UNREASONABLE ADJUSTMENTS: MEDICAL EDUCATION, MENTAL DISORDER, DISABILITY DISCRIMINATION AND PUBLIC SAFETY

Recently the Civil and Administrative Tribunal of New South Wales found that the University of Newcastle had discriminated against a medical student with borderline personality disorder and bipolar disorder on the grounds of her disability. This column summarises the case, and integrates a psychodynamic account of borderline personality disorder with Fulford’s conceptual analysis of mental disorder as action failure, that is no different in principle from physical illnesses, some instances of which appear to uncontroversially rule out of contention some applicants for medical training. It is argued that some applicants for medical and health care programs with mental disorders should not be selected, because their disabilities are not amenable to satisfactory accommodation in the university training period, and they are incompatible with clinical training and practice. Universities should develop “Inherent Requirement” policies that better integrate their responsibility to support disabled students with the responsibility, currently reserved entirely to regulators, to ensure safe practice by their graduates.

INTRODUCTION

Medical and other health professional educators and the institutions that employ them are charged with providing education and training that will ensure that their graduates are “work-ready” and safe practitioners, at least in the context of the supervised environments they initially enter for the next phase of their training. This duty is primarily focused on helping students develop the knowledge, skills and attitudes that are deemed appropriate for medical and health care practice.1 In most cases, the educational work serves the postgraduate purpose, and the duty of the universities to their students to provide them with an appropriate professional education, aligns with the duty to the community to graduate only safe, effective and compassionate practitioners.

However, this alignment may sometimes be threatened. This article describes a recent case and raises issues in response that focus on a tension between the duty of universities to their students as university students, and their duty to protect the community by ensuring students are appropriate trainees for the health professions. Individual medical and other health professional educators, particularly in the current climate of uncapped university cohorts and the imperative to educate sufficient numbers of practitioners for workforce needs, are perturbed by the requirement that universities not discriminate against their students, even when there exists a strong consensus amongst educators that certain students should not be permitted to graduate and to practise, and that it would have been better, for the community and for the students, had they not been admitted in the first place.

The case of BKY v The University of Newcastle (BKY)2 is an example of the kind of case where this tension arises. BKY is an Australian medical student who suffers from borderline personality disorder (BPD), and who was found to have been discriminated against by her university which denied her the opportunity to extend the time required to complete her training program. This article

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2 BKY v The University of Newcastle [2014] NSWCATAD 39.
summarises the decision, provides an overview of the primary condition affecting the student, and raises issues for consideration in the context of the requirements of medical practice. The discussion is necessarily tentative and suggestive, rather than declarative and conclusive. There are numerous unknown factors in relation to most physical and psychological maladies, and prediction is fraught. Nevertheless, this case and others involving psychological, emotional, cognitive and interpersonal disabilities point to a conversation that should occur to better balance the interests of individuals who aspire to professional health practice and the safety of the public whom they would serve.

**BKY v The University of Newcastle**

In *BKY* in the New South Wales Civil and Administrative Tribunal, the University was found to have discriminated against BKY based on her disability, in denying BKY an extension to complete the medical course. BKY is a registered nurse who had commenced the five-year medical course in 2004. Under university rules, the time allowed for completion of the course was eight years. BKY applied for an 18-month extension, but this was denied in January 2012.  

BKY had bipolar disorder (type II), BPD and severe psychosocial stressors related to the course and its requirements.\(^3\) She had attended a psychiatrist regularly throughout her earlier nursing degree, subsequently while employed as a nurse, and during her medical degree. She self-reported her conditions to the New South Wales Medical Board in 2008. During the medical program she worked as a nurse part-time in the John Hunter Hospital’s Intensive Care Unit.\(^4\)

In his evidence, the Dean of Medicine Professor Ian Symonds indicated that over eight years, BKY had progressed to the three-and-a-half year mark of the degree. She had passed 13 courses, repeated eight of these courses, failed four courses and been awarded withdrawal without penalty for five courses. She had not been required to “show cause” why her enrolment should be cancelled on the basis of unsatisfactory academic performance at any time during the course.\(^5\)

Professor Symonds considered that:

- there was a poor prospect of BKY completing the degree within the requested extension period of 18 months;
- further study would be detrimental to her health;
- BKY had had a downward academic trend over the previous three years, and there was an issue as to the currency of BKY’s knowledge in the “interests of academic integrity and professional standards”;
- there was a particular concern about BKY’s anxiety in relation to performance in clinical rotations; and
- there was a risk of unsafe practice even if BKY completed the degree.\(^6\)

BKY’s psychiatrist Dr O’Brien gave evidence to the effect that:

- BKY’s disorders were characterised by anxiety, especially performance anxiety approaching examinations with consequent avoidance behaviour, although she was able to complete avoided exams later;
- BKY had a poor sense of self-worth compensated for by academic achievement;
- the intensity of BKY’s fear of failure was sometimes so great that she would have a paralysis of ability to study;
- like others, BKY tended to take any way out of anxiety which was an avoidance of responsibility;
- she had advised the Dean that BKY had had a similar crisis during her nursing degree, but when faced with the prospect of not being able to finish, she completed the degree and worked competently thereafter;

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3 *BKY v The University of Newcastle* [2014] NSWCATAD 39 at [1].

4 *BKY v The University of Newcastle* [2014] NSWCATAD 39 at [14].

5 *BKY v The University of Newcastle* [2014] NSWCATAD 39 at [15]-[21].

6 *BKY v The University of Newcastle* [2014] NSWCATAD 39 at [29].

7 *BKY v The University of Newcastle* [2014] NSWCATAD 39 at [28].
• BKY was capable of functioning under deadline pressure when required; and
• BKY’s symptoms were unlikely to emerge and disrupt effective functioning as a medical practitioner.\(^8\)

Under the Anti-Discrimination Act 1977 (NSW), it is unlawful to directly or indirectly discriminate against anyone on the basis of disability, where these terms refer to less favourable treatment than treatment of someone not disabled in the same circumstances, or requiring a disabled person to comply with the requirement that non-disabled people would be able to comply with.\(^9\) It is unlawful for an educational authority to discriminate on grounds of disability.\(^10\)

The tribunal found that:

The evidence supports a finding that the psychiatric conditions affected the applicant’s thought processes, emotions or judgment and has resulted in disturbed behaviour. This falls within the scope of the sections 4(1)(e) and 49A(e) of the Act and therefore constitutes a disability within the meaning of the Act.\(^11\)

Two issues then needed to be proven: (1) whether BKY had been treated less favourably than someone without the disability in the same or materially similar circumstances (the comparison issue); and (2) whether such less favourable treatment occurred on the ground of the disability (the causation issue).

The tribunal found that the comparison issue was made out on the basis that both BKY and another student (whose case details were submitted by BKY and who the tribunal determined did not have a disability) both sought an extension on the basis of poor academic performance, and the non-disabled student was granted the extension in circumstances of that similar record.\(^12\)

Regarding causation, the tribunal inferred a probable connection between the decision not to grant BKY an extension and her psychiatric condition, on the basis of:
• the Dean’s concern re BKY’s currency of knowledge that should also have been applied to the other student;
• the Dean’s adverting to extenuating circumstances in the case of the other student – poor study habits, poor sleep, and living away from home – but not considering BKY’s psychiatric condition as extenuating circumstances in her case;
• the weight placed by the Dean on his opinion that BKY would not be able to complete the course in the time requested, compared with the other student who was improving, in contrast to Dr O’Brien’s view that she could do so, given her history of responding well to limits, with the psychiatrist’s opinion being favoured over the Dean’s on the basis that she was a psychiatrist and he was not;
• the weight given by the Dean to his opinion concerning the effect on BKY’s health of her continuing study; and
• the weight given by the Dean to his opinion concerning BKY’s suitability to practise safely, based on her psychiatric condition.\(^13\)

The tribunal in this case explicitly stated that it was not its task to determine if BKY would be fit to practise, following her completion of the degree. It noted that completion would not mean that she could automatically practise, that her psychiatric conditions were registered with the New South Wales Medical Council, and that it is the Council’s responsibility to determine if BKY is fit to practise.\(^14\)

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\(^8\) BKY v The University of Newcastle [2014] NSWCATAD 39 at [30]-[42].
\(^9\) Anti-Discrimination Act 1977 (NSW), s 49B(1)(a), (b).
\(^10\) Anti-Discrimination Act 1977 (NSW), s 49L(2).
\(^11\) BKY v The University of Newcastle [2014] NSWCATAD 39 at [72].
\(^12\) BKY v The University of Newcastle [2014] NSWCATAD 39 at [93].
\(^13\) BKY v The University of Newcastle [2014] NSWCATAD 39 at [99]-[112].
\(^14\) BKY v The University of Newcastle [2014] NSWCATAD 39 at [113].
ORDERLINE PERSONALITY DISORDER

BKY was agreed to suffer from bipolar disorder (type II), BPD and severe psychosocial stressors related to the medical course and its requirements. Bipolar disorder (type II) is a serious mental condition that may, at times, disrupt a doctor’s or other health professional’s ability to adequately and safely discharge their duties. Nevertheless, given appropriate insight on the part of the practitioner concerning early warning symptoms of exacerbations, such as depression or hypomania, timely withdrawal from practice during exacerbations, appropriate treatment during both exacerbation and intervening phases, and in some cases, oversight by the relevant health practitioner board, there is general agreement that health professionals with such a disorder can function effectively. There is a significant number of registered doctors and medical students who suffer from bipolar disorder of either type I or II.

The meaning and implications of “severe psychosocial stressors related to the medical course and its requirements” is not made clear in the tribunal’s judgment. However, it would be safe to conclude that anyone who had bipolar disorder (either type I or type II) and BPD would experience considerable stress in the context of a demanding tertiary education program, and the facts of the case bear this out. Nevertheless, many medical and other health professional students endure stresses of different kinds, and successfully negotiate the program to graduate and practise effectively and safely.

The existence of bipolar disorder and severe psychosocial stressors in a medical student should not, of themselves, or even in combination, prevent the student from completing a medical program and subsequently practising safely and effectively. However, BPD, as illustrated by some of the features exemplified by BKY and also more generally considered, presents a more problematic set of issues in relation to admission to medical and other programs, completion of the program, and subsequent practice. This section describes current understandings of this disorder and its prognosis. In the discussion section of the article, this understanding and aspects of the case of BKY will be utilised to explore issues concerning inherent requirements to commence and complete a medical program, in the context of the nature, demands and requirements of medical practice, a model of mental disorders as a subtype of the broad but single category of illness, incipient developments by Australian medical programs to impose “inherent requirements” on prospective medical students, current discrimination law, and the obligations of universities to the community.

Conceptualising the personality disorders

The personality disorders constitute a contested conceptual and clinical category of what is overall a historically contested, conceptually fraught and sometimes (though less so as time passes) clinically derided area of medical practice – psychiatry. It will not be profitable, nor would it be possible, to rehearse here the many debates about the nature of psychiatry, its scientific credentials and evidence base or lack thereof, its putative primarily evaluative status in contrast to the factual nature of “organic” medicine and so on. Suffice to say that these debates are clearly pertinent to the characterisation of certain dispositions, temperaments and behavioural patterns as disorders of personality. Nevertheless, there are certain dispositions, temperaments and behavioural patterns that have been labelled as personality disorders, which are associated with considerable psychological distress, self-harm, suicide, social and interpersonal dysfunction, harm to others, and vocational disruption. What follows is a current characterisation of personality disorders and BPD as generally understood in the professional psychological/psychiatric community. Of course there are differences of perspective, different views concerning aetiology, different treatment approaches and so on. But there is also an emerging, core psychodynamic understanding of what BPD is, what contributes to its development, what it means and represents, and what it implies for the future.

Hypomania is a less severe form of mania, which is more characteristic of bipolar disorder (type I) and which may include psychotic features.
It is helpful first to consider the personality and its organisation, from healthy to disordered states, and the varying severity of the disordered states. We can characterise the personality as and from the evident fact that there are ways of thinking, feeling, behaving and relating to others that, while highly variable across different people, show great stability over time in most individual people. These ways of thinking and so on may be conscious, but are often spontaneous and inferred as unconscious. In either case they are different ways of adapting to the changes in our environment that are constantly occurring. These include threats and losses that can produce anxiety, grief, loss of self-esteem, acting out and other cognitive, emotional and behavioural responses including a number of psychological defensive processes. To the extent that these responses produce significant problems to the person himself and/or disruption or harm to others, we may see them as being disorders of personality.  

While boundaries are inevitably difficult to draw precisely, the difference between a healthy and a disturbed personality lies in contrast across a number of dimensions: differences between flexible responses in thinking and feeling to external or internal stresses, and rigid responses and greater difficulty in coping; the contrast between a clear and a deficient sense of one’s own identity; the contrast between satisfying and dysfunctional relationships with others; the difference between the ability to manage stress without unduly imposing it on others and the lack of this capacity; and the contrast between the ability to regulate one’s emotions and behaviour and a significant diminution or the absence of that ability. In psychodynamic terminology, psychologically healthy people have achieved during their formative years a number of intrapersonal and interpersonal capacities: a stable self-identity and stable object relations (relationship with others); the tolerance of affective states in oneself and in others; affect regulation in response to changes; super-ego integration (a mature moral sensibility); adequate reality testing; and adequate ego strength and resilience. The different disorders of personality are characterised by different patterns of deficiencies in these capacities. During the 20th century the broad division between, and the restriction of psychological disorders to, the neurotic and psychotic conditions, was broken down further in response to the accumulating observations of a further broad category of patients who were not overtly psychotic but who displayed less realistic transference responses to the therapist than most neurotic patients, who retain many of the capacities noted above. While not being overtly psychotic, these patients are generally more disturbed than those with neuroses. Some observers have characterised this broad, “intermediate” category as displaying borderline personality organisation; this should be distinguished from the narrower BPD as described in the Diagnostic and Statistical Manual of Mental Disorders (DSM) as one of many different personality disorders. This distinction, however, is by no means hard and fast, since there are important overlaps and blurring of boundaries between the various personality disorders in the DSM. The broader concept of borderline personality organisation can be thought of in terms of a category lying on a continuum that includes healthy, neurotic, borderline and psychotic

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17 PDM Taskforce, n 16, p 18.
18 PDM Taskforce, n 16, pp 22-23.
19 Transference is a psychodynamic concept referring to the psychological process whereby the patient unconsciously attributes qualities of someone in the patient’s past to the therapist, and at the same time experiences feelings that were associated with that person in the current relationship with the therapist. See Gabbard G, Psychodynamic Psychiatry in Clinical Practice (4th ed, American Psychiatric Publishing, 2005) pp 18-20.
20 Gabbard, n 19, p 428; PDM Taskforce, n 16, pp 20-21.
21 The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the publication of the American Psychiatric Association that provides the categorisation of the mental disorders that is widely used in psychiatric practice and research. The most recent version, DSM-5, was published in 2013. See American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (5th ed, May 2013).
22 The personality disorders are listed in the DSM under the broad category of Axis II disorders, which also includes developmental disorders. For practical purposes, all other mental disorders are listed under Axis I.
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personalities, while it is also sometimes used to capture under one heading a number of the different DSM categories that fall under the “Cluster B” group of personality disorders, including borderline, narcissistic, histrionic and anti-social disorders.

The links, overlaps and blurring of boundaries between the broader notion of borderline personality organisation and the narrower concept of BPD is well illustrated through the work of Kernberg in the 1960s and 1970s. Kernberg described a borderline personality organisation as comprising:

- ego weakness expressed as the inability to sublimate drives, delay the discharge of impulses and to modulate anxiety;
- a tendency to regress to quasi-psychotic thinking when under the pressure of strong emotional influences;
- defensive psychological processes including splitting (for example, the alternating expression of contradictory behaviours together with the ability to be apparently oblivious or to deny this); compartmentalisation of others as “all-good” or “all-bad”; projective identification, where representations of the self are split off and projected on to others, sometimes in order to control them; and
- pathological internalisation of relationship with others so that the internal world and experiences of others cannot be appreciated.

While these characteristics also form part of the core of BPD, more narrowly construed, they also feature to greater or lesser extents according to both DSM category and individual patient, in the other DSM Cluster B diagnostic categories. The continuum of “personality disorderliness” is reflected in the fact that some patients are diagnosed with more than one discrete DSM personality disorder.

Clinical features, diagnosis, aetiology of BPD

DSM-5 characterises BPD as “a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts”. It provides diagnostic criteria as follows, and stipulates that at least five criteria should be satisfied to make the diagnosis. Readers should note the congruence between these clinical features and Kernberg’s broad features of borderline personality organisation.

1. Frantic efforts to avoid real or imagined abandonment (not including behaviour covered in criterion 5);
2. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation;
3. Identity disturbance: markedly and persistently unstable self-image or sense of self;
4. Impulsivity in at least two areas that are potentially self-damaging (for example, spending, sex, substance abuse, reckless driving, binge eating) (not including behaviour covered in criterion 5);
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behaviour;
6. Affective instability due to a marked reactivity of mood (for example, intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days);
7. Chronic feelings of emptiness;
8. Inappropriate, intense anger or difficulty controlling anger (for example, frequent displays of temper, constant anger, frequent physical fights);

24 Gabbard, n 19, p 427. Cluster A disorders include paranoid, schizoid and schizotypal personality disorders, and Cluster C disorders include avoidant, dependent and obsessive-compulsive personality disorders.
26 Gabbard, n 19, p 431; PDM Taskforce, n 16, p 29.
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.\(^{28}\)

The fact that not all criteria are required reflects the fact that people with BPD are impulsively extroverted or flamboyantly perverse in their behaviour, some people diagnosed with BPD do not behave as destructively, but nonetheless suffer from chronic despair and problems with affect regulation, identity stability, relationships with others, resilience and moral consistency.\(^{29}\) Whether a person with BPD tends to be more extroverted or more introverted in manifesting their particular combination of clinical features listed as DSM diagnostic criteria, the nature of these features and their congruence with Kernberg’s account of borderline personality organisation strongly suggest that they represent, sometimes even in opposite forms within the same individual, deep-seated and largely unconscious themes and conflicts.\(^{30}\)

These difficulties can be seen as impairments of self-functioning and interpersonal functioning, with these two areas demonstrating a group of psychological processes that take us somewhat further towards appreciating the complexity and severity of BPD. These processes are agreed by experts to be essentially primitive or immature defence mechanisms that are generally more distorting of the person’s inner reality and ability to function as an individual and in relation to others than those encountered in the neuroses.\(^{31}\) They interfere with what we take to be the normal boundaries of the self, with the stability of the person’s self-identity and with accurate self-appraisal. They undermine the pursuit of goals and the ability to reflect on those goals and standards of behaviour involved in achieving them that we associate with normal individual and social behaviour. They distort and at times extinguish empathy, removing the appreciation of others’ perspectives and the effect of one’s behaviour on others.\(^{32}\)

Two central defence mechanisms are splitting and projective identification, both of which were identified and described by Kernberg. Projective identification is generally agreed to be a process whereby a patient unconsciously “splits off” particular self-representations and projects these on to others (that is, attributes often troubling and/or undesirable aspects of themselves to someone with whom they have a relationship, including the therapist). The other person is genuinely considered to have these particular attributes and is treated accordingly. Other processes include denial and the ability to apparently blandly disregard quite disturbing things; exerting control over others (sometimes via projective identification) and often not seeing them as separate individuals; and introjection, or taking in others’ characteristics as one’s own; primitive idealisation (seeing another person as all good) or devaluation (seeing another as all bad). These processes are often powerful enough to evoke strong responses in therapists,\(^{33}\) either of anger, resentment and hatred, or of extreme sympathy to the extent that some therapists cross professional boundaries in efforts to rescue or save the patient from their continuing experience.\(^{34}\)

\(^{29}\) PDM Taskforce, n 16, pp 24-25.
\(^{30}\) PDM Taskforce, n 16, p 31.
\(^{32}\) Allen, n 27, p 119.
\(^{33}\) PDM Taskforce, n 16, p 25.
\(^{34}\) All the psychological processes/defence mechanisms mentioned here should strike at least vague, but in some cases crisply peeling bells, in readers. Those with knowledge of these things sometimes refer to certain of their friends (and enemies) as “high-functioning borderlines”. By this stage of the column, and certainly by the end, readers may consider this to be something of a contradiction, given the apparent gravity of the problems that people with BPD must cope with. We need to remember that, as stated previously, to the extent that these psychological defensive processes produce significant problems to the person himself and/or others, we may see them as disorders of personality. But defensive processes in themselves are normal, and our physical and social survival depend on their exercise. As much as the psychopathology in organic medicine, pathology is a matter of the exaggeration of normal phenomena. Just as an over-reactive immune system can make of a normal and necessary physiological function a pathological state, such as an allergic condition, so too can exaggerated psychological defence mechanisms help to constitute psychopathology. The “high-functioning” borderline person may well resent that description, but the person will fall somewhere along the continuum described above, from healthy, to neurotic, to borderline, to psychotic
Accounting for the phenomena of psychopathological states depends on a wide range of inquiries, theories, evidence and tests. Some disorders are more soundly based in knowledge concerning the physical structure and functioning of the brain and interruptions to these than others. The personality disorders are less well understood in biochemical and physiological terms than depression, for example, although this is not to say that depression is well understood. Following their recognition as a somewhat different kind of disorder from neuroses and psychoses, these disorders were initially explained according to psychoanalytic and psychodynamic theories and concepts. These concepts are now gradually receiving endorsement as brain imaging, other physical investigations and empirical research shed new and different light on what happens in different disorders, but psychodynamic approaches, broadly construed, remain the mainstay of treatment. This is not surprising, given the current understanding of the aetiology of BPD in particular, in the context of its symptoms and the apparent defensive processes that occur. There is now a reasonably coherent consensus on the links between aetiology, symptomatology and treatment. The following account utilises the most recent, distinguishable approach to these, viz the mentalising model of BPD, but it should be understood that, rather than a radically new departure, this model is a development of earlier psychodynamic theory concerning BPD, and incorporates much of that theory.

Traumatised children are four times as likely as those without such a history to develop personality disorders. This refers not just to BPD, but BPD has been the most systematically linked disorder to attachment trauma in infancy and childhood and the consequent impaired mentalising that is the core of the mentalising model. Gabbard has noted that earlier psychoanalytic formulations for BPD posited childhood neglect, loss and/or abandonment as the core aetiological factors, but that later empirical studies point to childhood abuse as a major contributing factor, with sexual abuse present in 60% of cases and parent-child incest in 25%. Of course, these figures also mean that abuse is not necessary for the development of BPD, nor is it sufficient. But again there is a strong professional consensus that sexual abuse is often related to a broader pattern of family discord and disturbance. More recent prospective studies have demonstrated that inadequate affection and nurturing, and aversive parental behaviour such as harsh punishments are associated with later development of BPD.

Abuse, neglect and trauma are believed to result in problematic attachment patterns. This statement is almost tautological for those with any familiarity with psychopathology, but indeed also for a large proportion of the population, as a result of the permeation and adoption into mainstream culture over almost a century of Freudian and post-Freudian psychoanalytic and psychodynamic ideas. Secure child-mother and child-parent attachment is seen as a crucial requirement for developing those capacities mentioned above, including stable self-identity and object relations, affect regulation and tolerance of affective states, super-ego integration, reality testing and resilience, and whose lack at least partially underpins many cases of all the personality disorders.

The mentalising model’s key initial concept is that of the crucial necessity for the presence of adequate, secure attachment of the infant to (in most cases) the mother, for the development of the ability to mentalise (that is, the ability to represent one’s experience including interpersonal personalities, as we do all. The boundaries and the descriptors are fuzzy, as are the therapeutic consequences. Many people, whose psychological defence mechanisms are not as exaggerated as those of a person with severe BPD, nevertheless have problems and cause problems to others, and, in principle, would benefit from some form of psychotherapy.

36 Allen, n 27, p 120.
37 Gabbard, n 19, pp 435-436. Note that these figures, as always, depend on the inclusion/exclusion criteria for the studies that produce them. This said, this finding is now well accepted.
38 Allen, n 27, pp 120-122.
experience in mental state terms) to recognise that one’s mental states and those of others are fallible and subjective, and to develop the capacity to infer others’ mental states from their behaviour, facial expressions and so on.

Early disorganisation of secure attachment disrupts these abilities and consequently disrupts the development of the normal structure of the self. Having one’s own mental states recognised and understood in a caring, nurturing environment is necessary for both the development of the ability to recognise and understand those of others, and to develop a sense of coherence of one’s self-experience. This coherence and ability are disrupted by traumatic experience, which induces a regression to more primitive and concrete modes of experiencing and thinking about things and the person or people who are the causes of the abuse. Because an infant’s needs for attachment and coherence do not disappear, under circumstances of psychological and/or physical trauma, different strategies to maintain these appear. These may include:

• paradoxical identification with the aggressor (in order to maintain attachment and some level of control) and consequent internalisation of the intentions of the aggressor as part of a new and alien “self”, but experienced as self-hatred;
• projective identification of this alien, unbearable self on to others to avoid self-harm or self-destruction as a result of self-hatred;
• regression to concrete modes of thinking whereby experience can no longer be contextualised in reality, with perception and conceptualisation in primarily physical terms and not in terms of mental states (that is, disappearance of the developing capacity for mentalisation);
• an associated lack of the capacities of imagination and mental playfulness, and the capacity to question one’s own thinking, leading to an inability to appreciate that one’s perceptions do not always reflect reality;
• restoration of coherence by controlling and manipulative behaviour of others;
• projective identification of the internalised, alien aspects of the self on to others, resulting in seeking attachments within repeated, dependent and abusive relationships, and not being able to leave such relationships on pain of abandonment (which would be a repetition of the original insult/trauma/neglect);
• self-harming actions as the only perceived means of bringing about caring from others, but also as a result of the concreteness and intractability of the perception of oneself as bad, and of physical action being the only way of changing this; self-harm is often triggered by perceptions of imminent loss (for example, of a partner) and may temporarily restore a sense of internal coherence;
• suicide as a response to perceived imminent loss of self-coherence;
• acts of violence towards others, especially if others fail or are perceived to fail to be the required receptacles and vehicles of the person’s projected, intolerable experiences, and so induce feelings of humiliation in the borderline person; in the absence of developed mentalising, the destruction of the other is, concretely, the destruction of the alien part of the self.

Again, readers will note the overlaps between these conceptualisations and those of Kernberg. More importantly, these strategies do not reflect a model or theory that is not based on close observation of the experiences and behaviour of people diagnosed with BPD. They help constitute a model that provides a coherent understanding of how and why these observed behaviours arise. Further, while some of these strategies are depicted as responses to overt trauma, it is not only discrete traumatic events that undermine the development of normal mentalising. It is likely that this results from a more general and pervasive pattern of upbringing characterised by lack of consideration of the...

41 Bateman and Fonagy, n 40.
42 Gabbard, n 19, pp 436-437.
43 Bateman and Fonagy, n 40.
44 The strategies described here deliberately integrate the processes that the mentalisation model proposes occur in infancy with some of the observations made of behaviours at later stages.
45 Bateman and Fonagy, n 40, pp 12-14, 16-17, 19-21, 24, 26-28; Gabbard, n 19, p 437.
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child’s perspective, general neglect or outright rejection, excessively harsh control, and incoherent and inconsistent communication, as noted above, and that traumatic events, including the sexual and other abuse that is strongly associated with BPD, occur within this broader environment.

**Treatment and prognosis**

BPD has been described by some as virtually untreatable. Treating BPD and the other disorders of personality is certainly difficult, emotionally taxing and lengthy. In recent years, different treatments have been developed and therapeutic pessimism has yielded to a more optimistic, yet guarded outlook. A 2003 meta-analysis of eight treatment trials showed that psychodynamic treatment and cognitive behaviour therapy were both effective in BPD, although there were limitations to this analysis, including the fact that outcome measures in most of the studies referred to Axis I conditions such as depression being associated with the diagnoses of BPD in most patients. However, if this association is often present, measurements of outcome that ignore Axis I pathology will not provide an accurate picture of overall treatment results.

The three prominent modes of current treatment are dialectical behaviour therapy (DBT), transference focused psychotherapy (TFP) and mentalisation-based treatment (MBT). In all three approaches, the dynamics of the patient-therapist relationship are fundamental, and in any approach to treating patients with BPD, the balance between empathic validation of the patient’s experience and challenging patients and encouraging them to change is easily upset, with counterproductive implications (see below). There are different emphases in each approach. DBT focuses more on skills training to regulate emotion, increase resilience, adapt to and cope better with change, and reduce destructiveness. TFP focuses on the patient-therapist transference, with the therapist’s interpretations of the transference helping to reintegrate the patient’s mental, representational world and “narrative coherence”, and to build the capacity for more secure attachment. In these ways, it approaches MBT more closely than does DBT.

MBT utilises individual and group psychotherapy to foster greater mentalising in attachment relationships, both one-to-one and in group settings. At the individual level, like TFP, MBT utilises the patient-therapist transference to enhance mentalisation and so stabilise the structure of the self, initially via externalising the alien self “into” the therapist, but subsequently bringing the patient to appreciate that they are in the therapist’s mind (that is, cared for and nurtured). Patients develop capacities to understand that there can be different perspectives on the same situation, particularly in group work and expressive activities. In the words of prominent therapists/researchers Bateman and Fonagy, this approach:

- aims to strengthen patients’ capacity to understand their own and others’ mental states in attachment contexts in order to address their difficulties with affect, impulse regulation and interpersonal functioning, which act as triggers for acts of suicide and self-harm.

For all three approaches (and others), evidence is available of symptomatic improvement. It is too early to claim that one is superior to the others, although Bateman and Fonagy’s eight-year follow-up

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46 Johnson et al, n 39; Allen, n 27, pp 120-122.
47 Bateman and Fonagy, n 40, p 29; Gabbard, n 19, p 433; Allen, n 27, p 118.
48 PDM Taskforce, n 16, pp 825-826.
49 Recall that BKY was described as suffering from both bipolar disorder and BPD.
50 Allen, n 27, pp 145-150.
51 Allen, n 27, pp 145-147.
52 Allen, n 27, pp 148-149; Gabbard, n 19, pp 449-450.
53 These are clearly hyper-cryptic summaries of these treatment modalities. Interested readers should consult the references provided in this column and others for more detailed descriptions.
54 Gabbard, n 19, p 449.
study of their MBT day hospital and out-patient program of the 1990s, the longest such study to date, showed continuing stability five years after the end of treatment across a large number of diagnostic and symptomatic criteria. Moreover, the apparent improvements in treatment outcomes from MBT square with Bateman and Fonagy’s theoretical approach, considering the occurrence of poor progress and indeed iatrogenic harm, as a result of some earlier attempts to build insight for patients from prematurely challenging transference inferences. Because the very nature of BPD is one of weakness of the patient’s subjectivity, and integrating one’s own and the therapist’s view on things requires the capacity to mentalise, premature provision of what the therapist considers to be correct insight may disrupt the attachment relationship that is being depended on for success, and this in turn further inhibits the patient’s ability to mentalise. This calls for a more graded approach to sustain the fragile balance between employing the attachment relationship to integrate the patient’s mental experience with different viewpoints, and triggering a retreat or other defensive action on the part of the patient by (seemingly to the patient) recreating the original abusive environment.

In spite of this short account of improvements in treatment outcomes, prognosis in BPD, as with the other personality disorders, is fraught. Generally speaking, most cases of personality disorder cause some level of dysfunction throughout adult life, and chronicity tends to be associated with an early onset; this is certainly characteristic of many cases of BPD. Poorer academic and occupational achievement is more likely if BPD symptoms were already present in adolescence, as are adult borderline symptoms, a diagnosis of BPD in adulthood and general impairment; these effects tend to persist despite the decline of overt symptoms with age. Poorer outcomes are associated with greater severity of borderline features, higher levels of borderline personality disorder criteria and functional disability, and a history of childhood trauma.

Some studies suggest that the prognosis for BPD is better than previously thought, with high remission rates over a number of years, for example 88% remission over eight years in one study, and improvement in overall psychosocial functioning to a “good” level from 26% to 56% of participants over six years in another study. However, there is an important prognostic theme across a number of studies that is relevant to the issues examined in this article.

In Zanarini et al’s 2003 six-year follow-up of patients with BPD, while 73.5% of participants met the DSM-based criteria for remission after six years, it was also observed that impulsive symptoms resolved the most quickly, affective symptoms were the most chronic, and cognitive and interpersonal symptoms were intermediate. In another study that compared patients with four different personality disorders, including BPD, with patients with major depressive disorder, it was found that functional impairments, especially social functioning, appeared to be an “enduring component” of personality disorder, with no improvement in social functioning in patients with BPD. In a more recent study by

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Zanarini and colleagues, it was observed that of the more persistent symptoms, some such as impulsivity (such as acts of self-mutilation and attempted suicide), seemed to resolve more quickly, while symptoms of chronic dysphoria such as anger and loneliness/emptiness, and interpersonal symptoms, reflecting abandonment and dependency issues such as intolerance of aloneness, seemed to be the most stable. The researchers concluded that BPD may consist of both symptoms that are manifestations of acute illness and symptoms that represent more enduring aspects of the disorder. Bateman and Fonagy argue that while these recent studies have demonstrated that the majority of patients experience substantial reduction in symptoms much sooner than previously thought, they note that it is the symptoms of impulsivity that show the most dramatic change, with less improvement in affective, interpersonal and social functioning. They consider that abandonment concerns, the sense of emptiness and vulnerability to depression remain in roughly half of the treated patients.

**DISCUSSION**

The central question raised by the case of BKY is not whether discrimination occurred. It did occur in the prevailing context of State anti-discrimination and health practitioner regulatory law, and the tribunal was correct to make the distinction between the discrimination question and that of fitness to practise in that context, and to decide in favour of BKY (but see below in relation to the legal context in which BKY was argued). However, the split between the question of student discrimination and that of fitness to practise is cause for concern. While universities have duties to their students, including not discriminating against them, they arguably also have duties to help protect the safety of the communities that support them. In addition, they have duties to prospective students where it is considered, in good faith, that it is not in the interests of the students themselves to be involved in a course that qualifies them to pursue certain kinds of work, but where it is highly probable that they will encounter significant difficulty in discharging the duties that work entails. This concern is reflected in those expressed to the tribunal about BKY by the Dean – her downward academic trend, the quality of her current and continuing medical knowledge, her anxiety in relation to performance in clinical rotations, and the risk of her practising unsafely – even though these did not constitute a lawful basis for refusing to grant her an extension of her program as a student. This discussion uses aspects of the case of BKY to argue towards an acceptance that this split requires careful reconsideration.

**Models of disease and illness**

There may be something of an unstated, paradoxical relative bias in favour of students with mental disorders, when it comes to questions of discrimination in relation to entry to medical and health care programs. A person who is blind, or someone who lacks arms through some unfortunate congenital genetic or exogenous cause, is likely to not consider undertaking such programs in the first place, or to be dissuaded by friends or family, or to be sympathetically directed elsewhere upon application for admission. The unspoken but agreed consensus is that a person with the limitations implied by these physical conditions will be unable to undertake all the requirements of the program. But were such an individual to insist on admission, and to claim that they were being discriminated against if admission were rejected, it is difficult to see why they would not succeed in having the claim of discrimination against them, as a student, recognised. In cases of mental disorder, the tendency for such cases to be similarly “headed off at the pass” does not seem to occur. Anecdotal reports suggest that there is a small but significant number of applicants to medical and health programs who are not rejected, but who – like BKY – exhibit limitations and behaviours that are of great concern to educators, but who are required to modify their programs to accommodate the particular implications of the disability. The following is a recent example of the limitations of one student that required course adjustments from an Australasian medical school:

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Disruptions to thought processing and storing information, together with impaired attention resulting in difficulties organising and sustaining tasks, susceptibility to distraction and disrupted concentration, and occasional absenteeism.67

Part of the reason for the apparent bias in favour of students with mental disorders in contrast to those with physical disabilities may be the considerable progress made by supporters of the broadly social model of disease and illness, in contrast to the traditional biomedical model. Steele describes the social model of disability as comprehending a person’s impairment (the individually located problem that the biomedical model would focus on) as a disability, to the extent that society disables the person with the impairment by failing to provide adequate services and organising and modifying itself to this end.68 At the extreme, the social model regards more or less all disability as being caused by social factors or their absence, such that the armless man would be rendered completely able if only sufficient social modifications and accommodations were made. Like other institutions, universities have made various modifications to their physical environments to improve access for students with physical disabilities. Similarly, accommodations and modifications are being made for certain cognitive limitations, such as in the example above, in the same spirit of inclusion that is also reflected in discrimination laws. Examples of these include allowing students to sit deferred examinations, allowing more time to complete examinations, providing for peers to take notes, allowing for extensions to program completion caps and so on.

This is consistent, inclusive and fair, and in the university environment, is generally workable in practice as well as being supported in principle. It is also likely to be of little negative consequence to the student or to others, once the student has graduated, in the case of non-professional programs. But while the university environment is generally similar for commencing students in both professional and non-professional programs, it is not the same once the professional students reach their clinical placements, and certainly not the same when these students reach professional practice.69 This suggests that the accommodations being required of medical and other health programs, at least for some students with mental disorders and consequent disabilities, are inappropriate in the context of the clinical environments that these students will enter as both students and junior health professionals.

The bias in favour of accommodating students with mental disabilities may also arise, in part as a result of the historical tendency to regard “physical” disease as real or more real than psychological conditions. Again, there is not room here to review the substantial literature on the history of the status of psychiatry within medicine, the status and authority of psychiatric classifications and so on. Suffice to say that, while great progress has been made to “normalise” psychiatry and its classifications within medicine and health care, the very nature of this area of practice, involving as it does problems of cognition, feeling, mood, will and behaviour with all their associations with values, responsibility and morality, means that it is not perceived to be as hard and factual as problems like blindness or armlessness are, and so may not be regarded as being as incompatible with practice as such conditions.70 It is important to dispel this perception.

In a different direction from that taken by the social model of illness and disease away from the traditional biomedical model, 25 ago Fulford provided an evaluative model of illness and disease in order to demonstrate a number of important ideas. First, both psychological and organic conditions

67 Personal communication to author.
69 This claim is not extinguished by the “broad church” exception. Some opponents of any discrimination will see health care and particularly medical practice as affording such a broad scope of vocational possibilities that everyone, no matter what their apparent limitations, can be accommodated. For example, some who are more sanguine than others about admitting students who are not compassionate and empathetic, argue that these students will likely find their way to vocations that involve minimal or no direct patient contact, such as pathology. While this is overly simplistic, the stronger reason that the broad church exception is faulty is that, at least as far as medicine is concerned, all graduates must complete the intern training year, which does involve considerable patient contact, in order to then follow any particular career path.
70 This is likely to be more the case with non-health professionals, and also is likely to be as much an unconscious sort of perception as a conscious one.
involved two components, their descriptive content and an evaluative element. In organic conditions, because of the strong consensus on negatively evaluating diseases, the evaluative element tends to disappear from view, leaving what appears to be a set of medical scientific facts, and allowing medicine to appear to operate without reference to values. This amounts to the biomedical model, with disease as the primary organising concept. Fulford argued for a reverse view of the illness/disease concepts, with illness as both logically and empirically prior to disease, given that we do not call something a disease unless people first negatively evaluate its symptoms. This view better explains our intuitions and the language we use in talking about disease and illness, than the biomedical model’s view.

Secondly, this account makes it easier to see both organic and psychological conditions as species of the same broad category of illness, since both involve both descriptive and evaluative elements. Fulford characterised both physical and psychological illnesses as “action failures” or failures of “ordinary doing” in the absence of obstruction, in the respective areas of human life. Thirdly, this conceptualisation allowed Fulford to attribute to mental disorders the same ontological and normative status as physical conditions. Again, this accords with our intuitions concerning the seriousness of many mental disorders, the degree of suffering they cause and the significant implications they hold for people’s welfare and flourishing.

If Fulford’s account is correct, we should regard mental disorders as no less likely to be incompatible with medical practice as physical conditions, subject to how compatible the particular symptoms, experiences and capacities of the patient with the condition are with the requirements of medical practice.

**Medical practice, communication and emotional intelligence**

Health care practice, and in particular medical practice, are demanding vocations, across physical, mental and existential dimensions. Of course there are variations on these themes. Some orthopaedic surgeons will need to be physically strong and resilient, as they are called on to work with heavy limbs, significant muscular and gravitational forces, and other challenges to physical abilities. This does not mean there are no female orthopaedic surgeons or that all orthopaedic surgeons are physical brutes. But the tasks required and the capacities to discharge them cannot be ignored. All doctors, at least initially and in most cases throughout their professional careers, communicate with patients, usually on a one-to-one basis. Over recent years medical programs have increased their attention to teaching and assessing communication skills in response to community and expert opinion that doctors have generally not communicated well with their patients. This is historically bound to the shift from the more paternalistic approach to the more patient-centred model of medical and health care. Most communication skills teaching focuses on strategies to optimise history-taking, breaking bad news, patient education and motivational interviewing, and other areas, and there is also an increasing emphasis on trying to teach – or at least to encourage – compassion and empathy.

Attention is paid somewhat less frequently and consistently in current medical programs to more complex aspects of communication in providing health care, such as the role of emotions and emotional intelligence, but this is now beginning to develop more explicitly, and will help fulfil the aspirations of accreditation bodies in the area of effective and compassionate communication. For example, the Australian Medical Council’s *Standards for Assessment and Accreditation of Primary Medical Programs* includes these graduate attributes:

- **2.1 Demonstrate by listening, sharing and responding, the ability to communicate clearly, sensitively and effectively with patients, their family/carers, doctors and other health professionals.**

73 Fulford, n 71, pp 109-110, 120-121.
2.8 Elicit patients’ questions and their views, concerns and preferences, promote rapport, and ensure patients’ full understanding of their problem(s). Involve patients in decision-making and planning their treatment, including communicating risk and benefits of management options.

4.2 Demonstrate professional values including commitment to high quality clinical standards, compassion, empathy and respect for all patients. Demonstrate the qualities of integrity, honesty, leadership and partnership to patients, the profession and society.76

The General Medical Council, in its Outcomes and Standards for Undergraduate Medical Education in the United Kingdom, states prescriptively that graduates will:

15(a) Communicate clearly, sensitively and effectively with patients, their relatives or other carers, and colleagues from the medical and other professions, by listening, sharing and responding.

20(c) Be polite, considerate, trustworthy and honest, act with integrity, maintain confidentiality, respect patients’ dignity and privacy, and understand the importance of appropriate consent.

20(e) Recognise the rights and the equal value of all people and how opportunities for some people may be restricted by others’ perceptions.77

It is interesting and important to note that the emerging literature on emotions and emotional intelligence in medical and health education, at this stage somewhat less than explicitly, expresses a commitment to awareness of the crucial role in communication between health professionals and patients of the psychodynamic processes involved in attributions of stigma, stereotyping, transference and countertransference, as well as some of the mentalising and regulatory capacities noted as disrupted or absent in BPD. (While these processes have always been important, they have been rather confined to teaching in psychiatry, and even then have not always received close attention, depending on the particular leanings of clinical teaching staff in relation to the more psychodynamically oriented approaches to mental disorders.) For example, Cherry and colleagues in their recent review of emotional intelligence in medical education, included in their literature search the “constructs of compassion, sensitivity, empathy, emotional self-efficacy, emotional management, emotional regulation and resistance to stress”.78 They noted that earlier authors have defined emotional intelligence in terms of appraisal and expression of emotion in oneself and in others, regulation of emotion in oneself and use of emotion to facilitate performance;79 and the means to perceive and express emotions and regulate emotions in self and others.80 Cherry and colleagues argue that emotional intelligence enhances all people’s ability to identify others’ emotional expressions and makes them “more satisfied with their personal relationships, more flexible in social interactions, better able to manage their moods and more adaptable when under stress”.81 These capacities, they further suggest, are even more important for professionals who work in highly emotionally charged work environments and who must respond appropriately to multiple emotional experiences on a daily basis.82

BKY, BPD and the tasks of medicine

Cherry and colleagues, and other commentators, wisely demur from extrapolating that emotional intelligence should be considered in medical school selection processes and that it should be taught as part of the medical curriculum. They base this hesitation on doubts about whether it is a personality trait, a learned ability or some combination of the two and the lack of any evidence that “teaching”...
emotional intelligence can develop professionalism, and also that viewing emotion as a set of teachable skills and behaviours risks the devaluing of emotion in practice. Nevertheless, if as Ogle and Bushnell point out, “[T]here is mounting evidence that aspects of intra- and inter-personal functioning that could be considered components of EI, such as empathy, are positively related to doctor competence and better patient outcomes”, and considering the conceptual links between emotional intelligence and the expression and regulation of emotion, a question is raised as to whether there may be a threshold of some kind below which some applicants with particular mental disorders should be considered unsuitable for medical and other health care programs, just as we would consider the blind or the armless applicant unsuitable.

Some care is required here in advocating empathy as an important requirement for health care professionals. Two senses of empathy are illustrated by the following definition: “(t)he capacity to enter into the experiencing world of the patient and all family members in order to understand what they are going through … To know how to deal with somebody who is to be given bad news we have to have some idea what they are experiencing.” Nobody can literally enter into the experiencing world of someone else. That would raise questions about our self-identity, boundaries and object relations. But our normal capacities for appreciating the perspectives of others do allow us to “have some idea what they are experiencing”. This is an important distinction; expectations of health practitioners’ capacities for empathy should be realistic and hence of the second sense noted here, but even this realistic sense of the capacity for empathy is at significant risk as a result of the distortions that occur in BPD.

As argued above, Fulford’s analysis of psychological illness as structurally (descriptive and evaluative components) equivalent to physical conditions is consistent with our knowledge of the suffering they cause and their implications for welfare and flourishing. It is also consistent with the New South Wales anti-discrimination legislation’s definition of disability as including the total or partial loss of a person’s bodily or mental functions, functions being defined as “powers, authorities and duties”, and as including a disability that a person has or is thought to have, or is thought to have had in the past, or will have or is thought will have in the future. Thirdly, it is consistent with the World Health Organization’s (WHO) classification of functioning, disability and health. The WHO classification sensibly integrates the biomedical and social models, and consequently recognises the reality of limitations of activity as “difficulties an individual may have in executing activities”, which are in turn defined as tasks or actions. The WHO also includes “social norms” in the range of norms, deviations from which may constitute impairment or disorder. This is important in the context of some mental disorders and their sometimes prominent association, noted above, with values, responsibility and moral relationships, and their effects on others.

83 Cherry et al, n 75 at 474.
86 Gillam et al, n 75 at 332.
88 The distinction, together with a belief in the “teachability” of emotion and empathy, have other implications for practice, also related to appropriate boundaries. Encouraging students and practitioners into falsely believing that empathy is truly about entering into the experiencing world of patients, arguably encourages sentimentality, or “the expression of emotions that one does not truly feel”, with consequent risks to patients, students and practitioners. See O’Mahony S, “Against Narrative Medicine” (2013) 56 Perspectives in Biology and Medicine 611 at 614-615.
89 Anti-Discrimination Act 1977 (NSW), s 4(1).
90 Anti-Discrimination Act 1977 (NSW), s 49(A)(a)-(d).
Psychological disorders should therefore be squarely in the sights of those interested in the fitness of applicants for medical and health education and practice. Moreover, those who subscribe to a more social model of disability should be even more perturbed than others by the differences between the preclinical student environment, in which various accommodations can appear to reduce dysfunction, and the clinical student and postgraduate settings, where that model should, in consistency, insist on the possibility that dysfunction will be exacerbated by the demanding physical, mental and existential environmental factors that doctors and health practitioners experience daily. This is because these features define the clinical environment, and they are not amenable to modification to accommodate certain disabilities. It follows that there will be some applicants for medical and health care programs who should not be selected, because their disabilities are incompatible with clinical practice.

There is a strong case to be made that the symptoms and signs that characterised BKY’s disorders, as adduced by her psychiatrist in *BKY*, fall into this category. Let us recall that the personality disorders are generally agreed to be ways of thinking, feeling, behaving and relating to others that are usually stable over time. They involve processes that can produce significant problems for the person and/or harm to others. These arise from failures to achieve capacities including stable self-identity, self-appraisal and resilience, stable object relations, tolerance and regulation of affective states, adequate reality testing, mature moral sensibility, appreciation of others’ perspectives, expression of empathy and recognition of boundaries. More specifically, DSM-5 characterises BPD as “a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts”. We can assume that BKY satisfied five or more of the diagnostic criteria that illustrate some of these developmental problems and patterns, with these being underpinned by at least some of the defence mechanisms described previously, including splitting, projective identification, introjection, and denial/control of/depersonalisation/devaluation/idealisation of others.

Particularly in the context of *BKY*, the implications of accepting the general contours of the mentalising model’s links between these processes and the intrapsychic and interpersonal manifestations and the broad prognostic implications of the disorder, are clear. BKY exhibited significant anxiety, especially performance anxiety on approaching examinations, and consequently developed a pattern of avoidance with the need to complete the exams at later dates. She was described as having a poor sense of self-worth and a fear of failure, and at times of having a paralysis of her ability to study. She would take any way out of this anxiety, and this was described as an avoidance of responsibility. More specifically, she suffered constant panic attacks in the third year of enrolment, and could not attend problem-based learning tutorials due to anxiety.93 She experienced exhaustion and continuing anxiety in the context of the demands of study,94 and applied for leave of absence from the program in 2010.95 This was due to being overwhelmed by the need to commute from Sydney, where she had decided to live, to Gosford, for the fourth (clinical) year of the program.96 Subsequently she was unable to drive from Sydney to Newcastle to sit an exam due to a panic attack.97

BKY’s psychiatrist suggested that she was capable of functioning under deadline pressure, but this capacity was certainly not consistent, in view of the manifestations of her disorder as described. The psychiatrist also stated that BKY was capable of completing the course, and predicted that her symptoms were unlikely to emerge and disrupt effective functioning as a medical practitioner. While the former may be true – albeit after approximately 10 years – the second prediction is surely questionable in view of the facts of the case, the nature of BPD, and the role of emotional intelligence in medical education and practice. Capacities for showing compassion, sensitivity and empathy, for regulating one’s emotions appropriately (particularly in stressful situations which are common in

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93 *BKY v The University of Newcastle* [2014] NSWCATAD 39 at [18].
94 *BKY v The University of Newcastle* [2014] NSWCATAD 39 at [20].
95 *BKY v The University of Newcastle* [2014] NSWCATAD 39 at [22].
96 *BKY v The University of Newcastle* [2014] NSWCATAD 39 at [25].
97 *BKY v The University of Newcastle* [2014] NSWCATAD 39 at [26].
medical practice), and for being resilient and resistant to stress, are likely to be compromised in people with BPD, because they are just the capacities that are conferred by the ability to mentalise. If the therapist-BPD patient relationship itself involves risks associated with transference and countertransference processes, then surely the relationship between a doctor with BPD and their patient is subject to a risk of interference by exaggerated forms of these processes, as a result of the residual fragility of the patient’s subjectivity and ability to mentalise. We should recall here that, although the prognosis for BPD has improved in recent years with treatments focused on psychodynamic processes, this appears to be selective. Most cases of personality disorder cause some level of dysfunction throughout adult life; presence of BPD symptoms in adolescence predicts poorer academic and occupational achievement; poorer prognosis in BPD is associated with more severe diagnostic features; social functioning, chronic dysphoria and interpersonal symptoms are more enduring components of the disorder, with some studies showing little or no improvement in these factors in BPD; and abandonment concerns, the sense of emptiness and vulnerability to depression remain in roughly half treated patients.

The extent to which these prognostic factors pertain to BKY is impossible to describe, but it should be recalled that BKY was diagnosed with BPD, that she had been treated by a psychiatrist and a psychologist for a long period of time,99 that she has – at least – significant limitations of her resilience and resistance to stress, significant limitations of emotional tolerance and regulation, significant incursions on her sense of self, and significant diminution of her ability to take responsibility. From the point of view of BKY, these restrictions are arguably incompatible with the demands of ordinary medical practice. From the point of view of patients, they signal potential threats to safety.

Inherent requirements

By the time this column is published, Medical Deans Australia and New Zealand99 will have convened a meeting of a working group of interested medical educators to continue a project initiated two years ago to develop a definition and framework for inherent requirements for medical practice, in order to establish national guidelines and establish a mechanism for medical schools in the two countries to share definitions and case studies of dealing with students with disability and impairment.

The University of Western Sydney (UWS) has already developed a comprehensive Inherent Requirements policy for its medical program,100 as one of a suite of “Inherent Requirements” documents published by this university across a range of courses.101 Inherent Requirements are generically defined by the UWS as:

1. The essential components of a course or unit that demonstrate the capabilities, knowledge and skills to achieve the core learning outcomes of the course or unit, while preserving the academic integrity of the university’s learning, assessment and accreditation processes.

The policy refers to the Commonwealth disability legislation that makes it unlawful for an educational authority to discriminate against a person on the ground of the person’s disability, in relation to admission, access to benefits or the development of curricula.103 It also refers to the Commonwealth government’s Disability Standards for Education 2005, which requires institutions to take reasonable steps that enable the student with a disability to participate in education on the same basis as a student

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98 BKY v The University of Newcastle [2014] NSWCATAD 39 at [15]-[16].
99 Medical Deans Australia and New Zealand is the peak body representing professional-entry level medical education, training and research in Australia and New Zealand: see http://www.medicaldeans.org.au.
100 University of Western Sydney, “Inherent Requirements for Medicine Courses”, http://www.uws.edu.au/it/inherent_requirements/inherent_requirements_for_medicine_courses.
101 For an example of how inherent requirements for individual programs have been developed at the University of Western Sydney, see Bialocerkowski A et al. “Development of Physiotherapy Inherent Requirement Statements – An Australian Experience” (2013) 13 BMC Med Educ 54, http://www.biomedcentral.com/1472-6920/13/54.
102 University of Western Sydney, “Inherent Requirements Key Terms”, http://www.uws.edu.au/it/inherent_requirements/inherent_requirements_key_terms.
103 Disability Discrimination Act 1992 (Cth), s 22.
without a disability, by making reasonable adjustments for the student.\textsuperscript{104} According to the Disability Standards, an adjustment is reasonable in relation to a student with a disability if it balances the interests of all parties affected.\textsuperscript{105} In determining whether an adjustment is reasonable, the Standards require certain considerations to be taken into account, most of these being focused on the student, but there is also a requirement to have regard to the effect of the proposed adjustment on anyone else affected, including the education provider, staff and other students.\textsuperscript{106} The inclusion of the provider, the staff and other students does not exhaust the scope of “anyone else affected”. In the context of professional programs, this presumably includes those patients and health carers who may be affected by the student’s actions during the course of clinical placements. Whether it extends to those patients who would receive services provided by the person, once they have graduated and become a registered practitioner, is less certain.

The UWS Inherent Requirements suite covers a number of generic domains: ethical behaviour, behavioural stability, legal requirements, communication, cognition, sensory ability, strength and mobility, and sustainable performance. For each domain a description and explanation of the requirement is provided, together with the nature of any adjustment that may be made to allow students to meet it.

The introduction to the Inherent Requirements for medicine courses states

Many of the activities associated with the professional practice of a medical practitioner are time sensitive, where the capacity to perform certain activities within specified time limits is required to reduce or avoid risks to patient safety and wellbeing. The safety and wellbeing of you and others is always of paramount importance.\textsuperscript{107}

The following selective and abridged Table is a synopsis of the particular UWS domain categories, their justifications, conditions that should govern relevant adjustments, and exemplars, that are relevant to the limitations demonstrated by BKY.

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<thead>
<tr>
<th>Domain</th>
<th>Justification</th>
<th>Adjustments</th>
<th>Exemplars</th>
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<tbody>
<tr>
<td>Behavioural stability</td>
<td>Required to work individually and in teams in changing and unpredictable environments. Medical students will be exposed to emergency situations and human suffering and will be required to have behavioural stability to manage these events objectively and professionally.</td>
<td>Must support stable, effective and professional behaviour in both academic and clinical settings.</td>
<td>Coping with own emotions and behaviour effectively when dealing with individuals in the clinical setting</td>
</tr>
<tr>
<td>Communication (verbal)</td>
<td>Adequate communication with patients is essential to diagnosis and management. Speed and interactivity of communication may be critical for patient safety or treatment.</td>
<td>Must address effectiveness, timeliness, clarity and accuracy issues to ensure patient safety.</td>
<td>Responding appropriately to a care request in the clinical environment.</td>
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</tbody>
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\textsuperscript{105} Australian Government, Department of Education, n 104, s 3.4(1).

\textsuperscript{106} Australian Government, Department of Education, n 104, s 3.4(2)(d).

\textsuperscript{107} University of Western Sydney, n 102.
Note that the conditions applicable to the adjustments are explicitly or implicitly applicable, not only to the academic environment but to the clinical environment and to patient safety. The sustainable performance domain, and others such as sensory ability and strength and mobility, are clearly relevant to the comparator cases – the blind and the armless applicants. It would be no more discriminatory to prevent a person such as BKY from being admitted to a medical program than it would be to prevent these applicants, on the grounds that in all three cases, no reasonable adjustment could be made in the relevant domains. In relation to the requirement of the Disability Standards, that in determining whether an adjustment is reasonable, regard be had to the effect of the proposed adjustment on anyone else affected, there are good reasons to think that BKY would fail to satisfy all four adjustment types indicated in relation to clinical placements as a student, and clinical practice following graduation.

However, BKY was argued in terms of the relevant State legislation, with no reference made to the Commonwealth legislation and its subsidiary Disability Standards for Education 2005. This reflects the fact that aggrieved students have the choice to argue their discrimination case under either jurisdiction, and may prefer not to risk an adverse costs order in the event of losing the case in the Federal Court. Nevertheless, this does not mean that the Standards are not relevant to matters argued under State legislation, in the sense of providing benchmarks that education providers should aim to uphold. It is somewhat surprising that the Standards were not adverted to by the university, in relation to the Dean’s concern about BKY’s declining health status in relation to continuing the program. As noted above, in determining whether an adjustment is reasonable, the Standards require considerations to be made in relation to the student, and one of these would be health and welfare.

This column does not attempt to canvas the range of Inherent Requirements that exist in jurisdictions comparable with Australasia. However, it will be helpful to briefly describe the situation in the United Kingdom. Although the primary concern of the Medical Board of Australia in relation to students is impairment, and there are mandatory reporting conditions imposed on medical and other providers, the United Kingdom has a different approach. For example, the General Medical Council (GMC) requires doctors to be fit to practise medicine, and the GMC’s Code of Conduct includes a duty to report any concerns about a doctor’s fitness to practise. In New South Wales, the Health Care Complaints Commission is the body that makes final decisions on investigation outcomes, and that prosecutes serious cases before disciplinary bodies.

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108 Personal communication by E Dickson to author.
109 BKY self-reported her condition to the then New South Wales Medical Board in 2008 (BKY v The University of Newcastle [2014] NSW CATAD 39 at [21]). The State boards were replaced by the Medical Board of Australia in 2010, with “branch” boards in each State. New South Wales legislated for the Medical Council of New South Wales, “whose main role is to ensure doctors are fit to practise medicine” (see Medical Council of New South Wales, “FAQ: What is the Difference Between the NSW Medical Council and the HCCC?”, http://www.mcnsw.org.au/page/305/about-us/frequently-asked-questions/faq-general/faq-what-is-the-difference-between-the-nsw-medical-council-and-the-health-care-complaints-commission). However, in New South Wales, the Health Care Complaints Commission is the body that makes final decisions on investigation outcomes, and that prosecutes serious cases before disciplinary bodies.

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Bioethical issues

TABLE continued

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<tr>
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<th>Justification</th>
<th>Adjustments</th>
<th>Exemplars</th>
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</thead>
<tbody>
<tr>
<td>Communication (non-verbal)</td>
<td>Ability to observe and understand non-verbal cues/consistent and appropriate facial expressions, eye contact – promote trust in academic and professional relationships. Being sensitive to individual differences displays respect and empathy to others.</td>
<td>Must maintain capacity to recognise, respond to or initiate effective non-verbal communication in a timely and appropriate manner.</td>
<td>Recognising and responding appropriately to cues in the clinical environment</td>
</tr>
<tr>
<td>Sustainable performance</td>
<td>Sufficient physical and mental endurance is an essential requirement to perform multiple tasks in an assigned period to provide safe and effective care without compromise.</td>
<td>Must ensure that performance is consistent and sustained over a given period.</td>
<td>Participating in tutorials, lectures, skills throughout the day. Providing consistent care over a negotiated time frame.</td>
</tr>
</tbody>
</table>
health care education providers in relation to impaired students who satisfy certain conditions, it has a less “hands-on” approach than the General Medical Council. The Council has a broader and more active involvement in student conduct, performance and impairment, and the behaviour of medical schools, than the Medical Board of Australia. It provides guidance to the schools on students’ professional values and fitness to practise, which is described as advisory rather than mandatory, although this is qualified by the following statement:

However, GMC quality assurance reports on medical schools may recommend that they comply with the guidance or may commend an institution for good practice. Also, given that the GMC has to be satisfied that graduates applying for registration with a licence to practise are fit to practise, it would be surprising if a medical school thought it sensible to disregard this guidance.

The guidance strongly emphasises the relationships between health, disability and fitness to practise. While giving strong support to the principles that “medical education and training should be able to accommodate people with a range of ambitions, different faiths and backgrounds, as well as those with health conditions and disabilities”, and that “in most cases, health conditions and disabilities will not raise fitness to practise concerns, provided the student receives the appropriate care and reasonable adjustments necessary to study and work safely in a clinical environment”, the guidance also indicates that medical students must be fit to practise medicine, and that “in exercising the responsibility to register only doctors who are fit to practise, the Council will always put the safety of patients above all other considerations”. Furthermore, a student’s fitness to practise is called into question:

(when) their behaviour or health raises a serious or persistent cause for concern about their ability to continue on a medical course, or to practise as a doctor after graduation. This includes, but is not limited to, the possibility that they could put patients or the public at risk, and the need to maintain trust in the profession.

Under these circumstances, the medical school must consider invoking its fitness to practise procedures, and this is distinct from any general disciplinary procedures that the university may have. While invoking the procedures will be infrequent, the guidance provides for: (1) a much greater involvement of the medical profession in the management of students who pose risks to public safety, either currently or potentially; and (2) a significantly greater responsibility on the part of universities to contribute to ensuring public safety in relation to the education and future practice of their students.

This position is supported by the statement Medical Students – Standards of Medical Fitness to Train, produced by Higher Education Occupational Physicians/Practitioners (HEOPS), the professional association for all occupational health professionals working in the United Kingdom higher education sector, and which develops sector-specific policies and guidance on the control and management of health risks in the sector, to assist national bodies such as the General Medical Council.

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110 Under the National Law, as implemented in each State and Territory, students are defined as impaired if they have a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect their capacity to undertake clinical training (Health Practitioner Regulation National Law Act 2009 (Qld), s 5). An impaired student who, in the course of undertaking clinical training, may place the public at substantial risk of harm, must be reported to the Medical Board of Australia by the education provider (Health Practitioner Regulation National Law Act 2009 (Qld), s 141(1)(b)).

111 General Medical Council, Medical Students: Professional Values and Fitness to Practise (2009) at [7], http://www.gmc-uk.org/education/undergraduate/professional_behaviour.asp#12scopeof.

112 General Medical Council, n 111 at [46].

113 General Medical Council, n 111 at [50].

114 General Medical Council, n 111 at [47].

115 General Medical Council, n 111 at [70] (emphasis added).

116 General Medical Council, n 111 at [71].


Council to develop policies and guidance on fitness to practise and protecting and promoting the health of staff and students. The HEOPS statement includes categories of functional capacity that should be assessed to ensure safe practice that are somewhat similar to the UWS list. These are mobility, upper limb function, vision, hearing, speech, literacy, numeracy, skin function/integrity, interruption of consciousness, and concentration, awareness, memory and ability to learn and understand.

Our blind and armless applicants would simply fail to meet the thresholds indicated for the relevant HEOPS criteria. While guidelines do not have the power to automatically prevent admission of such applicants to medical and other health courses, this is not a problem, given the clear incompatibility with medical practice of these disabilities. However, the category of concentration, awareness, memory and ability to learn and understand, which is the most relevant to students such as BKY, is more purely “cognitive” than comprehensively psychological. Moreover, no discrete thresholds of fitness to practise are proposed for this category as occur in the purely physical categories of upper limb function and vision. This may reflect the fact that occupational physicians are usually physicians and not psychiatrists, and the persistence of the ontological disparity between physical and mental disorders as challenged by Fulford.

CONCLUSIONS

This column has challenged this disparity, and argued that there will be cases where mental disabilities will be sufficiently serious and chronic to justify preventing the admission of a very small number of students to medical and other health care education programs. The emphasis on support of disabled students, vital though it is, needs a measure of rebalancing. There appears to be some dissonance between federal and State law, at least as illustrated by the clear basis in New South Wales law for the decision to uphold the appeal of BKY against the University of Newcastle’s refusal to extend her period of study, and the provisions in the Commonwealth Disability Standards for Education 2005, which qualify the requirement that institutions make reasonable adjustments for disabled students with the need to have regard to the effect of the proposed adjustment on the student, but also “anyone else affected”. The need to have this second kind of regard is recognised by the General Medical Council’s guidance to medical schools, which includes the requirement for implementing fitness to practise procedures when student behaviour or health is a cause for concern about the ability of the student, not just to continue the medical course, but also to practise as a doctor without putting patients at risk.

The alternatives currently available for most Australasian medical schools are less than satisfactory. In the more acute cases, educators often simply hope that time to complete the program will lapse for students about whom they are seriously concerned, both from the student’s own welfare point of view, and from that of public safety. Another “solution” is that the student’s difficulties will result in the sufficient progressive accrual of academic failures for exclusion on academic grounds. Given the strong support that universities provide for students, including various appeal processes, this is (anecdotal, though strongly so) frequently a long and difficult, and often disappointing road. Another possible response available to universities is to reduce the time for completion. This is unlikely to occur as long as the universities maintain an exclusive focus on health professional students as students, rather than as students and future health professionals. Finally, the compulsory registration of medical and other health practitioner students with the relevant boards, under the National Registration and Accreditation Scheme,119 may go some way to ameliorating the concerns of educators, in view of the boards’ statutory responsibility to protect the public. However, this would presumably require a change in the way the boards consider and manage the kinds of implications of certain mental disorders that have been canvassed in this column.120

120 Under the Disability Discrimination Act 1992 (Cth), s 19, it is also “unlawful for an authority or body that is empowered to confer, renew, extend, revoke or withdraw an authorisation or qualification that is needed for or facilitates the practice of a profession, the carrying on of a trade or the engaging in of an occupation to discriminate against a person on the ground of the person’s disability”. However, the Act also allows for discrimination where, “because of the disability, the aggrieved person
It remains to be seen what the Medical Deans Australia and New Zealand project will be able to achieve. A national definition, framework and guidelines for inherent requirements for medical practice will be a sound start, and the UWS policy is an excellent template. But the achievement of effective action will also require fundamental changes in the conception of their broader responsibilities on the part of the universities, further clarification of the application of State and commonwealth anti-discrimination law, and possible law reform.

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