

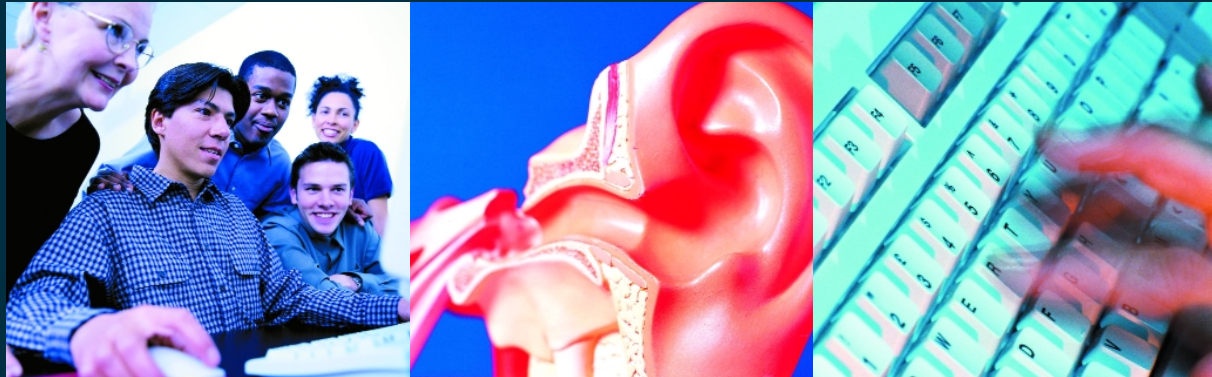


**The  
Higher  
Education  
Academy**

**Medicine,  
Dentistry and  
Veterinary Medicine**

**Special Report 4**

# **Disabled students, disabled doctors – time for a change?**



A study of different societal views  
of disabled people's inclusion to the  
study and practice of medicine

TE Roberts A Butler KAM Boursicot

ISBN 0 7017 0173 0

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# Introduction

This special report is the result of a study undertaken to assess the views of different sections of society (professional and lay) towards admitting disabled people to the study of medicine. The project was undertaken between January 2003 and January 2004, funded by a grant from the Learning and Teaching Support Network for Medicine, Dentistry and Veterinary Medicine (LTSN-01)<sup>1</sup>. The original idea came from Trudie Roberts (TER). Alan Butler (AB) designed, undertook and transcribed all the interviews and contributed to the report. Katharine Boursicot (KB) and Trudie Roberts analysed the data and wrote this report.

## About the Authors

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## Background

In recent years all institutions of higher education have struggled with the issue of disability. In 1995 the Disability Discrimination Act (DDA) laid down a marker when it required all such institutions to publish a disability statement. The DDA made explicit the duties that employers and providers had to disabled individuals. However, the provision of education was excluded.

In 2001 the Special Educational Needs and Disability Act (SENDA) was introduced which amended existing legislation and brought education within the scope of the DDA. This act makes it unlawful to discriminate against disabled students by treating them less favourably. The most recent changes to the DDA came into effect on 1 October 2004 and aim to ensure parity of access to any trade or profession for disabled people.

Worryingly, a recent study by the Institute of Employment Studies (IES, 2003) found that more than one third of qualification bodies they surveyed did not know whether the new regulations applied to them. Only one-fifth had reviewed their competency standards to ensure they were not discriminatory.

For medical schools this legislation has greater implications than just widening a door or providing managed access to a building. Conferring the degree of medicine on an individual brings with it provisional registration with the General Medical Council (GMC) and the entitlement to work as a medical practitioner with sick and vulnerable patients. The GMC sets

out the requirements of undergraduate medical training in its publication 'Tomorrows Doctors' (GMC, 2003) and its expectations of newly qualified doctors in its booklet 'The New Doctor' (GMC, 1997). Implicit in these documents is the notion that all doctors, regardless of the speciality in which they ultimately practice, are required to have the same basic knowledge and skills competence at the start of their postgraduate career.

In recent years, however, this has been challenged. A high profile case (Baty, 2002) in which a young, wheelchair user was refused access to a medical undergraduate course brought into sharp focus the apparent restrictive attitude of the medical professional governing body on the admission of disabled students to the study of medicine. Graeme Catto, the chairman of the GMC's education committee at that time, said:

*"The committee... cannot in law agree an alternative curriculum which covers a lesser order of knowledge and skill in the case of medical students who are known from the outset to be unable to complete a full graduate course consistent with the GMC's guidance"*

Commenting on the case, the Chairman of the Disability Rights Commission, Bert Massie, said:

*"The GMC should start to look beyond the legal arguments and see how it can welcome disabled people to the medical profession"*

Clearly the GMC, whose remit is 'guiding doctors and protecting patients' (GMC, 2001), has a duty of care to patients, to ensure, through its accreditation of undergraduate medical courses, that graduates who are admitted to the medical register are 'fit for purpose'. However, the interpretation of this is left to the individual medical schools, which may mean that different criteria in relation to the admission of disabled students apply across the UK. Thus students with the same disability may be admitted to one medical school whilst being denied entry to another. In the USA, where disability rights campaigners have been more vociferous, limited licensure<sup>2</sup> and tracking<sup>3</sup> have been introduced to allow disabled individuals entry to medicine. Could such measures be introduced here?

LTSN-01 had previously funded another project, led by Anne Tynan from the Royal College of Veterinary Surgeons, which evaluated web-based information relating to the admission of disabled people to UK medical, dental and veterinary schools. The results of this study were published by LTSN-01 in 2003, as a special report entitled 'Pushing the Boat Out' (Tynan, 2003). This was followed by a Progress Report in 2004 - 'The Sequel' – which evaluated the impact of the first publication. The reports elicited much feedback and comment; one of the indications was that 'there is a high level of support at all levels for the inclusion of disabled individuals in the healthcare workforce' (Tynan, 2004 p.5). However, there appeared to be a minority of opinion expressing negative attitudes to the admission of disabled people to the study of medicine, dentistry and veterinary medicine.

The purpose of our small qualitative research project was to explore current attitudes about disabled doctors, within the general public and the medical profession, and to examine issues around the inclusion of disabled entrants to medical undergraduate courses.

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<sup>1</sup> Now Higher Education Academy, Medicine, Dentistry and Veterinary Medicine.

<sup>2</sup> Limited Licensing: It has been argued that we should move towards a situation whereby, both at undergraduate and post registration level, an individual opts for a particular mix of subjects and specialities. This would entitle them to registration but not to practice in all areas of medicine.

<sup>3</sup> Tracking: a term that has been applied to the structuring of a medical undergraduate course so that a disabled student is enabled to work their way through the curriculum with the minimum of barriers and problems.

# Methodology

## Sampling rationale

The study was intended to be exploratory and set out to map the views of various key groups, who would have a legitimate interest in the inclusion of disabled people into the medical profession. The aim was to facilitate debate and discussion around the issue of disabled doctors and medical students, with the intention that this exchange of ideas might develop the agenda for future work in this area.

There were a number of pragmatic factors that shaped the sampling. As only one person was interviewing there were issues of timing, access, convenience and working within budget. As the study was small and exploratory, elaborate stratified random or cluster sampling was not possible.

The following categories of individuals were approached for inclusion in the project and agreed to be interviewed: admissions staff from four medical schools, disabled medical students at Leeds Medical School, non-disabled students at Leeds Medical School, practicing disabled doctors, members of the general public who were disabled, and members of the public who were not disabled.

**Table 1 – Numbers of Interviewees in each Group**

Groups	Admissions staff	Disabled medical students	Non-disabled medical students	Disabled doctors	Disabled public	General public	Total
Numbers	6 (4 schools)	6	6	8	15	17	58

### Admissions staff

Eight medical schools were contacted in order to arrange interviews with one or more admission tutors. Four were willing to become involved; the intention had been to engage a variety of schools. A new medical school was involved as was another which is currently regarded as ‘rather conservative’. Leeds Medical School, where the study was based, agreed to take part as did another very large northern medical school.

### Disabled medical students

Leeds Medical School keeps a central register of all students with an admitted disability. This was the only opportunity to identify a fixed ‘field’ and therefore a random number system was used to select candidates. One refused and was substituted by the next name on the list.

## Non-disabled medical students

AB was working with a second year group, and so asked for volunteers to become involved. Most wanted to take part, but only eight people were selected by asking alternate names from the class list. A group of students who had undertaken a project on the issue of disability were included. A mixture of Year 2 and Year 3 students attended the group session.

## Disabled doctors

As there is no national register of disabled doctors, it was not possible to have a random or structured sample from this group. Consequently, AB wrote a short article which was published in the Leeds Medical School alumni magazine, explaining the project and asking for volunteers. The interviewees were drawn from the responses to this article.

## Disabled public

A number of disabled groups in Leeds were contacted: three were willing to become involved. The Multiple Sclerosis Group attended a specialised day centre, and was very happy to help. As the respondents were quite young it was decided to balance this with two groups drawn from the population of people attending an Age Concern Day Centre. As AB had served on the committee of this centre some years before, access was granted. The interviewees all had multiple age-related disabilities.

## General public

Conducting a series of small group interviews with individuals drawn from a population as diverse as 'the general public' was a difficult challenge. For the purposes of our study we decided that we wanted to try to find individuals drawn from a mixture of ages, of differing gender and ethnicity and different social classes.

The groups chosen were:

- A group of secondary school students who were about to leave school
- A sample of patients waiting to see their GP
- A 'consumer group' set up by a local Primary Care Trust

A General Practitioner working in a working class area of Leeds agreed to help. One day a week the practice - a large group - held an open surgery, for which no appointments were required; the patients simply wait to be seen. After meetings with the partners agreement was obtained to conduct interviews during this waiting time. The sampling would be opportunistic, in that groups would be created from whosoever was in the waiting room, and was willing to become involved. The volunteers were assured that their place in the queue would be preserved. The practice provided a small room, and as people came more than two hours in advance of surgery, groups were created over a number of visits, and the interviews completed.

We wanted to capitalise upon the fact that the NHS is currently creating a number of 'consumer' groups in order to evaluate and monitor services. This seemed to be an easy way to tap into existing groups. A local Primary Care Trust allowed access to one of their 'consumer' groups. The group was ethnically balanced and very vocal about health related issues. They were also used to working as a group and providing feedback.

## Interview methodology

The semi-structured interviews were designed by AB. The methodology chosen draws on the concept of grounded theory as propounded by Glaser and Strauss (1968). A mixture of individual and group interviews was decided upon. The individual interviews were semi-structured (Fontana and Frey 2003). Although we had some pre-conceived ideas about the general ground that we wished to cover, we did not want to be constrained at this stage of the work by a comprehensive pre-set list of questions (Denzin and Lincoln 2003). Because so little work had been done in this area before, a free floating discussion was thought to provide the best method of generating ideas and insights from the respondents (Babbie 2001).

It was felt that reliance upon totally unstructured interviews would have led to a lack of focus and might have been unproductive. Using the semi-structured format it proved possible to gather uniform information from all respondents but at the same time follow up any diversions that the interviewee might care to explore. The aim was to maintain a balance between ensuring a similar coverage of topic areas for each interview, but at the same time allow and encourage digression and the generation of fresh ideas (Berg 2004). It was a format that was flexible enough to allow insights generated in one interview to be followed up and explored in those that followed, thus allowing the structure of ideas to develop.

The use of focus groups was thought to be suitable as a strategy for aggregating certain groups of interviewees: thus members of the general public, both able bodied and disabled, formed the basis of one focus group, while disabled and able bodied medical students were interviewed in another. The advantages that this methodology offers are not simply those of apparent economy of effort. A focus group will usually facilitate the generation of new ideas and allow those to be bounced around and tested. An individual, in a more formal interview session, might feel more constrained and less willing to risk opinions and contemplate new ideas (Madriz 2003).

The optimum number for a group is thought to be seven (Kreuger 1994). As a matter of practicality this was not always achievable, but groups of 4-5 proved capable of provoking and sustaining lively discussion. Some of the groups (Leeds medical students, secondary school pupils, Age Concern club members) were already familiar with each other and used to vocalising their thoughts in that company. The issue with such groups is, sometimes, not to encourage conversation and debate but to orchestrate it. There is first the need to ensure that group members need not feel pressurised into agreeing with other members. This may be done by making it clear, at the start of the group, that there are no right or wrong answers, but that all views are of equal value. It may be necessary to underline this by stressing that disagreement is acceptable and even desirable (Madriz 2003). One of the other important tasks for the focus group convener is to ensure that no false consensus emerges because one or two forceful members of the group talked and expressed their views to the exclusion of others. All members of the group were encouraged to become involved in the discussion; no member was privileged and all views and ideas were accorded equal weight and value.

## How was disabled defined in this study?

The exact definition of disability was explored by participants in the focus groups. Participants were asked to reflect upon the word 'disabled', and brainstorm what images were conjured up. Participants would quickly identify 'somebody in a wheel chair' and gradually other physical disabilities would emerge, including sight, hearing and speech impairments. Most groups would identify 'mental problems'; if they did not, they were prompted by the interviewer with examples such as schizophrenia and depression.

## Analysis methodology

All the interviews were recorded and transcribed. AB formed an initial narrative of the taped interviews with each group, with quotations from some of the interviewees.

KB and TER individually reviewed all the narratives and categorized the responses from each group into the themes on which the interviews were based. These were:

1. attitudes to the idea of disabled doctors
2. attitudes to specific disabilities
3. experiences with/as a disabled doctor
4. pre-course testing
5. limited licensing
6. tracking

These themes were chosen to stimulate the widest debate on disability and to ensure that the notion of disability was not confined to physical aspects. The professional groups were asked specific questions about ways in which disabled people could be included in the study of medicine and eventually into the medical workforce.

Discussion between KB and TER endeavoured to ensure that the views of all the groups were equally represented in a particular theme, except where some groups did not discuss some themes. KB and TER then created tables (2 to 7 below) to illustrate the views of the various interview groups in relation to each of the six themes. These results were then further analysed to draw out commonalities and differences of opinion, as will be explored in the discussion.

## Results

See tables 2 to 7 overleaf.

The tables illustrate a summary of the responses from the different groups of interviewees to each theme.

## Analysis of interviews

There appeared to be considerable agreement across the different interview groups in relation to the six themes addressed in this study, although, as described below, some issues caused marked polarization within the groups themselves. We have used the following abbreviations when ascribing quotations to particular groups:

- |      |                             |
|------|-----------------------------|
| ASG  | Admissions Staff Group      |
| DSG  | Disabled Students Group     |
| NDSG | Non-Disabled Students Group |
| DDG  | Disabled Doctors Group      |
| DPG  | Disabled Public Groups      |
| GPG  | General Public Groups       |

**Table 2**

<b>GROUPS</b>						
<b>Admissions staff from 4 medical schools</b>	<b>Disabled medical students at Leeds</b>	<b>Non-disabled medical students at Leeds</b>	<b>Practising disabled doctors</b>	<b>Disabled public</b>	<b>General public</b>	
<b>THEME 1</b>  <b>Attitudes to the idea of disabled doctors</b>	Mix of positive and negative attitudes - polarity	After admission not encountered too many problems	Certain disabilities (dyslexia) not an issue	4 wheelchair users Majority severely disabled and so influences answers	Less concerned about technical skills focussed on communication	Valued good comms skills over physical ability
	Caution re cost even from the more positive	Need to encourage more diversity in medical undergraduates	Concerns about being disadvantaged in group work with presence of disabled colleague	All adjusting by limiting clinical work but all working	Positive about wheelchairs - acknowledged practical issues	Disabled doctor might be limited in what they could do.
	No clear policy	Felt that disabled students had things to offer	More positive attitude if disability acquired later in career	Adaptability and accept career changes	Only able to work in certain areas	Polarity some not accepting some relaxed. Some more concerned and apprehensive.
	More positive attitude of disability acquired once admitted	Having disabled individuals in the profession would help change public perception of disabled people	Expectation that patients and peers would treat disabled doctors equally		Felt disabled doctors would be able to empathise better with disabled patients	Question of cost/value
				Polarisation Positive - more disabled students on course Negative - questioned cost effectiveness		Disabled doctors might empathise better

**Table 3**

<b>GROUPS</b>							
<b>Admissions staff from 4 medical schools</b>	<b>Disabled medical students at Leeds</b>	<b>Non-disabled medical students at Leeds</b>	<b>Practising disabled doctors</b>	<b>Disabled public</b>	<b>General public</b>		
<b>THEME 2</b> <b>Attitudes to specific disabilities - physical/mental</b>	Key problem is PRHO year and cardiac resuscitation Polarisation of views	Physical - wheelchair users problematic wards/hospitals/homes Physical Patient's right is be treated properly	Most felt wheelchair users caused a huge problem and not integrated with other students	Physical - there were problems and some procedures had problems	Positive to physical disability but with limitations on type of activity	Physical positive about wheelchairs but practical problems	
	Blindness - mainly negative a few positive Deafness - related to degree and if it affects communication	Blindness - negative Deafness - related to degree and if it affects good comm. skills	Blindness - very negative Deafness - issue of degree and compensatory skills	Sensory - major concerns about profound sensory disabilities especially sight Hearing - dependant on the degree	Sensory - very negative Hearing - related to degree and communication skills	Sensory Blindness - very difficult/impossible Prior knowledge of doctor may change this. Deafness - Serious prob but it didn't affect comms skills ok. Different if had previously known the doctor	Sensory Blindness - very difficult/impossible Prior knowledge of doctor may change this. Deafness - Serious prob but it didn't affect comms skills ok. Different if had previously known the doctor
	Mental health - big problem, reluctant to explore issue	Mental health - past problem ok	Mental Health - distinction between severe psychosis and depression should not be a problem if condition controlled and support and supervision available	Mental - very polarised, some very negative, some positive particularly those who had doctors with problems	Mental - very polarised, some very negative, some positive particularly those who had doctors with problems	Mental Health - Very polarised, any form of psychiatric history rules out. Others - if doctors rehab and monitored, ok	Mental Health - Very polarised, any form of psychiatric history rules out. Others - if doctors rehab and monitored, ok
Dyslexia not an issue for some, others concerned if severe	Dyslexia not a problem	Dyslexia not a problem	Dyslexia not a problem	Dyslexia not a problem	Dyslexia not a problem	Dyslexia not a problem	

**Table 4**

t

<b>THEME 3</b>		<b>GROUPS</b>						
		<b>Admissions staff from 4 medical schools</b>	<b>Disabled medical students at Leeds</b>	<b>Non-disabled medical students at Leeds</b>	<b>Practising disabled doctors</b>	<b>Disabled public</b>	<b>General public</b>	
<b>Experiences with/as a disabled doctor</b>			Limitation of disability pointed out by clinicians/teachers	Think there is no integration of physically disabled with rest of the class	Realise limitations caused by their disability	Previous good relationship with doctor not affected by acquiring a disability		
			No problem with medical school / University environment for wheel chair users		Colleagues supportive			
			Worries about hospital environment and homes and not being able to treat full range of patients e.g. collapse patient		Had to make major career changes			
					One speculated that the disability could undermine patient confidence			
					Electronic aids helpful			
					Feel contribution was important despite disability			
					With patient some doctors ignore their disability, others felt uncomfortable about it			

Table 5

<b>GROUPS</b>						
	<b>Admissions staff from 4 medical schools</b>	<b>Disabled medical students at Leeds</b>	<b>Non-disabled medical students at Leeds</b>	<b>Practising disabled doctors</b>	<b>Disabled public</b>	<b>General public</b>
<b>THEME 4</b>  <b>Pre-course testing</b>	Some in favour - need form of evaluation which is objective	Lukewarm response - only if everyone has to do it	Lukewarm response - felt current admission procedures do not pick out poor communication so could not envisaged reliable predictive test	Mixed reception		
	Way of avoiding hard decisions.	Just testing for disability not enough would need to be suitably qualified as well		Logistical and practical problems		
	Should be part of whole process of admission			Assessment of what makes a good doctor is poor. Little faith in testing procedures		
	Equity - test everyone			All students should be tested		
	Is testing everyone feasible			Some thought it was a good idea		

**Table 6**

		<b>GROUPS</b>						
		<b>Admissions staff from 4 medical schools</b>	<b>Disabled medical students at Leeds</b>	<b>Non-disabled medical students at Leeds</b>	<b>Practising disabled doctors</b>	<b>Disabled public</b>	<b>General public</b>	
<b>THEME 5</b>	<b>Limited Licensing</b>	Opinion divided - worries about creation of second class doctors	Hostile reaction - second class doctors	Polarisation of views	Positive			
				Worries about second class doctors	Reflect current picture			
				Could empower doctors able bodied and disabled	Not worried about second class doctors - rejected this idea			
				Interlocking nature of medicine - needs to be seen as whole	May produce new opportunities			
					Saw role for limited registration			

**Table 7**

		<b>GROUPS</b>					
<b>THEME 6</b>		<b>Admissions staff from 4 medical schools</b>	<b>Disabled medical students at Leeds</b>	<b>Non-disabled medical students at Leeds</b>	<b>Practising disabled doctors</b>	<b>Disabled public</b>	<b>General public</b>
<b>Tracking</b>	Limited enthusiasm	Unanimous support	Already happening				
	Risk discrimination against non disabled / single parents etc	Needs to be seen to be fair and produce competent doctors	Worried about maintaining standards				
	Needs to be open and overt	Needs to be some core things that everyone has to do	Will it discriminate against the able bodied				
		Could enforce career choice early on	Could get out of control				

## Theme 1: Attitudes to the idea of disabled doctors

Generally across all the groups, it was felt that there should be more acceptance of doctors with disabilities. However, there was concern in all the groups except the disabled doctors (DDG) and disabled medical students (DSG) about the cost-effectiveness of training individuals who would not be able to take part in the full spectrum of activities which constitute medical working practice:

*"Its all very well being politically correct and recognising disability acts but you are putting them through a very expensive training and taking a place that could be used by somebody else who could come through and do the job" (GPG)*

*"We may become known as the university that accepts disabled students, and we will become inundated with the cost pressures that it brings with it" (ASG)*

*"You could adapt a surgery, but you couldn't adapt every house so home visits would be difficult" (DPG)*

*"There are some areas of medicine that they could cope with"(DPG)*

Rather surprisingly there was concern about this even from some members of the disabled public:

*"I know we have MS but if I was in your position I would accept all the healthy ones first and put them (MS sufferers) at the back of the queue"(DPG)*

*"Admitting one (an MS sufferer) would be stopping the other ones becoming doctors"(DPG)*

The concern expressed was that disabled students might only have a limited professional career and that their particular condition may worsen and thus force them to withdraw from the workforce:

*"We are having so much money invested in us" (NDSG)*

*"When it costs so much for each medical student you have to be productive" (NDSG)*

The argument gained a head of steam from the male group members, but they were reined in somewhat by the females who pointed out that:

*"Other groups are not going to have a full career: if the productivity argument was fully advanced then far fewer women would be admitted into medicine" (NDSG)*

Opinion was polarised in the general public and non-disabled student groups about this issue. There was some positive feeling that more disabled students should be accepted into medicine:

*"It would do the medical school good to have more disabled students" (NDSG)*

*"We definitely need more" (NDSG)*

*"You are asking for serious trouble if you don't accept them (disabled students)" (GPG)*

*"If they are qualified they would be no different from any other doctor"(DPG)*

*"I had a dentist in a wheelchair. Because of polio he had a chair that went up and down. It didn't put me off he was a good dentist and I thought it was marvellous" (DPG)*

However some people found the concept very difficult to accept:

*"That's difficult; it's not something that you are used to" (GPG)*

*"I couldn't connect doctor with disabled at all" (GPG)*

*"I don't think they would be given the chance" (GPG)*

*"It couldn't happen" (GPG)*

*"Doctors have to be superhuman, so it wouldn't happen" (GPG)*

Others expressed some degree of concern or apprehension:

*"I would wonder if they could examine you properly" (GPG)*

*"I think it would undermine your confidence" (GPG)*

*"You would question it all the time" (GPG)*

*"The doctor is responsible for you so you would be a bit apprehensive" (GPG)*

But the final reaction was quite relaxed even positive about the thought:

*"It wouldn't bother me - just because they are disabled doesn't mean they don't have a good mind" (GPG)*

*"I would think - good on the doctor" (GPG)*

*"If they were paralysed and like in a wheel chair that would be fine" (GPG)*

*"Even if they can't do a particular examination they could always get another doctor in" (GPG)*

*"Wouldn't think much of it - in medical terms they would have to have been passed fit to see patients" (GPG)*

Most of the general public group were very positive towards the notion of a doctor in a wheel chair, particularly in a general practice setting:

*“As long as they had the mental capacity and still understand you I can't see it would make any difference”*

*“I would think they would do a good job as they have got something more to prove”*

However, more reservations were expressed when it came to envisaging the doctor in a hospital setting:

*“Its OK in a GP but in a hospital it doesn't seem possible as they have to move around all the time and work such long hours”*

*“It wouldn't affect my opinion of them if they were a GP, I'm not so sure if it was in a hospital situation”*

Some respondents highlighted the practical problems that a wheelchair using doctor would encounter:

*“The problem would be when they had to start doing things”*

This group speculated about the use of a nurse assistant who might complement the role of the doctor.

Many non-disabled students pointed to the emphasis now placed upon cooperative and shared work. Being highly competitive they felt that their efforts and grades would be dragged down by being joined by a disabled student in their joint work:

*“I wouldn't be prepared to do say, a cranial nerve project with a blind student, because I know I would not get the best mark that I could” (NDSG)*

*“There are so many joint and shared projects- would I end up doing more of the work and would it pull my marks down?” (NDSG)*

*“It wouldn't be fair, I would be put at a disadvantage” (NDSG)*

There was positive feeling that some disabled doctors might be better at empathising with patients.

*“They would know what the patient is going through. They would have more sympathy and talk more about things” (DPG)*

*“You would be more positive towards your own problem if you could see that somebody else had coped with it” (GPG)*

*“It is important for us as well, as students. Its all very well seeing disabled people as patients wouldn't it be great if we could see them as people and learn with them” (NDSG)*

Among the admission staff, there were some positive views:

*“For us it is not really a big issue having somebody with a disability would be a real bonus” (ASG)*

*“Other students could learn from them (the disabled student) about the practical impact of disability” (ASG)*

*“We think it is very valuable to have doctors who have a disability” (ASG)*

*“Having somebody with that kind of disability (wheelchair bound) would be a real bonus... other students could learn about the practical impact of disability” (ASG)*

*“Any silly PC view that 10% of our students must be disabled would be totally inappropriate...but I think we have to be open to admission of disability” (ASG)*

*“We see a positive virtue in acknowledging that medical students have health problems just like the rest of the population” (ASG)*

There was some discussion around the idea that disabled doctors should be limited in the areas they would be able or allowed to practice; disabled doctors were particularly supportive of the idea of working within a limited area, in keeping with what their disability would allow. The groups of disabled and non-disabled public individuals interviewed were less concerned about physical disability in their doctors and much more anxious about disabilities which might impair communication. They valued good communication skills over physical and technical ability:

*“Some people overcome their problems as long as I can talk to him and he can talk to me I would accept him” (GPG)*

*“As long as you can get through to them, and they can get back to you, and he is qualified, he must know what he is doing” (GPG)*

*“It wouldn't really bother me it's their manner, how they come across, I would look at the person” (DPG)*

*“If it didn't affect their work and they could communicate it would be OK” (DPG)*

These groups representing the public also expected that disabled doctors would be more empathic:

*“If you were suffering from the same thing they would understand you more” (DPG)*

*“They are more likely to be sympathetic rather than simply saying what can you expect” (DPG)*

*“They would be able to see both sides of the story” (DPG)*

*“If I were disabled I would know that he had been down that road and that I am going to be alright” (GPG)*

*“A recently paralysed patient would find it reassuring to meet a doctor in similar circumstances” (GPG)*

This view was echoed by disabled students themselves:

*"We need to encourage more diversity, everyone has got the right to do what they would like to do, a disabled person would bring their own personal experience to a patient's problems" (DSG)*

*"I think they have things to bring that other people don't have. Communicating with a patient is going to be totally different if you have had a disability" (DSG)*

*"I come at things (as a disabled person) from a completely different perspective" (DSG)*

*"I have a kinship with somebody else who has the same problem" (DSG)*

## **The acquisition of disability once admitted to medicine**

The situation whereby a student either acquires a new disability or suffers the flare up of an old disability once admitted to a course poses particular problems. Once again a variety of opinions were voiced about the appropriate response. In one camp were those who thought the occurrence should be subject to exactly the same procedures as that followed when admitting a new student:

*"We would have to treat them in exactly the same way" (ASG)*

This would involve invoking occupational health for a review, consulting with the GMC and listening to the views of constituent Trusts. It would also involve counselling the student concerned and if necessary supporting a change of academic course. In others the response was summed up in the phrase:

*"We would bend over backwards to help them" (ASG)*

Interestingly these differences of view did not necessarily reflect the attitudes displayed towards disabled applicants. Staff talked about closely monitoring the student making adjustments to the course and ensuring sympathetic and accessible placements:

*"We would do everything we could to keep the student on board" (ASG)*

Two of the disabled doctors had entered medical school with the disabilities that they still have. Both concealed the matter at interview or at least never volunteered the fact. One experienced rejection at one school because of the problem so never mentioned it again, and was subsequently admitted. The other commented:

*"In those days there was more of a stigma I knew I was bright enough and I knew it was what I desperately wanted to do - so I just went for it" (DDG)*

All seemed agreed that once the barrier of the medical school and the PRHO year was overcome acquiring a disability tended to result in a closing of ranks. The word club featured frequently in the analogy used:

*"It's like joining a club, difficult to get in" (DDG)*

*"It's a club really, once you are in they look after you" (DDG)*

*"People bend over backwards for you once you are a member of the club" (DDG)*

Respect and help from colleagues was a feature of responses:

*"Everybody has been really helpful" (DDG)*

*"If I was starting out with this disability it would have been much harder...when you have a bit of respect from colleagues it is easier to blend in with a disability" (DDG)*

When it came to discussion in the non-disabled student group about acquiring a disability once admitted to a course, and having to adapt to life in a wheel chair, some students identified with the fact that this could apply to anyone of them. Some felt that they would want to withdraw from the course:

*"I wouldn't fight (to stay in medical school) because it would be a disadvantage to patients. I would also have a lot of issues to deal with myself" (NDSG)*

Others said they would react positively and fight to maintain their place:

*"If somebody put me into a wheel chair today it would probably take 3 days to get home! But I would quickly adapt, some people develop amazing mobility in a wheel chair" (NDSG)*

Repeatedly the discussion returned to the problems to be faced in hospitals:

*"There would be major problems in the hospitals" (NDSG)*

*"I can understand that, as a PRHO, you may be confronted by somebody collapsing in front of you, you have to deal with it, somebody in a wheel chair wouldn't be able to do it" (NDSG)*

There was more general agreement that requiring the use of a wheel chair in mid career was potentially less problematic:

*"It shouldn't stop you" (NDSG)*

*"If qualified already it shouldn't be a problem" (NDSG)*

The idea that particular medical specialities are 'wheel chair friendly' was also aired:

*"May be easier if you acquire it later on as you can specialise in different areas"*  
(NDSG)

*"In the pre-registration year it would be a struggle, it will be a struggle for all of us, but there are plenty of specialities- for example dermatology and general practice- where they could cope"* (NDSG)

## Theme 2: Attitudes to specific disabilities

All the groups interviewed expressed concern that serious visual and hearing impairment would be major obstacles for practising doctors:

*“You have to look at a patient- look into their eyes- I don't think it is possible (DPG)*

*“It's a definite no, you could feel very uncomfortable with a blind doctor – I would personally” (GPG)*

*“They couldn't do an examination, they can't see a rash –It would make me hesitate” (GPG)*

*“No way could you have somebody without hearing at all” (GPG)*

*“I'd be frightened because they could misunderstand what you are saying and treat you for something different from what you said” (GPG)*

*“It would be very hard. It's all about communication; straight away you have a barrier. That's not to say they couldn't do the job correctly but unless you saw that doctor every time you went and built up a bit of a relationship it would be difficult” (GPG)*

*“You are already anxious, and this would make it worse” (GPG)*

*“Communication would be a major issue” (DSG)*

*“If you are blind I really don't understand how you could be a doctor” (DSG)*

*“Blindness is the biggest handicap of all for a doctor” (DSG)*

*“My gut reaction would be that it would be extremely difficult to comprehend a doctor who was totally deaf” (DDG)*

*“That would be very difficult...patients are not always easy to hear even if you have good hearing” (DDG)*

*“People have to be admitted (to medical school) on the merits of their own case; ok, but if they are blind they can't do it, but where does the boundary lie if you are deaf?” (NDSG)*

*“It would be extremely difficult....we pick up an awful lot of clues as to how people are from not only the colour and character of their skin, but also the expression of their faces” (DDG)*

*“I think to be able to cope with the full range of skills a G.P. would need it is very difficult to envisage managing without sight” (DDG)*

*“You would be taking away many of the things you need for a physical examination” (DDG)*

*“With the present constraints I would be very reluctant to take on somebody who was blind” (ASG)*

*“Somebody who is totally blind is going to miss so many visual clues from a patient....they would need the support of a sighted person” (ASG)*

A significant number of the general public were adamant about blindness:

*"Absolutely not - there are other things you could do" (GPG)*

Only a few were more positive:

*"If they had been deaf all their lives, and passed all their qualifications, they would be used to people so it wouldn't make a difference" (GPG)*

*"I would try it out...I wouldn't discredit the man because he was blind. I would find it quite interesting. I wouldn't be put off it altogether" (DPG)*

The issue of doctors with severe speech problems was also discussed one member of the DPG recollected having had a GP with a voice box following throat surgery. She reported that once the initial adjustment was made on her part she continued to see the doctor quite happily. Another commented:

*"I would find that a bit embarrassing but it wouldn't put me off. It would be me who felt uncomfortable"*

One person even saw such a handicap as positive:

*"If they had a speech difficulty at least they would have to give you longer than five minutes"*

Practical problems relating physical disabilities requiring the use of a wheelchair was considered by most groups to be surmountable. However, non-disabled medical students did express the view that the use of wheelchairs did cause problems and that wheelchair users tended not to be integrated with the rest of the student body:

*"X (a wheel chair user) seems distant from the rest of the class. X comes in last and sits on their own and has problems integrating" (NDSG)*

Interestingly, disabled doctors and medical students were concerned that patients 'did have the right to be treated properly' and were acutely aware of the limitations imposed by the use of wheelchairs.

Dyslexia was not thought to be a problem by some admissions staff, especially if the condition was not severe:

*"It's no longer an issue for us" (ASG)*

*"Dyslexia is not now a problem for us" (ASG)*

*"People with dyslexia quickly develop coping strategies and have no problem with the course" (ASG)*

*"Dyslexia is no longer a problem; there are so many electronic aids and new technologies that would pick up any errors they might make" (ASG)*

However, some admissions staff were concerned that if the dyslexia were severe, there might be problems:

*"We do reject people who are severely dyslexic and declare the problem" (ASG)*

*"An external (examiner) spotted some work by a dyslexic student and said ...He should never practice medicine" (ASG)*

*"A certain degree of dyslexia we simply can't live with" (ASG)*

*"It is very easy to hide (dyslexia) and we do have one or two students whom we shouldn't have admitted in the first place" (ASG)*

Mental health problems caused much more disagreement within the groups, with the general public group being very polarised in their views: some felt that any form of psychiatric history should exclude practice:

*"It would for me, when you go there you are putting your body in their hands, and you are trusting that stranger, so any doubts in your head would put you off" (GPG)*

*"You would always be wondering- does he know what he is doing?" (GPG)*

*"Three out of four people would prefer another doctor if they knew they had had a problem in their background" (GPG)*

and similarly in the disabled public group:

*"I am not very happy about it at all" (DPG)*

*"I suppose that they would not have any mobility problems, but most of the other things I would be very worried about" (DPG)*

Others felt that with suitable rehabilitation and monitoring, this would be sufficiently reassuring for such doctors to practice:

*"It depends upon the person having had treatment and how long it has been since they overcame it" (GPG)*

*"You assume somebody has okayed him somewhere along the line" (GPG)*

*"Some of the old doctors in the past used to be alcoholics all their lives and they got through alright as long as it doesn't interfere with their work" (GPG)*

*"They should be given a chance- after all they are only human" (DPG)*

This dichotomy of views was echoed in the non-disabled student group with distinction being made between severe psychosis which would prevent admission to medical school and the more common depressive illnesses:

*"Depression shouldn't prevent you from becoming a doctor" (NDSG)*

*"Mental health problems can be coped with in medicine but they need support" (NDSG)*

The consensus of the disabled public group was that whilst depression was something that could be overcome most other forms of mental illness left a dangerous legacy:

*"I would feel sorry for them but I wouldn't have a lot of confidence in going to see them" (DPG)*

In the area of alcohol and drug abuse there was some support for random drink/drug testing:

*"We have to work with the public and it would be no different if we were a teacher or a nurse" (NDSG)*

Similar reservations were expressed by the disabled public:

*"It's simply not good enough" (DPG)*

*"I wouldn't like to visit anybody with those problems" (DPG)*

*"A heavy drinker, I would find it very disturbing" (DPG)*

The admissions staff felt mental health was a major problem and were reluctant to discuss the issue. They also appeared to be rather mistrustful of the power of psychiatry either to advise or predict the course of the illness. As one put it to me when expressing their concerns:

*"Diagnosing seems to be relatively subjective, prognosis unpredictable and treatment rather hit or miss" (ASG)*

Most admissions staff resorted to explaining that they would rely heavily upon the advice they received from either Occupational health physicians in a local trust or a Consultant Psychiatrist linked in some way to the medical school. All respondents, in some way or the other, spoke about the concern they felt for patient safety:

*"For us the major issue is for patient safety" (ASG)*

### Theme 3: Experiences with/as a disabled doctor

For the public, a previous good relationship with their doctor prior to disability would lead to a more accepting attitude; even with issues such as impaired sight the GPG felt that if confidence had been built up they would have been happy to continue the relationship:

*"I used to have a GP who kept having to go away to the 'Detox Unit' but he was a very good doctor" (DPG)*

*"We had a family doctor for years who was always getting drunk. He was a bit of an Irish rogue, but everybody loved him" (DPG)*

Disabled doctors felt that their disability might undermine their patients' confidence in their medical attendant:

*"For me there was a problem with public acceptability" (DDG)*

*"You have to think about how the patients are going to react to you" (DDG)*

*"The relationship (if they, the patients, knew about my disease) can be completely undermined" (DDG)*

*"The trouble is that here is the doctor's professionalism and this can be discredited if they admit to illness" (DDG)*

*"If they knew, very vulnerable and needy patients could no longer treat me as a secure professional who could contain or look after them. A bit of them may want to be looking after me, or a bit of them saying why are you living and I am not?" (DDG)*

*"Disability groups may say 'oh it would be very nice to have a disabled doctor' but they don't actually think about the fact that probably a quarter of doctors over fifty have already got a serious medical problem" (DDG)*

*"You have to think about what other people perceive to be important". (DDG)*

*"How would you feel if you were the parents of a sick child and you saw this guy, apparently drunk, staggering towards you?" (DDG)*

Some disabled doctors reported that some patients ignored their disability:

*"No one has looked puzzled or complained or anything" (DDG)*

On the other side of the divide were those who felt that either their personal presentation would unsettle patients or that revealing a personal health problem would fatally unbalance the traditional doctor-patient relationship.

All the disabled doctors had made career changes as a result of their disability and acknowledged that their disability had placed limitations on their career choice. They felt that their colleagues had been supportive to them.

Disabled medical students felt that their disability had not caused any problems within the medical school or the university environment but expressed concerns about working in a hospital or patients' homes. Non-disabled medical students again raised the issue of the level of integration of wheelchair users with the rest of the students:

*“They would have no problems in getting around the medical school but would experience problems of integration, getting into and around the hospitals and having to travel separately to placements and visits” (NDSG)*

## Theme 4: Pre-course testing

The notion of pre-course testing is to assess the impact of a person's disability on the expectation of successful course completion and attainment of a license to practise. A set of practical tasks on application would provide an 'objective' measure of suitability for admission to medical school. It is reasoned that if a decision to reject a candidate is based upon their failure to perform some simple practical tasks rather than their disability no charge of discriminatory practice could be levelled at the institution as the failure to get into medical school is not because of blindness but because the individual could not thread a needle.

There was no enthusiasm from any of the groups interviewed as they were dubious about the feasibility of such processes and questioned the validity and reliability of any tests which might be used. Admission staff and disabled medical students in particular thought that if there was pre-course testing, all applicants should be expected to undergo the same assessment:

*"If we have to do it for disabled students we would have to do it for all students"*  
(ASG)

*"Some of our supposedly able bodied students may actually have disabilities"* (ASG)

*"It was political correctness gone mad"* (DSG)

*"Being scared that you will be sued by a disabled person because you did not let them in is the worst possible reason (to consider skills tests). Not only do you end up with a lousy doctor but they get in because of their disability not in spite of it"* (DSG)

Interestingly within the discussion about pre course testing the NDSG concentrated on testing of communications skills:

*"There are so many people in our year who are so disabled in terms of their communication skills that actually they should not be doing medicine"* (NDSG)

*"The current interviewing has to be far more rigorous as too many people get in at the moment who cannot communicate"* (NDSG)

*"The attitude seems to be (about the poor communicators) that they will mature. So if they are going to employ that idea in one area (communication skills) then it has to be applied across the board (i.e. to disabled students)"* (NDSG)

## Theme 5: Limited licensing

This issue caused a great deal difference of opinion within the groups. Disabled doctors felt limited licensing already reflected the reality of their working lives, without this being officially legislated:

*“De facto it is emerging” (DDG)*

*“I am registered with the GMC but I am restricted in what I can do” (DDG)*

*“In reality I hold a second division licence” (DDG)*

There was general concern among the other groups of interviewees about creating a subclass of disabled doctors who might not be as highly valued:

*“The idea is a good one but you would end up with certain fields of medicine that contained a large number of people with disabilities. The general public would begin to regard them differently and see them as second class” (DSG)*

*“I tend to swing between agreement and disagreement with the idea. But if only certain special students are put forward for this it would definitely be seen as a second class degree” (DSG)*

*“Knowing human nature what it going to happen is that it will become a ghetto – particularly knowing that medicine is already an old boys club” (DSG)*

*“Everybody with a disability is different and so it would simply be a form of discrimination” (DSG)*

*“I would challenge it to the death you would end up discriminating against all kinds of people” (DSG)*

*“I think there would be the danger of creating related professions of sub-medicine” (ASG)*

*“Different types of registration, I would support that as long as it was not used to create a second-class doctor” (ASG)*

However, disabled doctors and non-disabled medical students did express the view that limited licensing might produce new and empowering opportunities for all doctors:

*“It would empower doctors. Junior doctors are under terrible pressure to do things they feel they can not do- and that can be disabled or able bodied- but with a limited license you could say quite clearly ‘I am not licensed to do that’” (NDSG)*

*“There is a lot of truth in the belief that you can learn a lot working with somebody who has a disability” (DDG)*

Interestingly disabled doctors rejected with some force the idea that limited licensing would create second class doctors. They felt that students and doctors should take a hard look at why they were in the profession in the first place. If they were overly concerned about first or second-class status they were putting their interests above those of the patients:

*“What’s the point of doing medicine? It’s to benefit your fellow citizens not yourself” (DDG)*

*“Those who argue that it will produce second class doctors are missing the point it is about helping the patient in front of you..... put the patient first” (DDG)*

There were some concerns about deconstructing the holistic study and practice of medicine:

*“As a GP you have to know about everything. Diseases interlock and you can’t disentangle the various specialities – even psychiatry” (DSG)*

*“Doing a wide range of things will make us better doctors. There is a danger in specialising too early. Doctors need lots of skills so that they can advise somebody appropriately” (DSG)*

*“...Inter- locking nature of medicine; you can’t just pick out certain bits” (NDSG)*

*“Cutting out bits of your degree you would be cutting out a vast scope of patients you could be learning from” (NDSG)*

## Theme 6: Tracking

Tracking is a term that has been applied to the structuring of a medical undergraduate course so that a disabled student is enabled to work their way through the curriculum with the minimum of barriers and problems. As our medical courses increasingly make use of core and options models and students make choices about Student Selected Components (SSCs) it has been suggested that an individualised “track” through the course may be devised for disabled candidates. To some extent it became clear that courses already exercise this option - all be it covertly - on a small scale; for example, choosing placements and hospital settings known to be barrier free and disabled friendly.

There was limited enthusiasm for this from the admissions staff:

*“We are rather wary of the idea” (ASG)*

There was unanimous support for this idea from the disabled medical students while non-disabled medical students thought this was already happening with a ‘core and options curriculum’:

*“Medicine is something where everybody has a different knowledge base and it all comes together; so I wouldn't be against the idea so long as by taking a different course it was seen to be fair and it produces a doctor that's not dangerous” (DSG)*

*“Definitely a good idea; not making it easier just creating a particular route” (DSG)*

*“We already have different choices of SSC, it is already happening to a certain extent” (NDSG)*

All three groups interviewed on this theme felt that this process had to be fair and not lead to discrimination against non-disabled students:

*“There is a danger that the able bodied will be discriminated against” (NDSG)*

*“The argument that someone has to be accepted because they have a disability discriminates against me” (NDSG)*

*“We do this (at the moment) to some extent but we believe it should be overt and open to all (ASG)*

*“The system (if adopted) has to be open to others for example single parents and not just the disabled” (ASG)*

*“I would be in favour; we all go our separate ways anyway so why shouldn't it start earlier” (DSG)*

Non-disabled medical students expressed concerns about maintaining standards and both the disabled and non-disabled medical students felt there needed to be a core of knowledge and skills which everyone had to have:

*“Although I like the limited licensing idea I do think there should be a minimum that every doctor needs to know (NDSG)”*

*“We have to know something about all the specialities” (NDSG)*

*“There are core things like dissection and I believe that we should all have to do that” (DSG)*

## The GMC, fitness to practise and the pre-registration house officer (PRHO) year

In addition to the six themes discussed above, there was particular interest in some of the professional groups in relation to the role of the GMC, fitness to practise and the PRHO year. We report these because we feel that they are of special interest and importance in the discussion around the inclusion of disabled people to the medical profession.

All medical schools admission staff were concerned about the fact that they were not only taking on a new student of a certain intellectual ability but a potential young doctor. At the end of the course they may have passed all their exams and assessments but a major concern was:

*“Are they going to be fit for practice?” (ASG)*

A great deal of heart searching and agonising went on over this issue. Many tutors expressed the view that it was not fair to the students if their future fitness to practise was not considered on entry. Many felt that accepting a student with a disability, without consulting both the local NHS trust and the GMC would:

*“Risk putting the university into a false position” (ASG)*

Some questioned what they perceived as the ‘inextricable linking’ between passing the academic aspects of the course and the provisional registration with the GMC:

*“That linking needs to be questioned. The pre registration house officer year (PRHO) is the biggest hurdle to the acceptability of disabled students” (ASG)*

The questioning of the fitness to practice criteria was based upon the vagueness of the position adopted by the GMC but also the inevitability of somebody ‘graduating in medicine’ necessarily moving on to practise as a doctor. As one respondent noted:

*“Those intending to work as medical statisticians, coroners or medical journalists should be enabled to qualify, but without the practice element” (ASG)*

It was clear that medical schools have been looking to the GMC to help them with what many identified as a problem. Furthermore, some appear to blame the GMC for a lack of guidance and clarity. Some in particular would like to see the GMC involve itself more directly in decision taking around of the admission of the disabled student:

*“We desperately need a reference point, a point of contact and even some form of evaluation (from the GMC)” (ASG)*

*“The key is for the GMC to say what they think are the implications for disability in the PRHO year... What is the standard?” (ASG)*

*“They haven’t really given us the guidance” (ASG)*

*“We are all a bit uncomfortable at the moment” (ASG)*

*“Can you work in casualty? Is that really the criteria for entry to medicine?” (ASG)*

*"We are all working within the present outdated and limiting constraints of medical education" (ASG)*

*"We regard the GMC as a bit of a stumbling block because they never commit themselves" (ASG)*

*"Decisions from the GMC are very slow" (ASG)*

*"We must get agreement between the GMC and the (NHS) Trust line, otherwise the university is put into a false position" (ASG)*

*"Some sort of coordinated national approach from the GMC would be appreciated" (ASG)*

*"We want the GMC to provide clarity and consistency" (ASG)*

A clear division of opinion emerged from the interviews with the admissions staff group. There was broad agreement that the PRHO year was a major barrier for disabled people to enter medicine but its relevance was vigorously disputed. On the one hand were those who saw it as an important gateway, a 'rite of passage', into the profession while others saw it as an outdated irrelevance: an artificial exercise designed to exclude rather than facilitate:

*"The PRHO year is the biggest hurdle" (ASG)*

*"The modified (3 stage) PRHO year has not made things any easier" (ASG)*

*"There is still the old elitism... still churning(ASG) out the old dinosaurs" (ASG)*

*"The overly rigid format of the PRHO year" (ASG)*

*"Is the house job really necessary – I don't think so" (ASG)*

*"It's a hellish enough degree as it is, if they (disabled students) have made it through to the 5<sup>th</sup> year why should the PRHO year stop them?" (DSG)*

There was discussion about how to tackle this issue - for example, the possibility of organising the PRHO year in such a way that a disabled person could cope with the problems. One respondent spoke of a *specialty tailored* year whilst another spoke of the fact that:

*"He (a disabled individual) had a very carefully chosen PRHO year".(ASG)*

One of the key discriminators, and one mentioned by all respondents, was the ability to perform resuscitation. The understanding of GMC requirements is that PRHOs have to be able to demonstrate an ability to respond quickly to a cardiac arrest and carry out the appropriate procedures in order to offer resuscitation:

*"The core skills of a PRHO should be met by all medical students..... attendance at a crash team is the crunch issue" (ASG)*

*"The ability to get to a cardiac arrest quickly is essential" (ASG)*

However, others were critical of the importance of this as a marker of competence. In their opinion it represented an outdated view of the role of the doctor in the modern medical team:

*“How important is the PRHO in a crash team?” (ASG)*

*“I question this” (the need to demonstrate resuscitation) (ASG)*

*“These days so many other people- for example nurses- have been trained to do this (deal with a cardiac arrest) so a nurse may lead on a ward” (ASG)*

*“They have to be on a ‘crash team’ but it is rather silly to have to put everybody through crash call training if they don’t want to do that” (in their subsequent career) (ASG)*

*“Are we really just training them so that they can work in A and E?” (ASG)*

Responses from the disabled doctors group about the value of the PRHO year and the possibility of completing it with a serious disability were coloured by the age of the respondents as the nature of the year or indeed the need to complete one at all has changed so much over time. Inevitably discussion was drawn to the practicability of completing the year in a wheelchair. Respondents were very sceptical:

*“I do wonder if it is really feasible for a wheel chair user to get to a cardiac arrest and complete all the tasks” (DDG)*

*“I think it would have been impossible to complete it as I am now (in a wheelchair)” (DDG)*

*“When I did it it involved literally one hundred hours on your feet rushing between patients” (DDG)*

*“Going to A+E where the space is extraordinarily limited - beds and trolleys - then it becomes almost nonsensical” (DDG)*

*“I think it would be a nightmare you are not at the right height you would need a hydraulic one (wheelchair) on stilts!” (DDG)*

*“SHO jobs are quite hectic...on call...running down corridors...upstairs. In a technical sense I could still do it, but getting from A to B? I wonder how I would survive” (DDG)*

The importance of the PRHO year, particularly if someone wished to follow a career in acute medicine, did not seem to be in dispute:

*“Medical school teaches you nothing, the house officer year teaches you a hell of a lot” (DDG)*

*“In one year you get together a huge amount of knowledge and information...you discover how you manage yourself and how you work with other people” (DDG)*

*“If you can’t hack it in your house officer year you probably can’t hack medicine” (DDG)*

*“It sorts out those who are going to be doctors, and those who were good at passing exams” (DDG)*

## Discussion: overall summary of responses to the themes

In reviewing the responses from all the groups of interviewees to **Theme 1: Attitudes to the idea of disabled doctors**, there emerged a general acceptance that individuals with certain disabilities could be admitted to medicine. There was considerable feeling both in the professional and lay groups that this would enhance the practice of medicine. The cost effectiveness of training disabled doctors who might not be able to practise in some areas of medicine was not perceived to be of over-riding importance. It was however acknowledged that some disabilities would preclude practice in some areas. The general public were less concerned about physical and mobility impairment than impairment of the ability to communicate effectively. Not surprisingly, the disabled public groups considered that disabled doctors might be more empathic. If someone became disabled after entry to medical school or qualification, there was perceived to be greater support for accommodating their condition.

Discussion about **Theme 2: Attitudes to specific disabilities** elicited the general response that physical disabilities were thought less of a problem than severe sight, hearing or speech impairment as communication and observation were considered to be essential requirements to practise medicine. Whilst dyslexia was not considered to be a major problem, there was some concern about the severity of the condition which might affect a doctor's prescribing ability. Mental health problems produced polarisation of opinion, with the general public being much more negative than the other groups.

Within **Theme 3: Experiences with/as a disabled doctor**, members of the general public felt that a previous good relationship with their doctor prior to the onset of the disability would lead to better acceptance. The disabled doctors group was concerned that their disability may undermine their relationships with patients. However, they were all working, albeit within altered circumstances resulting from their disabilities.

There was very little enthusiasm from any of the groups for the ideas within **Theme 4: Pre-course testing**, because of the worries about the reliability, validity and feasibility of such tests. It was also felt that any pre-admission tests should apply to all candidates to maintain equity.

There was generally a negative view on **Theme 5: Limited licensing**, as this was perceived to be setting a precedent for the creation of a two-tier system of doctors. However, the disabled doctors group themselves saw that this was already happening, as an inevitable consequence of their limitations.

A number of interviewees felt that the concept of **Theme 6: Tracking** was already in place to a certain extent, with the core and options curricula prevalent in most medical schools. There was a plea for more equity and clarity about this practice. Many of the groups felt that there was a need for a core level of knowledge and skills to be attained by all medical graduates.

In addition to the six main themes discussed by the groups, there was much discussion within the professional groups about **The GMC, fitness to practise and the pre-registration house officer (PRHO) year**. The criteria set by the GMC for fitness to practise and the requirement for all graduates to go through a standard PRHO year prior to full medical licensing were seen as major barriers to the inclusion of disabled people wishing to study medicine.

## Conclusions

Generally there appears to be a positive swell of opinion regarding the admission of disabled individuals to the study of medicine. There is acknowledgement that currently there are practice issues in the early years of postgraduate training but these are seen as challenges for the medical profession to overcome. However disabilities that produce a major impact on observation and communication skills are considered not to be currently acceptable.

Many respondents felt that it is time for the GMC to provide leadership in this important area. This is a critical time for the medical profession, in terms of its relationship to society and state control. Expectations of doctors are changing: the demonstration of clinical competence and the certification of fitness to practise are now part of the new contract between medicine and society. The time is ripe for the reappraisal of the qualities that an individual should bring to the practice of medicine.

The Council of Heads of Medical Schools issued a statement addressing the composition of the medical profession:

*“The social, cultural and ethnic background of medical graduates should reflect broadly the diversity of those they are called upon to serve”*

(CHMS 2004)

With the enactment of SENDA, attention will have to focus on disabled people and the means to include them in the medical profession. Our study, while relatively small in its scope, elicited a generally positive view from different sectors of society regarding the inclusion of disabled people to the study and practice of medicine. Practicalities still need to be addressed within medical schools and in the working environment of doctors. However, important changes are required for flexibility and clarity in the GMC's guidance in relation to the criteria for fitness to practise, the granting of the licence to practise and the early postgraduate years. This is especially pertinent with the alterations in the early postgraduate years that are being implemented within the context of the Modernising Medical Careers programme and the proposed Foundation Years 1 and 2 requirements.

October 2004 brought more changes to the DDA, with employment provision being extended to include 'qualifications bodies and trade organisations'; this may well directly affect the GMC as it is the medical profession's licensing body. While the GMC has in the past successfully argued that it is not a 'trade organisation' and therefore does not fall under the terms of the DDA, qualification bodies are included in the new DDA amendments and they will have a duty not to discriminate and to make reasonable adjustments. They will also have to ensure that any 'competency standards' they have governing the requirements of the profession are objectively justified on clearly defined grounds.

The GMC, CHMS, the DOH and the NHS need to work together to effectively disseminate information on admitting disabled students to admissions tutors, to dispel myths and inequalities around the issue of disability and acceptance to study medicine. Unless this occurs, the responsibility for decisions around the admission of disabled students to undergraduate medical courses will continue to be passed between the GMC and the Universities. The Law Society has already reviewed its standards in conjunction with the National Bureau for Students with Disabilities (SKILL) and its accredited external providers of Law Practitioner courses. Perhaps now is the time for the medical profession to do the same.

We would like to thank all those who took part in this study, for their time and contributions. Many of the comments were inspiring; we feel that the main message of this study is summed up by this quotation from a non-disabled medical student who ended the group interview with:

*“It is important for us as well, as students. It’s all very well seeing disabled people as patients; wouldn’t it be great if we could see them as people and learn with them”*

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This study was made possible with miniproject funding from The Higher Education Academy: Medicine, Dentistry and Veterinary Medicine (formerly LTSN-01)



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