

Comments on the GMC's Welcomed and Valued report

Academy Assessment Committee

The Academy Assessment Committee welcomes this report and the guidance it gives. This is an area that Colleges, Faculties and education delivery agencies can have difficulty with while attempting to make appropriate arrangements to facilitate all doctors to achieve their maximum potential while preserving patient safety. It is an area which affects some specialties more than others, but broad and general guidance is welcome. In the future a forum for sharing experiences and solutions may be valuable. We do have some concerns about areas of content and the balance of the document which we feel is doctor centred, and these are described below. Nevertheless, this guidance will be a useful addition as this important area is taken forward.

General

1. The document is to be welcomed and has potential to provide very valuable and practical guidance to support disabled learners
2. The guidance it gives is informative, helpful and practical, but it is long and there is repetition
3. There is good clarity over definition of disability
4. The title of the document does not reflect the content. The document is a detailed explanation of requirements under equality legislation, aimed primarily at teaching and training organisations
5. The contents for Chapter 1 seems to come before the general introduction, the contents for other chapters comes after the chapter heading. Also it needs contents page at the front to allow the reader to identify chapters and pages of relevance.
6. There is a balance to be achieved between:
 - Ensuring patient safety
 - Ensuring competence standards are met
 - Doing all that is reasonably possible to enable doctors with a disability achieve their maximum potential and meet the competence standards.

The document appears to focus on reasonable adjustments. The need to meet competence standards is emphasised, but there is far less mention of patient safety than we would expect.

Boundaries between individual rights and protecting wider patient safety are ambiguous in the 2010 Equality Act and more guidance on achieving the correct balance would be valuable.

7. The document gives clear and detailed guidance on processes and practical steps that can be taken to support disabled learners at all levels of education and training, but does not provide enough clarification for providers about what constitutes a *'reasonable adjustment'*:
 - a. Guidance, with examples, on reasonable adjustments in formal examinations and in the workplace, both for day to day working and for assessments, would be valuable
 - b. What may be reasonable in the setting of a formal examination [e.g. allowing extra time] may not be when assessing capabilities in the workplace [e.g. time critical assessment of patients and investigation results]. Guidance on managing such scenarios would be valuable
 - c. Should there be a requirement to consider the impact on patients (acceptability and safety) of workplace adjustments?
 - d. An adjustment considered to be reasonable in one workplace setting may not be in others. Guidance on requiring workplace adjustments to be generalisable would be helpful
 - e. Some adjustments may be considered unreasonable. One such example would be extra attempts at examinations not given to those without a disability, assuming all reasonable adjustments had been applied to the attempts undertaken.
8. The guidance gives links to other guidance that is relevant. However, more comprehensive cross referencing to other relevant GMC guidance in Chapter 1 would be useful – use the chapter to outline the GMC's wider public safety role and outline the approach to all the relevant standards for disabled learners. Currently some information in relation to standards in Promoting Excellence is in Chapter 1 and 2, but it is not comprehensive. The relevant sections of other GMC guidance should be included and discussed in full in the relevant chapters of the new guidance. This will help to make it clear what is meant by all statements in that context.
9. There should be more done to raise the profile of disabled doctors and students amongst the medical profession e.g. articles in journals, platforms at conferences
10. The relative legal and statutory responsibilities of employers, education/training providers and learning not always made clear in the document.
11. If any support resources are developed then it would be helpful if they could be trainee-centered or led and promote peer-support initiatives alongside the more formal provision of support.
12. The document fails to address some significant issues for trainees and trainers in advice on managing those with long term disabilities where a likely scenario is their conditions may deteriorate, and how this may be addressed by training programmes.
13. Insufficient distinction is made between disability that is present on entering medical school or clinical work and acquired disability.
14. It is unclear how patients or lay groups contributed to the creation of the document.
15. There is insufficient consideration given to the differences between undergraduate and postgraduate examinations. In undergraduate medical education, the parent medical school is responsible for teaching, training and assessment and will be in direct contact

with the student and therefore more able to appraise their needs. In postgraduate medical education many examination providers (Colleges and Faculties) are not directly involved in teaching and training of their candidates and it is therefore much more difficult to appraise needs of candidates.

16. There is no guidance on how assessment providers, particularly in summative examinations, should gauge the “effectiveness” of adjustments provided. Consequently, there is a danger that an adjustment in an examination is only regarded as “effective” if the candidate passes.

Chapter 1: Considerations as a professional regulator

1. There is a very useful link to the generic professional capabilities framework.
2. Need to review the use of panels to explain how they are used in the introduction as it is currently unclear.
3. Suggest updating “2013 Review of Health and Disability in Medical Education and Training statement” setting out the legal advice received on the interpretation of the GMC’s role within the context of the Equality Act, to include the interpretation of the 2014 BAPIO judicial review findings as well as any differences that apply to the undergraduate versus postgraduate/employer training environment. This should then be referenced in this guidance.
4. The guidance could usefully contain additional information on things such as advice for wheelchair users on wards, theatres, practical procedures and attending cardiac arrest calls for trainees with moderate physical disabilities.

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

1. It is helpful to include the duties of medical education organisations and employers for students and trainees, and it gives a more complete picture.
2. It is helpful to have clear medicine specific statements at beginning of chapter in key messages box. However, there is a lot of unnecessary repetition.
3. Relevant sections of other GMC guidance should be clearly placed in context to the advice in the new guidance. For example, statements from Good Medical Practice, Promoting Excellence and the Generic Professional Capabilities Framework. Cross referencing would provide more clarity and lend to the earlier identification and provision of support.

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

1. There wasn’t much about providing appropriately confidential advice to students. There seems to be a stigma surrounding occupational health support which needs to be addressed and should respect the rights of using their services.

2. Has the process for the seven-step framework on p88 been piloted with doctors with a disability yet?
3. It would be helpful to be clear that in panel 7, that where a medical school has decided a time component is part of the competence standard being assessed in that particular assessment, what the limits of extra time allowed, if any, might be.

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

1. The explanation on p13 about the interaction of health, fitness to practise and patient safety is clear in good medical practice already. Examples of what is unlikely to impact of patient safety and what may do so would be really helpful to include.
2. It is the role of the regulator to help clarify the legal position and provide a statement outlining where responsibility lies in terms of the doctor disclosing relevant information on their health as early as possible in their training, and the employer and training programme being responsible for providing support once this has been identified.
3. The concept of shared responsibility for sharing information about doctors' health and disabilities is not helpful in its current form. Employers have a wider duty to provide safe environments for both patients and learners. Guidance has no mention of patient safety matters and the requirement to consult a suitably qualified colleague should be more explicit in this section.

Appendix 1

Comments on the guidance made by one College

The blurring of lines starts to occur around SpLD, some of which remain imprecisely defined, and which can apparently affect key cognitive tasks that have the potential to have an impact on patient safety. For example, doctors in acute units will routinely have to collate and assimilate high volumes of written and numerical information and make rapid judgements based upon that information. It is difficult to believe that a doctor who needs 50% extra time to undertake these tasks in a knowledge based examination, can have this time provided to them in the workplace.

- Insufficient consideration is given to the difference between adjustments to be applied to assessments and adjustments to be applied in professional practice. Little consideration is given to the issue of whether or not a given assessment is assessing practice, in what ways, and whether the competence standard in the assessment is identical to that in practice.
- Little consideration is given to the potential impact of some disabilities, for example dyslexia, on patient safety, as for example, in prescription writing or fluent and accurate interpretation of verbal and numerical patient data in acute clinical situations. The authors may confuse “absence of evidence” of a patient safety concern, with “evidence of absence” of the same.

Specific Comments

1. Page 6 *“No health condition or disability by virtue of its diagnosis automatically prohibits an individual from studying or practising medicine”*. [repeated on page 9/10/24]
 - a. There is clearly a difference here between studying and practising – some disabilities (e.g. quadriplegia) would make study much easier than the practice of most branches of medicine.
 - b. I make this point because the guidance should consider why and whether there need be a distinction between undergraduate study and postgraduate practice – ideally the approaches to adjustments should be identical, unless the individual studying medicine never intends to practice.
 - c. Furthermore, health conditions or disabilities that include disturbances of consciousness or substantial cognitive impairment would render both study and practice impossible. I appreciate the desire to be inclusive with this statement [which is repeated at many points in the document], but that desire should not lead to inaccuracy.
2. Page 6 *“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.”*
 - a. This statement would benefit from clarification.
3. Page 7. *“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.”*

- a. Adjustments should be applied to practice as well as assessments of practice.
4. Page 8 *"Data from medical schools show us that there are 3,727 medical students with a declared disability, which is 9% of the medical student population in the UK. * There are less data available for doctors, but 1% of doctors in training completing our annual national training survey declared a disability. † 9% of newly-registered doctors over a period of 18 months declared a disability. ‡ Nearly 10% of people applying for provisional registration in 2017 declared a health condition in their application. *"*
 - a. Breakdown of these figures into different types of disability would help. If not currently available, GMC should promote more detailed characterization.
 - b. It would also be useful, for context, to know how many students do not progress or continue because of disability?
5. Page 9 *"All medical students and doctors, regardless of whether they have a long-term health condition or an disability, need to meet the competences set out for different stages of their education and training."*
 - a. This is important, but perhaps at odds with later statements giving examples of some examination adjustments [for example, number of permitted attempts].
6. Page 10 *"The framework illustrates further that there is no long-term health condition or disability that by virtue of its diagnosis automatically prohibits an individual from studying or practising medicine."*
 - a. It is unclear how the framework illustrated supports this statement.
7. Page 11. *"the impairment has a substantial and long-term adverse effect on the person's ability to carryout normal day-to-day activities."*
 - a. This is part of the legal definition of disability
 - b. This is extremely important from the perspective of assessment practice, particularly with regard to dyslexia.
 - c. It is often stated that there is "no problem" with function in the workplace for individuals who request adjustments. Indeed, it is often stated that the examination is in some way "false" and does not replicate real-life competencies and conditions.
 - d. If it is the case that an individual can function without substantial or long term effect in normal day-to day activities then they are not by legal definition disabled, and adjustments need not be considered. Unless of course an examination is regarded as a normal day-to-day activity.
 - e. Consequent to that idea, if the examination is indeed assessing the ability to undertake a normal day to day activity [ie clinical practice in medicine], then the adjustments made should reflect those that can reasonably also be made in the pursuit of that activity [ie in the workplace], not simply in an examination setting.
8. Page 14 *The medical prognosis of the likely impact of the condition plays a role on whether this is deemed as a disability, but the effect of the condition does not need to be continuous or substantial.*
 - a. This requires clarification, as it seems at odds with the definition

9. Page 15 "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'."
- a. It would be useful if the GMC or EHRC could expand on the objective tests that might be applied to considerations of reasonableness.
10. Page 20 onwards. Summarises the GMC's considerations as a professional regulator.
 - a. There should be a section on Patient safety and/or fitness to practice
 - b. One consideration of the regulator should be the ability of the disabled individual to practise safely.
11. Page 23 "*When considering applications from disabled people, medical schools may find it helpful to consider the outcomes with the applicants, as the competence standards they will need to demonstrate over their studies.*"
 - a. Consideration should be given to extending this principle to selection after medical school, into specialty, as some disabilities may be less compatible with some specialties than others [for example blindness and surgical practice]
12. Page 24 *Not having any student fitness to practise concerns: All*
 - a. Practice in medicine is extremely broad. Medical schools and the GMC should consider whether conditions might be set on range of practice in the context of some disabilities. For example a student with a disability could conceivably complete the medical degree course with appropriate adjustments and support, and be fit subsequently to practice in some areas of medicine but not others.
13. Page 24 "*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, there should be no concerns in regards to their fitness to practise.*"
 - a. This is vague, unevidenced, and merits clarification or example.
14. Page 24 "The outcomes are competence standards for the purposes of the Act. This means all the outcomes need to be met, and medical schools do not need to make adjustments that would change the standard of competence required."
 - a. This should be rephrased to state medical schools should not or must not make changes to competence standards
 - b. Further considerations and examples of what this means for standards should be included.
15. Page 25 "However, 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."
 - a. This is critically important for assessment practice.
 - b. For example, is a time limited MCQ primarily designed to assess knowledge also testing fluency of assimilation of written and numerical information as required in most acute NHS workplace settings?

16. Page 26 *"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."*
- a. This statement is concerning. It is unclear why the onus for determining an impact on patient safety should lie with the doctor, and what means they would use to determine that impact.
17. Page 27 *"As a doctor continues through their practice, they have to continue to meet the competences required in the curricula at the different stages of training."*
- a. This is important ---- it is assumed that all earlier competencies have been met, presumably with adjustments that can also be provided in subsequent training
 - b. What if the adjustments provided in a medical school (limited, heavily supervised practice) can't be provided in postgraduate training?
 - c. Does this principle apply to assessments? E.g. If university gives 50% extra time, does this mean that a PG body must, even if it does not fulfil their definition of reasonable?
18. Page 31. *"It is not direct discrimination against a non-disabled person to treat a disabled person more favourably."*
- a. I assume this means more favourably than a non-disabled person is treated.
 - b. This is important in assessment practice. In effect it could mean that a competence standard is lower for a disabled person, or that some other requirement is less stringent --- for example numbers of attempts. This needs clarification.
19. P34 *"Legitimate aims for medical education might be maintaining academic and other standards or ensuring the health and safety and welfare of students, doctors and others"*
- a. Seems extraordinary not to use this as an opportunity to stress patient safety. The prime purpose of medical education is to ensure patient care. At the least, "patients" should be included as an example of "others".
20. P35 Much of this section about reasonable adjustments is set in the context of the disabled learners. The thought processes behind the text relate to learners, rather than practitioners. The specific challenges of adjustments in practice are not sufficiently addressed. A postgraduate trainee is a learner and a practitioner and the feasibility of adjustments in usual clinical training practice needs further thought.
21. P36 *"If the reasonable adjustments provided have not been effective, the organisation may need to consider alternatives."*
- a. This is important in assessment practice.
 - b. What does effective mean? An adjustment can remove disadvantage and a candidate may still not pass the examination, because, like some candidates without disability, they do not have the ability to pass. As such, the effectiveness or otherwise of an adjustment cannot be gauged on whether or not the candidate passes alone.
 - c. Alternative means of assessing effectiveness should be discussed.

22. P35 section – it might be useful in this section to discuss role and relationship of examination delivery bodies [College and Faculty based] and local education providers. The LEPS will typically be aware of the needs of their own trainees, but do not currently necessarily liaise with examination providers about those needs. A means of doing this routinely would be useful to all parties.
23. Panel 4 *“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.”*
- a. This is of importance in postgraduate training and the panel should not therefore simply refer to medical schools. The statement also requires clarification – if an adjustment cannot be provided in the workplace [for example 50% extra time to complete work in an acute medical unit, is it being suggested that the LEP must still provide that, irrespective of any consideration for patient care or the workload of other trainee learners?]
24. P47 *“All assessments must be based on defined competence standards, and reasonable adjustments should be made in the way a student can meet those standards.”*
- a. The inference of this statement is that all disabled students will be able to pass all assessments if the appropriate adjustments are in place. This is clearly not the case as ability will be normally distributed amongst disabled students, in the same way as it is amongst non-disabled students.
 - b. This should really read “ a student will have the best chance of meeting these standards.” A disability may not be the only factor that prevents a student from meeting a standard.
25. P47 section – this section should also encourage medical schools to liaise with LEPs regarding the feasibility and practicality of providing specific adjustments in the NHS workplace where the student will learn and ultimately work.
26. P51 *“Number of attempts or length of study: A school may have a PCP for a maximum number of attempts to complete an academic year, to complete the medical degree, or to pass an assessment. If appropriate for a specific student, the school could make a reasonable adjustment to that PCP and allow further attempts or a longer period of study.”*
- a. This should include a comment that this is acceptable provided the school can be clear that the competence standard has not been reduced by this adjustment.
27. P61 *“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.”*
- a. This is one of the few references in the entire document to the potential interaction between adjustments and patient safety. It might be best to note patients specifically here rather than the generic term “anybody”.
28. Page 70 Panel 7: *“Can schools provide an adjustment that is not considered as realistic in the clinical environment, such as extra time?”*
- a. This panel heading poses a critical question, but fails to answer it. It is particularly relevant in the postgraduate environment, for SpLD, where up to 50% extra time for

an assessment may be requested, that will or not or cannot be provided in the clinical environment.

29. Page 70 *“research has highlighted a number of coping strategies and ‘work-arounds’ that doctors with dyslexia successfully implement in their day-to-day practice. For example, using templates to help structure written work; spellcheckers, dictation of notes, visual/audio methods, checklists, medical apps, and speech recognition software (Locke et al 2015*)”*

- a. If these are effective in the workplace, without extra time, should they not be utilized by the learner in assessments, as a means of demonstrating/confirming that they can meet the competence standard being assessed?
- b. It should also be highlighted at this point that the literature review supporting this document paper found only 5 papers, all qualitative, all involving small numbers of individuals, and only one of which related to doctors [the rest relating to nurses.] This observation should prompt the GMC to note the need, at this point or elsewhere, to commission more research.

30. P78 onwards on PG educators and employers. *“Both postgraduate educators and doctors have a shared responsibility to make sure appropriate information is known about a doctor’s health. The Transfer of Information [TOI] and Special Circumstances processes can support sharing information in the transition between medical school and foundation training.”*

- a. This is helpful and should also apply to the sharing of information between examination providers and LEPS.

31. P78 *“The learning outcomes described in postgraduate curricula are seen as competence standards for the purposes of the Medical Act 1983. So, although the standard that doctors are required to meet can’t be altered, doctors must be supported through reasonable adjustments in how they demonstrate that standard.”*

- a. Again the phrasing here implies that standards can always be met through the provision of adjustments, and consequently, that the effectiveness or otherwise of an adjustment can be judged based upon whether the individual meets the standard.

32. P78 *“Organisations designing assessments have to decide exactly what standard is being tested through the specific assessment by blueprinting.”*

- a. We assume standard here means content?

33. P78. *“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.”*

- a. There is a word missing after the second use of health. The third sentence might better read “adjustments in the workplace must be undertaken with the primary consideration of potential impact on risk or safety for patients.”

34. P82 Entering foundation training

- a. There is an opportunity here to stress that doctors must meet the competencies/capabilities of the foundation programme to attain full registration, and to complete the foundation programme. This will be the first time that doctors

are required to work in a clinical environment, as opposed to be placed in a clinical environment as part of medical school training, and the conditions of such placement, in terms of the adjustments that can realistically or reasonably be offered or provided, may differ subtly, and in ways that compromise the ability to meet a standard. It should not be assumed that a doctor judged “fit to practice” at the point of graduation will prove to be so.

35. P88 this is helpful and should stress need for Dean/LEP to communicate with examination providers.
36. P101 *“Organisations can treat disabled candidates more favourably than non-disabled candidates.”*
 - a. This should be qualified with “Provided this does not alter the competence standard.”
37. Panel 13 p105 Health and fitness to practise; addressing the perceived risk to patient safety
 - a. There is a word missing after the second “health”
 - b. It would be preferable to expand on the evidence that has been used to inform the statements.
 - c. The flow chart is a generic description of fitness to practice that has no specific considerations relating to disability, and impact of it on performance, or perception of performance by other doctors or patients.