

Doctors with disabilities: licensed to practise?

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ABSTRACT – Doctors deal with patient’s disabilities every day but many in the profession have been nonplussed to see the focus of the disability rights lobbies shift from the recipients of care to the carers themselves. Until recently the number of practising doctors known to have significant disabilities was very low and for many reasons potential medical students were deterred from entering medical education. This piece would not even have been commissioned 14 years ago when the UK Disability Discrimination Act 1995 was passed. It is a measure of the change in society’s view of disability, reinforced by law, that the issue of whether there are disabilities which, in themselves, render a doctor unfit to practise can be analysed and discussed.

KEY WORDS: disabilities, doctors, fitness to practise, medical students

Disability – what is it?

Modern concepts of disability utilise the biopsychosocial model wherein disability and functioning are viewed as outcomes of interactions between health conditions and contextual factors which in turn may be external environmental factors (social attitudes, building design, climate, etc) and internal personal factors (gender, age, social background, character, etc) which influence how disability is experienced by an individual. It is really this change in the conceptualisation of disability that has altered society’s view of disabled people and their capacities and also prompted major changes in the law.

It is generally agreed that the World Health Organization (WHO) model of functioning provides the best framework for the understanding and evaluation of disability. It is important to distinguish between having a disease and having a disability, despite the confusing combination of the two concepts in UK legislation (the UK Disability Discrimination Act, DDA). Disability involves having an *impairment* – a deleterious change in normal structure or function, leading to activity *limitation* – a difficulty in performing some task or action and, so, *participation restriction* – a limitation in dealing with life situations. These elements focus on the practical consequences for an individual in their environment. As such they represent a move away from the ‘medical model’ of disability which focuses more on diagnosis and pathology rather than day-to-day consequences of

the impairment and for this and other reasons are not universally accepted. This variation in emphasis is reflected in the many different definitions used in legislation in different countries, especially when definitions of disability are used for compensation, for welfare payments, for education or training planning or for guidance in the field of employment.

A definition of disability more acceptable to disabled people therefore is that proposed by WHO and accepted by Disabled Peoples International as ‘the outcome of the interaction between the person with an impairment and the environmental and attitudinal barriers he or she may face’. Usefully WHO has exemplified its model in an International Classification of Functioning, Disability and Health (ICF) which classifies consequences of health problems, in contrast to ICD10 which codifies disease.

As the prevalence of disability increases due to survival of those with congenital impairments, better treatment of injuries and disease, and an aging population, the landscape has changed for disabled people. Higher education is more widespread, opportunities are less constrained by social class and democratic societies emphasise rights and non-discrimination. Combined with advancing medical practice and burgeoning new technology, openings for the disabled are becoming available. Attitudes may be slower to change: my own conversion to a different way of thinking occurred at a lecture many years ago at the Royal College of Physicians given by Professor Heinz Wolff who described how, when driving his new car, a tyre was punctured but, on opening the boot to locate the jack, he found it was for the wrong model and did not fit. The message is that disabled people are all too often given the wrong kind of jack.

UK legislation

The DDA formalised society’s changing view of disabled people and their potential. It did away with the concept of being ‘registered disabled’ and only operates in certain areas of life for example work, housing and transport. It is now unlawful to discriminate against disabled people in these domains. In the context of work, the DDA is a form of positive discrimination in favour of preserving employment opportunities for disabled people and is the legal embodiment of good occupational health values and practice. The original DDA (1995) covered most workplaces but there were exclusions. The 2005 amended regulations removed the small employer’s exclusion (affecting, as an example, general practices) and that of the emergency services (but not the armed forces). The act was also extended to cover educational establishments (eg medical schools) and qualification bodies (such as the General Medical Council (GMC)). A brief and necessarily incomplete summary of this complex piece of legislation follows.

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The DDA does not define disability in terms of working ability or capacity but in terms of everyday life: 'A person has a disability if he or she has a physical or mental impairment which has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities.' Guidance is provided by the Disability Rights Commission (DRC), a statutory body recently subsumed into the Commission for Equality and Human Rights, which lays out the relevant impairments:

- movement, mobility, manual dexterity, physical coordination, lifting and carrying
- continence
- cognition – hearing, speech, eye sight, memory, concentration, learning ability, understanding.

Importantly in the present context, mental impairment covers more than clinically well recognised psychiatric illness and the courts accept autistic spectrum disorder, learning disorders, such as dyslexia, and disorders of obscure aetiology, such as chronic fatigue syndrome, as potentially qualifying mental impairments. Allusions to anxiety, stress or depression in medical notes, are not, however, necessarily regarded as being evidence of mental impairment. Drug and alcohol misuse are not covered. The act recognises 'perceived disability' – being HIV positive, having had cancer or suffering from multiple sclerosis – on the grounds of their potential for progression even if there is no demonstrable effect on day-to-day activities. Individuals are protected against discrimination even if their condition is controlled by medication or the use of aids. As examples, a hearing impaired person whose hearing is near normal with the use of a hearing aid, a person with diabetes whose control with drugs is good, and a person who has good pain-free mobility following hip replacement for disabling arthritis would all be covered by the act.

From the above, it is clear that:

- the DDA uses the medical model to define impairment
- the application of the act in the workplace is complex, not always straightforward and even counterintuitive on occasions
- many disorders and conditions covered under the act do not conform to general perceptions of what being disabled comprises
- the act is continuously evolving as a result of the establishment of new case law and European directives
- 'fit for life' does not equate to 'fit for work as a doctor'. A doctor with a 'traditional' disability such as paraplegia would, with work adjustments, be able to function in most medical roles and the same would go for a doctor with insulin-dependent diabetes. Certain conditions such as untreatable tremor (not necessarily covered by the DDA) would preclude a doctor from working as a surgeon but not as a general practitioner. Some conditions covered by the act (eg dementia), would almost certainly preclude all clinical practice
- the DDA 1995 as amended in 2005 also placed a duty on all public sector authorities to promote disability equality. This

obviously includes medical schools, hospitals etc and those duties include:

- eliminating unlawful discrimination
- eliminating the harassment of disabled persons (related to their disabilities)
- promoting equality of opportunity
- promoting positive attitudes
- encouraging participation by disabled people in public life.

Thus public authorities involved in healthcare who must now plan their premises and their teaching with disabilities in mind will be playing an important part in effecting cultural change.

Prevalence of disability in the medical profession

There has been little systematic collection of data on the prevalence of disability in the medical profession in the UK, despite a call for this to be done by the British Medical Association (BMA) in 1997.¹

As for entry into medical school, figures from the University, Colleges and Admissions Service (UCAS) 2000/5 showed that only about 2% of those accepted for medical training declared a disability or chronic illness compared to a figure of about 6% for students in general.² The most common disability declared (for medical and non-medical students) was dyslexia. Psychological morbidity among medical students is higher than among other students but this is not reflected in declared disability.^{3–5} NHS Employers monthly sample surveys give a prevalence among doctors of 0.5% plus up to 2% undisclosed.⁶

Surveys by postgraduate deans have shown similarly low prevalence – as low as 0.002% in some cases which compares with the DRC estimate of 12% among the general 25–34-year-old population.⁷ Some doctors become ill or disabled later in their careers and reports from the USA and Canada suggest a prevalence rate of 2–5% among career grade doctors.⁸ The DRC states that around 20% of the UK workforce is disabled in some way (ie would potentially come under the provisions of the DDA). Incidentally, 50% of the four most recent GMC presidents are covered by those provisions.

It is not difficult to surmise why the prevalence of disabled people in medicine is so low: some potential applicants might believe their disability would preclude working as a doctor and this might be reinforced by a culture in medicine which is hostile to disability within its ranks. Some in the profession may simply feel that disabled doctors would find life difficult, would not be able to cope with the physical and emotional demands, or be able to practise in very narrow fields only and thereby prevent another able doctor from training and practising. I once put to a senior British diplomat in the same room as a senior Australian diplomat who happened to be blind, that we should encourage more disabled people into the diplomatic service. At the time, Britain had a blind home secretary. The British diplomat's response was to say that ambassadors abroad were supposed to represent the best their country can produce.

Other possible causes of low prevalence might be failure to disclose a non-obvious disability – either because of the fear of stigma or because a student might genuinely feel the disability in question could not possibly have an effect on their study and/or practice.

Entry to medical school

In 2007, the DRC held a formal investigation into professional regulation within nursing, teaching and social work and disabled people's access to these professions.⁹ The DRC clearly had medicine and dentistry in its sights and would probably have extended its investigations had it not been subsumed as described earlier. It pointed out the vague, quaint and disparate nature of health standards laid down for entry into those professions and came to the conclusion that entry to vocational courses should not be subject to health standards. They believed it was possible to translate the effects of any disability or long-term health condition into competencies for study and that admission criteria should be based solely on those competency standards. They regarded statutory health standards to be discriminatory and likely to lead regulatory bodies, universities and, in some circumstances, employers to discriminate against disabled applicants, students and professionals. They saw, in effect, no difference between vocational and non-vocational study but accepted that employers might have a different perspective from university educators. Health standards for student teachers have already been removed by the Scottish parliament.

Their view does not in fact conflict with the stated position of the Medical Schools Council:

Acceptance for medical school implies selection for the medical profession. A degree in medicine confirms academic achievement and in normal circumstances, entitles the new graduate who will be provisionally registered by the General Medical Council, to start practising as a doctor.

Also:

a disability...need not be a bar to becoming a doctor if the student can fulfil the rigorous demands of professional fitness to practise as a newly qualified doctor. Students with disabilities should seek advice from medical schools well before the deadline for UCAS submission so that individual circumstances can be considered.¹⁰

It has been suggested (accepting that different specialties have different requirements) that the attributes of a good doctor are: cognitive ability (including linguistic and mathematical intelligence, problem solving capacity and memory); humanity (kindness, empathy, emotional intelligence, team working ability); and diligence (careful practice, stamina, punctuality, probity).¹¹ Clearly many doctors fall short on some of these qualities; doctors with disabilities may also fall short on the same or different abilities. They may excel in others – empathy and diligence, for example.

A study of medical schools' admission practices showed 29 out of 31 assessed health as well as enquiring about disability in

their selection procedures. Most adduced a dual purpose – to identify applicants who would need support and those whose offer should be withdrawn if it was considered they would be unfit to practise on qualification because of disability or illness. Fifty per cent of schools rejected no applicants while three rejected half of their applicants on average each year. Over 60% of rejections were because of psychiatric illness. In some instances, applicants were rejected because of concern they would be unable to cope with study demands, rather than eventual fitness to practise.¹²

The theme was taken up by the BMA in its July 2007 guidance on disability equality in the medical profession.¹³ The social model of disability is adopted and the focus is on the accessibility of medical careers to disabled people and the support provided to disabled medical students and doctors. It was produced by the Association's Equal Opportunities Committee who comment on how disability equality has failed to keep pace with the high profile progress that has occurred in the medical profession with respect to race and gender.

The prime duty of the GMC is to protect patients by accrediting undergraduate medical courses and quality assuring graduates admitted on to the medical register. It has no statutory authority over the selection or admission of medical students. It does, however, require medical schools, who determine individually the specific criteria for selection into each institution, to put in place valid, open, objective and fair selection procedures.¹⁴ Practices vary but for disabled applicants, the quality assurance guidelines for the selection/admission of students recommend that the institution should:

- ensure that criteria and procedures used for selecting students are relevant to the requirements and the programme, including any professional requirements and do not unjustifiably disadvantage or debar disabled applicants
- ensure that appropriate support is offered and available for applicants attending interviews and other selection activities
- where appropriate, offer disabled applicants the opportunity to demonstrate their ability to use alternative ways for meeting programme requirements.¹⁵

Practising medicine safely

Doctors with disabilities (as defined under the DDA) do not necessarily present risks to patient safety. Although GMC statistics suggest that mental illness is the disability most likely to impair fitness to practise, it is unwise to generalise – stereotyping of this kind is one of the most common reasons for employers to be prosecuted under the DDA. Doctors who are not generally protected by the DDA, such as those with certain personality traits and substance abuse disorders, are more of a hazard.

Patient safety must be a prime concern of all those engaged in healthcare and a lower, less reliable standard of care cannot be justified in the interests of disability equality. Doctors who are disabled are entitled to have 'reasonable adjustments' made to their working conditions but the reasonableness is to be calculated taking account of all the circumstances, including potential

risks to the health and safety of any person, including the disabled person themselves, colleagues and, of course, patients. If genuine, health and safety considerations override those of disability discrimination – no adjustment which puts patients at risk can be considered reasonable. Health and safety reasons should, however, never be put forward as an excuse for discrimination. In many cases standards of safe care would not be compromised if reasonable job adjustments were made for doctors with disabilities. Basic principles of fitness to practise, including doctors' recognition of their own limitations and a willingness to ask for help, alongside the absolute priority of patient safety still apply – after all, risk assessment is a constant feature of healthcare. Thus disabled students and doctors must not be discriminated against on the grounds of a presumed risk to patient safety. At the same time, disabled people cannot presume that risk can be properly assessed without the disclosure of sufficient information. There has to be mutual trust.¹⁶ A balance can be struck between a service which needs a junior doctor who can respond rapidly to a cardiac arrest call and a disabled doctor who needs training in order to become a specialist in a field in which the ability to resuscitate is not a requirement for patient care.¹⁷

Mental health and learning disability

These conditions constitute the 'difficult end' of the disability spectrum among doctors. They also account for the highest proportion of types of disability. The subject is complicated by the fact that medical students or doctors with a mental illness or learning disability may not regard themselves as disabled, even when they fit the DDA definition. Whereas students and doctors are generally reluctant to disclose mental illness, the same is not true for disorders such as dyslexia and most universities have well established procedures for allowing dyslexic students extra time or special equipment to compensate for their disability. A recent controversial case highlighted the issue of dyslexia in the context of professional examinations.¹⁸ Paterson was a senior police officer who had reached that position despite suffering from mild dyslexia, recently diagnosed. An employment appeals tribunal found that his dyslexia may have started to develop significance because demands on him increased as he moved upwards through the ranks. He was given 25% extra time in a selection process (which he failed) to become a superintendent. The tribunal held that this must mean that he was disabled under the DDA. This was an important decision because, for the first time, a high level examination was considered to be 'a normal day-to-day activity'. This opinion acknowledges a European court decision which focuses the meaning of 'disability' on whether the impairment hinders participation in professional life over a long period.¹⁹ The tribunal said that day-to-day activities should therefore be read as including activities which are relevant to participation in professional life. This case, if firmly established in case law, will have profound implications for professionals, such as doctors, whose natural progression may be towards promotion via selection processes such as exam-

inations. It can be imagined how dyslexia might hinder the acquisition of a range of safety sensitive competencies in medicine – and also how good coping skills and appropriate work adjustments might ameliorate the risks.

Similarly, conditions such as Asperger's syndrome and other forms of autism potentially regarded as disabilities under the act could affect functioning as a doctor – characteristics, such as inflexibility, lack of 'commonsense', difficulties in multi-skilling, poor teamwork, failure to pick up cues, mitigate against good medical practice, even when compensated by high intelligence.

Mental illness can present enormous difficulties for doctors and there is recent advice from the Department of Health on how to deal with and support doctors who have mental health problems severe enough to constitute disabilities.²⁰ Colleagues are not always sympathetic and those that are often ascribe it to experience either as a sufferer or because of professional exposure. Whereas some conditions do debar doctors from working – uncontrolled psychosis, severe obsessive compulsive disorder, or active anorexia nervosa (especially in students) – many conditions if properly managed can allow doctors to practise normally in certain areas. For example, doctors with bipolar disorder have worked successfully where they have let others in their team know the diagnosis and consequences so that when they are showing signs of entering a hypomanic phase, rapid help can be delivered. In much the same way, someone with epilepsy or hypoglycaemic episodes can make colleagues aware. Perceived negative attitudes towards illness, particularly mental health problems can result in students and doctors failing to seek advice and treatment through the normal channels. Levels of stress, chronic anxiety and depression well above the norm for university students have been identified among medical students and the same goes for doctors. Because of fears of stigmatisation and a perceived need for the utmost confidentiality, many students and doctors with mental health problems seek help from the private sector so that data on the prevalence of such disorders are hard to come by.

Practical learning points

- As a result of changes in attitudes towards disability and a 'new' law with teeth, more and more potential doctors are applying to enter medical schools expecting to be admitted.
- Medical schools now have a duty to accommodate a wide range of disabilities presented by students. The same is true of hospitals and other healthcare establishments.
- Whereas no legal duty rests on applicants to medical school to disclose their impairment, they should be encouraged to do so in order that reasonable adjustments can be made.
- Aspiring medical students who have a disability – mental or physical – would do well to seek advice from an appropriately experienced occupational physician before applying to medical school in order to have a realistic assessment of whether they will be able to cope or not and discuss what adjustments could be made to the learning and working environment of the medical school and on attachments.

- Medical students who are infectious for blood-borne diseases are not generally disabled, but they will not be able to perform exposure-prone procedures. There are, nevertheless, possibilities for them to graduate and gain a license to practise.²¹
- Students or doctors who acquire disabilities during their student years or subsequently, who have progressive disabilities or suffer chronic diseases may well be able to continue studying and working albeit with restrictions or modifications. If and when they become unable or unsafe to practise, an informed decision on retirement should be managed by an occupational physician.
- Health screening before entering a medical course should continue, carried out by qualified occupational healthcare professionals who should enquire into recent illness, in addition to disability. The primary purpose of screening is to identify applicants who should defer entry in order to recover from illness or establish stability following the initiation of treatment (epilepsy, anorexia nervosa, adjustment disorders are examples; to discuss needs for support and environmental modification; (very rarely) to recommend rejection on grounds of ill health or disability serious enough to preclude study.
- An applicant to medical school should be rejected only where there is substantial evidence that they will be unable to attain the necessary competencies or will pose a risk to patient safety.
- All organisations with responsibility for the education, employment and regulation of doctors should promote the interests of disabled students and doctors and encourage disclosure of non-obvious disabilities by fostering a culture of safe support, not stigma. They should ensure access to occupational health services and nominate a board-level lead on disability whose responsibility it is to ensure that positive attitudes are encouraged, harassment dealt with, obstacles removed and reasonable adjustments made. An excellent practical guide to the issue in relation to medical schools is published by the Department for Innovation, Universities and Skills, in partnership with the GMC.²²

Acknowledgements

I am indebted to the Royal College of Physicians' Working Party on Doctors with Disabilities for material collected and presented by them and to Professor Elizabeth Paice, Lead Postgraduate Dean for London, for advice. Helpful suggestions were also gratefully received from Dr Alan Swann, Imperial College, and Dr Peter Wright, Department for Work and Pensions.

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