leased) in any location (campus or town-based, multi or single site) • University facilities e.g. classrooms, lecture theatres, catering, and residential accommodation • Specialist facilities e.g. laboratories 	<ul style="list-style-type: none"> • Extra equipment or services to help students participate fully in university life and the learning process • Kind of equipment schools will offer will depend on each individual and their condition 	<ul style="list-style-type: none"> • Includes registration processes, induction processes, curriculum design, programme structure and delivery, module specifications, codes of conduct, student handbooks, overall programme regulations (eg progression and assessment criteria), disciplinary procedures, complaints and appeals processes.
Medical schools...	<ul style="list-style-type: none"> • Can arrange a risk and access audit* of premises and to draw up an access plan. 	<ul style="list-style-type: none"> • Should put in place equipment they anticipate students may need to access the course • Should speak to individual students about their equipment needs 	<ul style="list-style-type: none"> • Should look at how business is conducted on a daily basis and make sure it is disability and ill-health aware, and does not disadvantage disabled learners
More information	Equality Challenge Unit briefing† on inclusive building design for higher education (p 20-21: checklist)	Disabled Living Foundation factsheets‡ to help choose equipment and services (e.g. for communication and vision, walking equipment, choosing a manual or powered wheelchair)	

* Centre for Accessible Environments, Access auditing. Available online at: <http://cae.org.uk/Mour-services/access-auditing/>

† Equality Challenge Unit, Managing inclusive building design for higher education. Available online at: www.ecu.ac.uk/publications/managing-inclusive-building-design-for-higher-education/

‡ Disabled Living Foundation, Full list of factsheets. Available online at: www.dlf.org.uk/content/full-list-factsheets

Panel 10:

Illustrative examples for the way things are done

Here are some illustrative examples of questions we get about the way things are done at medical school. Often situations are more complex than the illustrative examples, so decisions always need to be made on an individual basis.

- Unauthorised vs authorised absences: A school's absence policy may include a maximum number of authorised absences. A disabled learner is likely to need time off to attend medical appointments. If appropriate for a specific student, the school could make a reasonable adjustment to allow the student to attend all their appointments without taking unauthorised absences.
- Giving information in advance: A school may share academic material or schedules with students on a certain date. Disabled learners may benefit from having this information in advance – for example to plan their study or their travel to placement locations. If appropriate for a specific student, the school could make a reasonable adjustment to share this information earlier on.
- Studying part time: Some medical schools have made arrangements for individual students to complete a medical degree in an approach resembling less than full time, for all or periods of the course. If appropriate for a specific student, the school could apply this as a reasonable adjustment for a disabled learner to complete the course.

Consider specific course elements

Clinical placements

Medicine and other healthcare courses have teaching in the clinical environment where care is delivered, such as a hospital, health centre, GP practice or community. This brings the student in contact with patients and their families / carers, where they have to learn how to communicate in that context and perform relevant tasks under supervision. Medical schools often do this at multiple sites far from the university. These sites are not directly managed by the medical schools, but the schools will have agreements in place with the NHS providers for their students to do placements there.

Medical schools may wish to:

- provide support services at the clinical placement locations, which are compatible with the set-up of placements, for example a designated contact based at the hospital, practice etc. Alternatively, schools could offer other means for students to contact support services when on placement (eg out-of-hours contact or helpline)
- organise support for clinical placements as early as possible. Ideally, this would be at the very beginning of the course. Where clinical and non-clinical years are separate, it would be helpful to discuss support at the beginning of the final pre-clinical year
- give disabled learners their placement locations and rotas as early as possible

- include specific information for disabled learners in preparatory sessions for clinical placements (see tips for preparatory sessions in the appendix of the guide, panel A6)
- offer opportunities for disabled learners to shadow on clinical placements (before they start) so they become familiar with the environment and demands
- give training to clinical supervisors about the needs of students with long term health conditions and disabilities
- having a system of 'passports' or 'support cards' carried by students on placement. The passport or card will contain an agreed form of words with the student, to describe their needs. This can be shown to members of staff as necessary in clinical placements. See an [example of using student support cards](#) from University College London.

As students gain experience of the clinical environment it may be necessary for the support group to meet again to assess whether the student can still be supported to meet the outcomes related to clinical skills.

Assessments

Assessment is one of the educational components subject to the Equality Act's requirements. Medical schools may wish to:

- apply some measures across a group of students or for everyone taking the assessment for practical reasons. For example:
 - giving a certain amount of extra time to a group of students
 - placing students needing regular breaks at the back of the room or in a separate room
 - adding a rest station for everyone on a practical exam circuit
 - using coloured paper for all students taking an assessment.
- consider support separately for written and practical assessments, although they will be some overlap between the two settings
- encourage students to feedback on how effective the support has been as soon as they start taking assessments
- consider support 'passports' or cards for assessments. This could apply especially for practical examinations, where there are multiple stations and examiners
- consider automatically applying agreed support without re-approving them for each assessment round.

There is additional guidance on the interaction between competence standards and reasonable adjustments in higher education* by the Equality Challenge Unit.

We receive common questions about assessments at medical school:

* Equality Challenge Unit, Understanding the interaction of competence standards and reasonable adjustments. Available online at: <https://www.ecu.ac.uk/publications/understanding-the-interaction-of-competence-standards-and-reasonable-adjustments/>

Once student is accepted on the course

Health clearance and occupational health services

It is common practice to ask all applicants who have been offered a place to complete a health clearance form. The process is designed for the school to identify anyone who will need support in advance, and to decide the most appropriate kind of support.

Feedback from medical students shows that initial contact with services is crucial and will have a long-term effect on how the individual interacts with the system for support.

Panel 11: Occupational health services

What is occupational health?

- Occupational health is a specialist field concerned with the interaction between work (including vocational training) and health.
- The occupational health service consists of a team of specialist qualified doctors and nurses to offer advice for your health, safety and wellbeing while working or studying.
- The advice is impartial, objective, based on medical evidence and legislation, and bound by the doctor-patient confidentiality.

Why it is helpful to seek advice from occupational health

- The service offers independent advice regardless of who is paying for it.
- Receiving the appropriate advice at the beginning can save students from unnecessary distress or anxiety, and avoid other negative outcomes in the long-term (eg students taking breaks from the course to recover)

What type of occupational health service to involve

- A service that is fit for purpose for offering advice for medical students
- A service with a clear governance structure with senior clinical leadership
- A service with access to at least one accredited specialist physician with demonstrable current or recent experience in physician health (eg SEQOHS accreditation). It is good practice for the team experience and understanding of the professional caring environment and infection control issues.
- A service that will be available during important times in the academic calendar – eg beginning of the academic year.

- A service with an understanding of the different aspects of the course, medical training, and the medical school's processes.
- A service that will establish links and collaborate with other services at the university, including disability and student support services.

Occupational health assessment

The sample forms included in the appendix of the guidance can be used as a starting point for requesting an assessment from the occupational health service, and for the occupational health service sending a report to the medical school. These documents are presented as a guidance, and can be adapted according to the medical school's needs.

Induction as opportunity for sharing information

Medical schools may have an opportunity to find out information for supporting their students during enrolment and induction.

The medical school can:

- include information in induction materials about how the school and university support disabled learners
- give students contact details for all the available support services and the purpose of each, including student support services, student health services, confidential counselling services, occupational health services, disability services and the student union.
- have dedicated face-to-face induction sessions about supporting disabled learners, covering the whole student cohort (see tips for induction sessions in the appendix of the guide, panel A5)
- encourage students and give opportunities to discuss any health conditions or disabilities that are likely to impact on ongoing learning
- include examples or stories of disabled learners in the induction materials

Medical schools can remind students of this information regularly, for example by making it easily accessible on the school's website or holding refresher session on health and disability through the course.

Financial support

Disabled learners can apply for Disabled Students' Allowances (DSAs)* to cover some of the extra costs they have.

Students can get the allowances on top of their student finance. The amount they get does not depend on their household income, but on an assessment of their individual needs. Students do not have to repay DSAs.

* Help if you're a student with a learning difficulty, health problem or disability.
Available online at: www.gov.uk/disabled-students-allowances-dsas

The DSA includes three things:

- Specialist equipment allowance: This funds the cost of major items of equipment such as a computer or a digital recorder. It also covers the costs of insurance, technical support and repair.
- Non-medical helper allowance: This funds the cost of note-takers, readers, dyslexia support tuition etc.
- General allowance: This covers other disability related costs not included in the above, such as extra books, printing, photocopying etc. The general allowance can also be used to top up the other allowances if necessary.

More information for disabled students' funding is available on the UCAS website.*

Besides financial assistance with their studies, students may be able to claim additional funding towards day-to-day living. Students can claim this via the Department of Work and Pensions† and Student Finance NI‡ in Northern Ireland. This is not affected by any other student finance the student receives. The amount will be decided based on how their health condition or disability affects the support they need.

Once support needs raised

It is a matter for each school or university to assess how they approach each case. It is important to have a process for balanced and fair decision making that will apply across all cases. One approach we encourage medical schools to consider as good practice is the case management model.

Case management is defined§ as: *'A collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet [...] health and human services' needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes.'* As an approach, it has similarities to multidisciplinary teams in medicine.

Schools can use a stepwise process (see next page) to develop an action plan for supporting each student. The same process can be applied for students who disclose a long-term health condition or disability later on in the course, as well as students who acquire a long-term health condition or disability during their studies. This process gives an overview of what can be done; not all steps will be appropriate for all students, but it can be adapted to each individual case at the discretion of the medical school.

* UCAS, Disabled students. Available online at: www.ucas.com/ucas/undergraduate/getting-started/individual-needs/disabled-students

† Personal Independence Payment. Available online at: www.gov.uk/pip/how-to-claim

‡ Student Finance NI, Students with disabilities. Available online at: http://www.studentfinancenirni.co.uk/portal/page?_pageid=54,1268397&_dad=portal&_schema=PORTAL

§ Commission for Case Manager Certification. Available online at: ccmcertification.org/about-ccmc/case-management/definition-and-philosophy-case-management

Process map for supporting disabled medical students

This process gives an overview of what can be done; not all steps will be appropriate for all students, but it can be adapted to each individual case at the discretion of the medical school.



Step 1: Form support group

Medical schools may have a lead or a team that deals with support arrangements for incoming disabled students. The particular role or job title will differ between schools, but it would be helpful for a designated person or people to have the responsibility for supporting disabled learners.

The lead can communicate with other medical school and university teams to decide who ought to be involved in exploring support arrangements for the incoming students. The core group for support may include:

- a representative from the medical school with knowledge of the academic and clinical components of the course. It would be useful to include someone with a clinical background and an understanding of the specifics of teaching within the course and of clinical placements
- representatives from student support or pastoral services
- representatives from occupational health services
- representatives from disability services
- any other appropriate role within the school's system, for example patient or lay representatives.

The lead can coordinate with the parties that want to be involved to arrange conversations with the medical student going forward.

Step 2: Decide key contacts

After agreeing which parties would like to be involved, the lead can decide who would be the key contacts moving forward.

- Primary contacts for the student: ideally, this would be one named person that can communicate with the student for anything they need in relation to their health condition or disability and an intermediate to other services. The primary contact could be the lead or another member of the support group, and not involved in the student's progression. The lead can give their contact details, availability (e.g. specific working days / hours) and an alternative contact for when they are not available.
- Key internal contacts: The key contact for each of the services that will be involved in exploring support arrangements for the students going forward.

Step 3: Confidentiality arrangements

When handling information relating to individuals, organisations must make sure they do so lawfully. Medical schools must provide students with material on how their information will be used and their rights in respect of that information.

This will help to make sure any information shared by the student is not misused. It will also give students confidence in providing such information to schools. The Information Commissioner's Office

provides guidance on the information to include,* including a checklist (in Panel A10 of the Appendix). The Information Commissioner's Office sometimes offer free advisory visits† to organisations to give them practical advice‡ on how to improve their data protection practice.

A school might want to consider the following when collecting information from students about their health.

- Keeping a clear audit trail of decision making for supporting disabled learners as this is likely to help schools make sure they have taken appropriate steps to provide reasonable adjustments.
- Keeping a record of all conversations between the support group and student. It is good practice to agree the method of recording such conversations and for the student to see a draft record of any discussions.
- Creating a separate file with different access arrangements for confidential information related to health outside of the general student record.

Step 4: Case conference/joint meeting

The lead can organise a meeting between the student and the support group.

The support group may also consider having regular meetings with just its members present as an opportunity to discuss progress and evaluate cases, especially if they are handling several cases at once. The group let the student know about the meetings and give them an opportunity to attend if appropriate.

General things the group might cover are:

- an outline of the student's health condition or disability – to help understand the effect on their studies. It is not necessary to discuss specific medical details or symptoms.
- Considering how the student might be affected by the demands of the course, taking their health condition or disability into account.
- Working together with the student to reach a shared decision is best practice:
 - The student is the best person to explain how their health condition or disability affects them day to day.
 - The support group members are best placed to explain what the student will need to do day to day while at medical school.

* Information Commissioner's Office, Right to be informed. Available online at: <https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/individual-rights/right-to-be-informed/>

† Information Commissioner's Office, Advisory visits. Available online at: <https://ico.org.uk/for-organisations/resources-and-support/advisory-visits/>

‡ Information Commissioner's Office, A guide to ICO advisory visits. Available online at: <https://ico.org.uk/media/for-organisations/documents/2786/guide-to-advisory-visits.pdf>

The discussion could cover the different parts of student life while at medical school:

- 1 Logistics, accommodation and transport:** The student's living arrangements, travel to the university locations for their course, access to other university locations and services (eg library, student's union). Existing university policies are likely to cover much of this.
- 2 Academic part:** What the student will need to do day-to-day to engage with the course. This includes effectively following teaching activities (eg lectures, seminars, tutorials), having access to teaching materials in an appropriate format, studying or study skills support, and undertaking assignments.
- 3 Laboratory part:** A medical course involves sessions in a laboratory or skills lab, where students will use specific equipment and chemicals. The discussions may include what the student will need to attend, use equipment appropriately and complete tasks.

A simulation or a tour of the skills lab (if possible) can help the student have a more realistic picture of what they will need to do.
- 4 Clinical part:** The group can discuss several things about clinical placements:
 - Accommodation while on placements
 - Transport to and from placement sites
 - Navigating the clinical facilities eg accessibility of buildings
 - Typical tasks requested of students on placement (eg administrative and clerical tasks, simple examinations, other clinical tasks)
 - Schedule while on clinical placements
 - Use of equipment, chemicals and pharmaceuticals (e.g. gloves, needles, injectors, cannulas)
 - Use of assistive tools
 - Communication with patients and their families / carersA simulation or tour of the clinical placement sites (if possible) can help the student understand what they will have to do.
- 5 Assessment part:** The written and practical assessments medical students take to progress through different stages of the course.

The group can discuss the format of the assessments including the timing and equipment used. An assessment trial run or simulation can help the student understand what they will have to do. It is also good practice to organise a review after the first assessment a student takes.

6 Care arrangements:

The student might need ongoing appointments with health services to make sure their health condition or disability is managed. The group can:

- ask the student how frequently they will need to attend health appointments and at what locations
- agree on arrangements in advance, for example what leave the student will need during the academic year
- encourage the student to register with local services, so they can easily access health professionals as and when they need to for treatment and ongoing management
- Other pastoral care or financial support needed for the student to manage their health condition or disability

Step 5: Decision on whether student can be supported to meet the *Outcomes for graduates*

Medical schools must use *Outcomes for graduates* as the ultimate benchmark when deciding if a student can be supported through the course or not.

All graduates from UK medical schools must meet the same competence standard, as described in the *Outcomes for graduates*. But importantly you can make reasonable adjustments in relation to how those outcomes are assessed, except where the method of performance is part of the competence to be attained.*

To decide if a student can be supported to meet the *Outcomes for graduates*, the support group can:

- go through all the skills and procedures listed in the *Outcomes for graduates* and ask if the student would be in a position to meet them with appropriate support in place
- explore parts the student might struggle with: Ask the student 'how might you address this?'; 'can you see any problems with this?'; 'what coping strategies might you put in place?'; and 'how can we help with this?'

The discussions can be led by an accredited occupational health physician with experience in physician health. The occupational health physician can complete an assessment and take advice from other specialist organisations if needed; and give their view to the group on whether the student can be supported to meet the *Outcomes*.

* Medical students don't need to perform exposure prone procedures (EPPs) to achieve the outcomes of undergraduate medical education. Students with blood-borne viruses can study medicine, but they may not be able to perform EPPs and may have restrictions on their clinical placements.

Schools can consider any requests from a student for a second opinion or a referral to another occupational health service.

If the school decides the student can be supported to meet the *Outcomes for graduates*, the support group can formulate an action plan for the course. The group can also formulate an action plan with appropriate exit arrangements if after thorough consideration they believe the student will not be able to meet the Outcomes despite support (see Step 6).

Panel 12: Deciding whether to provide support

In their Good Practice Framework for supporting disabled students*, the Office of the Independent Adjudicator (OIA) recommends asking the following questions when applying policies and procedures.

- Is the student disabled?
- If so, what provisions (for example, policies and procedures) are we now applying to them?
- Do these provisions place them at a disadvantage?
- What could be done to prevent that disadvantage?
- Would it be reasonable for us to take those steps?

Based on the guidance from the Equality and Human Rights Commission, the medical school can ask the following questions:

- Have we considered this case individually, about the specific student and their unique circumstances?
- Have we explored treating the student better or 'more favourably' than non-disabled people as a part of the solution?
- Is / are the proposed adjustment(s) effective in removing or reducing any disadvantage the disabled student is facing? Have we considered other adjustments or changes that can contribute?
- How easy or practical is this adjustment?
- How much does this adjustment cost?
- Is there advice or support available? Have we explored getting expert advice to support balanced decision making? Could we contact specialist organisations?
- Do we believe this / these adjustment(s) would increase the risks to the health and safety of anybody (the student, other students, staff, patients etc.)? If yes, have we done a proper, documented assessment of the potential risks?

An adjustment could not be reasonable if there is a risk to safety. But the conclusion there is a risk or potential risk must be based on a proper, documented assessment rather than any assumptions, as we want to reassure learners that an objective decision-making process will be followed for their cases.

* OIA, Good Practice Framework for supporting disabled students. Available online at: www.oiahe.org.uk/media/117373/oia-good-practice-framework-supporting-disabled-students.pdf

Step 6: Action plan

Once a decision has been made on whether the student can be supported to meet the *Outcomes for graduates*, the support group can formulate an action plan with the student.

If the school decides the student can be supported to meet the <i>Outcomes for graduates</i> :	If the school decides the student cannot be supported to meet the <i>Outcomes for graduates</i> :
<ul style="list-style-type: none"> • Draft an action plan for support and reasonable adjustments, for the student to engage with each part of the course. • Draft with input from the student if possible. • Incorporate any recommendations provided by the occupational health physician. If there are concerns about feasibility, the group can discuss to reach an agreement on what would be possible. • Consider financial support for putting the plan in place. 	<ul style="list-style-type: none"> • Good practice to meet with the student and explain decision in person. • Decision can be explained in the context of Outcomes for graduates and Promoting excellence, which says it is not possible for learners to progress if they cannot meet the required learning outcomes (R3.15) • Encourage the student to consider alternative options, including gaining an alternative degree from the university and other career advice* • Some suggestions for having difficult conversations are in the appendix of the guide (panel A3).

Step 7: Monitoring and review

Once the action plan has been agreed, the school can appoint someone responsible for its implementation. Implementing the action plan is a shared responsibility between the medical school and the student.

- The key contact and the student can meet regularly to monitor the progress of the action plan, for example through a termly or annual review. The school can also give a contact for the student to raise issues in case they are not happy with the support provided.
- The student has to engage with the support process and contribute to the implementation of the action plan. If the student fails to comply with measures and adjustments designed to enable them to complete the course that may become a student fitness to practise issue ([paragraph 81, Professional behaviour and fitness to practise](#)).

* The school is likely to have clearly identifiable individuals or teams in the school for expert careers advice. The school can also point the student to external careers advice, for example by BMA Careers (<https://www.bma.org.uk/advice/career>) and Medical Success, Alternative medical careers advice for doctors. Available online at: <http://medicalsucces.net/careers-advice/alternative-medical-careers/>

Once support is in place

Evolving needs

Medical schools should keep in mind that the needs of disabled learners may change during the duration of the course.

It is good practice for the school to take steps to assess the effectiveness of the support given to disabled learners. These could include:

- regular 'checking in' conversations with the student
- means for the student to raise any issues about the support they are receiving
- a more formal review scheduled at regular intervals, e.g. termly or yearly.

The key contact from the medical school can handle small changes in the support received by the student, in liaison with the appropriate services.

If there are significant changes, the key contact from the medical school may wish to call another case conference or joint meeting to discuss how these can be accommodated. This is particularly relevant for deteriorating or degenerative conditions. If a student's condition changes significantly, the medical school support group may need to re-assess whether the student can still be supported to meet the Outcomes for graduates.

Taking time away from the course*

Some students may become unwell during their studies and need to take time away from the course to recover.

If the school or a medical student themselves thinks that they would benefit from taking time away from the course, the support group could meet again to reach a decision (involving the student if appropriate). The discussions could cover:

- why the student would benefit from/may want to take time away
- how long it is recommended for the student to take.
 - missing a considerable amount of teaching time or placements can make it impossible for a student to catch up on their work. The school needs to balance this with the negative effect that retaking a year can have on the student, so decisions need be made on a case-by-case basis
- what the student is expected to do, or what the student aims to do during that time (e.g. attend treatment programme)

* This section is based on the advice given to medical schools on this topic in [Supporting medical students with mental health conditions](#) (joint guidance with the Medical Schools Council).

- where they will be based during their time away: for example, locally and using university facilities, or returning home to have support from family and friends
- what level of contact they will have with the medical school and university
- how the school can help them reintegrate into the course when they return.

There will be times when the school and a student disagree about whether taking time away from the course is the right thing to do. The school should take reasonable steps to understand the difference of opinion and to develop an appropriate plan with the student.

The school should provide a high level of pastoral support as this will be a difficult time for the student. The same applies once a student who has taken time off returns to the course.

The school should think about ways to build flexibility into courses, so that students are able to catch up on the time they have missed.

Panel 13:

Can schools provide an adjustment that is not considered as realistic in the clinical environment, such as extra time?

The assessment is designed to test specific competence standards. A reasonable adjustment can be made to enable a disabled student to meet the same standard expected of all students – it cannot change or lower that standard. The key factor is whether the element adjusted is part of the competence standards tested in that assessment.

Extra time is a possible reasonable adjustment. It depends on whether the medical school decides that the time component is part of the competence standards tested in that particular assessment. This also applies to other components, for example whether a competence you want to test is spelling, punctuation and grammar, or the language used in the questions.

Medical schools can consider adjustments like the following examples. These examples are illustrative and decisions always need to be made on an individual basis.

- additional time for an assessment or specific components of an assessment
- not marking down on spelling, punctuation and grammar
- allowing students to use pen and paper
- allowing students to take the assessment in a quiet environment – for example, a person with dyslexia may find it very difficult to concentrate in busy overcrowded environments

When arranging support for assessments that simulate the clinical environment, medical schools may wish to consider that:

- it is natural for medical students to be more stressed than usual for an assessment. Stress can exacerbate a number of conditions – eg making a stammer worse than usual

- medical students and doctors are individuals of high ability and can develop successful coping strategies in clinical practice. For example, using templates to help structure written work; spellcheckers, dictation of notes, visual/audio methods, checklists, medical apps, and speech recognition software

Requests for adjustments need to be substantiated by the student, for example through a report by an educational psychologist. Similarly, schools have to substantiate declining requests for adjustments. A blanket policy is unlikely to be reasonable.

What is considered reasonable, and whether a particular adjustment would prevent the competence standard from being demonstrated, is a decision for each medical school to be taken based on the facts of each particular case.

Panel 14:

What can medical schools do when students are diagnosed with a health condition or disability as a result of failing an assessment?

If a student fails an assessment or a specific component unexpectedly, the school may explore if it is because of a long-term health condition or disability.

- Medical students are individuals of high ability, so it is likely that any health condition or disability affecting exam performance remained hidden. Students could also think that a diagnosis at a young age is irrelevant because it has not affected their performance in previous assessments, for example at school.
- The nature of assessment at medical school is particular to that setting, so students would not have been in that exam environment before.
- There are hidden disabilities that can affect exam performance – for example the [International Dyslexia Association](https://www.dyslexiaida.org/dyslexia-test/)* says '*Dyslexia affects 1 in 10 individuals, many of whom remain undiagnosed and receive little or no intervention services*'.

* [dyslexiaida.org/dyslexia-test/](https://www.dyslexiaida.org/dyslexia-test/)

Welcomed and valued:

Supporting disabled learners
in medical education and training

Chapter 5:

Transition from medical school to Foundation training

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This chapter is for: Medical schools

Key messages from this chapter

- Medical schools must only graduate medical students that meet all of the outcomes for graduates and are deemed fit to practise.
- There are two processes that disabled learners, medical schools and foundation schools can use to make sure incoming foundation doctors are allocated to an appropriate post for their training. These are the Transfer of Information (TOI) process and the Special Circumstances pre-allocation process.
 - The TOI process communicates information to the foundation school (via the TOI form) to put support and reasonable adjustments in place.
 - Pre-allocation on the grounds of Special circumstances is a separate process to allocate graduates to a specific location for their foundation post.
- Postgraduate educators and doctors in training have a shared responsibility to make sure the right information is known about a doctor's health.
- Less than full time training may help disabled doctors. Postgraduate educators can inform disabled doctors about the possibility of less than full time training, and direct them towards relevant information and guidance.

Towards graduation

Medical schools must only graduate medical students who:

- meet all of the outcomes for graduates AND
- are deemed fit to practise.

Any discussion about where the student can be placed and what they might be able to manage should be as early as possible, and earlier than the penultimate year of study. This discussion can be an opportunity for the student to reflect on career plans.

Any discussion about student fitness to practise should be separate to conversations about support in relation to a disability or long term health condition.

If you are worried that a student cannot meet the criteria because of their health condition or disability:

- We have [advice about students who might not meet our published outcomes for graduates](#). Schools must carefully consider whether this is the case.

- Schools must give advice on alternative career options, including pathways to gain a qualification (R3.16 from *Promoting excellence*)
- Schools must support students to address any concerns related to their health. One example is offering an additional year after graduation for students to gain additional clinical experience after they have completed all the formal components of the course.
- our fitness to practise guidance gives advice on [considering fitness to practise on the grounds of health \(page 34\)](#) in exceptional circumstances, a student who cannot graduate can be removed from the course on health grounds – [you can find more advice on this scenario \(page 71\)](#).

It is good practice for schools to encourage any students who were involved in student fitness to practise procedures (for whatever reason) to apply early for provisional registration. This is to make sure their application is processed on time for them to start the Foundation Programme.

It is also good practice for medical students to have their final year placements in the area where they will be starting their foundation post, if this is practically possible.

Transfer of information (TOI) process

The Transfer of Information (TOI) process exists to communicate information to the foundation school to put support and reasonable adjustments in place for incoming foundation doctors.

This happens through the TOI form, which is completed by the medical school and the student, and received by the foundation school a few months before the start of the Foundation Programme.

The TOI guidance for applicants* includes a summary and timeline of the process on pages 3-4. An adapted version is on the next page.

When graduating students complete their TOI forms, they are told to: *'provide sufficient information on the nature of your condition or disability to enable your foundation school to understand how it may affect you in your clinical training or work as a doctor, and to understand your support needs'*.

The medical schools can encourage their graduating students to contact the occupational health services where their post will be based, or to give their consent for the employer to inform the occupational health services.

Where support arrangements cannot be made in an existing post, the foundation school and postgraduate dean may consider establishing an individualised post, subject to training capacity, GMC approval and resources.†

* UK Foundation Programme, TOI guidance for applicants. Available online at: http://www.foundationprogramme.nhs.uk/sites/default/files/2018-10/TOI%20Guidance%202019_1.pdf

† UK Foundation Programme, Foundation Programme Reference Guide 2017. Available online at: <http://www.foundationprogramme.nhs.uk/sites/default/files/2018-07/Reference%20Guide.pdf>

Adapted version of TOI guidance for applicants

PENULTIMATE YEAR										
Preliminary discussion between medical school and local Foundation school director for cases where they want to make sure the student will have the appropriate support in the workplace.										
FINAL YEAR										
BY SEPTEMBER	AUTUMN	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	
Early review meeting (medical school and local foundation school): identify final year medical students with considerations for location or delivery of Foundation Programme.	Invite students identified through the early review meeting to attend a confidential meeting to discuss the level of detail to be provided on the TOI form.	Send guidance and a TOI form to all final year students applying for the Foundation Programme. Medical student to seek guidance if required from medical school on completing the form.								Foundation doctor and educational supervisor to discuss educational progress details at the initial meeting with educational supervisor Review whether the post is appropriate and the necessary support can be put in place
	Ask permission of graduating student to share more details about support and reasonable adjustments than captured in the TOI form with the foundation school directors, to get advice about appropriate posts.	By 30 May: Review TOI forms completed by students and add any relevant information if necessary. Endorse and sign final forms. Send original form to the allocated foundation school. Make copies of the form, one for the medical student and one for medical school records.								
	Consider having a more formal handover of the case to the foundation school once the student has been allocated, if the student consents to it.	By 14 June: Foundation school to consider if any adjustments or additional support may be provided to enhance the training and development of the new foundation doctor. Try and find an appropriate post for the incoming foundation doctors, with the local education provider and postgraduate dean.								

Pre-allocation through Special circumstances process

- Medical schools can encourage disabled learners to consider applying to the Foundation Programme via the [Special circumstances process](#). This is a separate process to allocate graduates to a specific location for their foundation post.

A post in a specific geographical area can help with attending health appointments or continuing a treatment programme, while staying in a familiar location near support networks.

Disabled doctors told us that training in a familiar environment was helpful as navigating new NHS environments could be challenging.

A student or graduate can apply for pre-allocation under four criteria,* two of which are relevant to having a long-term health condition or disability:

- Criterion 3: 'The applicant has a medical condition or disability for which ongoing follow up in the specified location is an absolute requirement.'
- Criterion 4: 'Medical school nomination for pre-allocation to local foundation school on the grounds of unique special circumstances'.

Foundation schools will review the special circumstances application forms. If a graduating student or doctor in training applies under Criterion 3, their application will include a supporting statement by the individual and information from occupational health. If a graduating student or doctor in training applies under Criterion 4, their application will include a supporting statement by the individual and information on their current situation by another signatory (a professional person who has recognised standing to support the application).

* UK Foundation Programme. Applicant guidance. Available online at: <http://www.foundationprogramme.nhs.uk/sites/default/files/2018-12/UKFP%202019%20Applicants%27%20Handbook.pdf>

Entering foundation training

The importance of sharing information

Postgraduate educators and doctors in training have a shared responsibility to make sure the right information is known about a doctor's health.

Not sharing information with postgraduate educators may lead to them not knowing that a doctor in training needs support. It may also cause problems for doctors in training, because they do not receive the support they need to work and train early enough. In some cases it may lead to concerns about a doctor's behaviour, when the behaviour is related to lack of support.

Less than full time training

Less than full time training may help disabled doctors. Postgraduate educators can inform disabled doctors about the possibility of less than full time training, and direct them towards relevant information and guidance.

Any doctor in training in a substantive post can apply for less than full time training.* Less than full time training can be done in three ways:

- in a full time slot
- in a slot share
- as a supernumerary doctor.

The minimum percentage for doctors in less than full time training should be 50% of full time training. In exceptional individual circumstances, postgraduate deans have flexibility to reduce the time requirement for less than full time training to less than 50% of full-time. However, doctors in training should not normally undertake a placement at less than 50% for a period of more than 12 months. No trainee should undertake a placement at less than 20% of full time (see [GMC position statement: Conditions for less than full-time training](#), November 2017).

The postgraduate dean considers and approves requests for less than full time training posts. It is helpful if doctors tell their deanery, HEE local team or foundation school that they wish to do less than full time training as early as possible.

Decisions by the postgraduate dean or nominated representative only relate to educational support for the doctor's less than full time training application. Employers will make a separate decision about the employment aspects of any request, including the proposed placement and any associated out of hours work. Notifying an employer as early as possible about a doctor in training's intention of working less than full time can help. The guardian of safe working can also be involved in the less than full time training decision making.

* BMJ Careers, Trainees' tales of less than full time training. Available online at: <http://careers.bmj.com/careers/advice/view-article.html?id=20008522>

The support for less than full time training is echoed in the *Foundation Programme Reference Guide 2017** (pages 46–50) and the *Gold Guide*† (7th edition, pages 30–34).

Panel 15:

More resources about less than full time training

- Health Careers page: information on eligibility, applying, tips and resources (<https://www.healthcareers.nhs.uk/explore-roles/doctors/career-opportunities-doctors/less-full-time-training-doctors>)
- BMA page (BMA members access): advice on flexible working and less than full time training (<https://www.bma.org.uk/advice/career/applying-for-training/flexible-training-and-ltft>)
- BMJ Careers article: case studies of doctors working less than full time (<http://careers.bmj.com/careers/advice/view-article.html?id=20008522>)

* UK Foundation Programme, Foundation Programme Reference Guide 2017. Available online at: <http://www.foundationprogramme.nhs.uk/sites/default/files/2018-07/Reference%20Guide.pdf>

† COPMeD, A Reference Guide for Postgraduate Specialty Training in the UK, 7th edition. www.copmed.org.uk/images/docs/gold_guide_7th_edition/The_Gold_Guide_7th_Edition_January_2018.pdf

Welcomed and valued:

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Chapter 6:

How can postgraduate
training organisations apply
their duties?

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This chapter is for: Postgraduate deans and their teams, including foundation schools, local education providers, medical royal colleges and faculties, doctors in training and trainers.

Key messages from this chapter

- Disabled doctors in training must be supported to participate in clinical practice, education and training.
- All doctors in training should have access to occupational health advice. Doctors may acquire a condition or disability at any stage of their career. If a doctor in training has a long-term health condition or disability, they may need specialist occupational health advice through an accredited occupational health physician, to make decisions about training and working
- It is a matter for postgraduate educators and employers to assess how they approach each individual case. One approach we encourage to consider as good practice is the case management model. Postgraduate educators and employers can use a stepwise process to develop an action plan for supporting each doctor in training. This process gives an overview of what can be done – not all steps will be appropriate for all doctors in training, but it can be adapted to each individual case at the organisations' discretion.
 - Step 1: Sharing information - Doctors in training share information about how their condition or disability affects them with their deanery / HEE local team and employer.
 - Step 2: Postgraduate dean as gatekeeper - Postgraduate dean or nominated representative to arrange the consideration for what support is needed.
 - Step 3: Form doctor's support network. Depending on decision by postgraduate dean or nominated representative, they can gather individuals to provide advice on how the doctor in training can be supported
 - Step 4: Decide key contact(s)
 - Step 5: Further confidentiality arrangements.
 - Step 6: Occupational health assessment. It may be helpful for a disabled doctor in training to have an occupational health assessment.
 - Step 7: Case conference /joint meeting. The support network may discuss any recommendations from the occupational health assessment, to form an action plan on how the doctor in training will be supported going forward.
 - Step 8: Action plan. The action plan could address a number of areas where the doctor in training can be supported. The purpose of any support implemented is to help the doctor achieve the level of competence required by the Foundation Programme curriculum or the specialty curricula – and not to alter or reduce the standard required. It is good practice for the action plan to be developed in collaboration with the doctor in training as much as possible.

- Step 9: Monitoring and review. There is a shared responsibility for implementing the action plan between the employer, deanery or HEE local team and the doctor in training.
- The educational review process can help monitor the support a doctor in training is receiving, record any relevant conversations in the educational portfolio or escalate concerns to the support network as needed.
- The preparation and evidence submitted by disabled doctors in training for the Annual Review of Competence Progression (ARCP) can be an opportunity to raise something about the support they are receiving and the environment in which they are training. The ARCP process is also a way to decide whether a doctor in training can be supported to meet the competence standards at their stage of training.
- Colleges and faculties should remove or revise any redundant aspects of the curriculum, not crucial to meeting the required standard that may disadvantage disabled doctors.
- Organisations designing assessments have a duty to anticipate the needs of disabled candidates.
- All doctors in training must have an educational supervisor who should provide, through constructive and regular dialogue, feedback on performance and assistance in career progression.

Overall systems and structures: what does good look like?

Disabled doctors in training must be supported to participate in clinical practice and educational activities.

The responsibility for postgraduate medical education and training currently rests with the postgraduate deans. The training relationship is complex, with the doctor being both a learner with this learning being overseen by the postgraduate dean, and also a working doctor with this responsibility being that of the employer.

We [commissioned research](#) to understand what helps provide successful support to doctors in training:

- Fostering a positive culture and a 'can do' attitude towards disability
- Supporting doctors in training in sharing information early and having an effective process to transfer information
- Having established and clear processes for supporting disabled doctors in training
- Effective communication across individuals and organisations supporting doctors in training
- Individualised tailored support
- Including doctors in training in collaborative decision-making

- Equality and diversity training: Postgraduate educators, local education providers and employers deliver equality and diversity training to their staff so they have a better understanding of the challenges of doctors in training with protected characteristics, including disability.
- Dedicating financial resources to supporting doctors in training with long-term health conditions and disabilities.

The attitudes doctors told us* they came across reflect the importance of implementing the principles of good practice:

'I came back to training after diagnosis of a lifelong condition which affected my basic daily functions and my supervisor expected me to be the same trainee as I was before I left – even though I had been through a life-changing experience'

Doctor in training

'I had to fight with the deanery to get everything. In all the hours I have spent writing emails, chasing people and thinking about this, I could have done so many other things for my career, my academic research, and my family'

Doctor in training

'I was off work with depression and I was asked if I was actually using the time to study more for my exams'

Doctor in training

'I arrived at the hospital and I was expected to know exactly what adjustments I would need without any conversations, when I had never worked there before'

Doctor in training

* In discussions we held with doctors, they also brought up a number of issues and suggestions, which you can see in our [summary](#) from these sessions.

Understanding the needs of doctors in training

Our research and expert advice highlight the case management model as best practice for supporting the needs of doctors in training.

Case management is defined* as: '*A collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet [...] health and human services' needs. It is characterised by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes.*' As an approach, it has similarities to multi-disciplinary teams in medicine.

Using that process flow can help create an action plan for supporting each disabled doctor in training.

This process applies for disabled doctors at any stage of training. The same stepwise approach can be considered for assessing doctors in training with new or evolving health needs.

All doctors in training should have access to occupational health advice. Doctors may acquire a condition or disability at any stage of their career. If a doctor in training has a long-term health condition or disability, they may need specialist occupational health advice through an accredited occupational health physician, to make decisions about training and working.

The deanery or HEE local teams with the doctors' employers can use and adapt the process as they feel is appropriate, for example by using some of the steps included, depending on the specifics of the case.

* Commission for Case Manager Certification. Available online at:
<https://ccmcertification.org/about-ccmc/case-management/definition-and-philosophy-case-management>

Process map for supporting doctors in training

This process gives an overview of what can be done; not all steps will be appropriate for all doctors in training, but it can be adapted to each individual case at the discretion of the postgraduate deanery / HEE local team and the doctor's employer. All doctors should have access to occupational health advice. Doctors may acquire a condition or disability at any stage of their career. If a doctor has a long-term health condition or disability, they may need specialist occupational health advice through an accredited occupational health physician, to make decisions about training and working.



Step 1: Sharing information

Doctors in training share information about how their condition or disability might affect their practice with their deanery / HEE local team and employer. The doctor in training does not need to share the nature of their condition, they can focus on how it affects their practice and what support or reasonable adjustments they would need.

Step 2: Postgraduate dean as gatekeeper

The postgraduate dean or nominated representative (for example an associate dean or the foundation school director) can arrange the next steps for considering what support the doctor in training needs.

Step 3: Form support network

Depending on decision by postgraduate dean or nominated representative, they can gather individuals to provide advice on how the doctor in training can be supported. We will refer to the people involved as the doctor's 'support network'. The doctor's support network could include:

- an accredited occupational health physician with current or recent experience in physician health, from the occupational health services where the doctor is / will be based
- the deanery or HEE local team
- the foundation school (if applicable), for example through the foundation school director
- the doctor's training programme director
- the director of medical education or nominated representative at the local education provider where the doctor is or will be based
- the doctor's named educational and clinical supervisors (one person could be doing both roles)
- the Human Resources team from the doctor's employer
- the Professional Support Unit (if available)
- the disability support officer (if available).

The doctor in training could be invited to some of the support network discussions. It is good practice to offer the doctor in training options for a few dates, and also the opportunity for them to bring a friend or representative for support.

Step 4: Deciding key contacts

It is good practice for disabled doctors in training to have a key contact they can liaise with for anything related to their support. The support network can assign the key contact(s) with input from the doctor. It may be practical for the key contact to be someone seeing the doctor on a regular basis, such as their educational supervisor.

Step 5: Confidentiality arrangements

When handling information about individuals, organisations must do so lawfully. Organisations must provide doctors in training with material regarding how their information will be used, and their rights in respect of that information. This will help to make sure any information shared by the doctor in training is not misused. It will also give doctors in training confidence in providing such information.

A privacy notice will not only help to make sure any information shared by the doctor is not misused, but it will also give them confidence in providing such information.

The Information Commissioner's Office provides guidance on what to include in privacy information,* including a checklist (in Panel A10 of the Appendix). The Information Commissioner's Office sometimes offer free advisory visits to organisations to give them practical advice† on how to improve their data protection practice.

An organisation might want to consider the following when collecting information from doctors in training about their health.

- Keeping a clear audit trail of decision-making for supporting disabled doctors in training as this is likely to help organisations make sure they have taken appropriate steps to provide reasonable adjustments.
- Keeping a record of all conversations between the support network and the doctor in training. It is good practice to agree the method of recording such conversations and for the doctor in training to see a draft record of any discussions.

Step 6: Occupational health assessment

It could be helpful for a disabled doctor in training to have an occupational health assessment. A high-quality assessment could be very valuable in informing support for the doctor in training. It is good practice for:

- The assessments to be done by an accredited occupational health physician, with demonstrable current or recent experience in physician health, and an understanding of the requirements from doctors in training.
- The assessments to be done through an in-person meeting between the occupational health physician and the doctor.
- If an agency has been hired to provide occupational health services, they provide details of who among their staff will be doing the assessments. It could be helpful for the service to confirm that one or a small number of physicians meeting those criteria will provide the advice for continuity purposes.

* Information Commissioner's Office, Right to be informed. Available online at: <https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/individual-rights/right-to-be-informed/>

† Information Commissioner's Office, Advisory visits. Available online at: <https://ico.org.uk/for-organisations/resources-and-support/advisory-visits/>

The occupational health physician can make an independent assessment of the individual doctor's needs and ways to enable them to progress through their training. The occupational health physician will decide if they need an opinion from an independent specialist or a specialist organisation as part of their assessment. Organisations can also consider any requests from a doctor in training for a second opinion or a referral to another occupational health service.

The Government has published guidance on employing disabled people,^{*} which includes advice from specialist organisations for a number of specific conditions such as mental health conditions, hearing and visual impairments and hidden disabilities (in Section 5 of the Government guidance).

An organisation can use or adapt the sample forms included in the appendix of the guide (panels A8-A9) as a starting point for requesting an occupational health assessment for a doctor in training, and for occupational health reports. The support network can decide if it is necessary to proceed to the next step and call a case conference or joint meeting, or if an action plan can be agreed straight away (step 8).

Step 7: Case conference / joint meeting

The support network can discuss the recommendations from the occupational health assessment.

The discussions will be individual to each doctor in training, but broadly they may cover:

- An outline of the doctor's health condition or disability – to help understand the impact on their training and practice.
- Reaching a shared decision about what support to put in place to help the doctor overcome any obstacles in their training and practice.
 - If the support network has any concerns about the feasibility of the recommendations in the report, they may consider raising these with the occupational health physician who completed the assessment.
 - The Equality and Human Rights Commission gives advice on factors to take into account when considering what is reasonable. These factors are outlined on the panel below.
- Working together with the doctor in training is best practice to reach a reasonable, balanced and evidenced-based decision.
 - The doctor in training is the best person to explain how their health condition or disability affects them day to day.
 - The support network members are experts on educational and employment aspects of being a doctor in training.

* UK Government guidance: Employing disabled people and people with health conditions. Available online at: www.gov.uk/government/publications/employing-disabled-people-and-people-with-health-conditions/employing-disabled-people-and-people-with-health-conditions

The discussion could cover the different parts of training and practice, including:

- accommodation and transport
- facilities, access and equipment
- working hours and rota design
- procedures and tasks
- interaction with colleagues and patients
- supervision
- leave
- care arrangements.

An action plan of how the doctor will be supported going forward can be formed from the discussions.

Panel 16:

Factors to consider when deciding what support to provide

Based on the guidance from the Equality and Human Rights Commission, the support network can ask the following questions. This is not an exhaustive list but it can help with the decision-making process.*

- Have we considered this case individually, about the specific doctor in training and their unique circumstances?
- Have we explored treating the doctor in training better or 'more favourably' than non-disabled people as a part of the solution?
- Is / are the proposed adjustment(s) effective in removing or reducing any disadvantage the disabled doctor in training is facing? Have we considered other adjustments or changes that can contribute?
- How easy or practical is this adjustment?
- How much does this adjustment cost? Have we considered other sources of funding like Access to Work?
- Is there advice or support available? Have we explored getting expert advice to support balanced decision making? Could we contact specialist organisations?
- Do we believe this / these adjustment(s) would increase the risks to the health and safety of anybody (the doctor, other doctors, staff, patients etc.)? If yes, have we done a proper, documented assessment of the potential risks?

* Equality and Human Rights Commission, What do we mean by reasonable. Available online at: www.equalityhumanrights.com/en/multipage-guide/what-do-we-mean-reasonable

Although this guidance is given in the context of employers considering what reasonable adjustments to provide, the principles may also be helpful for postgraduate educators to consider.

Panel 17: More information on Access to Work

Access to Work* is a government scheme for England, Scotland and Wales that gives help to workers with health conditions or disabilities. Any worker, including doctors in training, can get help from Access to Work, if they have a job or are about to start one. There is a similar system in Northern Ireland.†

A worker is offered support based on their needs, which may include a grant to help cover the costs of practical support in the workplace.

An Access to Work grant can pay for items or services the doctor in training needs, including:

- adaptations to equipment
- special equipment or software
- adaptations to the doctor's vehicle so they can get to work
- taxi fares to work or a support worker if the doctor can't use public transport
- a support service if the doctor has a mental health condition - this could include counselling or job coaching
- disability awareness training for a doctor's colleagues
- the cost of moving a doctor's equipment if they change location or job, which is a part of training in medicine

Access to work can also help assess whether a doctor's needs can be met through reasonable adjustments by their employer.

You can find more information for applying for Access to Work at www.gov.uk/access-to-work/apply.

Step 8: Action plan

The action plan formed by the support network will be implemented by members of the network and the doctor's employer.

The purpose of any support implemented is to help the doctor in training achieve the level of competence required by the Foundation Programme curriculum or the specialty curricula – and not to alter or reduce the standard required.

The action plan could address a number of areas where the doctor in training can be supported. Some examples are below. These are not exhaustive and if a doctor in training has an action plan it will be individual to them.

* UK Government, Get help at work if you're disabled or have a health condition (Access to Work). Available online at: www.gov.uk/access-to-work

† nidirect, Employment support information. Available online at: <https://www.nidirect.gov.uk/articles/employment-support-information>

- | | |
|---|---|
| 1 Accommodation and transport | <ul style="list-style-type: none"> • If the doctor is living in hospital accommodation: have reasonable adjustments been made to make it accessible? • How is the doctor travelling to work? Have reasonable adjustments been made to help with transport (eg taxis, parking spaces)? |
| 2 Facilities, access and equipment | <ul style="list-style-type: none"> • Are the premises and facilities accessible? • What, if any, equipment does the doctor need to navigate the premises? • What, if any, specialist equipment does the doctor need to work? |
| 3 Working patterns and rota design | <ul style="list-style-type: none"> • Would the doctor in training benefit from working hour arrangements? • Can the employer make adjustments to working hours (e.g. training less than full time, reduced or flexible hours, reduced daytime / night / weekend on-call duties)? • The doctor could consider temporarily working in a non-training grade. |
| 4 Procedures and tasks | <ul style="list-style-type: none"> • What, if any, procedures or tasks does the doctor need support in performing? • What reasonable adjustments have been made for the doctor to perform these? For example, lumbar support to perform surgery or speech-to-text software to write notes. • Can the doctor not perform certain tasks or procedures in their role? |
| 5 Interaction with colleagues and patients | <ul style="list-style-type: none"> • Does the doctor need help in their communication with colleagues and patients? • What reasonable adjustments have been made for the doctor? For example, a doctor with autism spectrum disorder could receive training to support them with their communication skills. |
| 6 Supervision | <ul style="list-style-type: none"> • Would the doctor benefit from increased supervisory support? |
| 7 Leave and care arrangements | <ul style="list-style-type: none"> • What, if any, pre-arranged leave does the doctor need to attend medical appointments? • Leave for medical appointments must not be taken out of doctors' annual leave. • What follow-up does the doctor need from occupational health services? |

It is good practice for the action plan to be developed in collaboration with the doctor on training as much as possible, and for the final action plan to be shared with them.

If there are concerns about the doctor demonstrating the required competences despite support this can be handled through the [educational review](#) and [Annual Review of Competence Progression \(ARCP\)](#) processes. It is good practice for the members of the doctor's support network to collaborate with their educational supervisor and members of the ARCP panel on this.

Step 9: Monitoring and review

The support network could appoint someone to be responsible for monitoring the action plan implementation, ideally a person in regular contact with the doctor in training.

There is a shared responsibility for implementing the action plan:

- The individual responsible from the support network could meet regularly with the doctor to monitor the plan, for example through a termly or annual review. This could be incorporated into existing reviews. The support network can also give a contact for the doctor in training to raise issues in case they are not happy with the support provided.
- The doctor in training should be encouraged to engage with the support process and implementation of the action plan.

Ongoing communication with the doctor in training will help understand if the reasonable adjustments and support in place are effective. The Equality and Human Rights Commission says that it may be that several adjustments are required in order to remove or reduce a range of disadvantages for a disabled person.*

Disabled doctors will make an individual decision about whether they want to share any information about their health with colleagues and patients. Postgraduate education organisations may support the doctors' decision and empower them to share information if they choose to.

Starting a new post – in the Foundation Programme and after

Shadowing and induction

A doctor starting a new post should be given an induction.

Additionally, new F1 doctors must be supported by a period of shadowing before they start their first F1 post. This should take place as close to the point of employment as possible, ideally in the same placement that the medical student will start work as a doctor.

The shadowing and induction periods are opportunities for disabled doctors to observe the environment they will be working in and consider what help and support they will need on their day-to-day job. It is also an opportunity to share information about their health condition or disability with appropriate contacts.

* Equality and Human Rights Commission. Making sure an adjustment is effective. Available online at: <https://www.equalityhumanrights.com/en/multipage-guide/making-sure-adjustment-effective>

Continuity of support through training and working

Educational review

Every doctor in training goes through a continuous process of educational review, including regular meetings with their educational supervisor. These meetings are an opportunity to touch base on the support the doctor is receiving for their health condition or disability, and document any relevant conversations in the educational portfolio.

The educational supervisor and doctor in training can agree an action plan to address any concerns about progress, and document it.

If the educational supervisor and the doctor think it is appropriate, they can escalate the issues to other members of the support network. There is more information on paragraphs 4.20, 4.30 and 4.32 of the *Gold Guide* (7th edition).

The case for minimising transitions

Transitions are a mandatory part of medicine and can be a challenge for doctors in training, but they can be a particular challenge for disabled doctors in training. This may not be because of the health condition or disability itself, but because the doctor has to do a lot of advance planning and develop coping strategies directly linked to where they work and their day-to-day role. The support they receive may also be linked to their location. For example, a doctor in training with mobility issues may plan carefully about access to sites. A doctor with an autism spectrum disorder may develop communication strategies tailored to their role and colleagues, and a doctor with a mental health condition may build a network of colleagues important to the management of their condition. We encourage postgraduate educators to consider minimising transitions that involve change in location to help disabled doctors in training. This is while still allowing them to demonstrate their skills and meet the competences required for their training. For example, a disabled doctor in training might benefit from completing all rotations of their Foundation Programme in one local education provider or in the same hospital.

Transferring information

Communicating a doctor's support needs in advance is key to making transitions as smooth as possible.

Postgraduate educators and employers would welcome information early for doctors in training at all levels to enable them to plan ahead the support needed for their training and development.

The *Code of Practice: Provision of Information for Postgraduate Medical Training* by NHS Employers, the British Medical Association (BMA) and HEE, aims to set minimum standards for HEE, employers and doctors around the provision of information during the recruitment process. HEE has committed to

providing information to employers (and to doctors via the Oriol system) at least 12 weeks before a doctor is due to start in post.*

Disabled doctors going into or through specialty training can also apply for pre-allocation to a preferred geographical region on the grounds of special circumstances, coordinated across all specialty recruitment processes. This can help with receiving treatment and follow-up for a medical condition or disability.

Progressing through training

Competence standards

A [competence standard](#) is defined in the *Equality Act 2010*[†] as 'an academic, medical or other standard applied for the purpose of determining whether or not a person has a particular level of competence or ability'. In postgraduate medical education, competence standards are included in the Foundation Programme curriculum and specialty curricula, produced by the AoMRC or medical royal colleges and faculties and approved by the GMC.

Disabled doctors told us that one or a few competence standards sometimes kept them from progressing. As a result, they had to change careers or leave medicine all together.

Colleges and faculties should remove or revise any redundant aspects of the curriculum, not crucial for meeting the required standard, that may disadvantage disabled doctors.

We empower colleges and faculties to make such changes to their curricula via our standards and requirements for postgraduate curricula in [Excellence by design \(CS2.3, CS5.1-2, CR5.3\)](#).

Colleges and faculties will be revising their curricula to describe fewer, high level generic shared and specialty specific outcomes. During this review cycle, they should consider whether they can support disabled doctors in training by removing or revising elements of the curriculum that are redundant.

We give advice on how to make curricular changes to support disabled doctors in our [Equality and diversity guidance for curricula and assessment systems](#).

* NHS Employers, BMA, HEE, Code of Practice: Provision of Information for Postgraduate Medical Training. Available online at: www.nhsemployers.org/your-workforce/recruit/national-medical-recruitment/code-of-practice-provision-of-information-for-postgraduate-medical-training

† Equality Act 2010, Section 54. Available online at: www.legislation.gov.uk/ukpga/2010/15/section/54

Assessments

Excellence by design, links curriculum design to assessments. We also have guidance on *Designing and maintaining assessment programmes*.

We were also part of the working group led by the Academy of Medical Royal Colleges (AoMRC) that produced their guidance on reasonable adjustments in high stakes assessments.*

Taking *Excellence by design* and the AoMRC guidance together, key points for organisations designing assessments are as follows.

- The learning outcomes described in postgraduate curricula are seen as [competence standards](#) for the purposes of the *Medical Act 1983*. The purpose of any support implemented is to help the doctor achieve the level of competence required by the curriculum – and not to alter or reduce the standard required.
- Organisations designing assessments, mainly royal colleges and faculties, have to decide exactly what standard is being tested through the specific assessment. Organisations will do this by blueprinting the curricular learning outcomes to the assessment. This must be decided before considering reasonable adjustments, because it will influence what components of the assessments reasonable adjustments can be made to.
- Organisations designing assessments have an anticipatory duty to expect the needs of disabled candidates.
 - That does not mean they have to anticipate the individual needs of every single candidate.
 - It means they must think about how the assessment is designed and carried out, and how it might affect disabled candidates. If the way the assessment is designed or carried out puts barriers in place for disabled candidates, then organisations need to take reasonable and proportionate steps to overcome them.
 - Barriers can be overcome through changing things in the physical environment (eg accessible venues), or providing auxiliary aids (eg coloured paper) or anything else around ‘the way things are done’ in respect of delivering assessments.
- Organisations should give candidates an opportunity to request support and reasonable adjustments for taking the assessment, and have a method for capturing these requests. Some organisations find it helpful to have a policy about evidence they need (eg report from treating physician) to consider the request, and a deadline for requests.
 - Organisations must consider all requests and make a decision on a case-by-case basis.
 - Panel 16 may be helpful in deciding what is reasonable when considering the requests. It is good practice for organisations to keep an audit trail of discussions and considerations leading up to the decision.

* Academy of Royal Medical Colleges, Managing access arrangements for candidates requesting adjustments in high stakes assessments (May 2018). Available online at: http://www.aomrc.org.uk/wp-content/uploads/2018/05/Managing-Access-Arrangements-for-Candidates-requesting-adjustments-in-High-Stakes-Assessments_MP_160518-PFCC-RJ-1.pdf

- If a request is declined, it is good practice for the organisation to give reasons. A form of a reasonable adjustment is to make changes to 'the way things are done'. This may include the college or faculty considering whether a candidate can be allowed extra attempts, in cases where a disability was diagnosed or the appropriate reasonable adjustments were agreed after a number of attempts had already taken place.
- Organisations should consider developing an appeals process, which candidates would be made aware of.
- Ultimately, the question of what is reasonable is a decision for a court or tribunal and organisations should consider seeking independent legal advice to assist their decision making in respect of what adjustments to provide.
- Organisations must provide a rationale that explains the impact of the assessments, including on disabled doctors.

Annual Review of Competence Progression (ARCP)

The ARCP aims to judge, based on evidence, whether the doctor in training is gaining the required competences at the appropriate rate, and through appropriate experience.* Every doctor in training has an ARCP normally done at least once a year.

For disabled doctors in training, the preparation and evidence submitted for the ARCP can be an opportunity to escalate previous discussions they have had about:

- the support they are receiving to meet the required competences or to gain the appropriate experience in the clinical setting
- changing to or from less than full time training.
- the environment in which they are training – for example, whether it is supportive, and any concerns about harassment, bullying or undermining behaviour (see the *Gold Guide* 7th edition, paragraph 4.56)
- any concerns they may have about the potential impact of their health condition or disability on their practice, progress or performance.

If the ARCP panel is discussing concerns about the progress or performance of the doctor, then the panel members can also explore whether there are any underlying health issues the doctor needs additional support for.

The ARCP process is also a way to decide whether a doctor can be supported to meet the competence standards at their stage of training. The ARCP panel will recommend one of the eight outcomes. The decision can be informed by a judgment on the doctor's knowledge, skills, performance (including conduct), health and individual circumstances. There are provisions within the ARCP process to do this, as described in the *Gold Guide* (7th edition). The doctor in training can be offered additional or

* COPMeD, A Reference Guide for Postgraduate Specialty Training in the UK, 7th edition.
www.copmed.org.uk/images/docs/gold_guide_7th_edition/The_Gold_Guide_7th_Edition_January_2018.pdf

remedial training to demonstrate they can meet the competence standards. Exceptional additional training time must be approved by the postgraduate dean, and this can be considered as a potential reasonable adjustment for disabled doctors (paragraph 4.85).

HEE reviewed the ARCP process* in 2017 with the aim of ensuring a fairer, more consistent process for all doctors, and produced short guides to the process for doctors in training.†

Career advice

All doctors in training must have an educational supervisor who should provide, through constructive and regular dialogue, feedback on performance and assistance in career progression (*Gold Guide* 7th edition, paragraph 4.18). The training programme director should also have career management skills (or be able to provide access to them) and be able to provide career advice to doctors in training in their programme (*Gold Guide* 7th edition, paragraph 2.48).

The career lead at the doctor's employer and the career unit at the deanery or HEE local team may also provide support and career advice.

Doctors in training can also seek career advice if they feel their circumstances have significantly changed due to their health condition or disability.

Return to work

Doctors in training must have appropriate support on returning to a programme following a break from practice, including for health reasons. Taking time out of training is a recognised as a normal and expected part of many doctors' progression, for a variety of reasons including health.

The Academy of Medical Royal Colleges has guidance for Return to Practice, including a return to practice action plan, setting up an organisational policy on return to practice and recommended questions and actions for planning an absence and a doctor's return.

HEE recently launched a programme for supporting doctors returning to training after time out. Supported return to training is available across England and includes things like accelerated learning and refresher courses, supported and enhanced supervision, mentoring, and help with accessing supernumerary periods. Doctors in training can contact their local HEE office directly for arranging support to return.

* HEE, Annual Review of Competency Progression. Available online at: <https://www.hee.nhs.uk/our-work/annual-review-competency-progression>

† HEE, Short guides to the ARCP process. Available online at: <https://specialtytraining.hee.nhs.uk/arcpc>

Panel 18:

Resources for career planning for doctors and return to work for doctors in training

Career planning

- BMA Careers: Career advice for several stages in doctors' careers (www.bma.org.uk/advice/career).
- BMJ Careers: A selection of articles on medical careers (careers.bmj.com/careers/advice/advice-overview.html).
- Health Careers: Information on being a doctor, including career opportunities, different roles for doctors, switching specialty, and returning to medicine (www.healthcareers.nhs.uk/explore-roles/doctors).
- Royal Medical Benevolent Fund: The health and wellbeing section of the RMBF includes career advice articles, including careers outside medicine (rmbf.org/health-and-wellbeing/).
- Doctors Support Network: Information on professional support and coaching for doctors with mental health concerns (www.dsn.org.uk/professional-support).
- Medical Success: Advice on alternative careers outside medicine (medicalsucccess.net/careers-advice/).
- Other Options for Doctors: A list of resources for doctors' career development (www.otheroptionsfordoctors.com/resources/career-development/).

Each deanery or HEE local team will have information about career support on their website.

Return to work

- AoMRC guidance for Return to Practice: <https://www.aomrc.org.uk/reports-guidance/revalidation-reports-and-guidance/return-practice-guidance/>
- HEE Supported return to training: <https://www.hee.nhs.uk/our-work/supporting-doctors-returning-training-after-time-out>

Email: gmc@gmc-uk.org

Website: www.gmc-uk.org

Telephone: **0161 923 6602**

Standards and Ethics Section, General Medical Council, Regent's place 350 Euston Road, London NW1 3JN.

Textphone: **please dial the prefix 18001** then
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