

Disability in the medical profession

Survey findings 2020





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Foreword

Disabled doctors and medical students are a valuable part of our medical profession, bringing unique perspectives and insight into patient experiences and healthcare. They also face unique barriers and challenges as they study, train and work in a system that was not designed with their needs in mind.

It is often assumed that those delivering healthcare are not affected by disability themselves. This may be because disabled people are not a visible part of the medical workforce. There has been relatively little research to understand the experiences of disabled doctors and medical students to date.

Consulting with disabled doctors and medical students, in winter 2019 the BMA designed and carried out a survey to increase understanding of the issues facing them. The aim was to find out how we can provide better support and help drive forward improvements in medical education, training and workplaces. The survey was completed just before the COVID-19 pandemic which has sharply highlighted the additional pressures and barriers that disabled doctors often face.

The pandemic has emphasised the importance of knowing about disabilities and health conditions within the health workforce and making adjustments to enable people to work safely. It has highlighted the barriers and fears around disclosure that sometimes exist, and the necessity of access to good quality occupational health services to provide specialist advice and support. The adequacy of return to work support may also come into sharper focus as those who have shielded or been seriously ill face the challenges of resuming their medical careers.

The response to COVID-19 has also involved unprecedented changes to the way that health services operate and creates an opportunity to rethink healthcare delivery and job design. Some of the changes that happened at the peak of the virus show that things that disabled doctors and medical students have been calling for, for many years, such as more remote working opportunities, can be implemented at large scale and at a rapid pace, if the will is there to do so.

Our survey captures the experiences and priorities of disabled doctors and medical students before the pandemic, but which the pandemic has in many ways amplified. We hope these findings and recommendations will inform action that is urgently needed to build a better and more inclusive profession and health service.

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BMA representative body chair,
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Key findings

- **There is a widespread belief that medicine does not have a disability-inclusive culture.** Two-thirds of respondents believe that there aren't visible and positive role models for disabled people at a senior level where they work or study. Only around one third (36%) felt comfortable telling people about their disability or health condition because they believed the organisation was disability-friendly.
- **Disabled doctors and medical students have significant concerns about disclosing disability or long-term health conditions in their places of work or study and report negative experiences when they do.** Over three-quarters (77%) of respondents told us they were worried about being treated unfavourably if they disclosed a disability or long-term health condition. Only two in five (41%) said that telling their workplace or medical school had led to improved support, and less than half (46%) said that their colleagues had been supportive since they disclosed their disability.
- **Many have experiences of disability-related bullying or harassment and it appears more prevalent at senior levels.** Around two-fifths of consultants (42%) and SAS doctors (38%) say they have been bullied or harassed in their current workplace as a result of their disability. This compares to a third of junior doctors and a quarter of medical students.
- **Improving awareness of hidden and fluctuating disability and long-term health conditions is a top priority.** Over two-thirds (69%) of respondents rated this a priority they would like to see action on. This may reflect the significant number of respondents who said they had a hidden or fluctuating condition themselves.
- **Many disabled doctors and medical students struggle to get the adjustments they need and are entitled to.** Just over half (55%) of disabled doctors and medical students who require reasonable adjustments say they have obtained them. Improving access to adjustments was another top priority for action identified by respondents. 69% said it was a priority for them. Difficulties securing adjustments included: lengthy and complex processes, slow or only partial implementation, lack of engagement in the process by employers and schools, perceived costs and impacts on others, and fears about asking in case of negative career consequences.
- **The most common adjustment requested was flexible working.** The majority of respondents (57%) said they had requested an alteration in their hours of work, training or study. Only one in ten (11%) had sought changes to buildings or premises and a third (34%) specialist equipment.
- **Workplaces and medical schools do not pay sufficient regard to the realities of living and working with a disability or health condition.** This was obvious in the attitudes towards disability-related absence. Only a quarter (26%) of respondents agreed that their place of work or study's sickness absence policies took proper account of their disability or health condition. Almost half (47%) had felt pressured to return to work or study before they were well enough to do so.

- **White disabled doctors and medical students report a more supportive environment than disabled doctors and medical students who are from BAME (Black, Asian or minority ethnic) backgrounds.**

White respondents were twice as likely to say they were comfortable disclosing a disability because their organisation is disability-friendly (38% compared to 20% of BAME doctors). White respondents were more likely than BAME respondents to agree that their colleagues had been supportive (47% vs 35%) and to say they had secured adjustments they needed (58% vs 39%).

- **Most doctors and medical students are unaware or unable to access sources of support such as a disability champion or network in their organisation.**

Where they did exist and were known about, they were rated as effective. However, only 7% of hospital-based doctors said there was a disabled staff network in their organisation and only 8% a disability champion at senior level. NHS England's recent Workforce Disability Equality Standard found that 63% of hospital trusts had a staff network and 65% had a disability champion at senior level. This suggests more work is needed to make doctors aware of these potential sources of support where they do exist, and to increase access to these types of support for doctors working in other settings.

- **Despite all the challenges, many disabled doctors and medical students exist and thrive at all career stages, branches of practice and specialties.**

They have clear priorities for what needs to be done to better support them in medical education, training and workplaces. There were specific calls for more tailored careers advice, advice on ill-health retirement and pensions, and better access to well-being and informal sources of peer support from other disabled doctors and medical students.

Towards a disability-inclusive profession

The survey findings point to eight areas of action to open up the profession and improve the experiences, opportunities and retention of disabled people and those with long-term health conditions.

1. **Visibility:** Raise awareness of hidden and fluctuating disabilities and long-term health conditions, and challenge negative attitudes to disability in medical education, training and workplaces. For example, promote positive and visible role models at all stages of medical careers.
2. **Disclosure:** Be clear about why information about disabilities or long-term health conditions are being asked about, who will have access to the information, and how it will be used. Ensure line managers and supervisors have training and access to advice so they can handle conversations about disability sensitively, constructively and appropriately.
3. **Reasonable adjustments:** Create centralised budgets for funding reasonable adjustments. Streamline processes for accessing adjustments, including clear timescales for each stage. Consider introducing occupational health passports, or similar, to prevent unnecessary repetition of consultations. For junior doctors, ensure specialist equipment that is purchased through Access to Work can be retained throughout training, regardless of rotations and changes in employer.
4. **Occupational health:** Ensure there is timely access to occupational health advice, provided by accredited specialists in occupational medicine, for all disabled medical students and doctors across all branches of practice in each of the four nations.
5. **Disability leave:** Review sickness absence policies to ensure disability-related sickness absence is recorded separately. Introduce a disability leave policy to ensure adjustments are made for disability-related absences (eg medical appointments, treatment, rehabilitation, replacement or servicing of equipment, or disability-related sickness absence). End the use of triggers in sickness absence policies based on Bradford factor scoring, which can lead to discrimination.
6. **Flexibility:** Create more flexible career and training pathways and more opportunities for remote and flexible working. Improve support for disabled doctors returning to work after a period of disability-related absence, including phased returns.
7. **Individualised support:** Provide more tailored support for disabled doctors and medical students including specialist career advice, pension advice, wellbeing services and peer-to-peer support initiatives.
8. **Intersectionality:** Identify how to address the disproportionate impact on disabled people of different genders and ethnicities.

About the survey

Disabled doctors and medical students were invited to complete an online survey which ran from November 2019 to January 2020. The survey was designed after consultation with members of the BMA's EDI advisory group and the Disabled Doctors Network.

It asked disabled doctors and medical students to tell us about important issues affecting their professional lives and select priorities for action to create a more equal and inclusive profession. In addition to multiple choice responses, it included opportunities for free text submissions on key questions, which provided further qualitative data to inform the findings and priorities for action set out in this report.

We received 705 responses from across the UK. There was an over-representation of women and doctors of white British ethnicity compared to the numbers in the profession and at medical schools. For more information on the survey respondents see Appendix 1.

A note on terminology

We recognise that people have different preferences about language and how they identify. Throughout this report we have chosen to use identity-first language ('disabled person') rather than person-first language ('person with disabilities'). This decision was taken in consultation with disabled doctors and medical students and reflects the preference of the majority, who view themselves as being disabled by the society, environment and systems in which they live, work and study (the social model), rather than by their individual physical and/or mental impairments or differences (the medical model).

Recognising neurodiversity

The neurodiversity model builds on the social model of disability to reject medicalised, impairment-based views of many diverse neurological conditions, such as autism, dyslexia and specific learning difficulties. Some neurodiverse respondents self-identified in this survey as disabled, and others did not. However, in both cases their reported experiences are often broadly similar to those of (other) disabled people, in terms of experiencing professional stigma, negative effects of disclosure, and difficulty getting support within systems, environments and processes that are not designed with them in mind.

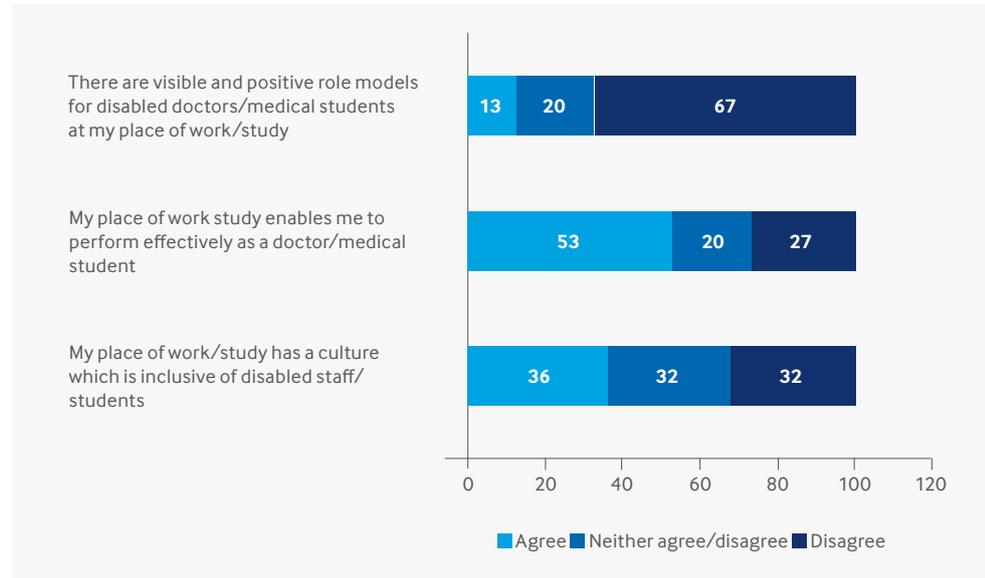
BAME (Black, Asian and minority ethnic)

In this report, BAME is used to refer to all respondents who identified as black, Asian or as an ethnic minority that was not white British, white Irish and any other white background. Due to small sample sizes, we are unable to disaggregate the survey data further and conduct more detailed analysis beyond the two broad categories of white and BAME. We also acknowledge that there are likely to be differences of experience within these two broad groupings and that further research is needed to understand how disability and ethnicity may lead to multiple disadvantages and intersectional discrimination.

1

Lack of visibility and barriers to disclosing disability

We asked respondents to tell us about their perceptions of the culture of their work or study environments. The results demonstrate that there is some way to go before medicine is viewed as a disability-inclusive profession where it is safe and beneficial to be open about disabilities or health conditions.



Lack of visible disabled leaders and role models

Two-thirds of respondents do not believe that there are visible role models for disabled people at a senior level where they work or study. Visible role models help to challenge negative stereotypes and perceptions of disability by demonstrating that disabled people can thrive in medical careers and bring unique skills and perspectives to patient care. They can also be valuable sources of advice and guidance on navigating particular career paths and specialities.

'If I know that a registrar or consultant battles with mental illness, I won't feel that alone. I'd feel reassured that if they could get to that stage, then certainly I will get there too.'

'I can't think of a single instance of hearing about potential role models at senior level who have disabilities. I would love to hear from/talk to doctors in this situation.'

Disabled GPs are the group most likely to say there are visible role models where they work, although still fewer than one in five (17%) believe this. Medical students are the group least likely, with just 7% agreeing, which is particularly concerning given the importance of having positive role models early in your career.

Medical students' responses also revealed isolation and a lack of support, which some believed was an attempt to 'toughen' them up for a difficult working environment.

'I wish there were people I could go to where I can talk to them about the struggles I face as a disabled student. It's difficult to find someone that understands me.'

'My medical school—in particular, I believe—is obsessed with 'hothousing' the students. It is a malignant atmosphere even for those with no additional issues. The response to issues being raised is essentially "man up".'

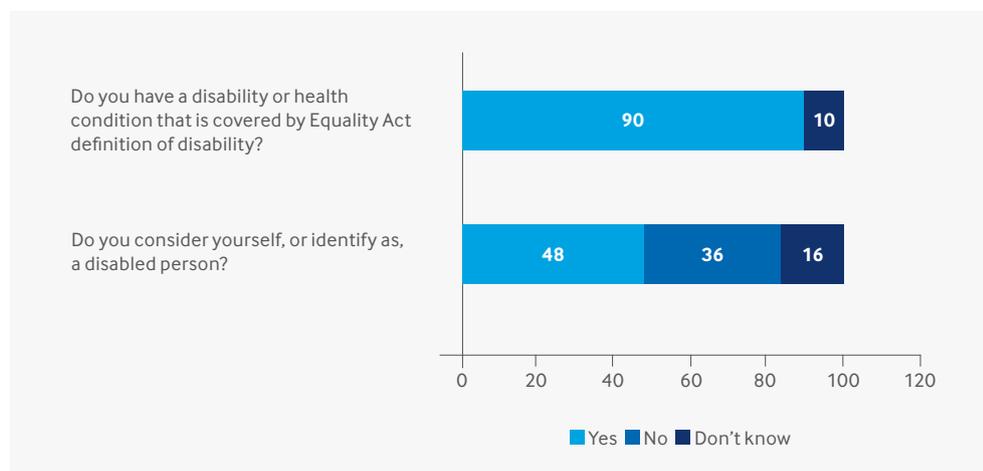
Telling people about a disability or long-term condition

Evidence shows that across the NHS workforce, many disabled people choose not to formally notify their place of work or study that they are disabled or have a long-term health condition. Around 19% of respondents to anonymous NHS staff surveys disclose a disability but only around 3% do so on the ESR (electronic staff record). The national report on the NHS England WDES (Workforce Disability Equality Standard) published in March 2020 showed that only around 2% of the clinical workforce disclosed a disability, and that disclosure rates decreased at later career stages.¹

We wanted to find out more about why disabled doctors and medical students may choose not to disclose their disability. Our survey found that a quarter (23%) of respondents had not disclosed to their current place of work or study and around one in eight (12%) had never disclosed to any place of work or study.

Identity and disclosure

While most respondents identified that they had a disability or health condition which met the legal definition of disability under the Equality Act 2010, there was a more mixed response to whether they viewed themselves as disabled.



Many elements make up an individual's sense of their own identity. The responses below highlight some of the complexity around this question, particularly as it relates to people's views of what it is to be a doctor. This has important implications for the way in which medical professionals are asked, and sometimes are required, to disclose disabilities or long-term health conditions.

'I feel that the word disability has so many negative connotations, all of which would make me feel like a fraud as a doctor if they were applied to me. I therefore feel unable to acknowledge the term despite falling under the definition.'

'I struggle with labelling myself as disabled - partly due to the stigma, and the perceptions that people with disabilities can't work as doctors - and partly due to a difficulty accepting it.'

'It's difficult to accept you have a lifelong disability. It feels like you are weaker in the elite world of medicine. I've always been treated as a problem both at university and the workplace.'

¹ <https://www.england.nhs.uk/publication/wdes-annual-report-2019>

Some responses also highlighted the fluid nature of identity. This was particularly evident in relation to conditions which fluctuated, and the degree of success with managing them. These responses also highlighted differences in experiences between people with a visible disability and those with hidden conditions.

'When I feel well then I do not see myself as disabled, but it is different when I get a flare up.'
'I know I'm disabled but I don't look disabled and I struggle with telling people I am disabled and asking for help because it's not obvious.'

For people with visible disabilities, there may be comparatively little 'choice' around disclosure, but there may still be decisions about the level of detail they communicate to others. This group may also experience people making assumptions about their disability based on stereotypes or lack of awareness; for example, that an ambulatory wheelchair user may not use a wheelchair at all times.

Fears about disclosure

Around three-quarters of respondents (77%) told us they were worried about being treated unfavourably if they disclosed a disability or long-term health condition at work or medical school. Only around one third (36%) felt comfortable telling people about their disability or health condition because they believed the organisation was disability-friendly.

Women were slightly more likely to agree (78%) that they were worried about being treated unfavourably if they disclosed disability than men (73%).

White respondents were slightly less likely (75%) to be worried about being treated unfavourably than BAME respondents (82%). White respondents were twice as likely as BAME respondents to agree that they were comfortable disclosing because they believed their organisation was disability-friendly (38% compared to 20%).

Reasons for non-disclosure

Among those who chose not to tell their employer or medical school about their disability, the most common reasons given were that they did not foresee any benefit, especially if it was not causing any particular difficulty with their work or study. Other factors included fear of stigma, wanting to fit in, impact on career progression, and lack of opportunity to disclose. There was also uncertainty over whether certain conditions 'qualified' as disabled.

'I struggle with the identity of being disabled. It's a negative connotation that focuses on what I can't do, not what I can do.'

'It would involve disclosing details of disability to seniors who may view it as a weakness and affect future career prospects.'

When disclosure is required

There are several points when doctors are asked to disclose and assess their capacity and possible future progression of their condition. While it is recognised that patient safety is usually the intent behind these questions, the approach and language used can be stigmatising. Questions that are posed negatively may reinforce concerns that disability is viewed as inherently negative in the context of medical careers.

GMC registration

When doctors apply to join the medical register, they are required to declare any health conditions that could affect their fitness to practice. Applicants can be asked to provide a range of detailed and potentially sensitive health information about themselves. However, respondents told us it is not always clear to them why particular information is required, or how this will be used to determine their fitness to practice. This uncertainty can cause considerable anxiety for some disabled applicants. These responses suggest that greater clarity around this process may reassure disabled applicants that they will receive the support they need to successfully pursue their medical careers.

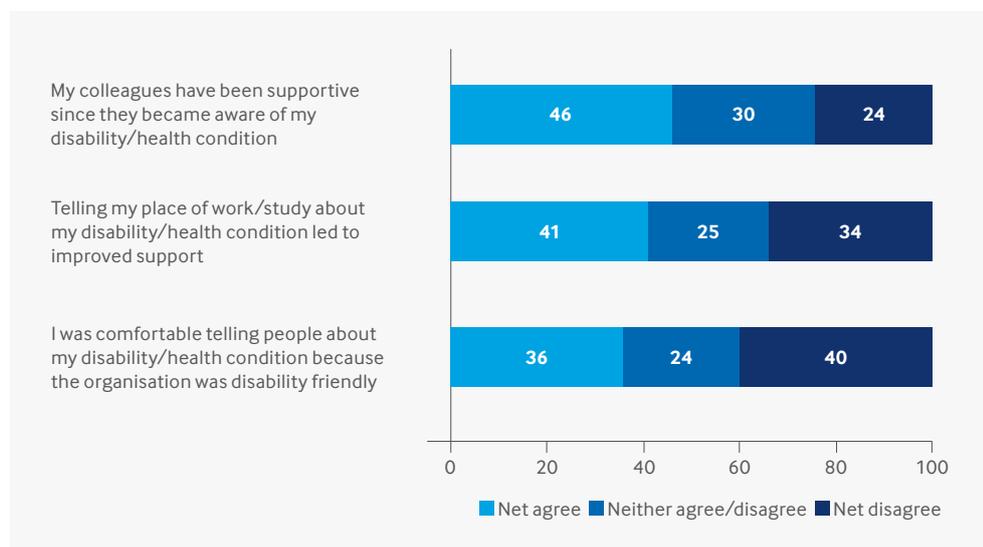
Does disclosing disability have a positive impact?

Doctors and medical students are encouraged to disclose disability through assurances that this will enable the right support to be put in place by medical schools and employers. The legal duty to make reasonable adjustments does not apply unless an organisation has knowledge of somebody's disability. So, it is concerning that many disabled doctors and medical students report negative experiences when they disclose.

Only two in five (41%) agreed that telling their workplace or medical school had led to improved support, and less than half (46%) agreed that their colleagues had been supportive since they disclosed their disability status.

Female respondents (47%) were more likely to say their colleagues had been supportive than male respondents (42%). Women were also more likely to agree (44%) that disclosing disability had led to improved support than men (32%).

White respondents were more likely to agree (43%) that disclosure had led to improved support than BAME respondents (33%). White respondents were also more likely to agree (47%) that their colleagues had been supportive than BAME respondents (35%).



'After I disclosed my medical condition, I was encouraged to leave my job. The ignorance and discrimination I have experienced has been extraordinary.'

'The first instinct of my educational supervisor was to tell me that she was worried I would not be able to cope/function as a consultant. She didn't say why or how she thought I would have difficulty, or suggest any ways of helping me, or any changes to my work patterns, she was just letting me know I was unworthy.'

'It feels like a constant battle and all feels a little tiring and exposing. I feel that I have to be open to get what I need, but it is strange just how many people have to know intimate details with my health as a consequence of the training programme.'

Some responses highlighted the positive impact of disclosure. Many of these comments came from doctors who had acquired disability or a long-term health condition during the course of their career. These comments showed that it was often small acts of empathy and consideration that had made a positive difference.

'One place of work was extremely supportive. I worked there when I was diagnosed. I was keen specifically not to be treated any differently, and to keep information very limited in terms of who was aware. They were extremely supportive in respecting this. Also noted that they were prepared to "bend over backwards" if there was something they could help with.'

'My current local department have been incredibly supportive. They knew me before my illness, kept in touch throughout treatment and created a job for me to come back to. I cannot fault them at all.'

Some respondents indicated that they had switched career pathways on the basis of the support available.

'I was previously working in a surgical speciality where I received very little support. I have since changed to general practice and have been treated with respect and received the changes I needed to the workplace in order for me to work to my best ability.'

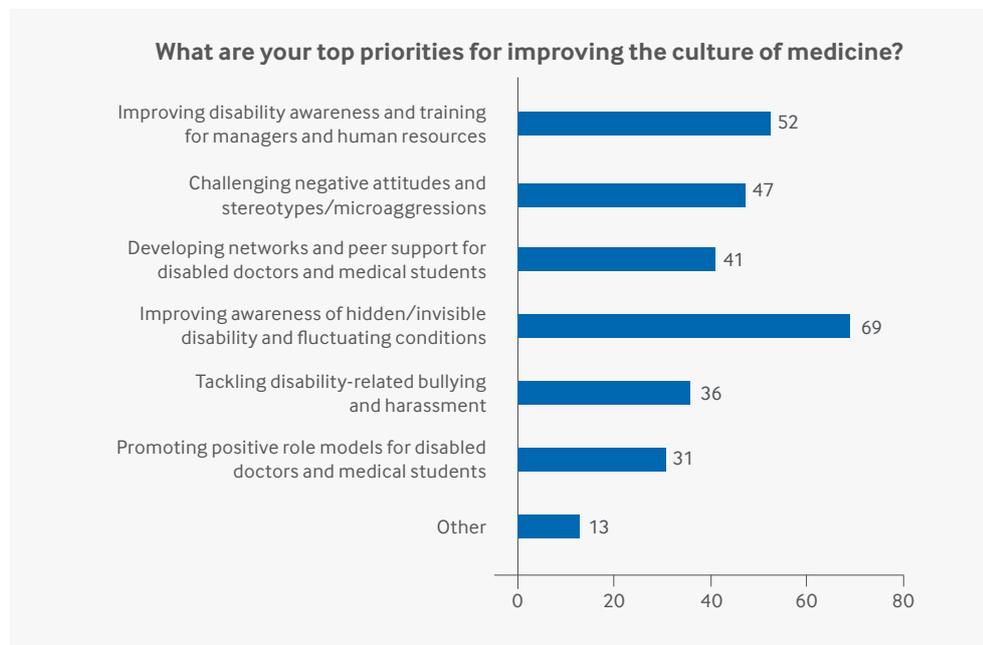
'My current hospital have been so supportive. I quit training to become a SAS grade doctor. My "problems" were not viewed as issues at all.'

2

Action needed to create a disability-inclusive culture

We asked respondents what actions they believe would help change the culture of medicine and make it more disability-inclusive. The top priority mentioned by 69% of respondents was improving awareness of hidden disabilities and fluctuating conditions, followed by improving awareness among managers and HR professionals, and challenging negative attitudes, stereotypes and microaggressions.

Analysis of priorities by grade revealed some differences depending on the career stage. For example, disabled medical students, junior doctors and GPs wanted to see more work on developing support networks and promoting positive role models, suggesting that these groups may feel more isolated, especially at the early stages of their medical career. Junior doctors may particularly struggle with finding and maintaining support networks due to the frequency with which they rotate through training posts. Both SAS grades (49%) and consultants (42%) felt that tackling disability-related bullying needed to be a high priority, compared to fewer than one in five (19%) medical students.



Improving awareness of hidden and fluctuating conditions

A significant proportion of respondents had hidden or fluctuating disabilities or conditions. These included mental health conditions, hearing impairments, lupus, epilepsy, diabetes, autism, specific learning difficulties, chronic pain and fatigue, cancer, and many others. Respondents said that despite working in healthcare, colleagues, employers and medical schools often failed to understand the impact of disability or a long-term condition on their lives.

'People often don't understand how chronic illness affects your life and how debilitating it can be at times. While my school supports me, my peers often think I am exaggerating or not telling the truth as they cannot see the pain I am in.'

'The biggest impact is on my days off and they see me functioning well at work, but don't appreciate my utter exhaustion.'

'The consultants I work for day-to-day are sympathetic, but I don't think really realise the impact it has on my life. This is probably because I try to minimise my symptoms as I want to be seen to be pulling my weight.'

Many, if not most, disabilities and health conditions can fluctuate, with people having relatively 'good' and 'bad' periods, depending on different factors and varying needs for support. Fluctuating health conditions can be particularly challenging to manage in a work or educational context because they are sometimes unpredictable. This means that a flexible approach to issues, such as rostering or managing sickness absence, is critical. Two in five (40%) of all people of working age are predicted to have a chronic or fluctuating condition by 2030. It is also worth considering that while the long-term health impacts of COVID-19 are not yet known, it is possible that it may result in greater numbers of healthcare workers managing long-term health conditions.

Lack of awareness of hidden conditions can make it difficult for medical schools and employers to know how to create disability-inclusive environments. For example, D/deaf medical students told us that simple changes, such as ensuring video and online training materials were subtitled, or that face-to-face teaching was set up to facilitate lip reading or BSL interpretation, could make a huge difference. Too often people 'forgot' to make these adjustments because they were not prompted by a 'visible' disability. The recent COVID crisis has also demonstrated the need to consider how equipment used by others can contribute to inaccessibility. For example, the widespread use of face masks has made it extremely challenging for both doctors and patients who rely on lip-reading as part of their communication.

Attitudes towards mental health conditions

Respondents highlighted particular challenges in managing mental health disability, which is seen as heavily stigmatised within the profession.

'Unlike physical disability, a mental health diagnosis makes you a leper. I have had positive support in one post but been too frightened to reveal my diagnosis elsewhere. As a caring profession medicine is very cruel to doctors with mental health problems.'

'I was told that being on antidepressants made me 'a liability' and that I should stop them immediately.'

'There was a 100% assumption that a person with a mental health problem would never be able to cope with the stress of medicine, I was also told I had no idea what a doctor's job entailed and therefore couldn't possibly understand the stress.'

While there has been plenty of attention on mental wellbeing and resilience for the medical workforce in recent times, sometimes the experiences of people with enduring mental illnesses and mental health disabilities are overlooked. Peer support services such as the [Doctors' Support Network](#) and the [Disabled Doctors Network](#) have useful resources for individual doctors, but systemic action is needed to ensure that mental health disability has parity of consideration.

Improving disability awareness of managers and HR professionals

Over half (52%) of respondents said greater disability awareness among managers and HR staff should be a priority. Lack of disability awareness in management and support functions can have a tremendously detrimental impact.

'It has been a challenge for some managers to appreciate what the disability means and hence understand the adjustments needed. Also, once adjustments were in place the attitude of some of those supporting me has been unpleasant.'

'My HR subjected me to performance management action, and it just worsened my anxiety and depression, making me think along the lines of ending my life back then.'

Challenging negative attitudes, stereotypes and microaggressions

Negative attitudes towards disabled people were a frequent theme throughout the survey. We heard several accounts of a lack of empathy and support from peers, colleagues, educators and employers. Whether these are rooted in a lack of understanding, or indicate more overtly negative attitudes towards disabled colleagues, their impact can be profoundly distressing.

'You would expect doctors to care for each other, this is the antithesis of my experience.'

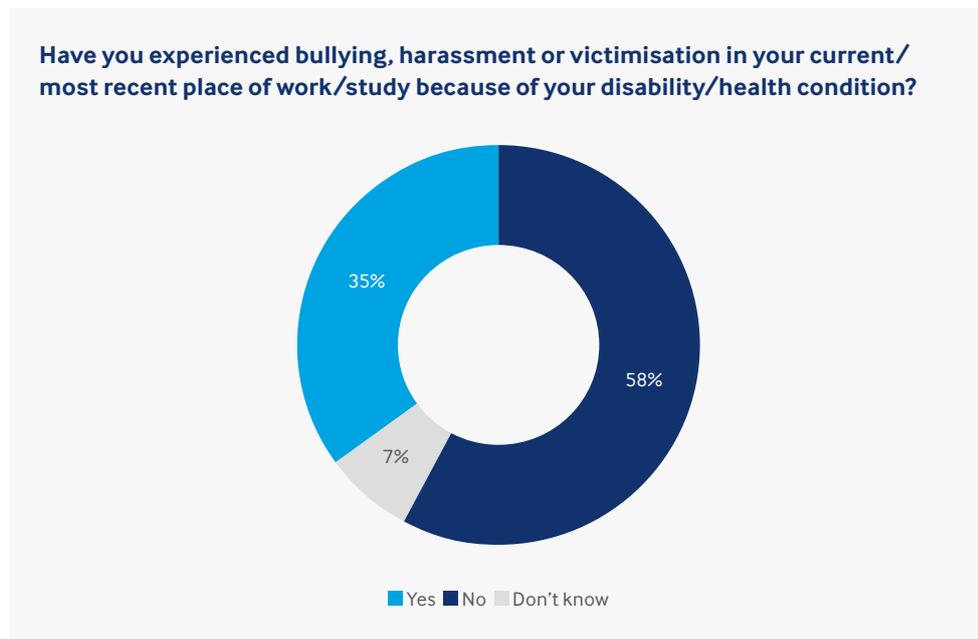
'There seems to be an attitude amongst many healthcare staff that some SpLDs [specific learning disabilities] / disability diagnoses are just "excuses" and "labels" for issues that apparently most people deal with.'

Some responses suggested that workforce pressures also contributed to disabled staff being made to feel like they were 'not pulling their weight' or were receiving 'special treatment'.

'Great support from occupational health and the consultant in charge of department and supervisor on this job. However, my peers/other juniors often make comments like "you're so lucky you have a day off/don't work nights" or "wow, how did you swindle that rota?"'

'The culture was that making adjustments for one person meant increasing the already unmanageable workload of others.'

Disability-related bullying and harassment



Over a third (35%) of respondents reported they had been bullied or harassed because of their disability or health condition in their current or most recent place of work or study. It appears to get worse at senior levels – 42% of consultants and 38% of SAS doctors said they had been bullied as a result of their disability, compared to a third of disabled junior doctors (33%) and almost a quarter of disabled medical students (24%).

Male respondents (41%) were more likely than female respondents (33%) to say they had experienced disability-related bullying or harassment. BAME respondents (44%) were more likely to say they had experienced it than white respondents (33%).

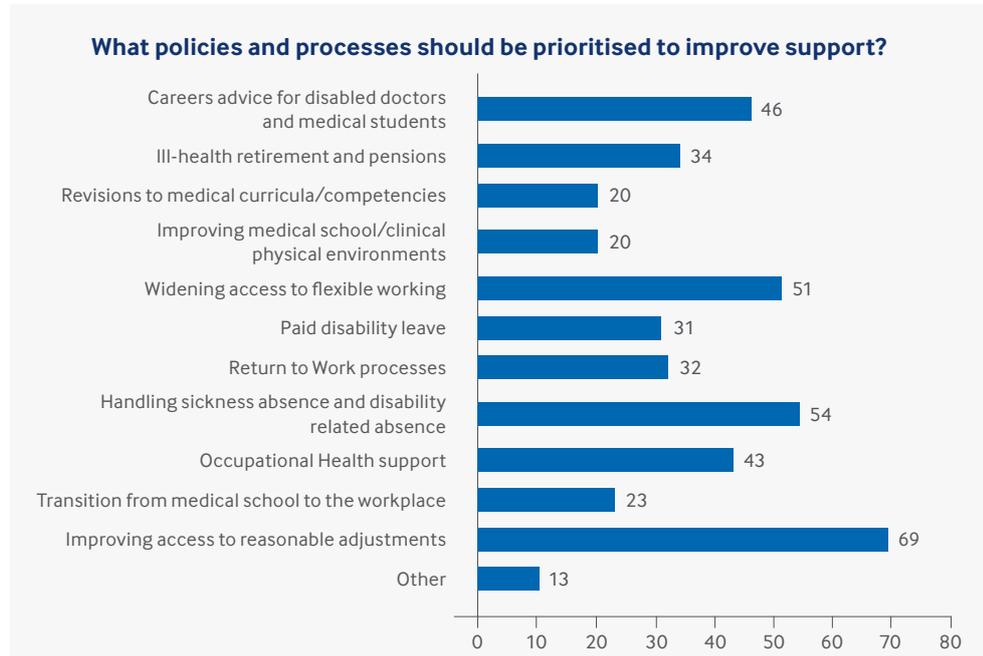
The NHS England Staff Survey² shows that by protected characteristic, disabled staff are the most likely group to experience bullying or harassment. 26% of disabled staff across NHS England reported being bullied or harassed, compared with 20% of NHS staff overall in the previous 12 months.

'After disability was disclosed through occupational health no support was offered by trust. Instead public humiliation increased about how I was a liability... Instead of helping I was intentionally put in situations where I could not physically cope.'

2 <https://www.nhsstaffsurveys.com/Page/1085/Latest-Results/NHS-Staff-Survey-Results>

3

Improving policies and processes in medical education and employment



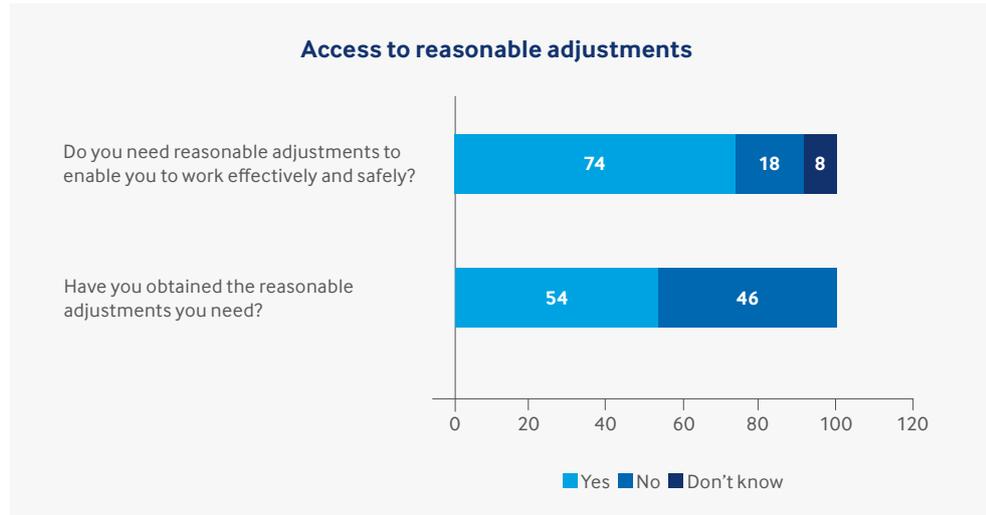
We asked respondents to tell us which policies and processes should be improved to create better support for disabled doctors and medical students. Across all grades of doctor and medical students, improving access to reasonable adjustments was the most common response, with over two-thirds (69%) identifying this as a priority area. Improving the handling of sickness and disability-related absence and widening access to flexible working also scored highly.

There were some differences by career stage. Medical students felt strongly that more needed to be done to improve the transition between medical school and the workplace, and develop support networks. Consultants and GPs considered pensions and ill-health retirement to be a priority. GPs also thought occupational health access and careers advice should be priorities. SAS doctors were particularly supportive of calls for paid disability leave, with half (50%) indicating this as a priority.

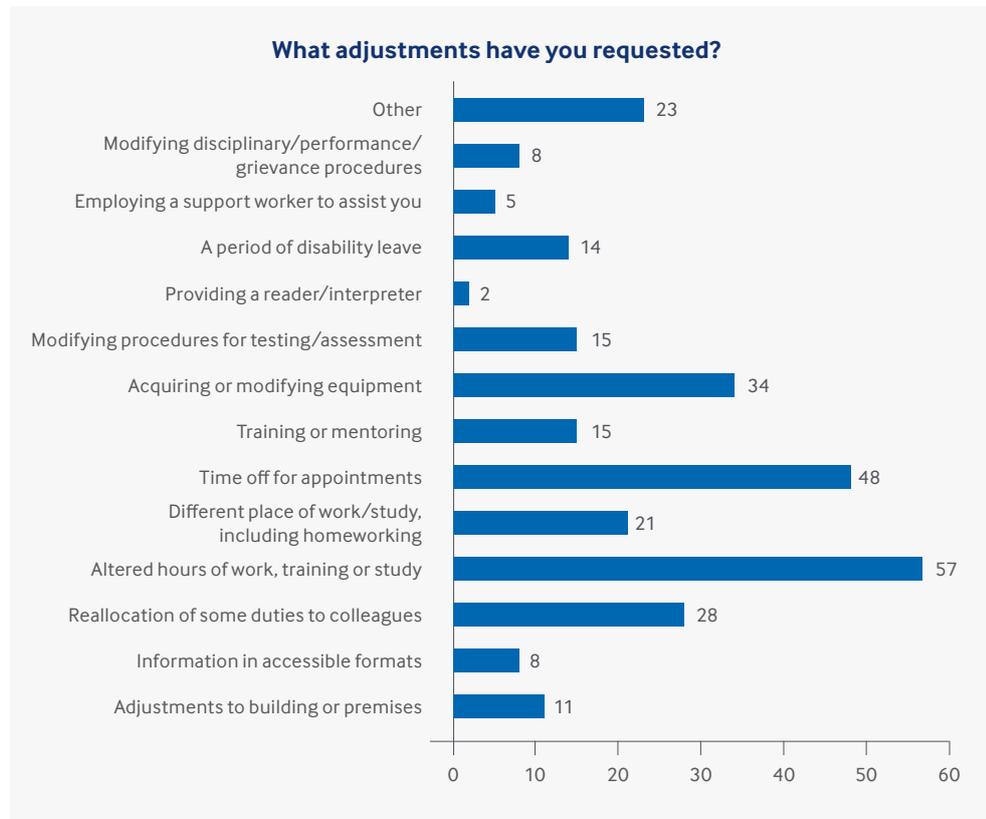
Improving access to reasonable adjustments

The aim of the legal duty on employers and education and training providers to make reasonable adjustments is to avoid putting a disabled person at a substantial disadvantage. They are required to do what is reasonable to adjust policies, practices, equipment or facilities. For many disabled doctors and medical students, securing adjustments they are legally entitled to, and need to work safely and effectively, has proved challenging. Only 55% of the respondents that need adjustments say they have managed to secure what they need.

There were some differences by gender and ethnicity – 57% of female and 49% of male respondents said they had obtained the adjustments they needed, and 58% of white British compared to 39% of BAME respondents had got the adjustments they needed.



It is often assumed that reasonable adjustments mean changes to physical environments or equipment. In contrast, our results show that changes to policies, procedures and practices are the most commonly requested category of adjustments. The most frequently requested type of adjustment was altering hours of work, training or study (57%) and almost half (48%) had requested time off for appointments. Only one in ten (11%) people had requested changes to buildings or premises and around a third (34%) had asked for specialist equipment.



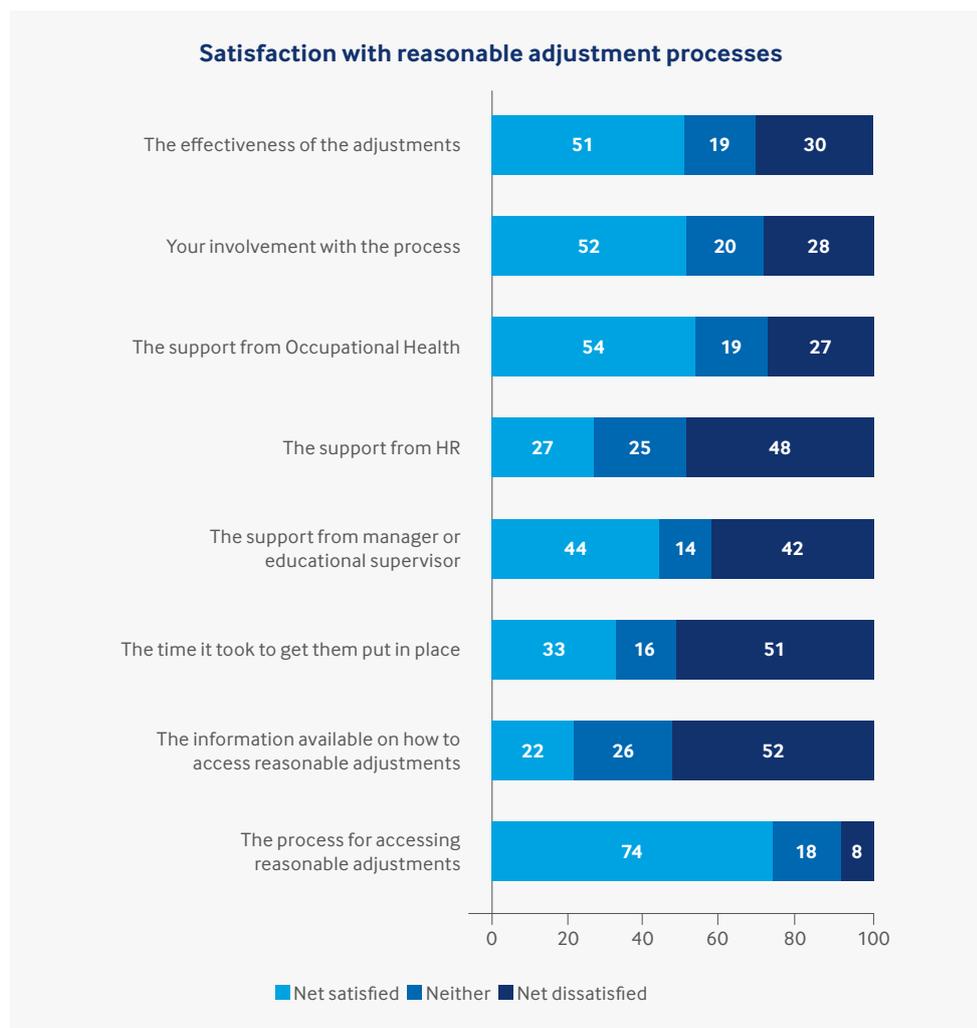
We heard various examples of barriers to securing the necessary adjustments.

These included:

- **Lengthy and complex processes:** *'Even if I do discuss this, he will guide me to a long, complicated process involving GP, occupational health, medical staffing and HR. I don't feel I can do it.'*
- **Potential negative impact on career:** *'Too embarrassed to ask – I work in psychiatry - worried that they would think I could not do my job properly.'*
- **Lack of timely intervention.** Although failure to make adjustments in a timely fashion can be a failure to comply with duty, there were examples of survey respondents not getting adjustments until months or even years after they had first sought them: *'I was questioned so much on why I needed what I needed and waited so long for senior managers to approve that there was so little time left in post, it was not worth getting the equipment.'*
- **Partial or incomplete implementation:** Several respondents had made partial progress towards gaining the adjustments needed but these failed to fully meet their needs. Or progress towards obtaining adjustments stalled once they had been agreed in principle: *'I have got some reasonable adjustments, such as exam modifications. However, taking time for appointments, which can be numerous in someone with multiple chronic conditions, is sometimes met with hostility, and rigidity.'*
- **Service pressures:** Respondents told us that adjustments, such as flexible working hours, were sometimes agreed but then withdrawn due to service pressures: *'The adjustments I need to function are forgotten when the pressure of patient care takes priority.'*
- **Funding:** If something is a reasonable adjustment, employers must pay for it (cost may be a factor when considering what is reasonable). However, cost arguments may deter people from seeking adjustments and disabled employees can be made to feel uncomfortable about asking for something that costs money.

Satisfaction with the process of obtaining reasonable adjustments

We asked respondents to rate various aspects of the process and their experience of obtaining reasonable adjustments. This revealed concerns around the quality of information available on securing reasonable adjustments, support from HR, and the length of time it takes to get adjustments put in place.



The costs and benefits of reasonable adjustments

With the right support, disabled doctors and medical students can pursue and maintain successful medical careers, becoming highly skilled, empathetic and valuable members of the medical workforce.

'My previous trust when in training very supportive, organised reviews or adjustments and were proactive in their recommendations and getting them arranged with my departments.'

Failures to provide support can lead to these doctors being lost to the profession entirely. This is bad for the individual, bad for patients, and bad for employers and the NHS as a whole, exacerbating retention problems and pressures on the remaining workforce.

Doctors who have acquired a disability and/or a long-term health condition later in their career sometimes feel that they are 'given up on' rather than supported to stay in work and contributing to the NHS.

'If they had quickly resolved the adjustments required and showed any inkling that they cared or wanted to support me, I'd have been able to get back to work with the adjustments in place and a phased return to work.'

'A sensible phased return could have seen me return not be forced to retire. I am now recovered and working privately but sad to have left the unit I led as a consultant.'

The most common adjustments requested – variations in work hours and time off for appointments – often incur little or no direct cost, and are likely to cost significantly less than losing a doctor completely from the health service. However, cost is still frequently cited as a barrier by line managers concerned about how this will affect departmental budgets.

The first national report on the NHS England WDES shows that 94% of reporting organisations said that funding for adjustments came from local budgets.³ This places significant pressure on individual managers and contributes to a culture where disabled individuals are made to feel as though they are ‘taking away’ resources from their team if they pursue their legal right to adjustments. Some respondents to the BMA survey indicated that they had resorted to funding their own adjustments, even though it is clear in law that they should not be expected to do so.

Some employers have taken a different approach to reasonable adjustments, centralising the budget and management of the process. For example, the Business Disability Forum highlights Lloyd Banking Group’s approach which has delivered financial savings, productivity benefits, cut administration and assessment costs and improved manager and employee satisfaction. This case study has been cited as good practice by the EHRC, and a similar model has been introduced in the UK Civil Service.

Reasonable adjustments and general practice

Specific issues around securing reasonable adjustments were highlighted in general practice, particularly for smaller practices and where occupational health support is lacking.

These issues were highlighted by GP partners and salaried GPs.

‘Really difficult in GP setting to get the partners to agree and the impact on finances and relationships within the partnership are challenging.’

‘It’s difficult as I’m a partner so in theory have some control. My colleagues weren’t accepting of the idea and when I accessed Access to Work there wasn’t any appetite to help me implement the funding, I felt like I was shirking work.’

Experiences of using AtW (Access to Work) funding and support

AtW (Access to Work) is a Government-funded employment support programme that aims to help more disabled people start or stay in work by providing practical and financial support for people who have a disability or long-term physical or mental health condition. AtW pays for adjustments which are beyond the capacity of individual employers to fund. Employers are expected to contribute a percentage of the cost, based on the size of the organisation.

The most common concerns were around the burdensome process and length of time taken to get adjustments.

Only 12% of BMA survey respondents had used the AtW scheme. Of these, 58% reported overall satisfaction with the scheme, while 23% were dissatisfied.

Respondents said there needed to be greater awareness of the scheme among employers because employer engagement is needed to ensure that applications are processed smoothly and in a timely fashion.

AtW also advises employers on reasonable adjustments but some respondents felt that the assessors did not have sufficient understanding of doctor-specific issues, for example GP practice funding, and of specific health conditions, notably mental health conditions.

3 <https://www.england.nhs.uk/wp-content/uploads/2020/03/nhs-wdes-annual-report-2019.pdf>

'It was helpful to have some support for adjustments, however it is then down to the practice to actually order equipment/make changes. It took the Practice Manager seven months to order the equipment funded fully by Access to Work and they refused to make the other adjustments they recommended.'

Less than full-time employees are potentially financially disadvantaged by a provision of the AtW scheme, which says that the individual needs to pay a percentage of the costs if they use the equipment outside work. This has led to equipment, such as wheelchairs, being locked away in offices at the end of a shift, meaning the user has to source another wheelchair to travel to and from work.

There are also some process issues around transferring equipment purchased through AtW between different employers, which can be particularly challenging for junior doctors on rotation. Lead employer arrangements can mitigate these issues to some extent. However, better arrangements need to be put in place which enable disabled junior doctors to access specialist equipment through AtW and retain it for the duration of their training.

Reasonable adjustments and medical schools

The reasonable adjustment duty on education providers, as well as applying to individual students, is also an anticipatory one. This means medical schools should be predicting and considering the needs of disabled students generally and should work with disabled students (and prospective students) to ensure that individual adjustments are made.

Our survey reveals considerable variation in experiences of seeking, and obtaining, reasonable adjustments at medical school.

'My reasonable adjustments were refused by my medical school as unreasonable despite being contained in OH reports and not involving any cost to the university.'

'They were recommended by the disability service, and then I was sat down with the medical school administration, and they essentially went down the list saying "this won't happen".'

'The individual teachers I encountered were enthusiastic about helping disabled students, however the administration of the medical school would not arrange additional support when students require something beyond that which their immediate teachers could provide.'

The role of Occupational Health

Just over half of respondents (54%) were satisfied with the support they received from Occupational Health in identifying and helping obtain effective reasonable adjustments. The majority emphasised that sustained input OH was often needed to secure positive results. However, this level of support can be difficult to maintain given that OH services are increasingly stretched, particularly during COVID-19.

'Occupational health were spectacular, really open and understanding and a huge support to ensure my adjustments were appropriately implemented very quickly. I am grateful to them for their help.'

'At times particularly in the first few years since diagnosis it was very difficult it's only with the continued support of occupational health that things really changed.'

However, the survey results also suggested that there was considerable variation in provision. Some responses highlighted that OH services had been outsourced, and that consequently there was little understanding of complex conditions or the support needed in medical settings.

'No longer has an occupational health consultant, done by agency so no follow up or anyone to assure recommendations implemented. Recommendations from appointment five years ago still not implemented which has had a huge effect in my career trajectory and pain levels.'

Occupational Health for GPs

Respondents working in general practice highlighted the additional difficulties they faced by not having access to the type of OH services that are available in hospital settings. The BMA has long called for a fully funded, comprehensive, and accessible OH service for all NHS staff.

The inconsistency in provision and funding across the UK was highlighted in the BMA's report on health and wellbeing at work⁴.

Failures to implement Occupational Health advice

Several survey respondents indicated that OH advice had not been implemented by employers.

'I found occupational health very understanding and supportive, but my trainers were not willing to permit any adjustments. They would not even talk to me about it. They told me I didn't appear to them to be having enough of a problem.'

'I was told to ignore occupational health advice and "just crack on".'

There appear to be particular issues with OH support for junior doctors on rotation who explained that they often have to repeat detailed OH assessments at each new placement. This was described as frustrating and time-consuming.

'I rotate every six months to different trusts. Every six months I've had to meet a new occupational health person and relay my story over and over again. Everywhere, I have to go through the process of an appointment with a nurse before an appointment with a doctor, despite knowing only the doctor has authorisation for the adjustments I need. This means using up my annual leave to attend multiple occupational health appointments every six-month rotation. Some occupational health departments are more reasonable than others. Some I have to fight for the adjustments I need and show evidence from my treatment team saying I need x y z. Others are amazing. I wish there could be one system, one report written that I could take to each trust - my condition is lifelong, it doesn't change every six months and it's traumatising to relive the details every changeover.'

One option that is being explored by several organisations to reduce the need for repetitive assessments is an OH passport. This would mean for disabled trainees, that they would carry information about their condition with them when they rotate to a different placement.

There are practical issues that would need to be addressed and it would not remove the need for individual discussions about appropriate adjustments on each placement, however, if well implemented, it has the potential to make the process less onerous for both trainees and OH services.

Sickness and disability-related absence

Only a quarter (26%) of respondents agreed that their place of work or study's sickness absence policy took proper account of their disability or health condition. Worryingly, only 13% felt that their HR department had a good understanding of issues relating to disability-related absence.

Disability and sickness are not the same. Disabled staff may require time off work in relation to their disability. This could be due to sickness or flare ups in their condition or for routine management, for example, to attend appointments or consultations or have treatment related to it. Disabled people can, of course, also get sick from illnesses that are unrelated to their disability or long-term health condition, just as non-disabled people can.

⁴ <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/health-of-doctors-and-medical-students/supporting-health-and-wellbeing-at-work-report>

Two in five (40%) of respondents told us they had to use annual leave to attend appointments related to their disability or health condition. Annual leave allows people to take paid time off from work so that they can rest and re-energise. Employees who take regular holidays can be more motivated about their work and perform more effectively than those who do not.⁵

If disabled doctors and medical students are having to use this time to attend appointments instead then they are not able to use that time to rest. This is likely to contribute to worsening overall health and increased risk of burnout.

Some of the respondents said that even when they do get time off to manage their disability or condition, they are pressured into ‘making up for’ their absence. This is often counterproductive, as the increased workload exacerbates the effects of their disability or long-term condition. It also reinforces the unfair view that disabled doctors and medical students are a burden on the teams they work in, rather than understanding that at times they will need additional support to contribute and work effectively.

‘I had two weeks off for treatment, with a phased return recommended by occupational health. I was advised by management that I would need to organise swaps myself for these with other trainees, and “pay these back” on return to full duties, alongside the on-call I already had then.’

‘After my sick leave I was subjected to twice the expectation, and despite having more to do than could be accomplished within my working hours my educational supervisor failed to address this making snide comments about not keeping up and failing my ARCP and putting pressure on me not to take my annual leave.’



⁵ <https://www.openaccessgovernment.org/annual-leave-is-still-essential-when-working-from-home/87313>

Disability leave policies

Disability leave enables disabled people to take (usually paid) time off to manage their disability, for example, to attend appointments, undergo treatment or rehabilitation, or to allow for the need to replace or service equipment. The creation of a disability leave policy is recognised as good practice by NHS Employers and the Equality and Human Rights Commission. However, just 5% of survey respondents said that their place of work or study recorded disability leave separately from sick leave.

Failure to distinguish between sickness absence and disability-related absence means that many disabled people fall foul of rigid performance management processes which are triggered by an individual having a set number of days away from work or study. 29% of respondents told us that they had been subject to performance management action due to disability-related absence. Women (32%) were more likely to say this was the case than men (22%).

Use of the Bradford Factor in sickness absence policies

Some NHS employers use the BF (Bradford Factor) to calculate the impact of employee absence on the organisation. The formula is predicated on the idea that short, frequent episodes of absence have a more detrimental impact than one extended period of absence. However, disabled people, particularly those with fluctuating conditions, can quickly reach a high BF score, especially if they have a condition that is characterised by flare-ups or episodic symptoms.

NHS Employers [promote](#) use of the BF as a metric for monitoring absenteeism despite the impact it may have on those with some long-term health conditions and without explaining the importance of ensuring its use does not lead to disability discrimination, for example in absence management policies where a certain BF score as an automatic trigger for performance management action. Even if this does not lead to further disciplinary action, this system can be highly stressful to people managing fluctuating conditions.

Presenteeism

Almost half (47%) of disabled doctors and medical students told us they had experienced pressure to return to work before they were healthy enough to do so. The NHS England WDES results show that 32% of all disabled staff reported feeling this pressure compared to 23% of non-disabled people.

Doctors and medical students receive mixed messages about presenteeism. On one hand, it is recognised that presenteeism contributes to poor workplace cultures, drives people from acute to chronic ill-health, increases the likelihood of burnout, and reduces productivity. On the other hand, the continued use of systems such as Bradford scoring means that disabled people are actively disincentivised for taking time off when they need it, because doing so risks triggering performance management and/or capability proceedings.

Medical schools' management of sickness absence

Medical students are particularly concerned about how sickness absence is managed within medical schools, where absences of more than 14 days can trigger a formal process that can result in a student having to repeat a year. The GMC Welcomed and valued guidance suggests that medical schools should exercise discretion to ensure that disability-related absences, for example to attend appointments, are not counted as part of this allowance. However, our survey responses suggest that this is not always done in practice.

'Taking time for appointments, which can be numerous in someone with multiple chronic conditions, is sometimes met with hostility, and rigidity. Disciplinary procedures are also rigid, and do not adapt to better suit the needs of people with specific learning differences.'

Return to Work

Good return to work processes are vital to support people back into the workplace or study environment after a period of absence. If done well, they provide an opportunity to discuss support needs, agree any adjustments needed, and support the wellbeing of returners, who may feel anxious or uncertain after a lengthy period away.

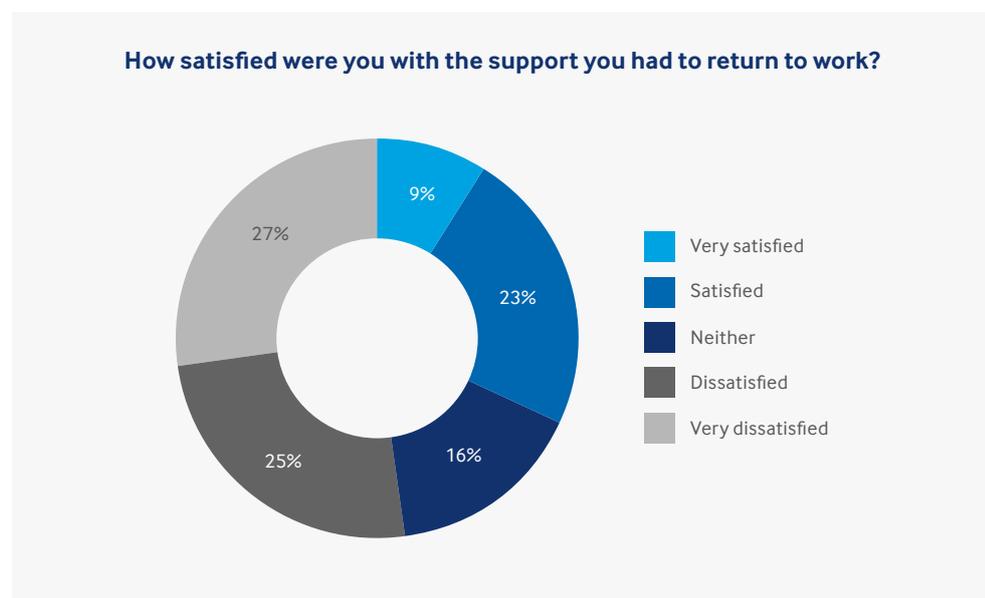
'If handled well, it can be therapeutic returning to work as it's a sign life is returning to normal.'

Poor return to work processes can create additional stress and pressures on the returning individual and the wider team. They can also fail entirely, with the individual needing to take further time off or in extreme cases, unable to return to work or study at all.

Almost two in five respondents (39%) had taken a period of more than one month off work or study in the last two years in relation to their disability or health condition. We asked this group to rate their overall satisfaction with their return to work experiences. Less than one in ten (9%) were very satisfied with how their return to work had been handled, with more than half (52%) saying they were dissatisfied. Over a quarter (27%) of all respondents said they were very dissatisfied.

Broadly, junior doctors were more likely to be satisfied than consultants or GPs with how their return to work and training had been handled. This may be, in part, because there is a national programme (in England) designed to improve the return to training experience for all trainees who have been out of training for three months or more. However, the relatively low overall satisfaction scores, even for juniors, suggest that more needs to be done to improve return to work support.

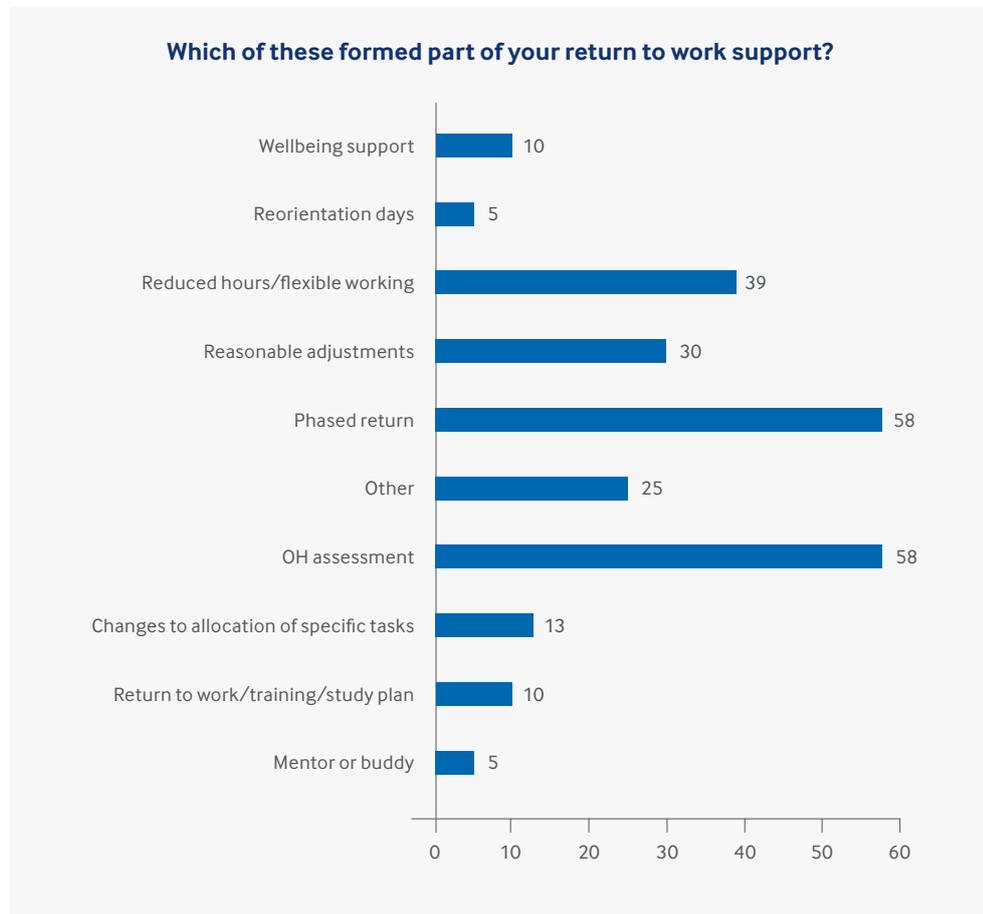
Disabled doctors who have been shielding during COVID-19, or have been seriously ill during this period, will also need effective return to the work support after such prolonged absences, particularly if there have been changes to working practices and ongoing risks as a result of the pandemic.



We asked this group what support had been offered to help them return to work or study. The graph below shows the variability of support offered in these circumstances. Many respondents highlighted some straightforward areas where they thought return to work or study could have been improved. These were largely to do with improved communication, pastoral support and reassurance that any issues would be handled confidentially and sensitively. Other suggestions included clearly agreed plans, mentoring or reorientation sessions, and for students, greater support in catching up with any missed work.

'It would have been extremely helpful if a medical professional or colleague, anyone really, had forewarned me of the stages of returning to work after a prolonged absence and that what I was experiencing was normal and temporary.'

'I would have liked increased pastoral support and more clarity on the effect of leave on my training. I felt pressured to return to work before I was ready due to lack of clarity--all I was told was that 'my absence would have an effect on my training.'



Widening access to flexible working

Adjustments to working patterns are one of the most frequently requested adjustments. This is not surprising: many disabilities and health conditions, particularly those that fluctuate or flare up periodically, can be more effectively managed if there is flexibility in working patterns. This can range from formally agreed LTFT working hours to informally agreed local arrangements, such as later start and finish times, to the removal of specific elements of a role such as on-call or night working.

Flexible working arrangements can mean the difference between a disabled doctor staying in work or leaving the profession entirely. However, our survey findings suggest that this type of adjustment is often one of the hardest to get.

'They were happy for me to access equipment but were not accepting of the fact that my disability meant that I was not able to do my job in the same way as others. They used my disability to question my ability to do my job.'

Requests for flexible working are often turned down because of the perceived impact on the wider service function, even though a refusal risks worsening a doctor's condition, increasing absence and at worst, losing a doctor completely.

'Every relapse I've ever had has been following nights. When I was a trainee, it was such hard work (despite numerous supportive letters from my neurologists and GP) that I just gave up. Thankfully the wonderful OH specialist saw my evidence and immediately fixed my hours... I am now symptom free'

Many disabled doctors need to train or work LTFT. However, LTFT respondents highlighted problems around rostering.

'Reduce stigmatisation of LTFT working and encourage employers to rota more creatively than simply putting LTFT trainees in a full-time slot and expecting their colleagues to pick up the slack.'

'The clinician who oversees the rota appears to have little insight into disability awareness, for example, suggesting placing me on "easier" rotations, rather than adjusting the work for rotations which are actually of career value to me.'

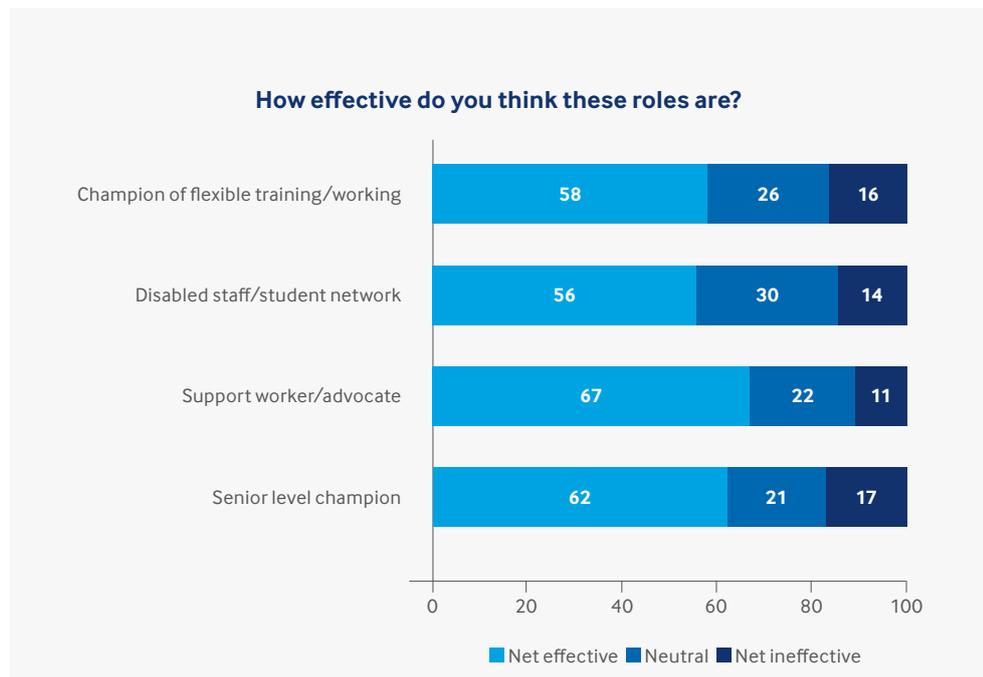
4 Effectiveness of organisational support initiatives

There are several sources of support that different organisations can put in place for disabled doctors and medical students.

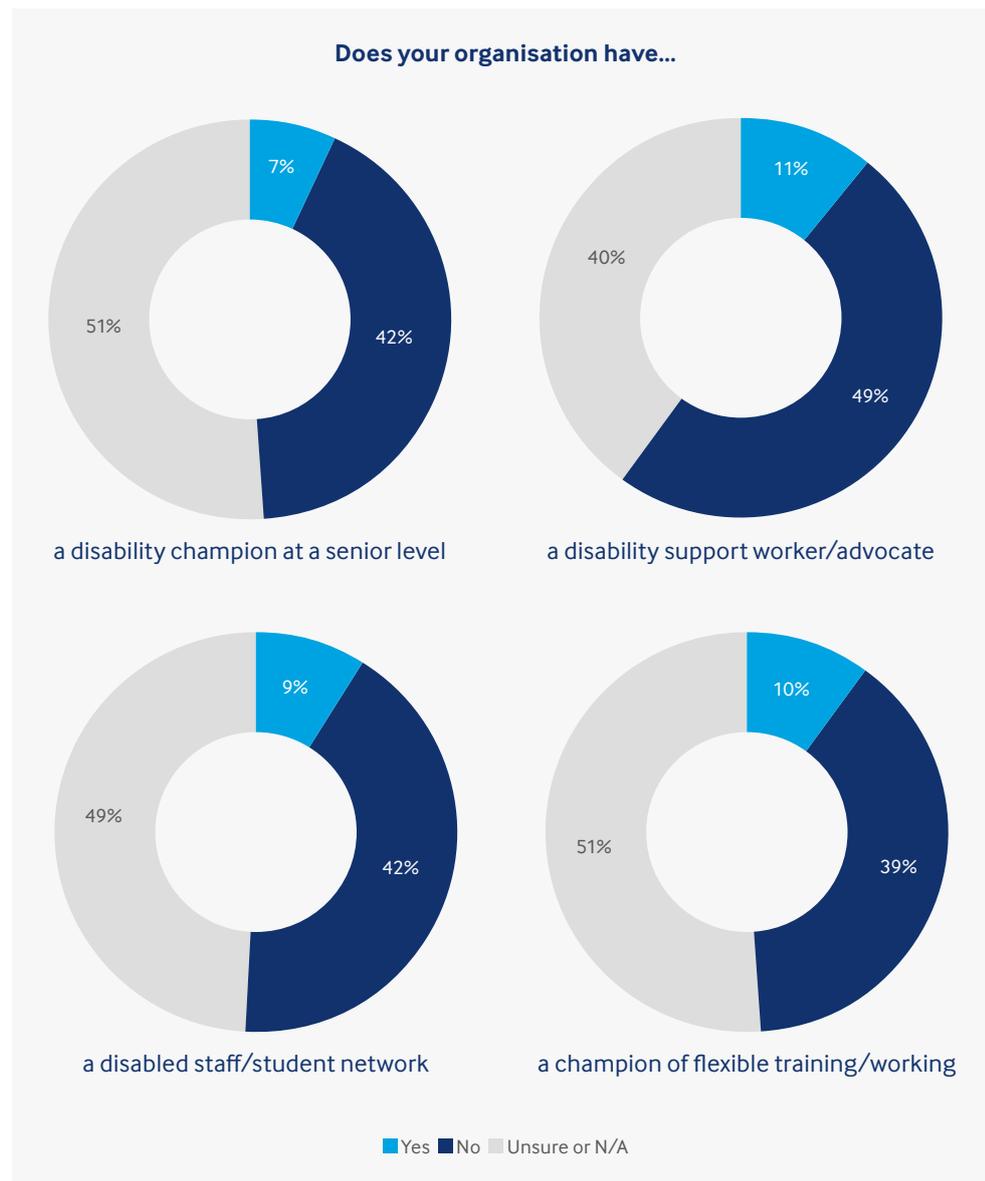
Some options include:

- disability champions at senior levels
- disability support workers and advocates
- disabled staff or student networks
- champions of flexible training and/or working.

The majority of respondents perceived that these types of support were or would be effective.



However, overall our survey findings suggest that very few disabled doctors and medical students are aware of or have access to them in their organisations.



Comparing our survey findings with the NHS England WDES metrics suggests that far more needs to be done to raise awareness among the medical workforce of the organisational support initiatives that are in place, particularly in hospital settings.

- According to WDES, 65% of NHS trusts in England report they have a disability equality champion at board level.⁶ However, only 8% of hospital based disabled doctors in England who responded to our survey knew their organisation had a disability champion at a senior level.
- 63% of trusts in England said they have a disabled staff network or similar. But fewer than one in ten (9%) of respondents to our survey knew there was a disabled staff or student network in their organisation, and only 7% of hospital-based doctors in England were aware their organisation had such a network. 26% of medical students across the four nations said they were aware their organisation had a disabled staff or student network.
- Champions of flexible training should be available to every LTFT doctor in training in England⁷. However, only one in five (22%) of trainee respondents in England was aware a flexible training champion existed, with half unsure (50%) if there was one or not.

⁶ <https://www.england.nhs.uk/wp-content/uploads/2020/03/nhs-wdes-annual-report-2019.pdf>

⁷ <https://www.nhsemployers.org/pay-pensions-and-reward/medical-staff/doctors-and-dentists-in-training/terms-and-conditions-contracts/champions-of-flexible-training-guidance#:~:text=Every%20less%20than%20full%20time,advocating%20for%20them%20where%20necessary.>

Access to informal peer support

The above forms of formal support were almost entirely unknown to respondents working in general practice. We were therefore interested to know whether GPs were more likely to access or want informal peer support.

Informal peer support appears to be most available to junior doctors (20%) and medical students (16%) and decreases at senior grades: 9% of SAS doctors and 8% of consultants said they had access to informal support. 14% of GPs said they had access to informal peer support. Interestingly, GPs were much less likely (43%) than medical students (81%), junior doctors (73%), SAS doctors, (68%) and to a lesser extent consultants, (52%) to say that they wanted informal peer support. This finding highlights the need to tailor support structures to individual branches of practice.

Requests for more tailored support services

Survey respondents suggested several areas where they would like to see more tailored support across the course of doctors' careers.

- **Careers advice:** Almost half of respondents (46%) said that appropriate careers advice was a high priority for them. Respondents said they would welcome pragmatic and practical advice around career pathways so that they could make informed decisions about whether they felt particular options were suitable for their individual circumstances. Disabled people are the experts in their own conditions but there are very few career planning resources for disabled doctors and medical students. Further guidance for doctors at different stages of their careers who become disabled or acquire long term health conditions would also help these doctors to get the support they need to continue with their careers.
- **Ill-health retirement and pension advice:** A third of respondents (34%) said that ill-health retirement and pension advice should be a priority. The rules around ill-health retirement and pensions for disabled doctors are complicated. There are specific restrictions and conditions attached to these pensions. Many of the issues with the existing system derive from a view of disability or ill-health as being a binary state: you are permanently well enough to work, or permanently too ill to work. This assumption fails to recognise that intermittent work is the pattern most likely to be adopted by people with serious fluctuating conditions. Doctors who are retired on ill-health grounds are likely to face pension inequity, particularly if they retire young, as they are unlikely to have accrued a large pension pot and there are very limited options for them to do any form of medical work to supplement their income. There have been calls to review the pension system to make it more flexible and to take better account of the needs of disabled doctors. However, in the shorter term it is vital that disabled doctors can access expert pension advice.
- **Wellbeing and peer support:** Overall 60% of respondents said they would like to access informal peer support but only 15% said they were currently able to do so. Respondents highlighted the need for wellbeing support for physical and mental health issues, and to ensure that services are fully accessible.

Appendix 1 Demographic breakdown of respondents

There were 705 survey respondents in total.

Gender

70% of respondents identify as female, 26% as male, and 2% non-binary. The remaining 2% selected preferred not to say or prefer to self-describe.

Ethnicity

Respondents were given a choice of 17 categorisations, including 'other' categories and free text options. Four respondents in total chose to leave the question blank. Due to small sample sizes, aggregated findings have been presented in this report to allow for comparative analysis. We acknowledge that there may be significant diversity of experience within these aggregated groups.

	% of respondents
Arab	1%
Asian/Asian British- Bangladeshi	0.5%
Asian/ Asian British- Chinese	0.9%
Asian/Asian British- Indian	6%
Asian/Asian British -Pakistani	2%
Any other Asian background	1%
Black/Black British- African	1.3%
Black/Black British- Caribbean	0.1%
Any other Black/African/Caribbean background	0.2%
Mixed/multiple ethnic backgrounds White/Asian	1%
Mixed/multiple ethnic backgrounds White/Black African	0.7%
Mixed/multiple ethnic backgrounds White/Black Caribbean	0.4%
Any other mixed/multiple background	1.5%
Any other ethnic group	2.7%
White British/English/Scottish/Welsh/Northern Irish	70%
White Irish	3%
Any other white background	7%
Did not respond	0.5

Geography

Responses came from across the UK. The majority were based in England, reflecting the geographical spread of doctors and medical students in the UK.

Nation	% of respondents (rounded up)
England	81%
Scotland	11%
Wales	5%
Northern Ireland	4%

Age

32% of respondents were under 35 years old, 47% were between 35 and 54 years old, and 20% were over the age of 55.

Branch of Practice

	% of respondents
Consultant	27%
SAS grades	11%
Junior doctor	19%
GP (including partners, salaried and locum)	15%
Medical student	15%
Retired	5%
Unemployed/career break/other	8%

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