General Medical Council

Doctors or Super Humans? Health and Disability in Medicine

Scottish Medical Education Conference
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NB. This presentation includes excerpts from draft guidance, which is subject to change based on the response to the public consultation

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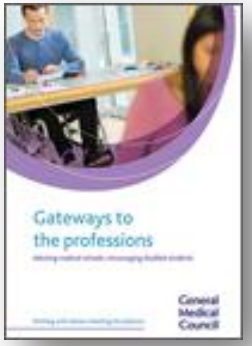
Disabled students and doctors: Our considerations as the professional regulator

- Public sector equality duty - promote equality, eliminate discrimination, foster good relations
- Our standards say organisations must support disabled learners
- As the professional regulator, we firmly believe disabled people should be welcomed to the profession and valued for their contribution to patient care.
- We are also a qualifications body – every doctor has to meet the same competence standards, but reasonable adjustments can be made in mode of assessment of these standards.

What are we doing?



- Revising *Gateways to the professions* guide
  - Supporting disabled students and doctors through medical education and training
- We have restructured the guidance and focused on:
  - Explaining our considerations
  - Explaining the duties of different bodies
  - Making the content more user-friendly and giving practical suggestions about how these could be met
- Formed an external expert steering group, commissioned external research and ran roundtable sessions with key groups

We will be launching a public consultation on the draft guide and publishing the final version in 2018

Welcomed and valued – why?

- Because disabled doctors have a great amount to contribute to patient care

*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*

***As a patient, I experienced and appreciated first-hand the care and sensitivity required for medicine** […] My personal experiences as a patient have become the **foundation of my career in practicing medicine** and will shape me into a better doctor*

***Each person has things to offer** and in a team can contribute to excellent patient care. […] 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*

Welcomed and valued – why?

- Because the medical workforce should represent the population it cares for - a diverse population is better served by a diverse workforce that has had similar experiences and understands their needs.

'About 15% of the world's population lives with some form of disability'

World report on disability (WHO & World Bank), 2011

'There are nearly 13.3 million disabled people in the UK, nearly one in five of the population'

Scope, 2017

Welcomed and valued – why?

- Disabled people in the medical profession increases understanding and improvements in the care of disabled patients, a substantial group with specific healthcare needs.

'Physicians worldwide generally lack training about caring for persons with disabilities, thus frequently compromising their health care experiences and health outcomes'

World report on disability, (WHO & World Bank), 2011

'Disabled people are more likely to experience health inequalities and major health conditions, and are likely to die younger than other people. Accessibility of services is problematic, and disabled people are less likely to report positive experiences in accessing healthcare services.'

Being disabled in Britain (EHRC), 2017

Welcomed and valued – why?

- Because both on a global and a national scale, we need more doctors and we should recruit from under-represented groups as much as possible

*'Globally, there is a **shortage** of almost **4.3 million** doctors, midwives, nurses and other health workers'*

World Health Organisation (2006)

'The BMA is today warning that patient care is at risk due to a chronic shortage of doctors across most areas of medicine'

BMA press release, September 2017

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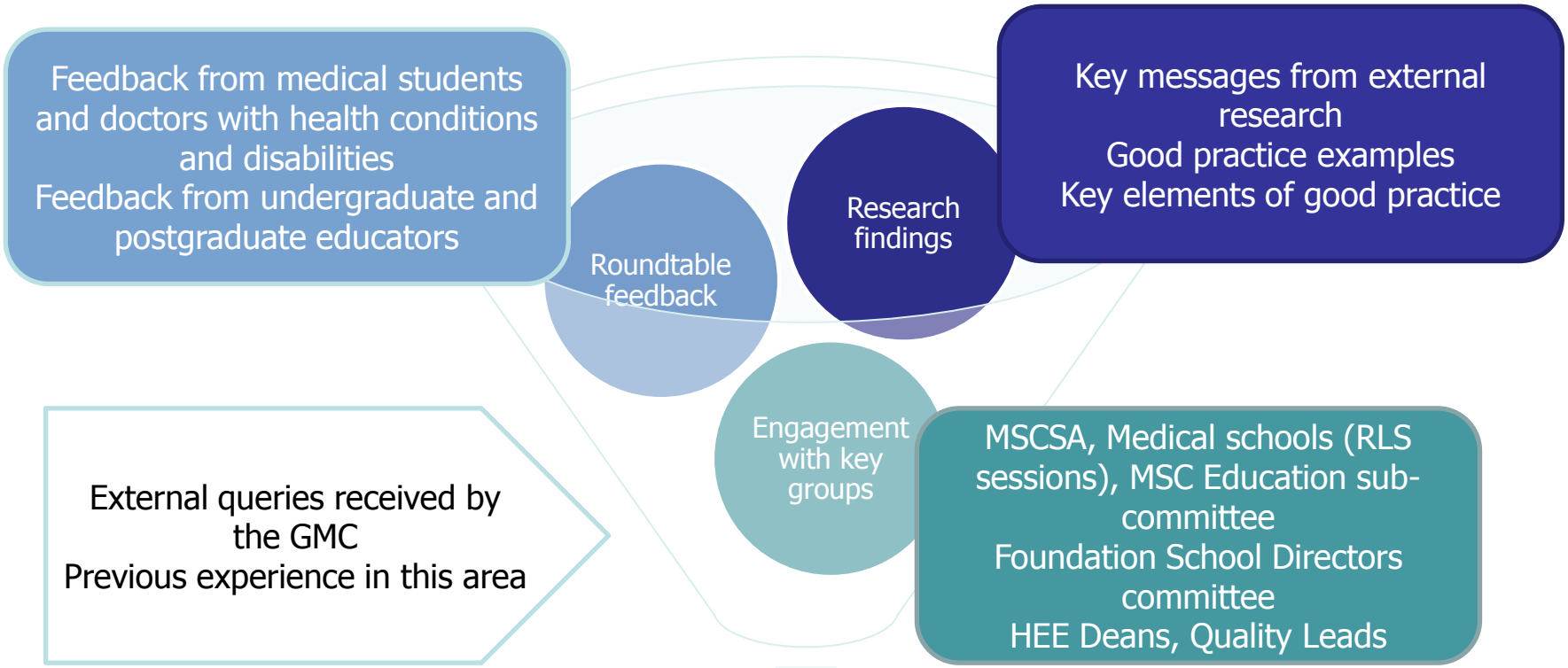
Developing the new guidance

Working with doctors Working for patients

Drafting the updated guidance



Draft guidance

('Welcomed and valued')

External research approach

April - May

Set up and design
Refine approach, sample, data collection tools

May - June

Mixed-method research
Conduct qualitative and quantitative research across target stakeholder groups

July - Aug

Analysis & reporting
Analysis across data streams and produce series of outputs

Scoping outputs

Set up meeting
3 x scoping interviews
Sampling matrix
Data collection tools
Research framework and rationale

Quantitative data collection

Online survey
33 Med School Staff
43 HEE local teams/deaneries

Qualitative data collection

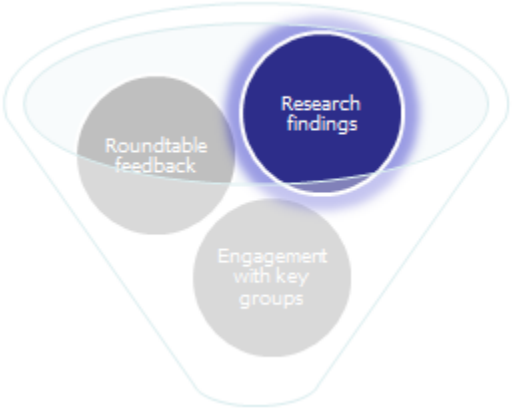
Follow up phone interviews
6 x Medical School (Heads)
13 x HEE local teams/deaneries
5 x Employer Reps (Foundation Directors)

Depth interviews at case study sites & telephone interviews
22 x Head of Student Support & Disability Support Officers
26 x Medical Students who have/not declared an impairment

Deliverables

Progress report July 2016
Draft final report August 2017
Final report
Summary oral presentation of findings

Key insights from the research (1/4)
Awareness of guidance, content and format



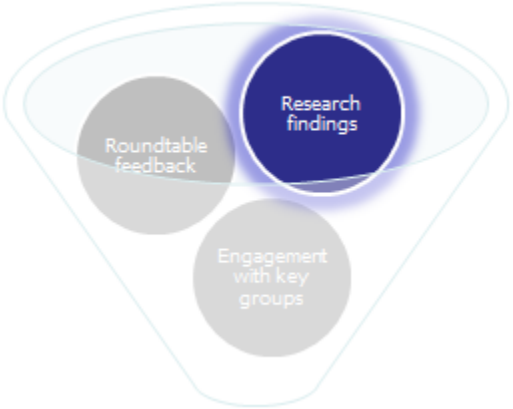
76% of those surveyed think the current guidance should be updated. Medical schools were more familiar with the guidance than postgraduate educators.

Respondents wanted the revised guidance to include:

- a clearer explanation about who is 'disabled'
- specifics about reasonable adjustments
- assurance for decision-making processes
- help for having difficult conversations with students and doctors.

Respondents wanted options to quickly access and interact with the content
Critical that we make the guidance accessible

Key insights from the research (2/4)
Supporting disabled learners

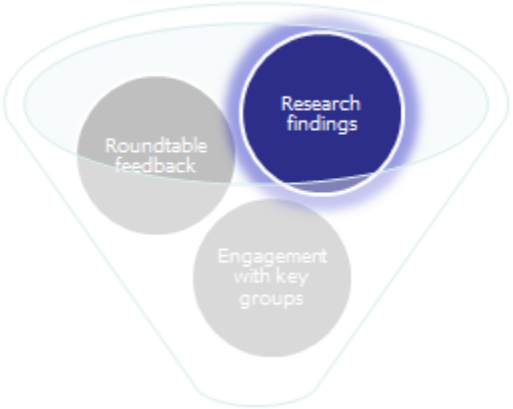


Eight key principles for supporting disabled learners across medical education:

- fostering a positive culture
- clear established processes
- supporting information-sharing
- tailored support
- effective communication
- universally accessible environments
- staff training and workshops
- monitoring and review

Current practices for supporting students and doctors are variable. No single process followed.

Key insights from the research (3/4)
Undergraduate education



Students sometimes did not share information because they:

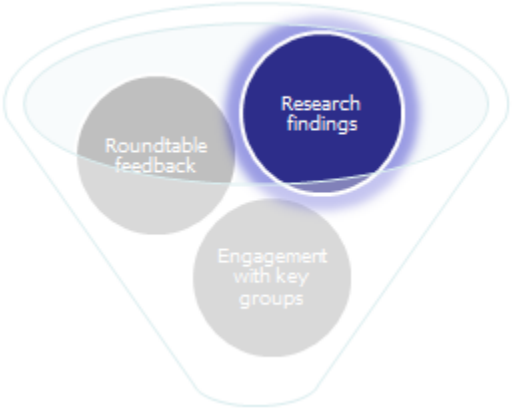
- did not know or were not sure they had a health condition or disability
- they were not sure what support is available
- were worried about SFTP implications

Medical students with long term health conditions and disabilities encounter different types of barriers:

- communication and information barriers
- physical barriers
- financial barriers
- cultural barriers
- rare experiences of discrimination

Transfer of Information (TOI) forms do not always contain enough information about the needs of disabled learners

Key messages from the research (4/4)
Postgraduate training



Postgraduate educators* were concerned it can be difficult to create an inclusive, open and supportive culture within the workplace.

Level of support available in the undergraduate setting may not be available in the postgraduate setting.

Could there be a risk to patient safety?

Lack of flexibility with course requirements and competences

**NB. This is based on a small sample of qualitative interviews with postgraduate deans and vice deans*

Key insights from roundtable sessions: Medical student reflections

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

Key insights from roundtable sessions: Medical student suggestions

More data available on support from schools: National rankings/annual appraisals/audit data with student experiences	Ability for students to voice their concerns directly in a safe space	More signposting to support; Schools picking up on cues to offer support
Adjudicator role: national association of disabled students	Official policies and documents, more succinct and accessible – clear statement about ability to study medicine with a health condition/disability	Forward planning and involving students in decisions, follow up to ensure helpful
More tailored adjustments depending on condition, not static and consider impact at particular time	Role models ('I've done it so you can too') and more information about clinical practice	Standardise exam format in terms of reasonable adjustments eg carry over adjustments made for OSCEs (as done for written exams)

Key insights from roundtable sessions: Doctors' reflections

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

Key insights from roundtable sessions: Doctors' suggestions

Supra-regional/national occupational health services	Accountability through overseeing organisation or expert advisory panels	Reasonable adjustments made in timely manner; highlight legal framework and responsibility of employers
Role of HR promoting appropriate expertise, recommending assessments, preventing bullying	All professional guidelines from medical education bodies to include a section on disability	Attitude of enablement, changing culture, 'you are welcome and you are valued' → GMC asked to take a stand on this
Treat as individuals and develop approaches in partnership, with tailored communication	Being more flexible with competences doctors have to meet, for example by placing conditions to practice and easier transfer between specialties	Repository of support provided and mentoring system of support

You can find out more…

- The full research report and the main themes from the roundtables are available on our website: https://www.gmc-uk.org/education/standards-guidance-and-curricula/projects/health-and-disability-review

- The research findings are discussed in this paper: https://www.mededpublish.org/manuscripts/1499
  DOI: https://doi.org/10.15694/mep.2018.0000057.1

- You can read a blog about what we have done in the review so far: https://gmcuk.wordpress.com/2018/03/21/health-and-disability-review-what-have-we-learned-so-far/

Activity

- Please discuss what you would like to see in the revised guidance

– in response to the issues raised in the research and roundtables

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Overarching concepts

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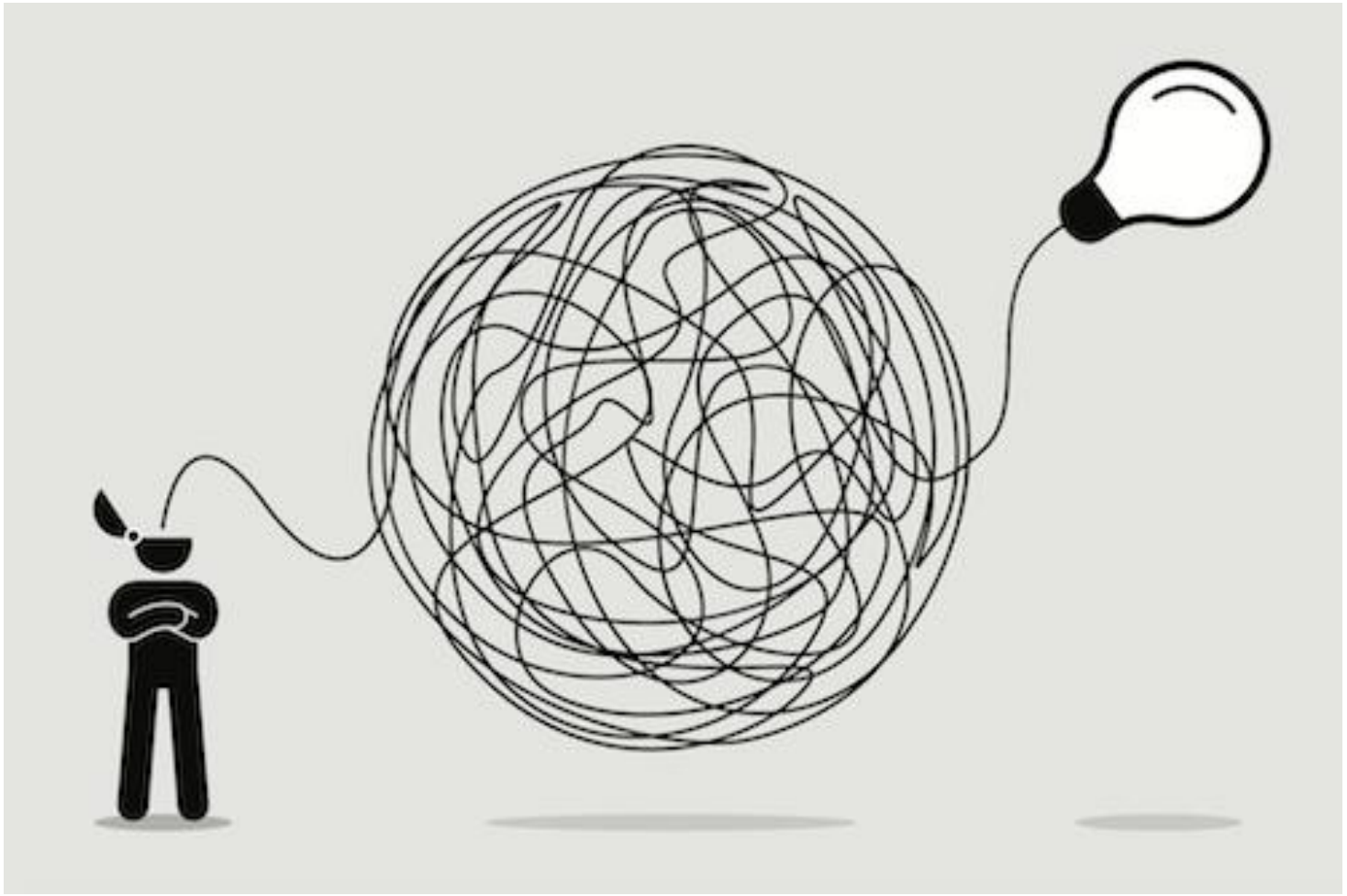
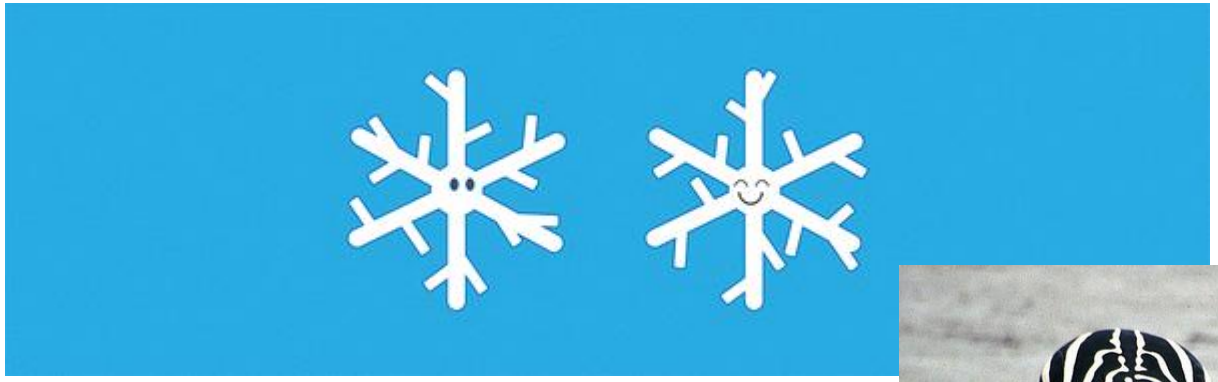
Overarching concepts (1): This is a very complex area, with difficult decisions involved



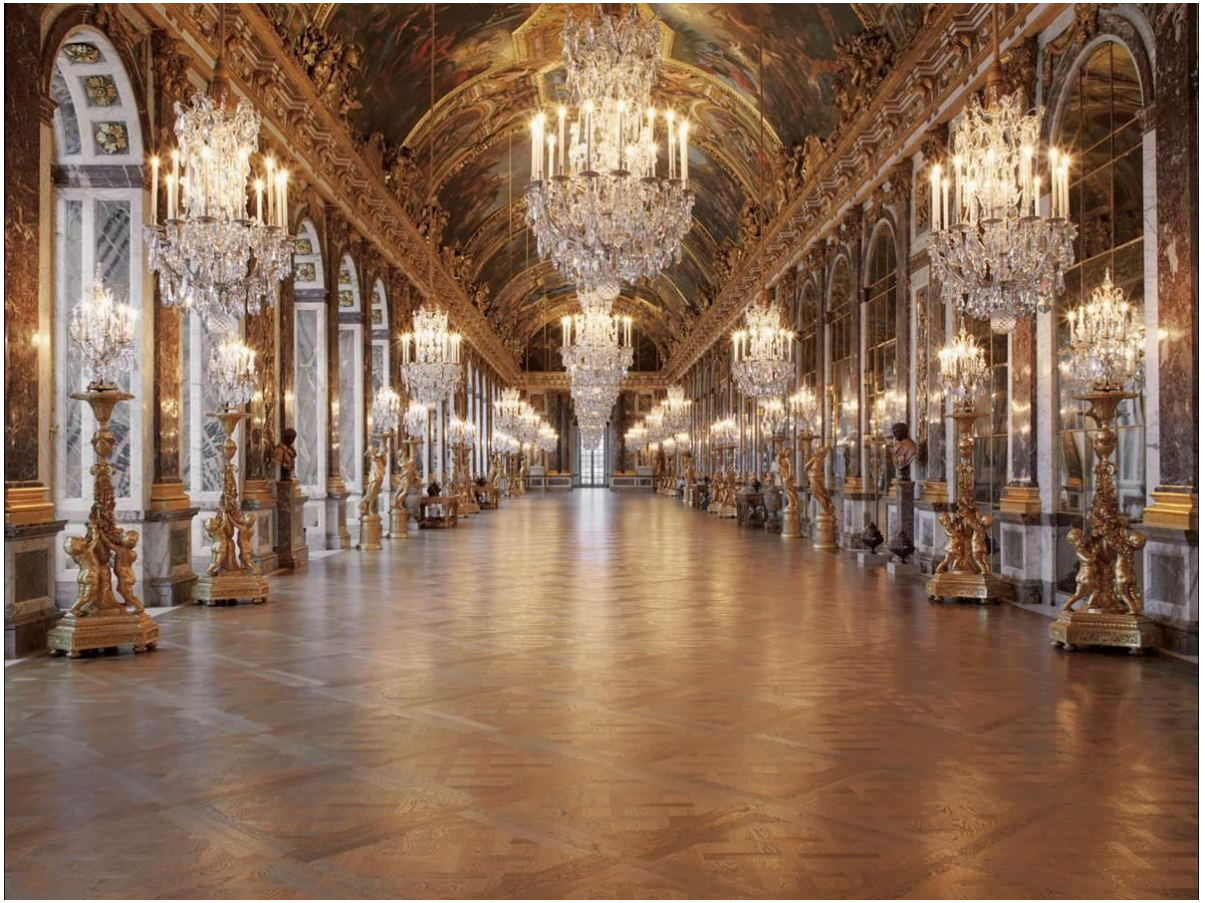
Overarching concepts (2): Everyone has to achieve the same threshold

Overarching concepts (3): We are operating in a complex landscape

Overarching concepts (4): Each case will be unique, even if there are similarities



Overarching concepts (5): Absolute consistency is not the aim – and is not possible



Overarching concepts (6): Decisions have to be made by each medical education body

…but organisations can follow the same principles to reach fair decisions

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More details on content

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Overall structure of new guide – *Welcomed and valued*

Chapter 1: Our considerations as the professional regulator

Chapter 2: What is expected of medical education organisations and employers

Chapter 3a: How can medical schools apply their duties?

Chapter 3b: How can postgraduate educators and employers apply their duties?

Chapter 4: Appendix with additional resources

What are we saying

A few of the key messages from the guide

Our considerations as the professional regulator

- **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.
- Organisations **must consider all requests for adjustments**, but only have the obligation to make the adjustments they consider reasonable.
- 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 reasonable adjustments to the mode of assessment as needed.

What is expected?

What are we saying

A few of the key messages from the guide

Complying with equality legislation

Avoid unlawful discrimination	Make reasonable adjustments
Direct discrimination	Avoid substantial disadvantage
Indirect discrimination	Anticipatory and ongoing
Discrimination arising from disability	Decisions on case-by-case basis
Victimisation and harassment	Keep detailed audit trail

What is expected of employers?

Meeting our standards for medical education and training (*Promoting excellence*)

S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum

- R3.2 Access to resources to support health and wellbeing; educational and pastoral support
- R3.3 Learners not subjected to undermining behaviour
- R3.4 Reasonable adjustments for disabled learners
- R3.5 Information and support for moving between different stages of education and training
- R3.7 Information about curriculum, assessment and clinical placements
- R3.14 Support learners to overcome concerns and if needed give advice on career options

Medical schools: All applicants, current students, and in limited cases former students
Postgraduate educators: All applicants and doctors in training under organisation

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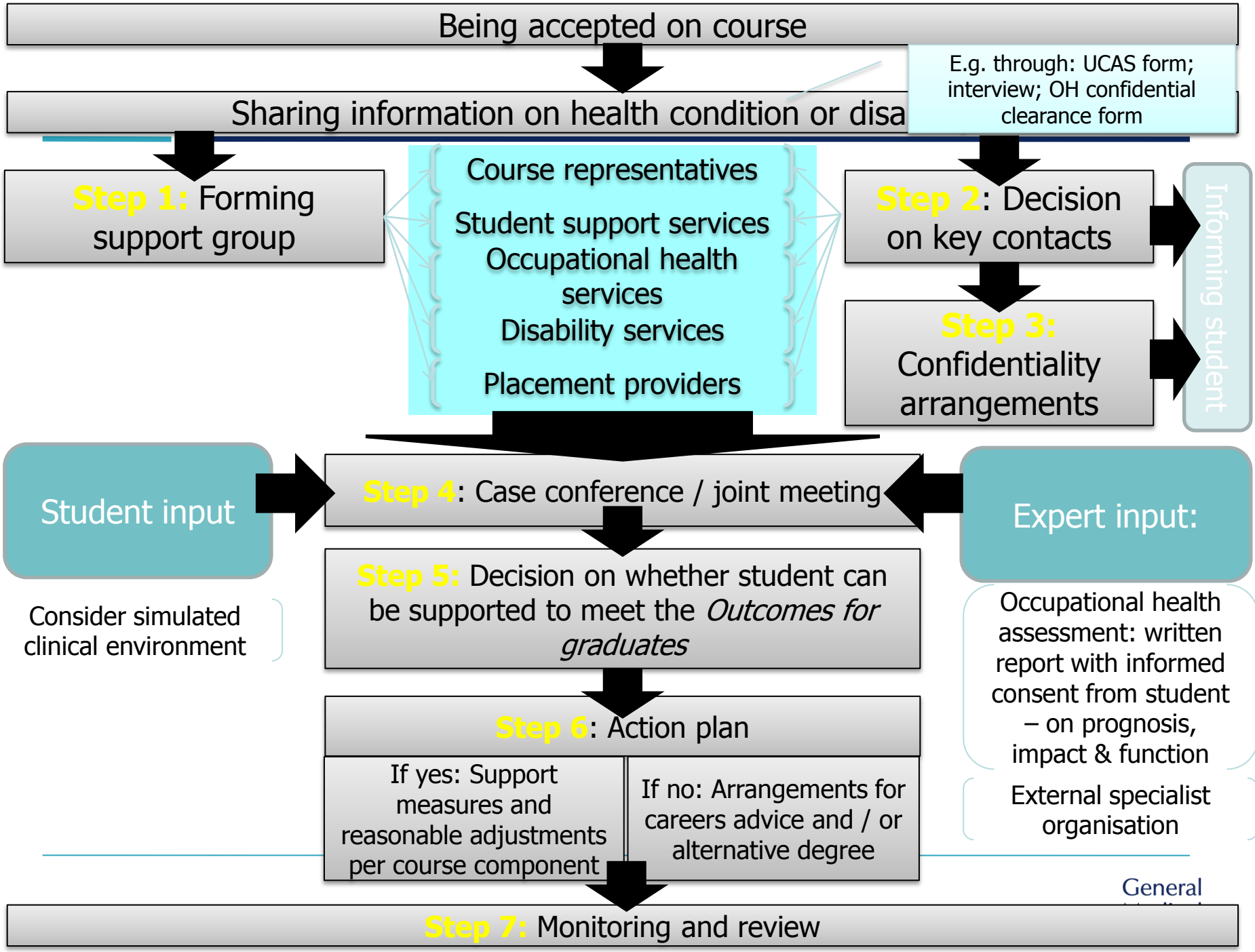
What are we saying

A few of the key messages from the guide

How can medical schools apply their duties?

- Medical schools should make sure **everything about 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 the time.
- 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 possible.
- It is good practice to **involve occupational health** services with access to an accredited specialist physician, with current or recent experience in physician health.
- Schools must **be prepared to respond to evolving needs** of their students.
- 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.


Being accepted on course
Sharing information on health condition or disa
E.g. through: UCAS form; interview; OH confidential clearance form
Step 1: Forming support group
Course representatives
Student support services
Occupational health services
Disability services
Placement providers
Step 2: Decision on key contacts
Step 3: Confidentiality arrangements
Informing student
Student input
Step 4: Case conference / joint meeting
Expert input:
Consider simulated clinical environment
Step 5: Decision on whether student can be supported to meet the Outcomes for graduates
Occupational health assessment: written report with informed consent from student – on prognosis, impact & function
Step 6: Action plan
If yes: Support measures and reasonable adjustments per course component
If no: Arrangements for careers advice and / or alternative degree
External specialist organisation
Step 7: Monitoring and review

What are we saying

A few of the key messages from the guide

How can postgraduate educators and employers apply their duties?

- Inform disabled doctors about **less than full time training**
- **Shared responsibility** between postgraduate educators and doctors to make sure appropriate information is known about doctor's health
- Postgraduate educators and employers would **welcome information early** for doctors at all levels to enable them to plan ahead
- 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.
- The **educational review process** can help monitor the support a doctor is receiving
- The preparation and evidence submitted by disabled doctors for the **Annual Review of Competence Progression (ARCP)** can be an opportunity to raise something about the support they are receiving and also a way to decide whether a doctor can be supported to meet the competence standards at their stage of training.
- Organisations designing assessments have to decide **exactly what standard is being tested** and have **a duty to anticipate the needs of disabled candidates.**

Further tools: Equality and Human Rights Commission – factors to consider

- You can treat disabled people better or **'more favourably'** than non-disabled people.
- The adjustment must be effective in helping to **remove or reduce any disadvantage** the disabled student is facing.
- You can consider whether an adjustment is **practical.** The easier an adjustment is, the more likely it is to 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**

Exercise

- Please use the decision-making framework given as a suggestion in the guide and apply it to cases you are familiar with.

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Final thoughts

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When are we doing it?

Vision for the future

My house and my workplace have been made accessible for me. But I realise that I am very lucky, in many ways.

It is very clear that the majority of people with disabilities in the world have an extremely difficult time with everyday survival, let alone productive employment and personal fulfilment.

In fact we have a moral duty to remove the barriers to participation, and to invest sufficient funding and expertise to unlock the vast potential of people with disabilities.

Professor Stephen Hawking, World Report on Disability

Feedback and discussion

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Thank you

Please email hdreview@gmc-uk.org for any further information

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