A pilot study of primary care workers with a disability

RHONA MOLONEY

RICHARD HAYWARD

RUTH CHAMBERS

SUMMARY

Eighty practice managers identified 55 colleagues with disabilities in a postal survey. Most of the 15 people with disabilities who were subsequently interviewed described colleagues having helpful attitudes but changes had not been made to practice workplaces or systems to retain them at work. Proactive support for disabled workers might improve retention in the National Health Service workforce.

Keywords: disability; staff; work; retention; health service.

Introduction

PROBLEMS faced by those with a health impairment, disability or handicap[1] (termed 'disability' hereafter) could be minimised by colleagues and National Health Service (NHS) employers and managers changing work environments and practices to match the needs of disabled workers.[2,3] We explored the extent to which measures are being taken to retain general practitioners (GPs) and employed staff with disabilities at work in general practice.

Method

Questions were drawn from preliminary interviews with five disabled workers and practice managers outside the main study. A postal survey to practice managers of the 100 general practices in North Staffordshire in 1999 sought information about numbers and extent of disabilities of colleagues working in, or recently retired from, their practices. The questionnaire (A) also enquired about the practice's adherence to the Code of Practice of the *Disability Discrimination Act 1995*[4] and any structural or process changes to practice workplace or systems to help those with disabilities overcome any functional limitations at work. Non-responders were reminded twice. The senior GP responded if there was no practice manager in post.

Practice responders passed a second questionnaire (B) to any currently employed or recently retired colleague(s) with a disability to complete and indicate if they were willing to be interviewed. Both questionnaires were piloted and refined.

Results

The response rate for questionnaire A was 80% (80 out of 100 practices); average partnership size was three GPs. Twenty-eight (35%) practice responders reported 55 colleagues with disabilities; 29 practice responders (36%) reported that no-one working in their practice had any disabilities; 23 responders did not complete this question. Table 1 describes the range of reported chronic ill-health or disability.

No responders reported that changes had been made to the practice workplaces or systems to help those with 'chronic ill-health or disability' remain at work. Thirty-two responders (40%) believed that their practice 'completely' adhered to the Code of Practice of the Act, six 'sometimes' or 'rarely', and 31 (39%) did not know; there were 11 non-responders. Thirteen responders (16%) knew of the 'Access to Work' scheme. Sixty-one (76%) practices provided access to a disabled toilet and half (40) of practices provided access to every part of their premises for a wheelchair-bound member of staff.

Eighteen questionnaires (B) were returned by people who described themselves as having a disability or chronic ill-health. Fifteen semi-structured interviews were carried out with six GPs, two practice managers, and seven ancillary staff; four were male and three people declined an interview.

The interviewees' age range was 20 years to 65 years, (half were aged between 50 years and 60 years). Twelve interviewees worked for 30 or more hours per week. Two had developed health problems in childhood.

Seven interviewees reported limited function, including: filing records, climbing stairs, hearing problems, and undertaking house calls. Three had rheumatoid arthritis, two had spinal problems, one had multiple sclerosis, and one had hearing loss.

Eleven interviewees had found work colleagues helpful in minimising the effects of their health problems; three others reported indifference and one active unhelpfulness. Only one thought that it would be useful to consult an occupational physician.

Tips and techniques suggested to minimise the effects of disabilities were: raise awareness of the effects of disabilities (4), computerise filing (2), install minicom system (2), extend out-of-hours GP co-operative, reduce noise in reception, and introduce time for reflection on disability.

Discussion

The explanation for why few workers with disability or chronic ill-health were identified may be that their problems were mild or not recognised by the practice responder, or physical or functional difficulties were concealed. Alternatively, few people with disabilities may actually work within general practice because although they may apply they may not be appointed, or they may be reluctant to apply, or insufficient effort might be made to accommodate their needs so that they leave. The relatively few responders who returned questionnaire B, compared with those identified by the practice managers, may point to a reluctance to acknowledge disability. The difficulties in identifying and interviewing those with disabilities might have been avoided by practice visits rather than a practice survey.

We were advised to use the term 'chronic ill-health' rather than 'disability' by those interviewed as a preliminary to framing the survey questionnaires; however, this lack of definition may have caused confusion such that conditions like 'hearing loss' were variably interpreted as to whether they fell within the remit

R Moloney, MSc, DipN, RGN, research assistant; and R Chambers, BMedSci, DRCOG, FRCGP, professor of primary care development, Staffordshire University. R Hayward, BMedSci, BM BS, DRCOG, MA, PhD, general practitioner, Newcastle-under-Lyme.

Submitted: 11 November 1999; Editor's response: 6 March 2000; final acceptance: 12 July 2000.

© *British Journal of General Practice*, 2000, **50,** 984-985.

Table 1. Reported range of 'chronic ill-health or disabilities' of colleagues that 'either affects their work or that they have overcome so that it does not affect their work' (n = 55[a] people working in 28 of the 80 responding practices).

Range of chronic ill-health or disability	Number of colleagues identified
Visual	1
Hearing	8
Difficulty with mobility	6
Difficulty with arms, hands or shoulders	6
Problems with their back	13
Significant depression	4
Significant stress	5
Other mental health problems	1
Chronic chest/heart	2
Gastrointestinal problems	2
Epilepsy	2
Diabetes	5

[a]Responders could indicate more than one type of chronic ill-health and disability; two responders described workers with more than one disability.

of the study and some subjects with these conditions not counted in. Any future research in this field should establish a working definition of 'disability' that is unambiguously interpreted and understood by medical and non-medical subjects.

Overcoming functional and practical difficulties of disabilities appeared to have been left to the individuals concerned, with personal help from colleagues. However, there was little proactive or reactive help from employers, contrary to the responsibilities laid out in the Act, of which many study practices seemed unaware. The Act makes it illegal for employers of 15 or more staff (current threshold) to discriminate against people with disabilities when selecting, training or promoting employees; and it is good practice for employers with fewer than 15 staff to adhere to the Act standards in the same way. The Act requires employers to make reasonable adjustments to the workplace, adopt flexible working routines and positive attitudes to accommodate people's disabilities, and help to retain them at work.

This pilot study should challenge NHS employers to be more sensitive to the needs of workers with disabilities and review whether they are taking sufficient action to fulfil the legal requirements of the Act. Such an approach should contribute to reducing current problems with recruitment and retention in primary care as well as demonstrating good employer practices in the NHS. More knowledge of the 'Access to Work' scheme might create opportunities to facilitate disabled people working in primary care settings.

Further research might focus on exploring the general applicability of the tips and techniques used by workers with disabilities to overcome their functional limitations. The most popular suggestion was to raise awareness of disability and its effects. Those with disability might benefit too if they and those in control of resources were more aware of the potential advantages of expert occupational health care in enabling NHS employers to accommodate the needs of disabled workers.

References

1. World Health Organisation. *International classification of impairments, disabilities and handicaps*. Geneva: WHO, 1980.
2. Silvester S, Allen H, Withey C, *et al*. *The provision of medical services to sick doctors.* London: Nuffield Provincial Hospitals Trust, 1994.
3. British Medical Association. *Meeting the needs of doctors with disabilities.* London: British Medical Association, 1997.
4. Secretary of State for Education and Employment. *Code of Practice of the Disability Discrimination Act 1995.* London: HMSO, 1996.

Acknowledgements

We are grateful to the North Staffordshire Medical Institute who funded the study, Dr Gordon Bancroft for statistical help, and Dr Stephen Duckworth of Disability Matters for his advice.

Address for correspondence

Dr Richard Hayward, Higherland Surgery, 3 Orme Road, Newcastle-under-Lyme, Staffordshire ST5 2UE.