isabled Doctors Network

NHS
Practitioner Health

Factsheet one

Disability, Equality, Diversity and Inclusivity.
What are they, and why are they important?

Disability, Equality, Diversity and Inclusivity.

Doctors, like any other professional group, can experience ill health or disability. Disability may occur at any point in their studies or professional career, or, even, long before they become interested in medicine.

What is a disability?

Awareness of disability issues can be poor amongst some medical professionals.

Both mental and physical disability in doctors are very diverse.

"*I strongly believe that a vital component of the relationship between the medical profession and disabled citizens is not just the treatment of disabled patients but how healthcare organisations treat disabled employees at all levels. Surveys indicate that most patients have no problem with being treated by disabled doctors; partly as a result of shared experiences and a greater understanding of patients' needs. But this report outlines the negative attitudes which have prevented disabled doctors from pursuing a medical career*."

Sir Bert Massie[1].

General context of Disability

Any person can become disabled at any time. Many personal and professional conflicts arise when doctors become patients, and these seem to multiply when doctors develop disabilities.

'Patient acceptance' is a concern that weighs heavily on most physicians with developing disabilities. Research has shown that for a physician, in the face of new disability, the physician-patient relationship holds up well[2].

The reaction from patients to 'visible' disabilities can be quite interesting.

[1] http://www.hscbusiness.hscni.net/pdf/BMA-_Disability_equality_in_the_medical_profession_July_2007_pdf.pdf
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1002815/

For example, Dr Cheri Blauwet, writing in the *New York Times*, comments[3]:

"*In my busy outpatient clinical practice, I witness the spectrum of patients' reactions when they find out that their doctor is, herself, disabled. Typically those first few seconds after entering an exam room — before the patient's guard goes up — are the most informative*."

This is, actually, not an uncommon reaction. See, for example, also Dr Kelly Lockwood's experience on BBC News, as reported in July 2018[4].

Doctors with disabilities, both visible and less visible, can face '**stigma**'. Stigma faced by people living with disabilities can be a barrier to both personal and professional participation, and, all too often, negative attitudes, ignorance, and poor communication skills among health professionals can really obstruct the delivery of good clinical care. People with disabilities also need to ensure their own health needs are addressed and these needs should not be ignored by others either.

An initiative "*Improving Lives: The Future of Work, Health and Disability*" resulted from the evidence that people living with disabilities and long-term conditions can end up being disadvantaged in the workplace, and are more likely to leave employment '*as a result of a wide range of barriers and historic injustices*'[5].

The numbers of people *surviving* once-fatal illnesses, accidents or limiting disabilities, are actually increasing, and there has been a growing concern that it is economically essential for people with disabilities to be able to enter and remain in the work space, if they wish to.

Introduction to Equality, Diversity and Inclusion

Despite legislation on diversity in the workplace, people with disabilities still do not experience the same access to work opportunities as do their counterparts without disabilities. Culture is an issue. Many employers have been shown to harbour ill-founded views about the work-related abilities of people with disabilities; these

[3] https://www.nytimes.com/2017/12/06/opinion/doctor-wheelchair-disability.html

[4] https://www.bbc.co.uk/news/video_and_audio/headlines/44697815/the-challenges-faced-by-doctors-with-disabilities

[5] https://www.gov.uk/government/publications/improvinglives-the-future-of-work-health-anddisability

negative views are often a result of interrelated concerns that permeate the entire employment cycle[6].

It is possible (and common) to miss critical issues in caring empathically and effectively for persons with disabilities through not involving persons with disabilities in identifying their own training needs.

"*They know neither specific clinical needs nor basic fundamentals, such as how to: recognize disability in its full diversity; communicate effectively with persons with disabilities; identify various contributors to disability, including social and environmental factors; and understand where disability fits into individuals' lives, values, preferences, and expectations about their health and futures essential foundations for patient-centered care*."

(Iezzoni and Long-Bellil, 2012[7])

When facing problems, it can therefore be very challenging to know who to approach for information, answers or support.

Having a health condition or disability alone does not constitute itself a fitness-to-practise concern.

The GMC looks at the impact a health condition is having on the person's ability to practise medicine safely, and determines this individually on a unique case-by-case basis.

Direct contact with patients with disabilities had a specific impact on trainees' levels of anxiety and empathy. It is considered good practise that accreditation standards for postgraduate medical programmes can require the inclusion of disability education[8].

The legal definition of disability

[6] https://link.springer.com/article/10.1007/s10869-018-9602-5
[7] https://www.ncbi.nlm.nih.gov/pubmed/22726853
[8] https://www.ncbi.nlm.nih.gov/pubmed/30115582

According to the definition of **disability**[9] under the **Equality Act** [2010], you're disabled under the Equality Act 2010 if you have a physical or mental impairment that has a '*substantial*' and '*long-term*' negative effect on your ability to do normal daily activities.

Other jurisdictions have comparable legislation[10].

The person must have **an impairment that is either physical or mental,** this includes sensory impairments such as those affecting sight or hearing.

The key thing is not the impairment but its effect. Impairments such as migraines, dyslexia, asthma, or back pain can count as a disability if the adverse effect on the individual is **substantial and long-term**.

Long-term means that the impairment has lasted or is likely to last for at least 12 months or for the rest of the affected person's life.

Substantial means more than minor or trivial.

More helpful explicit guidance is given through the supporting documentation[11], "*Equality Act 2010: Guidance on matters to be taken into account in determining questions relating to the definition of disability*".

[9] https://www.gov.uk/definition-of-disability-under-equality-act-2010

[10] Under current law, employers should always keep in mind the provisions and potential sanctions covered under the Equality Act 2010 and, in Northern Ireland, the Disability Discrimination Act 1995 and Special Educational Needs and Disability (Northern Ireland) Order 2005.

[11] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/570382/Equality_Act_2010-disability_definition.pdf

Physical or mental impairment

The definition requires that the effects which a person may experience must arise from a physical or mental impairment.

"*The term mental or physical impairment should be given its ordinary meaning. It is not necessary for the cause of the impairment to be established, nor does the impairment have to be the result of an illness. In many cases, there will be no dispute whether a person has an impairment. Any disagreement is more likely to be about whether the effects of the impairment are sufficient to fall within the definition and in particular whether they are long-term. Even so, it may sometimes be necessary to decide whether a person has an impairment so as to be able to deal with the issues about its effects."* (**A3**, *p*. 8)

"*It may not always be possible, nor is it necessary, to categorise a condition as either a physical or a mental impairment. The underlying cause of the impairment may be hard to establish. There may be adverse effects which are both physical and mental in nature. Furthermore, effects of a mainly physical nature may stem from an underlying mental impairment, and vice versa*." (**A6,** *p.* 9)

"A disability can arise from a wide range of impairments which can be:

- *sensory impairments, such as those affecting sight or hearing;*
- *impairments with fluctuating or recurring effects such as rheumatoid arthritis, myalgic encephalitis (ME), chronic fatigue syndrome (CFS), fibromyalgia, depression and epilepsy;*
- *progressive, such as motor neurone disease, muscular dystrophy, and forms of dementia;*
- *auto-immune conditions such as systemic lupus erythematosis (SLE);*
- *organ specific, including respiratory conditions, such as asthma, and cardiovascular diseases, including thrombosis, stroke and heart disease*
- *developmental, such as autistic spectrum disorders (ASD), dyslexia and dyspraxia;*
- *learning disabilities;*
- *mental health conditions with symptoms such as anxiety, low mood, panic attacks, phobias, or unshared perceptions; eating disorders; bipolar affective disorders; obsessive compulsive disorders; personality disorders; post-traumatic stress disorder, and some self-harming behaviour;*
- *mental illnesses, such as depression and schizophrenia;*
- *produced by injury to the body, including to the brain* (**A5**, *p*. 8/9)

This is clearly a helpful list, although the standard rules of statutory interpretation will apply.

It is worth noting the '*parity of esteem*' also applies to disability – in that disability can be caused by both mental and physical conditions potentially.

What is the Equality Act [2010]?

The **Equality Act** [2010][12] is the pivotal legislative instrument.

Protection against discrimination due to disability was first legislated for in the **Disability Discrimination Act** [1995].

The official response of NHS England to the Equality Act (2010) is provided in a statement, "NHS England response to the specific equality duties of the Equality Act 2010"[13].

The **Equality Act** [2010] protects employees, and examples of areas it covers include:

- recruitment;
- terms of employment, including pay;
- promotion, transfer and training opportunities;
- dismissal or redundancy;
- disciplinary proceedings and grievances.

[12] http://www.legislation.gov.uk/ukpga/2010/15/contents
[13] https://www.england.nhs.uk/wp-content/uploads/2018/06/nhse-response-to-specific-equality-duties-of-the-equality-act-2010.pdf

Discussing the concepts of disability

The word "**disability**" has been used widely to identify the active or residual impairments that result from disease and injury, as well as the physical, mental, or emotional functional limitations or difficulties a person has as a result of the residual impairments, and also the participation restriction the person experiences when the environment is not supportive[14].

In reality, the term "disability" colloquially has become a shorthand expression or an umbrella term that denotes a number of phenomena.

A complicating factor in definition and measurement is that there is not a clearly marked separation between those with disabilities and those without disability. Disability may be said to be on a *continuum*.

People may be disabled in one situation and not another, depending on what is required of them, or what the environmental conditions are[15].

To label a person with a chronic disease as a '*patient in a permanent state*' is an unhelpful framing.

Each is affected *differently* by their condition, and each reacts in their own individual way.

In medicine, the instinct is to focus on one individual medical label, which deflects us away from what really matters *to* patients.

Managing an individual with chronic disease can therefore be framed as an example of 'conflict resolution', between reconciling treatment needs of the doctor of the patient. But it is equally true that something which a doctor with a long-term condition themselves, is likely to understand and appreciate far more deeply than a doctor without this lived experience.

[14] https://www.sciencedirect.com/science/article/pii/S1047279713004031?via%3Dihub
[15] https://www.medicinejournal.co.uk/article/S1357-3039(18)30098-7/abstract

Models of disability

Different understandings of the relationship of impairment to limitation inform two contrasting approaches to disability, often framed as polar opposing models: the medical and social.

The **medical model** says that disability arises from an individual's medical condition. The medical model understands a disability as a physical or mental impairment of the individual and its personal and social consequences, and regards the limitations faced by people with disabilities as resulting primarily, or solely, from their impairments.

The **social model** understands disability as a relation between an individual and their social environment. The exclusion of people with certain physical and mental characteristics from major domains of social life or society is manifest not only in deliberate segregation, but in a built environment and organised social activity that precludes or restricts the active participation of people seen or labelled as having disabilities. Although disability can be narrowly construed as being due to the impairment or physical/mental outcomes caused by a medical condition, it is also a social construct that results from the social and physical environment in which a person lives their life.

While there is no comprehensive list of impairments which constitute a person being disabled, examples of the types of impairment include:

- sensory impairments;
- mobility difficulties and other physical impairments;
- mental health problems;
- learning difficulties;
- cognitive impairments.

It is important to note that the definition also covers illnesses and conditions which some people may not instinctively associate with disability, such as asthma, depression, heart disease or diabetes.

The medical model of disability views disability as a result of a physical condition that is intrinsic to the individual, and that may reduce the individual's quality of life. Disabled citizens are *defined* by their illness or medical condition, and medical diagnoses can be used to determine access to social benefits, housing, healthcare, education, leisure and employment.

In this framing, the individual disabled person's impairment is the problem, and therefore, the impairment and disability are viewed as synonymous. As a result, curing or managing an impairment involves identifying the illness, medical condition or loss of function, understanding it and learning to control it.

On the other hand, the social model of disability recognises that an individual is actively disabled by society through attitudinal, environmental and organisational barriers. This is a powerful distinction, as it posits that disability is not simply as an inevitable or predetermined result of impairment or medical condition.

This model makes a clear distinction between impairment (i.e. the loss or abnormality of psychological, physiological or anatomical structure or function) and subsequent disability.

Disability clearly results from a complex mix of individual factors (personal characteristics, diseases and disorders, impairments, individuals' abilities to perform activities and participate in daily life) and social and environmental facilitators and barriers[16]. This approach suggests critical directions for training physicians about disabilities.

Many of the issues faced by disabled doctors, imposed by wider society, therefore squarely lie in the provision and inaccessibility of services that result in a general prejudice against an integrated community life for disabled people. Specific to doctors, this implies that the inherent structure of medical training and careers could be considered as causative, at least in part, for some of the difficulties and barriers faced by disabled doctors today.

The social model does not give straightforward insights into how definitions in social policy should be formulated and operationalised, but it does raise a number of

[16] https://www.ncbi.nlm.nih.gov/pubmed/22726853

important issues for social policy. Similarly, whilst it does not give straightforward insights into how medical training and working should be formulated and operationalised, it also raises a number of important issues that should be considered when making future re-structures.

The social model implies that policies should be directed at the removal of barriers to full participation for disabled people, rather than '*problematising*' the disabled person. This suggests that policy should be concerned with identifying disabling situations, rather than disabled people.

For example, we can see this approach in action in the development of regulations on building design and transport, which are intended to prevent the construction of new disabling situations and to reduce existing physical barriers. This approach should also be taken when reviewing the structure of medical training and working with the aim of identifying and mitigating against disabling situations, rules or regulations. Clearly the issue is far more complex in medicine, because of the *central* issue of patient safety. However, this in no way makes this unachievable.

The definition of disability, historically, has been highly contentious for several reasons.

First, it is only in the past century that the term "disability" has been used to refer to a distinct class of people. Historically, "disability" has been used either as a synonym for "inability" or as a reference to legally imposed limitations on rights and powers.

Second, many different characteristics are considered disabilities, and there might seem to be little about the functional or experiential states of people with these various conditions to justify a common concept; indeed, there is at least as much variation among "disabled" people with respect to their experiences and bodily states as there is among people who lack disabilities.

Important cases from the Employment Appeal Tribunal

The 'Cox case'

In the case of **Mr I Cox v Essex County Fire and Rescue Service: UKEAT/0162/13/SM**[17], Mr Cox had informed his employer that he was suffering from bipolar affective disorder. This was, however, never properly confirmed to the employer by medical evidence, and Mr Cox would not agree to the disclosure of his medical records.

The Tribunal and the Employment Appeal Tribunal both decided, on the facts, that, in the absence of a definitive diagnosis, the employer did not have actual or constructive knowledge of the disability[18].

The 'Gallop case'

Where there is a dispute in litigation about whether the employer knew or ought reasonably to have known of the employee's disability, one issue considered in precedent case law is the extent to which an employer can rely on the content of an occupational health assessment that does not indicate that the individual satisfies the Equality Act definition of disability. Without that *actual or "constructive" knowledge*, an employer cannot be liable for disability discrimination[19].

In **Gallop v Newport City Council** (2013) the Employment Appeal Tribunal (EAT) upheld that the employer was entitled to deny actual or constructive knowledge of the employee's disability "*by relying simply on its unquestioning adoption of OH's unreasoned opinions that Mr Gallop was not a disabled person*"[20].

[17] https://www.gov.uk/employment-appeal-tribunal-decisions/mr-i-cox-v-essex-county-fire-and-rescue-service-ukeat-0162-13-sm
[18] https://www.employmentcasesupdate.co.uk/site.aspx?i=ed18637
[19] https://www.personneltoday.com/hr/ascertaining-whether-an-employee-has-a-disability/
[20] https://www.employmentcasesupdate.co.uk/site.aspx?i=ed19473

“Disability employment gap”

The **disability employment gap** reflects the many levels of discrimination that disabled people can face.

Disabled people across Britain are less likely to be in employment than non-disabled people. Since 2010 there has been extensive reform to UK Government employment support programmes (*e.g*. “Access to Work”), but there are specific concerns about their effectiveness for disabled people (“*Being disabled in Britain: a journey less equal*”: EHRC, 2017[21]). There are genuine concerns about whether support programmes have much efficacy for practising doctors because of the relative inflexibility of medical training and the complexities of employment arrangements during training. Greater diversity in the healthcare workforce is seen as a promising strategy for addressing racial and ethnic healthcare disparities by improving access to healthcare for patients, improving the patient experience, and increasing patient satisfaction[22].

Problems can even happen at the recruitment stage (*e.g.* a lack of suitable job opportunities with flexible hours, or barriers at the application or interview stage). Indeed, barriers have been reported by disabled doctors undergoing specialty selection processes which have recently been reviewed in order to improve access. Unless this situation improves, many disabled people who want to work will continue to be excluded from the workplace in general[23], and this includes the NHS.

The loss of skills and experience, the limitations on workplace diversity, and the devastating personal impact of losing a career or vocation, are also recognised as counterproductive to society too.

Conversely, it has been a consistent finding that people with disability or chronic illness may have unique abilities and experiences to contribute to medical practice, and that a diverse medical profession would, in fact, better relate to the community it serves[24].

[21] https://www.equalityhumanrights.com/en/publication-download/being-disabled-britain-journey-less-equal
[22] https://www.sciencedirect.com/science/article/pii/S2452301120300016X
[23] https://www.tuc.org.uk/sites/default/files/DHIWsurveyreportEng.pdf
[24] https://bmcmededuc.biomedcentral.com/articles/10.1186/s12909-019-1715-7

The importance of identifying negative attitudes

There are many factors, such as personal experiences, age, race, gender, education level, marital status, place of residence, and socioeconomic status, that can influence an individual's attitude toward persons with disabilities.

Research has found that negative attitudes of health care professionals toward people with disabilities are a primary reason why patients with disabilities do not access health care services[25].

In medicine, a physician's attitude toward a patient or situation is important because prevailing attitudes and misconceptions can be potential barriers to successful diagnosis and treatment[26]. According to Chubon (1982), negative attitudes toward individuals with disabilities can form "*invisible barriers*", whilst persons with disabilities aspire to pursue community involvement and community resources.[27]

The NHS is the largest employer in Europe, so, arguably, it should make significant efforts to retain and/or retrain doctors who are expensive to train and whose skills and experience are in short supply.

Supporting the health and wellbeing of people in and out of work, ensuring that people with health conditions are assisted to stay in or return to work, and ensuring that disabled people get the professional care and support they need are, in the first instance, simply the right things to do. In an ideal and wholly lawful world, this support would be guaranteed.

[25] https://www.ncbi.nlm.nih.gov/pubmed/15609846
[26] https://www.ncbi.nlm.nih.gov/pubmed/12422321
[27] https://europepmc.org/article/med/6217329

Disability, Equality, Diversity and Inclusivity.

According to the seminal General Medical Council ("GMC") report, "Caring for doctors: Caring for patients", which is about wellbeing in the medical profession, West and Coia (2019), comments[28]:

"*The benefits of diversity include improved performance and innovation. These are realised in cultures or climates of positive inclusion rather than exclusion. Inclusive practices ensure all (including women, BME staff, lesbian, gay, bisexual and transgender (LGBT+) staff, staff with disabilities) influence key decisions and processes within their teams and organisations. This results in a richer information pool, more comprehensive decision making, more positive staff attitudes and higher levels of patient satisfaction. Steps should be taken to ensure that the needs of doctors more likely to be perceived as 'outsiders' are considered and are given voice and influence*." (*p*. 36)

A review by Liz Miller (2009) found that doctors often have poor mental health, with psychiatric symptoms present in up to 28% of participants; sickness absence among doctors remains low, and doctors may conceal their problems and continue to work even when they are unwell[29]. It is therefore even more important then, that we create an environment in which doctors feel able to divulge their illnesses and disabilities in order to obtain support and advice to allow them to remain in safe clinical practice.

There is a bigger 'pool' from which disabled doctors may be selected, compared to in previous years. Training opportunities are more widespread, opportunities less constrained by social class reflecting a culture of protected human rights including non-discrimination. Combined with advancing medical practice and burgeoning new technology, opportunities for disabled doctors should be more widespread[30].

Institutions involved in clinical training must be able to determine and provide, with appropriate support, the optimal reasonable adjustments for equal access to the curriculum for doctors, while ensuring competence and fitness-to-practise.[31]

[28] GMC report, "Caring for doctors: Caring for patients", West and Coia (2019), https://www.gmc-uk.org/-/media/documents/caring-for-doctors-caring-for-patients_pdf-80706341.pdf
[29] https://academic.oup.com/occmed/article/59/1/53/1417887
[30] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4952495/
[31] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30215-4/fulltext

Should I disclose my disability?

Medical training is a competitive, tough, and demanding course. It is therefore understandable that this question should be posed.

Postgraduate educators and doctors in training have a shared responsibility to make sure the right information is known about a doctor's health. GMC 'Good Medical Practice' specifically states that, "if you have a serious condition that could affect your judgement or performance or if this could be affected by its treatment, you have a duty to disclose this. You must not rely on your own assessment of the risk to patients."[32]

The skills needed for a disabled learner are the same for anyone. You will need to be given opportunities to learn medicine by listening, doing, thinking, and you will be examined on doing things, your ability to communicate, and your ability to learn knowledge and apply it to new situations. Similarly, the 'Outcomes for Graduates' and the CCT requirements of your chosen specialty are the same for everyone. Therefore, you will not be subject to additional requirements should you disclose a health condition or disability. However, although the final outcome and competencies are the same for everyone, the way in which they are achieved can be changed as a 'reasonable adjustment'. So, it is in your own interests to disclose a disability or health condition as early as possible. If your condition or impairment should then have an impact upon your methods for achieving the required outcomes, this can be considered and allowed if judged to be 'reasonable' and your progress not hampered by a lack of communication.

As a person, anyway, it can be incredibly difficult to accept your disability.

As a medical doctor, it can be an even greater challenge. This is perhaps because of the "*medical matrix*"[33]. As medical doctors, we detach ourselves from patients' problems and see ourselves as iron clad and unshakable. Disability is then perceived as an unusual attack on our '*self*'. This puts us across that line between doctor and patient, blurs the distinction – that safety barrier that allows us to detach ourselves.

[32] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice/domain-2----safety-and-quality#paragraph-28
[33] https://journals.sagepub.com/doi/abs/10.1177/0533316418823117

Suddenly, we find ourselves on the other side of this relationship. We are one of them, the same as our patients and indeed, we are now a patient of another doctor. There are things that we are unable to do, unable to achieve, no matter how hard we study or push. This journey of acceptance can be a very challenging, complex and emotional one indeed. As a disabled doctor, accepting our disability can shake us to the core.

The issue of disclosure is especially relevant to where the signs of disability are not immediately obvious, and it may help to explain why managers may be unaware of the actual number of workers with disabilities in their applicant pools.

There exist 'hidden' impairments (for example, mental illness or mental health conditions, diabetes, epilepsy), which will count as disabilities, because they meet the definition in the Act. Hidden chronic illnesses which cause fatigue seem to be the most difficult conditions for people to understand, including doctors and other clinicians. Many disabilities are effectively hidden to all but the affected party. Included in hidden disabilities are a wide range of physical and psychological conditions that often have no visible manifestation or have visible features that are not clearly connected to a disability, such as diabetes, arthritis, and depression[34].

There will still be people who keep their impairments hidden. It is possible that many individuals might disclose their condition after job offer and the employer will then seek advice from an occupational physician on their fitness for work[35].

In some cases, people may choose to conceal their disabilities because they fear negative repercussions on their careers should they disclose them. In other cases, they do not want to feel different from their peers[36]. In the case of a doctor, being able to conceal a hidden disability might be a tempting means of refusing to acknowledge it. In the environment of the medical profession, where patient safety is always front and centre and fitness to practice feels to be the first concern of any colleague to learn of our disability, the temptation to conceal a disability is very real.

Because poor mental health is likely to be a 'hidden' or 'invisible' disability and many people are reluctant to disclose a condition, it is good practice for an employer to make adjustments for someone experiencing poor mental health even if they do not necessarily consider they have a disability under the **Equality Act** [2010].

[34] https://link.springer.com/article/10.1007/s10869-018-9602-5
[35] https://academic.oup.com/occmed/article/61/7/453/1461813
[36] https://link.springer.com/article/10.1007/s10869-018-9602-5

Applicants with hidden or invisible disabilities may forego disclosure unless an accommodation is necessary, although they may also forego disclosure even if it means withholding accommodation requests. In many instances, workers with invisible disabilities might be able to conceal their disabilities quite readily from interviewers, co-workers, and supervisors, as in the case of a person with hearing loss who relies on lip reading.

Employees' concerns surrounding disclosure might, in fact, be valid; there is evidence that some managers discriminate against individuals with disabilities or make different employment decisions based on disability status.

It is during clinical placement activities that trainees may experience difficulties associated with their disability. In addition to being detrimental to the student, a lack of support or a general misunderstanding can result in staff resentment and place pressure on organisational relationships[37].

Onlookers can have difficulty 'believing' in them and unspoken attitudes or crass comments can demoralise the doctor living with the condition. However, there are huge changes that need to be made specifically within the medical profession, before doctors feel able and confident to freely and openly disclose a disability.

The **Expanded Disability Status Scale** (EDSS) is a method of quantifying disability in multiple sclerosis and monitoring changes in the level of disability over time[38]. It is widely used in clinical trials and in the assessment of people with MS.

The belief that 'real' disability can be seen, often leads to the assumption that anyone who is not visibly impaired is "*not really disabled*". All too often, disabled people whose impairments are not apparent to others report being challenged with the words "*you don't look disabled*". In the high-pressure environment of the NHS, requests for reasonable adjustments or simply day-to-day help in the presence of an invisible disability, can be greeted with assumptions, comments and accusations that are created out of ignorance or poor understanding. These can be extremely difficult to face, harmful to physical and mental health and are often cited as the reason for doctors not asking for the help they need.

[37] https://www.collegianjournal.com/article/S1322-7696(08)60471-0/pdf
[38] https://www.mstrust.org.uk/a-z/expanded-disability-status-scale-edss

Sadly, this can all too commonly lead to health deterioration, further progressive disablement and a downward spiral that potentially can lead to failure of training progression, reduction in working hours and income and in the extreme, losing doctors from the profession who have many key positive attributes that patients can hugely benefit from.

Fitness for work

Fitness for work is an issue that can arise for any employee – whether because of a change of job or because they are returning to work after sickness. It should be remembered that fitness for work is about both the functional capability of the employee to do the work in question and the risk involved to them and others of them doing the work. Saying an employee is not fit for a particular job does not mean they are not fit to do any job.

The importance of promoting equality and the domestic law

There have been a number of encouraging developments in disability equality in recent years including the establishment of the Disability Rights Commission (DRC) in April 2000 and important legislative changes.

Equality Act [2010]

The **Equality Act** [2010] came into force on 1 October 2010, bringing together over 116 separate pieces of legislation into one single Act[39]. The Act provides a legal framework to protect the rights of individuals and advance equality of opportunity for all.

It provides Britain with a discrimination law which protects individuals from unfair treatment and promotes a fair and more equal society. It applies to everyone, including doctors.

[39] https://www.equalityhumanrights.com/en/equality-act-2010/what-equality-act

Where a person is taking measures to treat or correct an impairment and, but for those measures, the impairment would be likely to have a substantial adverse effect on the ability to carry out normal day to day activities, it is still to be treated as though it does have such an effect.

Cancer, HIV infection, and multiple sclerosis are deemed disabilities under the Act from the *point of diagnosis*. Those registered with a local authority or certified by a consultant ophthalmologist as blind, severely sight impaired, sight impaired or partially sighted, are deemed disabled without the need to prove the stages of the definition.

International approaches

Important themes in the “Sustainable Development Goals" (SDGs) from the United Nations[40] include:

- education;
- economic growth and employment;
- creation of inclusive, safe, resilient, and sustainable cities;
- reduction of inequalities;
- data collection related to monitoring the SDGs.

The inclusion of more health-care providers with disabilities offers one way to improve understanding about the needs of patients with disabilities.

WHO's International Classification of Functioning, Disability and Health

Perhaps the best-known example is the WHO's International Classification of Functioning, Disability and Health (ICF, 2001), which emphasises that disability is a “*dynamic interaction between health conditions and environmental and personal factors*.”[41]

The **International Classification of Functioning, Disability and Health** (ICF) conceptualises disability as an umbrella term for impairments, activity limitations and participation restrictions. Disability is the interaction between individuals with a health condition (*e.g.* depression) and personal and environmental factors (*e.g.* negative attitudes, inaccessible transportation and public buildings, and limited social supports). It has been argued that the definition in the World Health Organization's 1980 International Classification of Impairment, Disability, and Handicap[42] has a “traditional” view of disability.

[40] https://www.ncbi.nlm.nih.gov/pubmed/26638946
[41] https://www.who.int/classifications/drafticfpracticalmanual.pdf
[42] https://link.springer.com/chapter/10.1007/978-3-642-75593-4_7

UN Convention on the Rights of Persons with Disabilities (CRPD)

CRPD is an international human rights treaty adopted in 2006. The UK agreed to follow it in 2009[43]. By following CRPD, the UK agrees to protect and promote the human rights of disabled people, including eliminating disability discrimination, enabling disabled people to live independently in the community, ensuring an inclusive education system, and ensuring disabled people are protected from all forms of exploitation, violence and abuse. All people with a disability have the same general health care needs as everyone else, and therefore need access to mainstream health care services.

Article 25[44] of the UN Convention on the Rights of Persons with Disabilities (CRPD) reinforces the right of persons with a disability to attain the highest standard of health care, without discrimination.

Article 27[45] of the CRPD concerns work and employment, prohibits discrimination on the basis of disability with regard to all matters concerning all forms of employment, including conditions of recruitment, hiring and employment.

This factsheet is part of a series of nine factsheets on disability and practitioner health, produced jointly by NHS Practitioner Health and the Disabled Doctors Network. They have been co-authored by Dr Shibley Rahman and Dr Kelly Lockwood.

[43] https://www.equalityhumanrights.com/en/our-human-rights-work/monitoring-and-promoting-un-treaties/un-convention-rights-persons-disabilities
[44] https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-25-health.html
[45] https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-27-work-and-employment.html