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Walker, Lizzie and Hargreaves, Janet

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Preparing disabled students for professional practice: managing risk through a principles-based approach

Abstract

Aim: A discussion exploring the ways disabled students are managed in practice settings. It proposes and argues for morally and legally viable principles to guide risk assessment and inclusive decision making in practice.

Background: Equality law means that universities are bound not to discriminate against students on the basis, amongst other things, of disability. As a consequence in the UK there is a perceived increase in numbers of disabled people applying for and succeeding as health professionals. Whilst placement providers are equally obliged by the law to have inclusive policies; competing needs including patient safety, public confidence and professional regulations mean that adjustments that can be made in an educational environment to appropriately support student learning, may prove to be more difficult in placements that provide direct care to the public.

Data Sources: This discussion is an outcome of recommendations from published research by the authors and their research partners. It is supported by related literature, critical debate amongst academics, disabled students and disabled and none disabled practitioners.

Implications for nursing: Ensuring a nursing workforce that mirrors the diversity of the population it serves is of universal importance. Effective management of disabled students can contribute to achieving this goal and to promoting a positive view of disabled practitioners.

Conclusion: legislation is necessary to protect disabled people from discrimination. To respect this legislation when preparing nurses and other health professions a clear understanding of the law and a principles-based approach to guiding risk is important.

Keyword: risk management, disabled students, impairment, inclusive practice, placement, nursing practice, health professional practice

Summary Statement

Why is this discussion needed?

- A diverse nursing workforce is desirable to reflect the population it serves and necessary to comply with equality legislation.
- Supporting disabled students in professional situations where they are working directly with vulnerable members of the public requires effective risk management.

What are the key findings?

- Research experience suggests that it is not possible to know the full presence and nature of disability in a student group; thus processes that only address visible and declared disability are flawed.
- Research findings highlight that disability is an ambiguous and emotive concept which requires open, non-prejudicial debate, effectively, to support students and colleagues in practice.
- 'Fitness to Practise' is the hallmark of registration or licence to practice; research suggests there is a lack of clarity regarding the benchmarks that should apply where impairment is a factor.

How should the findings be used to influence policy/practice/research/education?

- Academics, mentors and assessors in practice should discuss and be clear about the assessment of competency required for safe practice.

- Students should be supported to effectively risk assess in preparation for practice experience; the principles offered in this paper can be used to facilitate this.
- Decisions regarding disclosure of disability and support in practice should be based on principles which can offer guidance and be applied universally, rather than targeted at known disabled students.

INTRODUCTION

Professional education that leads to registration or a licence to practice a given profession is highly prized. A feature of such education is that a significant percentage of the educational program is undertaken as assessed practice in a real health care setting. Further, practical examinations such as Objective Structured Clinical Examinations undertaken in simulated environments are common across many disciplines. This leads to a complex dynamic in terms of the management of the learning strategy for each student who needs to acquire the knowledge, skills and aptitude to master their profession at threshold competence for registration or licence to practice. There is a growing evidence base that some professional ability can be tested through academic assessment and in simulated environments (Bland *et al.* 2011) but demonstration of competence in real time in professional settings remains essential for success.

Demonstration of competence in practice is rightly set at a high standard for any student, but there may be additional challenges where the candidate has an impairment that is disabling. Of itself this has never been an unconditional bar to professional success; notable names from the history of nursing include Florence Nightingale (Bostridge 2008) and Dame Agnes Hunt (Hunt 1938) both of whom made major contributions to the development of nursing and health care despite significant functional impairments. However current entry requirements, prescribed curricula and opinions that might be held by the professions and the public make achievement harder for disabled people (DRC 2007).

Reviewing standards for teaching, nursing and social work the Disability Rights Commission (DRC 2007) concluded that professional standards can be discriminatory and can deter

disabled people from applying for these courses. French (2004) has also reported that disabled people faced barriers to qualifying as health professionals and Wilson Kovacs *et al.* (2008) use the phrase 'glass cliff' to describe the difficulties faced by disabled people in gaining work, recognition and promotion. If nursing and other health professions are to truly represent the population they work with, ensuring that disabled people are able to confidently demonstrate their competence to practise is important.

Background

This paper proposes guiding principles for risk management that are inclusive and affirmative for disabled students who are seeking to demonstrate their competence and thus 'fitness to practise' when giving direct care to the public. Four background factors are important: the law, the regulating authority, the university and the placement provider:

The law

Equality legislation in the UK over the past 10 years has provided an infrastructure to support the development of more equal access to many professions by setting out legal obligations and rights. The Special Educational Needs and Disability Act, (Department for education and Skills DES 2001) and the Disability Discrimination Act (Department of Work and Pensions DWP 2005) increased the responsibilities of employers and educational establishments to disabled people. They were followed in 2010 by the Equality Act (Government Equalities Office GEO 2010) which increased legal responsibilities and brought a range of equality issues (such as gender or sexual orientation) into a single piece of legislation. This current Act means that people cannot be discriminated against on the basis of their disability, thus disabled people should have an equal opportunity to aspire to learn and practice in the health professions without facing discrimination. A European Commission

report (European communities 2012) which compares equality legislation across the US, Canada, South Africa and India identifies similarities and the converging of legal principles such as protected characteristics suggesting that there will be more similarity than difference in this area on an international level.

Professional regulation

Professional regulation is also based in regional or national legislation. Whilst there are variations by nationality and profession, three overarching principles are common: maintenance of patient safety, upholding public confidence in the profession and the setting and maintenance of educational standards. In the UK, Regulators [for example the Nursing and Midwifery Council (NMC), the General Medical Council (GMC) and the Health and Care Professions Council (HCPC)] are governed by parliamentary Act and their brief extends to guiding the design of pre-qualifying courses that inculcate these shared values and test safe practice.

Whilst the Equality Act (GEO 2010) includes an exemption where the demonstration of ‘competence’ in a professional capacity is required, the onus is on the education provider to make explicit the level of competence required and the ways it may be measured. Thus it is not acceptable to suggest that a particular impairment - for example the need for a wheelchair - might rule out the possibility of a professional qualification; the measure must be the extent to which the person can perform the essential competencies of the profession.

Universities

Universities consider equality legislation and professional regulations when designing and delivering curricula. All students are offered a supportive and well designed series of

processes that are in place to guide and support disabled people applying for and undertaking university education. Courses are designed with inclusivity in mind and disabled students have individualised learning plans that allow for 'reasonable adjustments': this means that whilst all students must achieve at the same level, disabled students are not disadvantaged by their impairment. In the UK data from the Higher Education Statistics Agency (HESA 2013) shows that students receiving 'Disability Support Allowance' (an indicator that they have declared and are being supported with a disability) fare as well as or slightly better than average in successful completion and academic grades, suggesting that support is effective.

Adjustments for academic work are now routine, with an emphasis on inclusion rather than accommodation: well established protocols and a campus designed with inclusivity and ease of access are embedded. However, more thought needs to be given to the design, preparation and support for practice based elements of courses.

Placement providers

Whilst some UK placement opportunities are offered by privately run establishments, the majority are in organisations commissioned by the National Health Service (NHS) to deliver care. The NHS has been a partner in professional education since its inception in 1948. It is with these placement providers that the greatest challenge to effective management for disabled students is manifested. The NHS is subject to the same equality legislation and has a contractual responsibility to support students, offering structured educational experiences, appropriately qualified mentors and a supportive learning environment. In addition, qualified practitioners are expected to have a teaching and mentoring role with students as part of their professional registration. However education is just one aspect of the placement provider's business, whose primary purpose is the delivery of health care to the public. Balancing

students' needs and safe effective health care has the potential to bring into sharp relief the challenges of supporting disabled students in practice.

Data sources

This discussion is an outcome of recommendations from research, where the current authors were collaborators. This has already been reported: (Hargreaves *et al.* 2009, Dearnley *et al.* 2010) and published: (Hargreaves *et al.* 2013, Walker *et al.* 2013). The research explored the experience of disabled students in university settings and professional practice, the experience of disabled professionals working in the NHS and the attitudes of disabled and none disabled NHS practitioners to disabled students. In addition the discussion presented in this paper is supported by other published research that focuses on disabled professionals and on critical debate amongst academics, disabled students and disabled and none disabled practitioners.

Discussion

Several factors emerge that affect disabled students. Firstly this discussion explores issues around the need to understand what it means to be 'disabled', an acknowledgement that disability is an ambiguous and emotive subject and a debate about what it means to be 'fit to practise'. Secondly a risk assessment based on principles is proposed to guide informed decision making.

Exploring the issues

Who is disabled?

The Equality Act (GEO 2010) defines a person as disabled:

‘...if he or she has a physical or mental impairment and the impairment has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities’ (S6(1)).

This means that for example a person with a broken leg or acute infection does not meet the definition as, although they may be very disabled in the short term, this is time limited and a full recovery can generally be assumed. Equally a long term condition that is improved ‘by medication, medical treatment or an aid’ (Lewis 2012, p.17) may not be classified as a disability because effective management means it does not have an adverse effect on the person’s ability. The range of impairments that might be significant but not preclude successful completion of a professional course are too numerous to name but are likely to include physical or sensory impairments such as mobility difficulties, partial sightedness or deafness and cognitive impairments or mental health problems such as depression, bipolar disorder or autistic spectrum disorders (Office for Disability Issues 2011).

Impairments which are not generally problematic for the person may become so when training for a health professional qualification. The most common example is that of the wide spectrum of neurological learning difficulties including dyslexia, dyspraxia and dyscalculia (Pollack 2009). Problems with reading and writing, sequencing and using numbers that may be managed or avoided in everyday life become disabling as in depth study, the following of instructions, verbal and written reporting and drug calculations are critical processes that must be accurate and timely.

Against this backdrop our experience of attempting to identify population and sample cohorts of 'disabled' students for research purposes (Hargreaves *et al* 2009) revealed four separate categories:

- Students who know they are disabled, choose to declare this and seek the support of the university services are the most visible and easiest to both support and research
- Students who know they are disabled and declare this to the university but either need no additional support, or choose not to access this service may be visible to the researcher in the overall university statistical data but are generally excluded from research samples as they have not given permission for their status to be shared
- Students who know they are disabled but choose not to declare this or seek any support from the university services are effectively invisible to any research or support that may be undertaken or offered. This is their right, but may have, or be perceived to have implications for professional practice
- The final group is students who are unaware of a disability until it is identified during their studies. Typically this will be one of the ranges of neurodiverse learning difficulties, such as dyslexia, which may emerge as a student attempts to study and write at a higher academic level

The significance of these categorisations is that one cannot assume anything about the disabled or non-disabled status of students, or indeed colleagues working in any health environment in the UK or elsewhere.

Disability is an ambiguous and emotive subject

The inclusive ethos of disability legislation aims to minimise the difficulties presented by the invisibility of many disabled people however attitudes to disability are varied.

Disability literature offers two contrasting models– the *social* model (Barnes & Mercer 2011) argues that the factors that mean someone cannot undertake day to day activities are built into society – thus a wheel chair user is disabled by a world that is designed with non wheel chair users in mind, not by the impairment leading to the wheelchair use. By contrast the *medical* model locates the disability in the person; thus the adverse effect experienced is because their impairment means they cannot walk up steps. Barnes (1992, p. 55) states that:

‘Disability’, therefore, represents a diverse system of social constraints imposed on people with impairments by a highly discriminatory society — to be a disabled person means to be discriminated against. (Barnes)

Traditionally medical model thinking has dominated attitudes towards disability for health professions, for example: ‘*a blind person cannot be a nurse*’. Current legislation encourages challenge through social model thinking by asking: ‘*why not?*’ Sin and Fong (2007, P.1426) summarise this as:

The scope for discrimination to occur, unwittingly or otherwise, is considerable when the evidence suggests strongly that decisions around fitness can be influenced by blanket negative assumptions about the capabilities and competencies of disabled people.

What does it mean to be ‘fit to practise’?

The crucial factor in judging the relevance of disability to a person’s ability to become a successful health profession is if they are able to be ‘fit to practise’. This is the threshold standard for any person’s right to be on a professional register and have a licence to practice.

Professional regulators set standards that need to be assessed to demonstrate fitness. These typically include; cognitive skills such as number work for understanding research results, physiological measurements or drug calculations; the analysis and synthesis of information related to the profession; physical dexterity related to the role; the demonstration of compassion and social skills. In conjunction with these skills students need to be able to demonstrate their mastery in real time and usually in a professional situation where they practice under supervision with members of the public.

Disabled students should not pose any greater difficulty than any other student: following appropriate preparation and any specific support for impairment (referred to as 'reasonable adjustments') all students are assessed against the same standard. Those who are not able to demonstrate fitness to practise do not gain professional registration. However the literature suggests that perceptions of disability may be as significant as actual difficulties arising from impairment:

The Disability Rights Commission identified what they believed to be systematic discrimination built into professional regulation for nursing, social work and teaching professions. They argued that interpretation of regulations is significant:

There is also a growing recognition that how fitness standards operate 'on the ground' in relation to decision-making can have a real impact on disabled people's opportunities for and experiences of, studying, qualifying, registering and working in the profession. (Sin & Fong 2007, p. 1425)

Tee & Cowan (2010), undertaking an action research project to develop support materials for disabled nursing students and their practice based mentors found that once the idea of the student being disabled was raised this sometimes had an effect on perceptions that was not accurately based on the actual impairment. This was echoed in Hargreaves *et al.* (2013) where qualified health professionals were invited to complete a survey regarding understanding of and attitudes towards disability. Whilst many responses were positive and affirmative, some suggested that disability might be an opportunity for people to qualify who were not at the right standard and that anxieties about assessing fitness to practise, which were present for many professionals with teaching responsibilities, were more significant where disability was present. Walker *et al.* (2013) explored data from the same study further, revealing beliefs in practice that disabled students get 'special treatment' and may not be 'safe'.

Cook *et al.* (2012, p. 564) report research where disabled medical students were given a card, which they could use to introduce their needs relating to their disability to clinical staff.

Whilst students generally reported positive outcomes the authors also suggest that:

Students were judicious in requesting adjustments, thus reflecting their concerns over the disclosure of disability, the threat that their behaviour might be misinterpreted and their acquiring of the competencies necessary to become a doctor.

For those who acquire impairment, becoming disabled may be a life changing event. Case studies of doctors with severe illness leading to disability (Binder & Sklar 2008) identified that: two were unable to return, thus not 'fit for practice' and one returned but on different duties as they were unable to undertake their previous role. The implications are significant

regarding the loss of expertise in the professions and the loss of role, status and income for the person involved.

In other circumstances disability may be incremental and thus difficult to quantify. Soteriades *et al.* (2008) explore the links between increased weight and difficulty in doing the job as a fire fighter. Difficulties with mental health and fitness to work are equally well summarised by Glozier (2002). The impairments where weight is concerned may be balanced finely, as height- weight ratio, dexterity and strength will be more significant than a simple calculation of body weight. For mental illness cognitive function may be particularly difficult to adjust for and social attitudes may be unfairly prejudicial highlighting that perception of risk may be at odds with reality.

Assessing and managing risk

Perceptions of risk

A key theme from the research underpinning this discussion paper is that risk is a recurrent concept. Hargreaves *et al.* (2013) present data from disabled NHS staff who portray themselves as a risk, putting their own needs as subordinate to the needs of their colleagues and patients. This is puzzling and does not neatly fit with current social and medical models of disability. Walker *et al.* (2013); reporting on disabled student interviews in the same study show them also seeing the risk as being about themselves as individual students having to 'fit in' to NHS systems, because of the primacy of patients' needs.

The subordination of self to service is not necessarily prejudicial and many respondents saw their impairment as 'enabling' rather than 'disabling' because it supported their learning about and understanding of the human condition (Hargreaves *et al.* 2013). Nevertheless the research

does seem to suggest that disabled practitioners place (or feel they are expected to place) their own needs and impairments at a point of lesser importance than the needs of people they are responsible for and the smooth running of the service they work in. In addition disabled people in the workplace do not always declare their disability to colleagues, preferring to make their own risk assessments with regard to their personal safety and the safety of people they have responsibility for. This does not appear to be a reckless desire to 'hide' impairment: rather, as above, it reflects self awareness and their judgements about the relative importance of their own needs and rights. In the face of such behaviour from staff already working in the NHS, the pressure on students to conform is huge, limiting their confidence and ability to appropriately expect their needs to be viewed as important too.

In contrast Scott (2012) who interviews physically disabled professionals in the US, identifies four 'hero' models that are prevalent in the discourses offered by her research participants and are absent in our research. Rather than presenting 'hero' profiles our health professionals were more inclined to give preference to other peoples' needs or see their impairment as something that was a nuisance, not an inspiration, to others. A factor in this contrast may be that the majority of disabled people we encountered had hidden impairment whereas Scott's participants were visibly physically disabled: thus the option not to disclose was unavailable to them.

Managing risk

Models have been developed to assist in the identification and support for disabled students in practice. A good example is Griffith *et al.* (2010, p.35) who suggest a 6-stage process:

1. Disclosure: identifying and assessing need(s)
2. Establishing support systems and processes in practice
3. Mid-placement review; determine alternative strategies
4. Development of detailed plans and models of support; establish critical information base
5. End of placement review; evaluation
6. Revise support strategy

However we argue that disclosure itself is a problematic process, as Tee & Cowen (2002), Crouch (2010), Hargreaves *et al.* (2013) and Walker *et al.* (2013) found that the systems in place to support disabled students in professional practice were not always understood or followed.

Walker *et al.* (2013) propose a model of risk assessment that incorporates support, acknowledgment of the perceived risks and the barriers to disabled practitioners.

This paper explores risk management further, identifying three issues that emerge as most troubling for practice and offering a principle based approach to guide risk assessment:

- When is it acceptable (or not) for a student not to declare an impairment to their placement provider?
- When is an adjustment 'reasonable'?
- When is assessment of competence compromised?

Suggested guiding principles

Question: When is it acceptable (or not) for a student not to declare an impairment to their placement provider? (See Figure One)

By setting the principle to ask these questions the student must address issues that are significant in practice. For example a wheelchair user entering a placement area that they know to be accessible requires no adjustment and may have nothing particular to disclose, whereas a student requiring the use of assistive software to demonstrate their competence may need to disclose, as without this support for their impairment they are disabled and may not be able to safely demonstrate their ability.

These questions also allow for teasing out where disclosure may be advisable or desirable, but at the student's discretion, or where a known risk means that it would be unlawful not to disclose. Discussion may also help where, for example an insulin-dependent diabetic student or a student recovering from a mental health problem may only feel there is a risk under extreme conditions of prolonged work without a break or high stress. Talking through how they might manage in practice offers a realistic and mature risk assessment and action plan.

Question: When is an adjustment 'reasonable'? (See Figure Two)

The notions of 'reasonable adjustment' and 'feasibility' may be a source of debate however they can be simply stated as a 'reasonable' response to an adjustment that will enable the individual to work effectively. In the Equality Act (GEO 2010) the four steps to consider are if the person is protected (meaning they have a disability as defined by the Act), if there is a duty to make an adjustment and if that adjustment is reasonable. Finally to consider what the employer knows about the situation. The provision of ramps and lifts is a good example of a

widespread reasonable adjustment for accessibility to the majority public buildings, with a small number exempt because they are small businesses, or listed buildings where the cost of 'adjustment' would be prohibitive. The use of a 'smart phone' as a calculator, memory jogger and spell checker is also reasonable but may need explaining to a colleague or patient who perceives the students as 'wasting time' or being disrespectful.

Conversely the provision of a piece of expensive assistive software that is specific to one student and cannot be transported may be reasonable in the university, or for a year-long work experience, but not for a short placement. Finally the use of a sign language interpreter or note taker will be possible in the university, but may need careful consideration in practice to ensure that the students' level of competence and the acceptability of their level of communication can be assessed. This final case illustrates the need for negotiation and forward planning. There may be professions, or professional situations where the need for another person to help with communication means that the student cannot demonstrate competence, or patients may not wish to or feel freely able to talk through a third party.

Question: When is assessment of competence compromised? (See Figure Three)

A reasonable adjustment might be for a student to use a Dictaphone to keep notes or an electronic personal organiser to ensure appointments are kept. However it is harder to quantify 'reasonableness' in circumstances where more time, or a reduced workload is requested. In Hargreaves *et al.* (2013) an example given was of an assessor feeling that a student nurse managing a reduced caseload could not demonstrate the level of competence needed to appraise the situation, multi task and prioritise safely. Thus if the level of competence requires working at a particular pace, or managing a caseload of a specific

number of people it may be reasonable to facilitate a longer period of preparation, or a reduced caseload to develop the necessary skills, but not at the point of assessment of competence. A clear, transparent conversation about the principles means that both student and assessor can prepare and the assessment is fair.

Implications for Nursing

Legislation is necessary to protect disabled people and to allow them to pursue a life and career without prejudice. An unintended consequence of such legislation is that mechanistic, bureaucratic systems need to be in place to identify, assess and support disabled people entering the education system. Nursing is no exception; education and practice providers need to follow the correct procedures but in this discussion we have argued for a wider debate and a more open, principle based approach.

This approach aims to shift conceptualisation of disabled nurses as problematic, a risk and a source of worry to one where disability is contextualised, risk managed effectively and individual difference is valued. It is hoped that the principles outline above can guide and inform practice and provide a platform for further empirical research.

Conclusions

Active support for disabled people to aspire to and achieve their potential is guided by equality legislation. There are also strong arguments morally and ideologically for embracing diversity as a valuable resource for humanity (Garland-Thomson 2012) and because disabled people bring particular insight and skills (Hargreaves *et al.* 2013). However notions of fitness to practise where competence needs to be demonstrated in practice are challenging.

Our own research and that of others, shows that there are real and perceived barriers, but that these can be discussed, removed or minimised. In doing so we can develop policy that facilitates confident achievement of set professional standards and respects the additional knowledge and aptitude that disabled people bring. Through this students can pass or fail on the basis of their ability to reach a required standard, regardless of disability.

Preparing people to become professionals always involves an element of risk, as competence is predominately learned and demonstrated through exposure to real world, real time work. This paper recommends that by focusing on guiding principles, rather than definitions of disability or impairment, risk assessment can be individual, transparent and robust.

Figure One: When is it acceptable (or not) for a student not to declare an impairment to their placement provider?

Principle:

Does the student have an impairment that, in the context of the practice placement:



Limits their ability to practise to the required standard?



Presents a risk to themselves or others?



Requires reasonable adjustments?



Then disclosure is a reasonable professional expectation

Comment [R1]: Can this be placed in a figure or box and labelled as such, placed at the end of the manuscript and referred to in the text

Figure Two: When is an adjustment 'reasonable'?

Principle:

Does the student have impairment(s) which, in the context of the practice placement:



Could be overcome by an adjustment?



And it is a reasonable adjustment is [in terms of support, time, cost, feasibility & acceptability]?



Then adjustments should be available [and - if they can be made routine they should be made normal practice for all].

Comment [R2]: ditto

Figure Three: When is assessment of competence compromised?

Principle:

In the context of competency assessment in a specific practice situation is the:



Threshold standard for competence clear and consistent for all students?



Reasonable adjustment agreed and actioned?



Or Lack of reasonable adjustment clearly documented and justified?



Then the student is judged to be competent by this standard or not, regardless of impairment.

Comment [R3]: ditto

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