isabled Doctors Network

NHS
Practitioner Health

Factsheet five

Introduction to employment issues

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One doctor writes,

"*I would like every potential doctor to be viewed as a person, with a set of physical, psychological, and social, strengths and weaknesses. A creative and realistic look at these strengths and weaknesses would be far more productive than rough sorting into 'normal' and 'disabled' medical students. If this attitude were continued throughout the medical career, then I believe we could achieve major improvements in the health and welfare of our workforce, as well as that of our patients*."

From "All doctors are disabled, but some are more disabled than others", Susannah Khatan[1]

Managing risk is a universal feature of healthcare and regulation in all jurisdictions. Disabled students and doctors must not be discriminated against on the grounds of a presumed risk to patients[2].

Medical doctors with disabilities, as a result of their high standards of integrity, may fear that others will assume they are less able to do a good job than 'able' doctors, and more likely to harm patients.

It is sadly still commonplace for colleagues of doctors with health conditions/disabilities to jump to conclusions about their fitness to practice without seeking to confirm the validity of these concerns prior to making comments or reports on them.

A strategy where we recruit from all under-represented groups is desirable. It is crucial to remove the barriers that continue to deny disabled people equality of outcomes in work and more broadly.

The overwhelming consensus is that a diverse population is better served by a diverse workforce amongst doctors that has had similar experiences as patients, and understand the met and unmet needs of patients.

No health condition or disability, by virtue of its diagnosis, *automatically* prohibits an individual from studying or practising medicine. Basic principles of fitness-to-practise, including doctors' awareness of and insight into their own limitations, as well as a willingness to ask for help, alongside the absolute priority of patient safety, still apply.

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1741228/
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4952495/

Introduction to employment issues

NHS England states,

"*NHS England is committed to high quality care for all, now and for future generations. We know from evidence that we cannot successfully achieve this vision without advancing equality and reducing health inequalities*."

Their second equality objective is to improve disabled staff representation, treatment and experience in the NHS and their employment opportunities within the NHS.

One must make sure that doctors with a disability are not particularly disadvantaged by the way an organisation does things, unless this is a 'proportionate way' to achieve a 'legitimate aim' of the organisation, *e.g.* maintaining education standards or health and safety.

The **Equality and Human Rights Commission** is the body responsible for implementing the **Equality Act** [2010] and which provides much useful advice in this area[3]. It organises information on its homepage for individuals, organisations and the public sector in general.

There are a number of useful other organisations.

START Ability Services[4]

This organisation was established to provide efficient, expert solutions to businesses and individuals. Its consultants are experts in disability equality issues and psychological interventions.

The Association of Disabled Professionals (ADP)[5]

The ADP was set up for disabled people who wanted to enter or remain working in the professions or who considered work in management. It provides a forum for disabled people to share both their problems and their experiences of successful personal development and valued work

Disabled Entrepreneurs Network (DEN)[6]

DEN provides networking opportunities for disabled entrepreneurs in the UK, including providing opportunities to support disabled individuals achieve self-employment, a gateway to making a living and independent living.

Access to Work[7]

The "Access to work" government scheme offers people who are disabled or have a physical or mental health condition practical support based on needs, which may include a grant to help cover the costs of practical support in the workplace.

An Access to Work grant can pay for special equipment, adaptations or support worker services to help you do things like answer the phone or go to meetings, or help getting to and from work.

[3] https://www.equalityhumanrights.com/en
[4] http://www.startability.org.uk
[5] https://www.adp.org.uk/about.php
[6] https://www.disabledentrepreneurs.co.uk
[7] https://www.gov.uk/access-to-work

Dealing with issues facing disabled doctors in employment

Smith, Goldacre and Lambert (2016) reported[8] a large-scale questionnaire study covering responses from doctors concerning many aspects of their medical careers, reflecting upon their personal experiences of chronic illness or disability.

Main themes raised in their outstanding study included: poor support for doctors with chronic illness or disability, delays in and changes to careers (either planned ahead or imposed), the impact of pressure at work, difficulties returning to work after illness, limitations on career choices and inadequate careers advice for doctors with chronic illness or disabilities.

There are various issues about disabled doctors being given further support regarding career pathways:

- a need to change specialism to accommodate illness;
- inflexibility in support forcing exit from a specialism;
- illness leading to delays in training;
- the pressure of work and inflexible rotas leading to a need to take time off work, reducing hours or changing careers due to stress or other mental health problems.

[Smith, Goldacre and Lambert (2016)]

"Less than full time training"(LTFT)

"Less than full time training" is defined[9] in European law (EC directive 93/16/EEC[10]) as training that meets the same requirements as full-time training, from which it differs only in the possibility of limiting participation in medical activities time-wise compared to a full-time trainee.

LTFT is supposed to be accessible to doctors in training who have a well-founded reason for being unable to work full-time. Eligible are doctors who have physical or mental health problems, who would like to continue their training but are unable to do

[8] https://www.ncbi.nlm.nih.gov/pubmed/28050260
[9] https://www.rcog.org.uk/en/careers-training/resources--support-for-trainees/training-guidelines/less-than-full-time-ltft-training/faqs/#what
[10] https://op.europa.eu/en/publication-detail/-/publication/044a8e3e-34bf-4874-a976-33a361d64577

so full-time, under "category 1"[11]. Such doctors are professionally disadvantaged by circumstances and less able to fulfil their potential on a full-time than on a part-time basis.

There are **three** options for LTFT training

- "Slot sharing" is the most common with 2 trainees sharing 1 slot.
- LTFT in a full time slot is becoming more common with the increasing numbers of unfilled training posts.
- Supernumerary post. If neither of the other 2 options is possible then your Deanery/Local Education and Training Board may consider placing you in a supernumerary post for a short period of time. This is funded from a different 'pot' which is limited so this opportunity is often closely guarded. If a supernumerary post is needed for a number of training posts, then funding may need to be re-applied for for each individual post. This is the responsibility of your training programme directors and head of school to undertake and is NOT your own individual responsibility.

Postgraduate educators can inform disabled doctors about the possibility of less than full time training, and direct them towards relevant information and guidance. It is possible to work less than full time from any point from the start of your foundation programme on-wards throughout the rest of your training and career.

The GMC currently requires that trainees undertake no less than 50% WTE ("whole-time equivalent"). In very exceptional circumstances, your LETB may agree to an absolute minimum of 20% WTE for a specified period[12].

For "category 1 health reasons", you will need to provide a letter from the Occupation Health department at your current Trust with the recommendations for you to train LTFT and how long the request is for. Pending the letter from OH you may provide a Medical Certificate from your own GP[13].

Sick leave

Traditionally, doctors with long-term conditions or disabilities have generally set the bar rather high for taking sick leave.

[11] https://lasepgmdesupport.hee.nhs.uk/support/solutions/articles/7000018501-am-i-eligible-to-train-ltft-

[12] https://www.gmc-uk.org/education/standards-guidance-and-curricula/position-statements/less-than-full-time-training

[13] https://lasepgmdesupport.hee.nhs.uk/support/solutions/articles/7000018503-what-evidence-do-i-need-to-provide-to-train-ltft-under-category-1-

Being off work because you're disabled is not the same as time off for 'being ill'.

There are three ways[14] you can be absent from work:

- sick leave;
- flexible working;
- annual leave.

If your employer knows that you are disabled, flexible working and time off for medical appointments can be reasonable adjustments. This option depends on your disclosure of disability.

Sick leave is defined as time taken off work due to ill health.

If someone has time off because of sickness that is not related to their disability, this should be recorded as sick leave in the usual way.

An employee's employment contract will usually set out the details of the employer's sick leave policy. A typical "sick pay scheme" usually starts after a minimum period of service (for example, a three-month probationary period). You would then receive your normal pay during any period that you are off work due to illness, up to a specified number of weeks[15].

Depending upon your level of training, rules surrounding sick leave may vary. Often, there is a maximum number of sick days allowed in any given training year which will vary depending upon your level, your scheme and your deanery location. If sick leave in excess of this maximum allowance is taken, the time may be required to be paid back prior to the Certificate of Completion of Training (CCT).

It can also be helpful for disabled doctors to explain to colleagues that, sometimes, sick leave can be predicted. In such cases, advanced warning with some notice might be possible.

Disability leave

[14] https://www.scope.org.uk/advice-and-support/sick-leave/
[15] https://www.nat.org.uk/sites/default/files/publications/Sep-2012-Factsheet-Sick-leave-and-disability-leave.pdf

Disability leave is different from sick leave. The UNISON model disability leave policy defines disability leave as: *"…paid time off work for a reason related to someone's disability. It may be for a long or short period of time, and may or may not be pre-planned…."*

Disability leave can cover a range of disability-related absences, including from attending clinic appointments to taking time off to come to terms with a new diagnosis or cope with treatment side effects - what is required will vary from person to person.

Reasonable adjustments under the act can include things such as flexible working to allow for medical appointments.

If your employer does not know that you're disabled, then they will treat you as just being 'ill'. This means that their usual sick leave policy will apply to you. Most policies do not allow time off for medical appointments.

The English law becomes activated if the employer has knowledge you're disabled.

It is worth noting that whilst on a training programme, whilst disability leave may be an additional allowance to sick leave in terms of pay arrangements, if the total maximum allowance of days off per year is exceeded, the time may still be required to be 'paid back' prior to achieving CCT.

Return to work

Some doctors who want to return to work after illness, report a lack of support with achieving this. Some doctors report facing barriers or discrimination when trying to return.
Returning to work can itself be a challenge to mental health.

Reactions from colleagues upon returning to work, may include assumptions that the returning doctor's judgment can no longer be trusted. There can also be social embarrassment and awkwardness over how (or whether to) discuss the reasons for the absence[16]. If this process is not handled supportively, the doctor may feel the need to take further absence and possibly enter the welfare system.

It is likely that in many cases, employers will simply accept a GP's judgment on when an employee is able to return. But there may be some cases when occupational

[16] Mark Bell, Mental Health at Work and the Duty to Make Reasonable Adjustments Industrial Law Journal, Vol. 44, No. 2, July 2015, 194-221.

health becomes involved earlier on – for example, where there has been an outbreak of an infectious disease – and may want a longer period before the employee returns to the workplace, especially if the GP is not fully aware or familiar with the nature of the work.

A GP can recommend a period of rehabilitation on a medical certificate. This could include an employee returning to work on shorter hours or in a less demanding role for a period of up to three months.

Issues when moving posts regularly

You are likely to be moving post every four - six months in the foundation years and in some specialty training programmes.

This can prove challenging when you require adjustments in the workplace, for any reason.

Meeting with your foundation programme lead/educational supervisor at the start of Foundation training to discuss your condition with them to make them aware of difficulties you may face and what reasonable adjustments may be possible, would be a wise move.

Liaising with your Foundation school lead and educational supervisor to ensure all clinical supervisors of all posts are made aware of your condition and the implications of this, prior to you starting the post is also an advisable step.

Make sure that your clinical supervisor is allocated in plenty of time.

Contacting your clinical supervisor for an upcoming post around a month in advance of the post starting and arranging a face to face meeting with them if possible, to discuss adjustments needed is a very good idea. For example, walking around your new working environment with them to assess any access challenges, etc that you may face so that these can be addressed prior to your first shift.

Trying to have a named contact in the human resources dept, to discuss your job plan/rota commitments with is also advisable.

The main reason for referring an employee to occupational health is to help a manager resolve a situation where an employee's health might be affecting their fitness to carry out their job, or their job may be adversely affecting their health in some way[17].

[17] https://www.personneltoday.com/hr/good-practice-making-occupational-health-referrals/

In doing this, a manager can seek advice from human resources on policy, employment law and how to deal with employees who might have personal problems, as well as asking for help from occupational health on matters of health relating to an employee's fitness for work.

For further information on how to liaise with occupational health, please see Factsheet 6 – The Importance of Occupational Health.

Make available to all new clinical supervisors any relevant and useful occupational health documents from previous assessments.

If you experience any difficulties during a post, especially if these may impact upon your ability to gain required competencies or undertake assessments, inform your supervisors of this as early in the post as possible so they can be rectified to minimise the impact upon your progression through training as much as possible.

Informing people at the end of a post is of limited usefulness and may not leave enough time to complete assessments, *etc*.

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.