GDI Navigator to Excellence:
Summaries of Disability Articles in the Journal of Academic Medicine
2001-2012
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About the Group on Diversity and Inclusion (GDI)
The Group on Diversity and Inclusion (GDI) serves as a national forum and recognized resource to support the efforts of AAMC member institutions and academic medicine at the local, regional, and national levels to realize the benefits of diversity and inclusion in medicine and biomedical sciences. The purpose of the GDI is to unite expertise, experience, and innovation to inform and guide the advancement of diversity and inclusion throughout academic medicine and the community.

About Diversity
Diversity as a core value embodies inclusiveness, mutual respect, and multiple perspectives and serves as a catalyst for change resulting in health equity. In this context, we are mindful of all aspects of human differences such as socioeconomic status, race, ethnicity, language, nationality, sex, gender identity, sexual orientation, religion, geography, disability and age.

About Inclusion
Inclusion is a core element for successfully achieving diversity. Inclusion is achieved by nurturing the climate and culture of the institution through professional development, education, policy, and practice. The objective is creating a climate that fosters belonging, respect, and value for all and encourages engagement and connection throughout the institution and community.

About Health Equity*
Health equity is when everyone has the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance. *Source: Centers for Disease Control and Prevention

Visit www.aamc.org/gdi for additional information.

About the Journal of Academic Medicine
Academic Medicine is the official, peer-reviewed journal of the Association of American Medical Colleges. The journal serves as an international forum for the exchange of ideas, information, and strategies to address the major challenges facing the academic medicine community as it strives to carry out its missions in the public interest. The journal’s areas of focus include: education and training issues; health and science policy; institutional policy, management, and values, research practice; and clinical practice in academic settings.
People with disabilities represent an important part of the diversity of students, residents, faculty, staff, and patients involved in academic medicine. The *Journal of Academic Medicine* regularly covers this important topic and this summary encompasses select articles published between 2001 and 2012 that explore the nuances of the term disability, new options for training doctors to care for people with disabilities, and the endeavor of educating physicians with disabilities. Part one includes those articles dedicated to new approaches to educating, teaching, and training about disabilities in order to improve patient care. Part two includes articles related to the implications of disability for health care practitioners themselves, whether for an aspiring physician or a seasoned clinician. The discourse around perceptions, stereotypes, and stigma with regard to treatment and behavior of patients, students, or health care professionals with disabilities are explored in both types of article.
New Approaches: Teaching and Training for Better Care for Patients with Disabilities


Article 1. *Objective Assessment and Structured Teaching of Disability Etiquette*

Sunil Sabharwal, M.D., Medical College of Wisconsin


-Issue:
- Patients with chronic disabilities often perceive a lack of sensitivity among physicians during clinical encounters.
  - complaints of being treated as objects rather than persons

-Need to:
- Ensure that physicians in training are aware of and practice appropriate etiquette when treating patients with disabilities.

-Possible solution:
- Teach general competency skills established by the Accreditation Council for Graduate Medical Education (ACGME) that have an emphasis on humanistic aspects of patient care, which include:
  - interacting with patients in a caring and respectful manner as well as respecting the dignity of all patients and colleagues—not excluding those with disabilities

-Developed several objective, structured clinical examination stations (OSCE) in order to evaluate and teach skills in a more uniform way.
- Training included two stations:
  - The first, a video of inappropriate behaviors by the physician that the medical student needed to identify with a checklist to evaluate whether the student identified the behaviors.
  - The second involved the medical student appropriately turning over a paralyzed patient in order to do a back examination—a different checklist was used to evaluate this process and assess the ability to ensure and respect the patient’s comfort and safety while repositioning them.
  - Trainees were given immediate feedback on performance during the evaluations.
Article 2. **Considering the Culture of Disability in Cultural Competence Education**

Gary E. Eddy, M.D., and Kenneth L. Robey, Ph.D.


- “Culture of Disability” is a pan-ethnic culture for which a set of physician competencies are required to ensure appropriate, culturally sensitive care to persons with congenital or acquired disabilities.

  o Disability culture:
    - People with disabilities have forged a common group identity:
      - share a common history of oppression and bond of resilience
      - generate art, music, literature, and other expressions of lives and culture, infused from the experience of disability
      - claim disabilities with pride as part of identity

    (As defined by Steven E. Brown, co-founder of the Institute on Disability Culture)

  o Socially stigmatized positions, similar to ethnic minorities, are subjected to stereotypes, prejudiced attitudes, and subtle or blatant institutional barriers.

    - Barriers will be in place until health care providers and environments in which they practice change.
    - Need to become more supportive and welcoming toward persons with disabilities.
    - Health care disparities:
      - Those with disabilities significantly lower self-rating of poor health.

    o Lack of cultural sensitivity and a tendency to subtly avoid this population may contribute to these disparities.

  o Flores’ elements of cultural competence can be applied to the disability culture:
    - language issues
    - patient/parent beliefs
    - folk illnesses and remedies
    - provider practices
    - normative cultural values

  -The physician must be reflexive and aware of his or her own beliefs and values and their impact on clinical practice. (709)

    o “Sociopsychological research has demonstrated that people tend to interact with persons who have disabilities differently than they do persons without disabilities.” (709)

    - ‘Infantilizing’ speech implicitly asserts that persons with physical disabilities are somehow more child-like than persons who do not have disabilities.
“Individuals with disabilities often have complex medical conditions that require a multidimensional approach.” (709)

- Some of the values that underpin the disability culture include:
  1. acceptance of human differences
  2. a matter-of-fact orientation toward helping and being helped
  3. tolerance for lack of resolution or cure, and dealing with the unpredictable
  4. a sense of humor about disability
  5. skill in managing multiple problems
  6. a carefully honed capacity for closure in interpersonal communication
  7. flexible, adaptive, resourceful approaches to tasks and problems
  8. understanding that needs are different depending on the level of dependence
  9. interdependence valued more than independence (the opposite of the value system in the able-bodied population) (709)

- Do the following contribute more to experience and construct of disability, or is it primarily the underlying biological aspects of the condition that lead to the individual’s sense of disability?
  - social setting
  - attitudes of general population
  - environmental barriers

- World Health Organization’s (WHO) definition of disability:
  - impairment to the structure of a human body
  - impairment to the physiological and psychological functions of a person
  - activity limitations, such as difficulty executing specified activities
  - participation limitations in society in general

  - Each dimension outlined above can be impacted by:
    - personal factors (problems of the person)
    - environmental factors (problems of the environment or society)

- Cultural incompetence:
  - Inhibits effective patient-provider relationships:
    - The patient and/or the family may feel frustrated that their needs and concerns have been discounted.
  - Lack of exposure to persons with severe disabilities will:
    - limit the physician’s understanding of the various clinical processes and associated conditions that are common among persons with disabilities
    - affect the physician’s attitudes about those with disabilities regarding individuals’:
      - daily self-care capabilities
      - intellectual abilities
• vocational and lifestyle prognoses
• “It would seem reasonable to assume that a complete understanding of disability culture will need to incorporate both the personal, biological contributions, and environmental or social factors.” (710)

Findings and Recommendations:
  o “During training, physicians need to have more exposure to persons with disabilities.” (710)
    • Studies found that medical students’ expectations of capabilities and prognoses of individuals with cognitive disabilities were significantly lower compared to physicians who had professional involvement with patients with similar disabilities.
  o Curriculum that provides focus on persons with disabilities
    • Medical school curricula need to provide greater focus on persons with disabilities; students could develop an approach to the patient that is mutually satisfactory.
  o Exposure to faculty, students, or other health care professionals with disabilities
    • Beyond exposure to patients who have disabilities, exposure to faculty and other medical students who have disabilities may be helpful.
    • Such exposure may lead to an understanding of their future patients who have disabilities with regard to:
      • capabilities of success
      • social potential
      • occupational potential
  o Opportunities:
    • The program’s focus is compatible with Wear’s notion of “insurgent multiculturalism” in cultural competence in medicine.
    • Examine the attitudes toward persons with disabilities that may affect the physician-patient encounter, as well as other contributing factors to the health care disparities faced by those individuals.
      • i.e., troublesome areas of communication
    • “Focus of cultural competence goes beyond the patient-provider relationship to a fuller understanding of the social causes of inequality.” (711)
      • Lack of cultural competence may result in:
        o inadvertently ignoring patients’ values or needs
        o ignoring patients all together

Conclusions:
1. A culture of disability exists and aspects of it have implications for the health care process.
2. A concept of cultural competence must extend to include those competencies necessary to care for members of this culture.
3. A culture of disability should be included as one of the many cultures addressed in cultural competence initiatives within medical school curricula.

4. Faculty should consider the use of the natural environment of persons with disabilities as educational settings to build disability-related competencies and an appreciation for the culture of disability.
Article 3. *The Future of Psychiatry as Clinical Neuroscience*

Charles F. Reynolds, III, M.D., David A. Lewis, M.D., Thomas Detre, M.D., Alan F. Schatzberg, M.D., and David J. Kupfer, M.D.


**Problem:**
- According to WHO, neuropsychiatric disorders account for at least 20 percent of the global burden of illness-related disability.
  - Psychiatry's core mission is to assess, treat, prevent, and alleviate the distress and impairment caused by complex brain disorders.
  - Need new approaches to:
    - strengthen relationship of psychiatry and neurology
    - enhance public health relevance
    - emphasize early and sustained multidisciplinary training (research and clinical)
    - bolster academic infrastructure
    - reorganize and refinance mental health services both for:
      - preventative intervention
      - cost-effective chronic disease management

**Thesis:**
- Re-integrate clinical neuroscience and psychiatry into undergraduate and graduate medical training and research, as both address dysfunction in anatomical circuits and connectivity.
  - SWOT Analysis: strengths, weaknesses, opportunities, and threats of psychiatry

**Strengths of Psychiatry**
- Assessment tools in psychiatry and treatment:
  - diagnostic instruments
  - maintenance pharmacotherapy
    - need to incorporate multiple dimensions (severity, stress, impairment) into the assessment procedures
    - better accommodate advances in relevant basic brain and behavior sciences to enhance clinical relevance
  - systematic evidence base now available to inform treatment
  - optimizing treatment outcomes and personalizing treatment for those with psychiatric disorders
    - care management
    - allow evidence-based practice to reach both specialty mental health and general medicine settings
    - multi-component interventions take into account burdens of coexisting medical, neurological, and psychosocial challenges
- Weaknesses of Psychiatry

- Lack of internal resistance to the clinical neuroscience perspectives needed to bring the findings of psychiatric genetics, brain imaging, cognitive and affective neuroscience, and psychometric theory to define etiology, pathophysiology and treatment-relevant phenotypes to personalize treatment.

  • Needs:
    • Greater emphasis on biological and psychosocial variables that predict or modify short-and long-term treatment.
    • Invest greater scientific effort into studies of the etiology and pathophysiology of major brain disorders.
    • Integrate advances in psychiatry and neurology into undergraduate and graduate medical education.
      • inequalities in delivery of mental health services to vulnerable populations
      • integration of mental health services into other areas of medicine
      • unmet mental health needs of medical students and physicians (whose rates of suicide are two-three times greater than the general population)

- Opportunities for Psychiatry

- Conduct research into the causes of mental illness.
  • Chart developmental trajectories of mental illness to determine when, where, and how to intervene.

- Develop mental health treatments and approaches responsive to diverse needs and circumstances.
  • allow it to combat stigma against the mentally ill
  • develop preventative interventions for people at high risk

- Advocacy and consumer health info initiatives through partnerships with affected patients and families to improve payment of mental health services via parity and improve financial incentives for young people to enter the field.
• Strengthen the impact of treatments for mental illnesses on public health.

  o Psychiatry has the duty to change the institutional culture of academic medicine.
    • Support medical students and physicians seeking mental health services for themselves.
      o Teach how to better recognize depression in themselves and their colleagues which may
decrease suicide rates.

- Threats to Psychiatry
  o Financial
    • Medicare’s discriminatory copayment requirement of 50 percent
    • Infrastructure needs of psychiatric and mental health research from basic labs to community-based partnerships require ongoing, planned investment.
      • disadvantaged and underserved people
  o Medical Practice
    • Structural barriers:
      • lack of electronic health records
      • decreasing institutional support
      • acute versus chronic care
    • Social realities:
      • persistence of stigma
      • health science policy
        o inadequate funding of mental health research and lack of support for mentoring

- Strategies to Ensure Future of Psychiatry and Neuroscience:
  o Education and Training
    • Introduce medical students to clinical neuroscience in psychiatry in first year of medical school and integrate perspectives across disciplines.
      • early exposure to patients living with disorders
    • Recruit medical students into summer research electives in psychiatry and clinical neuroscience by providing mentoring and shadowing programs.
      • third year, integrate clerkships in psychiatry and neurology (versus two separate ones)
    • Teach medical students how to recognize depression in themselves and in their colleagues.
      • Encourage them to use mental health services to combat the internal and external stigmas against mental illnesses.
    • Provide psychiatric residents in community settings with culturally appropriate skills for underserved and disadvantaged patients.
    • Foster greater cross-training during psychiatry and neurology residencies.
      • Train psychiatric residents in general medical and pediatric settings.
      • Expand education of psychiatry residents in disease-relevant understanding of molecular, developmental, and systems neuroscience to bring future advancements into clinical practice.
o Change Health Policy
  • Pass and enforce legislation calling for parity of coverage for physical and mental illness.
  • Abolish discriminatory Medicare policies requiring 50 percent copayments for mental health services.
  • Increase federal investment into research and services:
    • causes, diagnoses, treatments of complex brain disorders
    • people with severe or persistent mental illness/complex brain disorders
  • Foster integrated approaches by NIMH, National Institute on Drug Abuse, Institute of Neurological Disorders and Stroke, etc.

o Institutional Leadership Issues
  • Clinical neuroscience: reintegration of undergraduate and graduate medical education psychiatry and neurology under rubric of clinical neuroscience.
    • Offer certification by American Board of Psychiatry and Neurology in clinical neuroscience with subspecialty qualification for divergent interests.
  • Enhance medical students’ incentives for choosing careers in clinical neuroscience.
    • Create endowments for junior and senior professors in clinical neuroscience to ensure opportunities for maintaining career development.
  • Create infrastructure to support core laboratories in clinical neuroscience.
    • Foster future integration across disciplines.
    • Provide interdisciplinary research and clinical training.
  • Remove barriers to use of mental health services by medical students and physicians.

o Research and Clinical Practice
  • Develop broad programmatic approaches to multidisciplinary research in clinical neuroscience and discovery.
    • new assessment and treatment strategies informed by basic science
    • interventions and series informed by ethnography and health economics
  • Seek ways to bridge science and service by testing models of care that facilitate implementation of evidence-based practices and assess scalability.
    • Integrate clinical practice of psychiatry into other medical settings.
  • Use non-mental health specialty settings to teach non-psychiatrist physicians how to:
    • screen for mental illness, provide initial treatment, know when to refer patients to mental health specialty care
Article 4. *Evaluation of Medical Student Performance on Objective Structure Clinical Exams With Standardized Patients With and Without Disabilities*

Rachel S. Brown, M.D., Catherine Leigh Graham, M.E.B.M.E., Nancy Richeson, M.D., Junlong Wu, & Suzanne McDermott, Ph.D.


**Issue:**
- Patients with physical and intellectual disabilities often do not receive adequate health services.
  - Important for medical students to receive training in health care provision for people with disabilities (PWDs)
    - Barriers accessing health care, physicians lacking:
      - understanding
      - communication tactics
      - comfort positioning, examining, developing management plans for care
- 2006 University South Carolina School of Medicine (USC SOM) Department of Family & Preventative Medicine introduced disability curriculum and didactic sessions in the second and third years of medical school.
  - Sessions covered information about:
    - disability prevalence
    - disability culture
    - special considerations for patients with mobility, sensory, and intellectual disabilities (IDs)
  - Lectures given by a faculty member with an adult child with an ID and a staff rehabilitation engineer with a spinal cord injury (SCI).
    - Physicians must be able to assess the relevance of a person’s disability as it relates to the chief medical issue, while understanding that special issues related to each disability must be integrated into the encounter.
  - Objective evaluation of a student's ability to apply these skills to future clinical encounters with PWDs is essential.
    - Objective Structured Clinical Exams (OSCEs)
      - Effective in testing:
        - knowledge
        - patient care skills
        - ability to communicate and develop rapport
        - understanding of systems-based care
      - Use of standardized patients (SPs) with disabilities in OSCEs
        - assess students ability to care for PWDs outside of the context of their disability
Physician can give direct feedback to students.

-Hypothesized that students would achieve lower scores on the OSCE for scenarios using SPs with disabilities.

-Statistically significant results:
  - SP without vs. SP–SCI: lower score in history taking, physical examination skills, ordering lab tests, and interpersonal skills for SP–SCI
  - SP without vs. SP–ID: lower scores similar to SCI, except in counseling, or interpersonal skills
  - Students were four times more likely to order a hemoglobin test for patient without a disability in the diabetes scenario.

-Purpose:
  - To determine whether students evaluate PWDs in common outpatient scenarios differently from the way they evaluate patients without disabilities by analyzing OSCE scores of medical students.

  - SPs with disabilities were not used to demonstrate disability-specific complaints, but instead were used to depict typical primary care problems.

  - Students who saw SP–SCI patients scored statistically significantly lower on all four components of the encounter versus students who saw an SP without a disability.

  - Students who saw SP–ID were more than two times as likely to provide all four components of counseling (smoking cessation, exercise, salt intake reduction, and medication instruction) when the SP did not have a disability.

  - Perhaps students felt that they were less likely to influence the lifestyle of the person with ID, or would offend the caregiver insinuating lack of care.

  - Students did not perform as well on SPs with disabilities compared to those without disabilities.

-Highlights:
  - Discrepancy and need for further education about importance of incorporating a person’s disability into the general visit protocol without losing sight of chief complaint.

  - Medical student education should include instruction on appropriate care of PWDs.
Article 5. **Objective Assessment and Structured Teaching of Disability Etiquette**


-Issue:
- The population of PWDs is one with a thinner margin of health than many others.
  - Training students to provide quality medical care to this often overlooked population is vital.
- The office of the surgeon general reported that PWDs experience significant health disparities.
  - They cited the lack of provider training as a major barrier to high-quality health care for this population.
  - identified the training of health care providers as a central solution
- Medical schools are increasingly adapting to teaching students about disability with the use of standardized patients (SPs).
  - Simulated patient:
    - term used by the creator of the first SP curriculum to refer to a well individual, who, following careful training and preparation, portrayed a patient with an illness based on an actual case
      - used the term standardized patient as an umbrella for both simulated patients and actual patients who have been carefully coached to present their own illnesses in a standardized and unvarying way
    - SP program used to teach clinical skills
    - SP program used to assess clinical competence
      - promotes perspective-taking, reflection, and self-assessment
      - facilitates teachable moments that can be controlled
- Some research suggests PWDs are the most credible source of information about living with a disability.
  - best for educating medical students about health care needs and the everyday realities of living with a disability
“Medical schools seeking to incorporate disability content into their curricula should seriously consider using SP programs. The rewards for everyone are substantial.” (1169)

Benefits for both SPs and medical students through this program:

- Authenticity and learning about disease when SPs are actually people with disabilities versus actors
- Gains in medical students understanding:
  - Prevalence of disability
  - PWDs are just like people without disabilities (have full lives, etc.)
  - How to effectively communicate
  - Dispelling common myths surrounding disability
  - ADA and how it affects this population

Paula M. Minihan, Ph.D., M.P.H.; Kenneth L. Robey, Ph.D.; Linda M. Long-Bellil, Ph.D., J.D.; Catherin L. Graham, M.E.B.M.E.; Joan Earle Hahn, Ph.D.; Laurie Woodward, M.D.; and Gary E. Eddey, M.D., on behalf of the Alliance for Disability in Health Care Education


-Problem:
  o Adults with disabilities face persistent barriers to obtaining quality primary care services; this undermines national efforts to improve the health status of this group.
  o A network of services and support in place to promote the health of children with disabilities is not available to adults with disabilities or their physicians.

-Purpose:
  o To explore desired educational outcomes of disability-related training to optimize primary care experience for PWDs.
    • used Bloom’s taxonomy which refers to a framework for understanding realms of educational outcomes based on cognitive (knowledge), affective (attitudes and values), and psychomotor (skills)
      • knowledge, attitude, and skills = generalist physicians should possess in order to care for patients with disabilities
  o Defined disability:
    • by incorporating the essence of the biomedical definition with the contemporary social model
      • Iezzoni’s definition: “difficulty in performing daily activities and fulfilling social roles because of physical, sensory, emotional, or cognitive impairment, often compounded by environmental barriers.” (1172)
        o “One’s definition of disability influences the knowledge, attitudes, and skills that are viewed as prerequisites for the optimal care of patients with disabilities.” (1172)
    • Factors influencing the health of patients with disabilities:
      • public policies, laws, regulations
      • community
      • organizations
      • interpersonal
      • patient with disability
  o Social definition of disability:
    • reflects a complex interplay between the individual and his or her social and physical environment
“Disability-related training is appropriate at all levels of health care education and practice.” (1175)

-Suggestion:
  o “Even residents and the most seasoned generalist physicians could benefit from exposure to the most basic information (knowledge), to positive interactions with persons who have disabilities (attitudes), and to the opportunities to become more proficient in their interactions (skills).” (1176)

-Ultimate Goal:
  o Influence behaviors of generalist physicians, particularly their post-training behaviors toward PWDs.
  o Provide training to increase their knowledge, broaden their attitudes, and enhance their skills in order to better support PWDs.
    • Integration of these into behaviors and practices that improve the health of PWDs is the essential and definitive outcome (regardless of measurable attainments in knowledge, attitudes, and skills).
Article 7. **Defining Disability in Health Care Education**

Linda M. Long-Bellil, Ph.D., J.D.; Darlene M. O’Connor, Ph.D.; Kenneth L. Robey, Ph.D.; Joan Earle Hahn, Ph.D.; Paula M. Minihan, Ph.D., M.P.H.; Catherin L. Graham, M.E.B.M.E.; and Suzanne C. Smeltzer, R.N., Ed.D., on behalf of the Alliance for Disability in Health Care Education


- **Problem:**
  - 2008 American Community Survey—approximately 36 million non-institutionalized people (12.1 percent of the total population) have one or more disabling conditions.
    - PWDs have poorer health than those without disabilities.
      - Many medical students still graduate having spent little or no time on curricula related to disability issues and even less time interacting with PWDs.
  - American’s with Disabilities Act Amendments Act of 2008
    - Imperative for health practitioners in the U.S. to understand legal responsibility for making reasonable modifications for PWDs is a part of the act.

- **Definition of disability in health care context:**
  - Focuses on extent to which a physical or mental impairment affects the overall functioning of an individual, or the likelihood that he or she will develop secondary medical conditions.
    - Educational content emphasizes role of the health professional in helping a PWD to maintain his or her maximum health and functioning.
      - Functioning can be compounded by, and thus also alleviated by, environmental conditions.
      - This also applies to social stigma.
-Problem:
  o Few medical schools or residencies formally address disability in their curricula.
  o Accreditation and licensing processes do not require that clinicians or institutions have even basic expertise around disability.
  o No established competencies or guidelines for U.S. medical training have been published.
    • Lack of medical training results in physicians being unprepared to provide care for PWDs and leads to health care disparities.
  o Secondary conditions are more often a determinant of PWDs health status than the disability itself; yet these often go unaddressed.
    • For example, medical, psychological, social, and financial concerns directly contribute to their disability (obesity, osteoporosis, depression, etc.).
    • Health care disparity between PWDs and those without has grown.
      • “U.S. Healthy People 2010” initiative set forth objectives aimed at promoting the health of PWDs and preventing secondary conditions.
  o Inadequate preparation of doctors is related to inadequate treatment of PWDs.
    • Few physicians have the clinical competence and comfort level required to treat PWDs.
      • Physicians report feeling ill-prepared to care for PWDs.
        o citing lack of knowledge and limited resources
      • Have negative perceptions about these patients, believing PWDs are:
        o medically and socially complex
        o time consuming
        o difficult to relate to
        o poorly insured
-Literature suggests training and increased familiarity with PWDs leads to favorable outcomes:
  o greater confidence, comfort, and willingness to provide care
  o The University of South Florida Health, Morsani College of Medicine (USF) addressed this widespread curricular deficit.
    • incorporated videos in the clerkship depicting:
      • viewpoints of PWDs
      • barriers to appropriate health care access
      • ways to overcome barriers
- PWDs as teachers have the greatest educational impact:
  - credible expertise about their own disabilities
  - dispel pernicious stereotypes of PWDs leading pathetic, sad lives
    - told students their stories
    - guided appropriate communication and examination techniques
  - not trained at the same level as a SP
- PWDs are thoroughly briefed by an educational coordinator about the program’s objectives, ensuring consistency among encounters.

-Module:
  - Students obtain a history and perform a brief exam on four patients.
    - Faculty members monitor the interaction through a real-time audio/video connection.
    - After the session, the model patients, caregivers, students, and faculty gather in a ‘learning circle.’
      - comment and reflect on the afternoon’s issues and experiences
  - Lectures provide an overview of how PWDs have historically encountered stigmatization and isolation.
    - Review:
      - current philosophies, including self-determination, person-centered planning, communication etiquette, and disparities in health and health care
  - USF medical students were evaluated at the end of the 12 weeks.
    - Final written exam included questions related to disability issues, such as etiquette and basic information from reading and discourse.

-Team-based approach to health care
  - Opportunities:
    - community-based activities
    - community site visits
    - service learning and home visits
    - interprofessionalism

-Evaluating the curriculum:
  - USF medical students demonstrate improved knowledge, attitudes, and comfort in caring for PWDS after completing a series of modules aimed at educating about disabilities.
    - positive outcomes leading to improved well-being and health care access for this underserved population
    - Culturally competent physicians understand, or are at least cognizant of, their patient’s cultures, beliefs, values, and sensitivities.
      - Cultural competence is necessary when caring for PWDs.
o Appreciate the patient’s functional status and address the associated secondary conditions, which may be medical, psychological, cognitive, social, or financial in nature.
  • understanding that the disability itself does not equate to poor health
  • Long-term tracking of students to gauge their ongoing professional involvement with PWDs
-Overall:
o Curriculum intervention
  • Identify competencies specific to disability education that are not intermittent, elective, or solely focused on specific disabilities.
  • Need to standardize efforts: differ in content, curriculum placement, and duration.
Implications of Disabilities Along the Health Care Continuum: Medical Students or Health Care Professionals with Disabilities


**Article 11.** Altchuler, S.L. (2009). Granting medical licensure, honoring the Americans with disabilities act, and protecting the public: can we do all three? *Academic Medicine, 84*(6), 689-691.


Article 9. *Learning Medicine with a Learning Disability: Reflections of a Survivor*

Dr. Weiner, assistant professor, departments of medicine and pediatrics, director of the combined residency in medicine-pediatrics, and Robert Wood Johnson Generalist Physician Faculty Scholar at the University of Illinois at Chicago


- Dr. Weiner described three useful tactics that worked for him while in medical school.
  - He outlined his suggestions for success for other students with learning disabilities in medical school:
    - find what learning and studying routines work best for disability
    - skip lectures in order to learn at own pace
    - avoid study groups and libraries that may be distracting
- Be open about special needs and disability, despite stigma and pride.
  - Accept one's self even if failure has occurred.
    - essential in an environment that challenged who he was and is today

- **Suggestion:**
  - “Medical students with learning problems seem to find solace in talking with a faculty member who speaks openly about struggling academically.” (709)
-Report compares MCAT examinees who received accommodations and their performance versus standard examinees.
  
  Admissions to medical school is contingent upon undergraduate GPA and MCAT scores.
  
  Students who do not meet predetermined criteria may be excluded from the pool of applicants, regardless of additional desirable application credentials.

-Accommodations that alter the conditions under which the MCAT is taken—scores are flagged with an asterisk*.
  
  Medical schools just see the flag, they do not receive:
  
  - reason for accommodation
  - nature of accommodation

-Some speculate students with learning disabilities (LDs) and/or ADHD are unlikely to survive academic rigors of medical school and the profession.
  
  Review of psychometric, legal, and social policy issues involved with testing PWDs can be found in Pitoniak and Royer. (361)
  
  - GRE, ACT, SAT, and GMAT discontinued use of flagging

-The AAMC is considering whether to continue flagging scores obtained when specific accommodations alter testing.
  
  Of 300,281 students from 1994 to 2000, 297,880 took the MCAT under standard conditions and 2,401 took the MCAT with accommodations*.
  
  *(There were 88 scores thrown out due to taking it one time and having accommodations, but then the most recent score was taken without accommodations.)
  
  In 866 cases, the most recent score was analyzed because it was with accommodations, and the first time the MCAT was taken was under standard conditions.

-Analyzed demographics, description of disability, and accommodations used by 2,401 that received accommodations over seven years:
  
  - 57% men and 47% women received accommodations
  - 11.7% of standard test takers were a part of underrepresented minorities
  - 11.9% were the flagged examinees
    
    - 1,320 (55%) have LDs
    - 409 (17%) have ADHD
-Accommodated examinees achieved higher mean scores than standard examinees on all sections of the MCAT (small, but statistically significant).
  - ADHD, LD, other, both LD & ADHD, and then standard (order of achievement level on MCAT from highest to lowest)
  - Total score of 866 “standard-accommodated” was a difference of almost 3.6 times greater than what would be expected for an examinee to take the MCAT “standard-standard.”

-Issue:
  - Higher mean MCAT scores reflect either appropriate compensation or overly generous accommodations.
    - Literature on extended time for course examinations for post secondary students reveals most students are able to raise their scores if given additional time.
      - However, students with LD make significantly greater gains than those without documented disabilities.
      - This study supports that literature.
  - Practical significance of difference between these means, viewed as admission criteria or predictor of success in medical school, may be negligible.
    - Scores flagged may indicate:
      - Accommodations compensated for their disabilities, which demonstrate that the student has slightly more academic ability than standard examinees as measured by the MCAT.
      - PWDS may be more adept at realistically assessing their educational experiences, abilities, and potential. Prospective examinees with disabilities on the lower end of the academic spectrum may opt out of pursuing a medical career at a higher rate than similarly qualified standard examinees.
        - would bring the mean for the standard examinees down
      - Extended time could have been overly generous, resulting in inflated scores.
        - Rather than defaulting to time-and-a-half and double-time, as is current practice, extended time could be calculated in a more precise and individually appropriate manner.
  - [Since time of article, practice has changed]
    - National testing agencies have been dealing with the controversy of whether or not to flag non-standard test administrations.

-Two remaining questions:
  - Are examinees with flagged scores admitted to medical schools at a rate comparable to examinees with standard scores?
  - Do examinees with flagged scores progress through medical school and into the medical profession as well as examinees with standard scores?
**Article 11.** *Granting Medical Licensure, Honoring the Americans with Disabilities Act, and Protecting the Public: Can We Do All Three?*

Steven I. Altchuler, Ph.D., M.D.


- **Issue:**
  - Physicians suffer from the same illnesses as others do, and some may limit ability to practice medicine safely.
  - State medical licensing boards may have asked questions prohibited by the Americans with Disabilities Act (ADA).
    - Ethical tension between:
      - non-malfeasance (protecting the public from harm)
      - individual autonomy (respecting the rights of each individual physician)
  - Medicine is a profession—a calling that requires specialized knowledge and lengthy training.
    - Pursuit of the learned art in the spirit of a public service is the primary purpose. (689)
      - traditionally self-regulating
      - dedicated to the service of others
  - Medical boards—the regulatory bodies of the state or territorial government—serve to protect the welfare of the citizens.
    - maintain the societal contract through the licensure process
    - power is derived from law—the Medical Practice Act
      - Practice of medicine is a privilege with unique rights and responsibilities.
      - Primary responsibility and obligation of the state medical board is to protect the public in interest of health, safety, and welfare.
      - Typically reactive agencies do not conduct proactive investigations.
        - respond to complaints about unprofessional, improper, incompetent, unlawful, fraudulent, and/or deceptive practice of medicine
  - **Illness and denial**
    - A physician in denial about their own mental health may not seek needed treatment or may fail to report limiting disabilities on licensure applications.
      - Data from board disciplinary records support that not all physicians who have illnesses preventing them to practice safely voluntarily refrain from practicing.
      - Some physicians continued to practice medicine, resulting in patients harmed.
    - In Minnesota—State Agency Health Professionals Services Program (HPSP)
      - Separate from the medical board and follows and treats health care professionals of all disciplines who have medical impairments (690)
        - Individual can self-report to HPSP; no information is passed on to licensing board
        - individual keeps their license intact
Advocacy groups rank boards listing them by percentage of doctors who suffered ‘serious disciplinary action.’ Boards that didn’t restrict enough licenses ranked lower and were labeled ‘worst states.’

However, medical boards are aware of the physician workforce shortages. They must ensure physicians who can practice safely are doing so and are licensed.

Stigma associated with many illnesses that may—or may not—limit one’s ability to practice medicine safely.

Paul Wellstone Mental Health and Addiction Equity Act was passed in 2008.

- Requires insurance plans to offer the same coverage for psychiatric illness as they do for all other illnesses
  - Concern about loss of licensure/privileges that could prevent physicians from seeking mental health care
    - Even when they recognize their need for it (690)

- Ethical tension—medical boards may have overstepped the legal bounds of the ADA by asking questions on the licensure application.
  - Non-malfeasance versus individual autonomy
    - Some illnesses do not impair physicians’ ability to practice safely.
      - These physicians may respect their limitations and have adaptations that allow them to practice in a safe manner.
    - These physicians expect, and the ADA requires, that they not be subjected to undue hindrance in being able to practice safely.
      - Physicians have the right to obtain a license without being subjected to undue burden. (690)

- Medicine versus law: How can we help everyone win?
  - Avoid overstepping ADA bounds by making no inquiries about health and only responding to complaints.
    - Does not protect the public
  - Question physicians aggressively about health to uncover any potential red flags.
    - Does not respect rights of PWDs

- Collaboration/mediation—required for resolving tension between protecting the public and protecting the rights of PWDs.
  - Both sides need to acknowledge and respect that the other has legitimate concerns, needs, and interests.
    - Solutions must be found that allow boards to identify physicians with impairments that limit their ability to practice safely.
      - Must recognize some individual’s denial of limitations and may not want to report them
  - All sides need to believe their concerns are understood and appreciated; no one loses.
    - Find solutions better for all—the public, our patients, and our professions. (691)
Article 12. *Implications of the 2008 Amendments to the Americans with Disabilities Act for Medical Education*

W. Thomas Smith, PharM.D., J.D., and William L. Allen, M.Div., J.D.


-ADA: “affords anti-discrimination protection to persons who have a physical or mental impairment that substantially limits one or more major life activities.” (768)
  - Two major components:
    - whether one has a disability that qualifies for protection
    - if so, whether the accommodations requested are reasonable
      - unfortunately, terms left up to the courts to determine what they mean in a given case
        - Some persons were determined to not be sufficiently impaired to qualify for protection:
          - impairment not “substantially limiting”
          - impairment did not actually limit a “major life activity”

-Past:
  - Many students that challenged an institution’s denial of accommodations in a court of law were unsuccessful—determined not to qualify as legally disabled. (768)
    - ADA was enacted in 1990: employers, educational institutions, and other public entities have grappled with adapting to its requirements.
      - Some medical schools removed barriers and provided accommodations for PWDs pursuing professional medical education.
        - Other medical schools asserted accommodations for particular PWDs would “unreasonably alter the educational programs” and PWDs would not be able to meet the requirements of medical practice “rendering accommodations at the medical school level unreasonably impracticable.” (768)

-Focus on learning disabilities:
  - Educational institutions received majority of accommodation requests from people with LD and/or ADD/ADHD.
    - controversies around medical education/professional certification

-ADA Amendment Act (2008):
  - Addressed whether or not impairment is disability that qualifies for protection under the ADA.
    - Major life activities include: “caring for oneself, performing manual tasks, walking, seeing, speaking, breathing, learning, and working.” (769)
    - added to the list under ADAAA “thinking” and “concentrating” (769)
Wong vs. Regents of the University of California (2004)

- Diagnosed with a reading disability in elementary school. Learned how to compensate by spending extra time on reading assignments.
  - Graduated from college and graduate degree in biology.
    - Took MCAT four times (without accommodations) and was admitted to UC Davis School of Medicine.
  - Completed two years at medical school and passed required U.S. Medical Licensing Examination (USMLE) Step 1 without requesting accommodations.
    - Failed first clerkship during clinical rotations in year three, and withdrew from second clerkship.
    - After leave of absence, the university’s disability resource center diagnosed Wong with a learning impairment that limited his ability to process and communicate information and recommended that Wong receive extra time to prepare for his clerkships. (769)
    - Succeeded in several clerkships and got favorable evaluations
  - Requested similar reading period for his pediatrics rotations and was denied by clerkship director as “unreasonable, unfair, and contrary to the purpose of the curriculum.” (769)
    - Wong passed written and oral part of rotation; but ward performance was judged as unsatisfactory and he was dismissed from medical school.

- In 1999, Wong sued in federal district court claiming the university violated his rights under the ADA.
  - University dismissed Wong’s claim without a trial:
    - accommodations sought were unreasonable
    - was not ‘otherwise qualified’ to continue because he could not perform the tasks he would need to perform as a physician (770)
  - UC Davis did not challenge the legitimacy of Wong’s disability nor argue his disability should not qualify under the ADA as a protected disability.
    - Wong was able to learn and work “with greater facility than the average person.” He didn’t have protected disability under ADA.
      - Therefore, he did not have to justify the claim that the accommodations he requested were unreasonable.
        - Disabilities had to substantially limit ‘most’ people; not simply that a particular individual (like a medical student) may find limiting.
  - Ninth Circuit—given the academic success he achieved in the past without accommodations, he was just as able to learn as most people. (770)

-Analysis under ADAAA:
  - Plaintiffs will no longer have to prove the conditions that substantially limit their abilities to perform major life activities.
    - Courts can no longer take into account mitigating measures PWDs use to assist in performing such activities.
o Shift from whether or not the plaintiff has a qualifying disability to whether the student's request for accommodations are reasonable.

-Wong's case:
  o He was provided accommodations for earlier clerkships and passed those.
    - Why were the accommodations for the pediatric rotation denied?
      - "The changes resulting from the ADAAA are likely to compel institutions to define more carefully what is essential to education for the professional practice of medicine in order to justify the denial of requests that go beyond the scope of reasonable accommodations." (770)

  o Substantially limited in performing a major life activity, "an individual must have an impairment that prevents or severely restricts the individual from doing activities that are of central importance to most people's daily lives." (769)
    - Survey from 1992-2006—American Bar Association's commission on mental and physical disability law:
      - Employee plaintiffs suing their employers in federal court for disability discrimination have prevailed less than five percent of the time.
      - Undergraduate, graduate, and professional students who brought suit under the ADA for denied accommodations also lost.
        o Students unsuccessful because the courts claim that "they could read at an 'average' level, were attending a professional school, and did not have a condition that 'substantially' limited a 'major life activity.'" (769)

-Implications for medical educators:
  o Medical schools should base decisions on reliable diagnoses of disabilities by appropriately accredited and experienced professionals who are qualified to make such diagnoses. They should:
    - not be employed by institution
    - know "the competencies required for both classroom and clinical medical education” (771)
  o "Under the ADAAA, we expect courts to look unfavorably on medical schools that summarily reject students' claims of disability, and favorably on those schools that carefully and extensively consider each student's claim and consult with outside experts when necessary." (771)
  o Analyze given accommodations so do not compromise:
    - patient well-being
    - educational mission of the institutions
    - essential functions of the profession and its social contract

-ADAAA caused a shift from whether a student has a qualifying disability to whether requested accommodations are reasonable.
  o Congresses intent:
    - Remove barriers that unnecessarily prevent PWDs from full participation in educational and professional opportunities.
      - "Inconsistency and apparent incoherence of accommodations allowed as reasonable in
some clerkships, yet unreasonable in another, is problematic.” (771)

- Need collaborative reflection and consensus building for consistency to demonstrate “across the curriculum the plausibility of allowing accommodations without unreasonable altering the educational mission of the institution.” (771)

-The effect of ADAAA on Jenkins vs. National Board of Medical Examiners (2009)

- A third year medical student with a reading disorder sought additional time on USMLE Step 1.
  - denied by National Board of Medical Examiners (NBME)
  - filed disability claim under ADA in federal district court
- However, reading under time pressure did not “substantially limit meaningful tasks central to most people’s daily lives.”
  - Jenkins appealed to the district court’s decision in the U.S. Court of Appeals for the Sixth Circuit.
- ADAAA came into legal effect and led Sixth Circuit to overrule the district court’s decision.
  - Even if student’s disability qualifies for protection under ADAAA—it does not mean student will receive accommodations requested. (771)
  - “Determination of accommodations is not dictated by the accommodations that the student has received in the past, nor previous definition of disability.” (771)
  - NBME’s responsibility (private entity) provides licensure examinations and complies with federal mandate—offer examinations “in a place and manner accessible to persons with disabilities, or be made accessible through alternative means.” (771)
  - challenge of balancing a student’s need for accommodation versus. the need to maintain integrity of higher education and licensing exams

-Concluding points:
- Title III of the ADA states:
  - “Accommodations not required if they fundamentally alter the measurement of the skills or knowledge that the examination is intended to test or would result in an undue burden.” (772)
- Expansion of the term “major life activities” includes reading, concentrating, and thinking.
  - stigma associated with having a mental impairment/LD—many people not willing to self-identify
- NBME and other national standardized examining groups still think that accommodations, like extra time for PWDs, undermine comparability of scores and reliability of the meaning of the results for institutions that rely on scores for measuring individual achievement, competency, or aptitude.
- “Advocates of extra time for persons with learning disabilities contend that only with such accommodations are the results truly comparable.” (772)
  - “Only then are persons with learning disabilities on a level playing field with those who do not have learning disabilities.” (772)
Article 13. *Balancing Responsibility to Patients and Responsibility to Aspiring Physicians with Disabilities*

Donald E. Melnick, M.D.


*In response to article outlined above: Smith WT, Allen WL

-Problem:
  o The overriding goal of medical education and licensure is to produce qualified physicians that possess knowledge and skills to be entrusted with the health and well-being of other individuals.
  o There are potential implications of the ADAAA for medical schools in their admissions processes, accommodations provided, and assessing skills and qualifications of students.
    • The medical profession (including academic institutions) should focus more on appropriateness of accommodations versus procedural issues of ADA eligibility and the subsequent passage in ADAAA.

-In 1990 the ADA took effect. Since then little progress in reaching consensus on minimum essential physical and cognitive requirements of being a physician that cannot be compromised without fundamentally threatening patient well-being, institutions’ educational mission, and the profession’s social contract. (674)
  o refocus efforts on deciding when accommodations are warranted where there is a shared goal of “producing skilled individuals who can deliver safe and effective health care” (674)
    • The profession of medicine has obligation to guide aspiring physicians into the profession—leads to support of people with disabilities.
      • There are many PWDs who can contribute significantly to the medical profession.
      • “Individuals with disabilities who successfully navigate the rigors of medical education and licensure may well have a deeper understanding of and compassion for the needs of certain patients.” (675)
  o State medical licensing authorities feel inherent tension that ADA challenges medicine and its educational establishments:
    • Professional culture demands providing an effective learning environment for all students.
    • Values encourage supporting aspiring PWDs to pursue careers in medicine.
      o but must not “compromise patient well-being, the educational mission of our institutions, or the essential functions of the profession and its social contract” (675)

-Equity for those not receiving accommodations
  o Intended to give individuals with disabilities an equal opportunity; not superior.
    • Modifications in policies, practices, or procedures—including academic requirements in post secondary education—need not be made if they would “fundamentally alter the nature of
the goods, services, facilities, advantages, or accommodations involved.” (675)

- The profession has a responsibility, not often evident in court cases related to the ADA, to place the interests of patients above the interests of the aspiring student.” (675)

- Accommodating disabilities without fundamental alteration of education or assessment
  - Medical profession has done little to develop a consensus on what constitutes ‘fundamental alterations’ in the preparation and assessment of a physician.
  - The Liaison Committee on Medical Education (LCME) requires that each medical school formally articulate technical standards for the admission of applicants with disabilities.

-Opportunities:
  - no similar standards for graduate medical education
  - no national consensus among state licensing authorities “regarding essential physical and cognitive capabilities for physicians, even if a minimum set of defined capabilities exist” (675)
    - little progress made in accumulating evidence to document whether specific accommodation does or does not represent a fundamental alteration
    - Current educational model requires each physician to demonstrate a minimum proficiency in the undifferentiated practice of medicine.
  - What are the requisite physical and cognitive abilities? Do they include the following:
    - adequate hearing
    - motor and sensory facility
    - ability to interpret visual imagery/color
    - ability to make decisions under time pressure in a chaotic environment (attention/concentration)
    - ability to gather information accurately from and convey information to and about patients

- “We might reach a consensus that an undifferentiated physician should be able to perform all of these core functions and that accommodations that circumvent their performance in education or assessment represent fundamental alterations.” (675)
  - However, it’s easy to envision specific physician practice roles where these abilities would be irrelevant.
    - Therefore: “If we agreed that limited practice might be warranted for individuals with certain disabilities, we would still need to define the requisite capabilities for each domain of authorized practice.” (675)
      - If we allow “accommodations for these core abilities, will patients be placed at risk when receiving care during the generalized graduate medical education experience?” (675)

- Hosterman and colleagues provide an overview of a rich set of tools for providing accommodations in the medical education environment.
  - MCAT, USMLE, specialty certifying exams have sought ways to accommodate that:
    - do not fundamentally alter
    - provide misleading scores
• create inequities for people with disabilities
  o *Why does the AAMC still flag MCAT scores for students with the accommodation of extra time?

- Conclusions:
  o “Engage in a national dialogue and research endeavor to determine when we can agree on an evidence-based model of essential abilities for medical practice.” (676)
  • Seek to support individuals with disabilities; but not by fundamentally altering ability to teach and assess the essential abilities.
  • Research—ensure that accommodations are leveling the playing field.
    • versus providing unwarranted advantage or licensing people not fully capable of delivering safe health care
  o “Disabled individuals with the skills and abilities to deliver safe and effective health care should be actively supported at every stage of the educational continuum.” (676)
  o “More should be done to increase the number of qualified individuals with disabilities in the ranks of the profession.” (676)
    • make steps towards eliminating health equity gaps

Joel DeLisa, M.D., M.S., Robert Silverstein, J.D., and Peter Thomas, J.D.


*In response to article outlined above: Smith WT, Allen WL

- Colleges that attempted to avoid or minimize compliance with the ADA by focusing on whether an individual achieved sufficient disability status to be protected by the law will need to pay closer attention to the development and implementation of nondiscrimination policies, particularly policies relating to reasonable accommodations and academic modifications/adjustments.” (677)

-Policy implications of the ADAAA on colleges of medicine and the NBME

- should focus on undertaking comprehensive, evidence-based review
- aggressive implementation of policies, practice, and procedures
  - Facilitate equal and effective educational opportunity for PWDs.
  - programmatic accessibility
  - reasonable accommodations
  - academic modifications and adjustments

-ADA = civil rights law, signed by George H.W. Bush in 1990

- “Clear and comprehensive national mandate to eliminate disability-based discrimination”(677)

-Primary focus:
  - “issuance and implementation of policies, practices, and procedures by covered entities, including colleges of medicine that facilitated equal opportunity (nondiscrimination) for qualified individuals with disabilities” (677)
  - “physical and program accessibility and reasonable accommodations and academic modifications and adjustments” (679)
  - intended to protect anyone who was discriminated against on the basis of disability
    - current physical or mental impairment that substantially limited a major life activity
    - not a current impairment, but record or history of one
    - not a current impairment, but regarded (adversely treated) as having such an impairment (actual or perceived)

- Three core components:
  - “Discrimination includes the failure to treat each individual on a case-by-case basis based on facts and objective evidence.” (677)
    - Treatment cannot be based on fear, ignorance, prejudice, stereotypes, labels, or pernicious mythologies.
• “Discrimination includes the failure to provide individuals with disabilities opportunities that are as genuine, effective, and meaningful as those provided to others.” (677-678)
  - Colleges must make programs physically and programmatically accessible; provide reasonable accommodations and academic modifications for PWDs.

• “Discrimination includes the college’s failure to administer its programs for individuals with disabilities in the most integrated setting appropriate to meet the needs of the individual students.”(678)

-The question of impairment qualifying as disabled under ADA was not supposed to have extensive analysis or result in undue focus.
  - Smith and Allen pointed out in their article that people were considered “not disabled enough” to warrant protection under the ADA by the courts and were denied a trial.
  - The Supreme Court interpreted the ADA strictly to set standard to qualify for protection; but distracted attention from the mission of the ADA.

  - Supreme Court decisions caused catch-22:
    - individual not allowed to participate in covered entity because too disabled
    - At the same time, this individual could be “not disabled enough” to qualify for protection under the law.
    - significantly diminished the civil rights protections under the ADA intended by Congress

-The ADAAA restores the original intent of the ADA by:
  - reinstating the intended broad scope of protection
  - shifting focus from threshold issue of disability to the primary issue of developing and implementing nondiscriminatory policies, practices, and procedures
  - directing courts and administrative agencies to interpret the term ‘disability’ in favor of broad coverage and determining whether an impairment “substantially limits a major life activity” without regard to the ameliorative effects of mitigating measures
  - medication, medical supplies, learned behavior, or adoptive neurological modifications
  - “rejects the interpretation by the courts that an individual must have an impairment that prevents or severely restricts the individual from performing multiple activities from this list and specifies that an impairment that substantially limits one major life activity need not limit other major life activities to be considered a disability”(678)

-Higher education community concerned that refocus could be construed as Congress changing its policy regarding reasonable accommodations and academic modifications.
  - “Construction clause”:
    - Nothing in the ADAAA alters the provision specifying that reasonable modifications in policies, practices, or procedures shall be required “unless an entity can demonstrate that making such modifications…including academic requirements in post secondary education would fundamentally alter the nature of the goods, services, facilities, privileges, advantages, or accommodations involved.”

-Medical educators must refocus their attention on reasonable accommodation policies.
  - Compliance is often left to admissions committees with limited attention from curriculum committees and clerkship directors.
• Collaborative reflection and consensus building across academic “fiefdoms” should result in greater consistency.

• Allow for more “imaginative” means of achieving competencies for students with disabilities.

- Significant message of the ADAAA is that colleges of medicine and the NBME must refocus attention on the implementation of comprehensive, evidence-based nondiscrimination policies, practices, and procedures applicable to qualified persons with physical, sensory, and mental disabilities (not only individuals with specific learning disabilities).

  o “The particular focus should be on policies related to physical and program accessibility and reasonable accommodations and academic modifications and adjustments.” (679)
Article 15. *The Career Trajectories of Health Care Professionals Practicing with Permanent Disabilities*

Leslie Neal-Boylan, Ph.D., APRN; Amy Hopkins, M.D., Ph.D., M.P.H.; Rachel Skeete, M.D., M.H.S.; Sarah B. Hartmann; Lisa I. Iezzoni, M.D., M.Sc.; and Marcella Nunez-Smith, M.D., M.H.S.


**Problem:**
- Several missed opportunities for supporting health care professionals with disabilities.
- The workplace needs to be welcoming for all individuals, including PWDs.
  - reasonable accommodations is still not clearly defined
- This article explored the experiences and perceptions of nurses and physicians with self-identified disabilities.
  - intended to inform discourse on policies supporting a diverse health care workforce on the local and national levels
  - In 2008, 19 percent of the general adult population in U.S. reported having a disability.
    - How can we best support health care professionals with self-identified disabilities and ensure patient safety is a top priority? (172)
    - Defined disability:
      - “an alteration in an individual's capacity to meet occupational demands because of a chronic condition associated with a functional limitation.” (172)
- Study consisted of qualitative interviews of 10 nurses and 10 physicians—represented a spectrum of self-identified disabilities/chronic conditions.
  - Interviewees also represented a range of geographical locations, ages (from 30-80), racial/ethnic self-identifications, clinical work settings, and health care professional roles.
    - balance of gender (in total 11 females and nine males) and time of diagnosis (pre or post the participants' professional training)
    - disabilities/chronic conditions reported by participants included:
      - “sensory impairments, progressive degenerative neuromuscular conditions, chronic cardiopulmonary or cerebrovascular diseases, and pain syndromes” (173)
- Five common themes consistent among the participants:
  - Living and working with a physical/sensory disability narrows career choices and trajectories of health care professionals.
  - Making job choices and career transitions in response to how they were treated or anticipated they would be treated due to disability. (173)
    - If a diagnosis was known prior to medical education, “the process of selecting a specialty was consciously influenced by his or her diagnosis.” (173)
    - Frequent change of setting, specialty, or job because they felt they were unable to continue in current position or were encouraged by others to leave.
• “Participants consistently expressed being held to a different standard than their peers and often felt pressured to prove themselves capable of their jobs.” (173-174)
  o “Participants often felt colleagues were skeptical of their sometimes nontraditional approach to work tasks.” (174)

• Physicians discontinued “doing procedures despite never having had adverse complications or patient complaints.” (174)

o Nurses and physicians struggle with decisions regarding whether to disclose and discuss their disabilities at work.
  • “Whether the disability was visible or non-visible, participants worried that colleagues held preconceived notions associated with specific diagnoses that were skewed because of their own experiences caring for patients with the same diagnoses.” (175)
  • “Participants were worried that colleagues would either think they were more disabled or functional than they were on the basis of their own clinical experience and expertise.” (175)

  • Reasons for hiding disability:
    o fear of not being hired
    o fear that patients, peers, and supervisors would treat them differently

  • “Interestingly, participants were more comfortable disclosing their diagnoses to patients than to supervisors and colleagues.” (175)

  • ‘passing for normal’ if disability is non-visible
    o eagerness to raise awareness regarding disabilities in an effort to limit misconceptions and discrimination

o Rarely sought recourse from their institutions or outside agencies for accommodations—instead viewing patient safety as a personal responsibility.
  • overcompensated with extra training or make themselves more marketable
  • found ways to control the pain that was preventing them from doing task
  • developed creative solutions and avoided certain situations to hide disability
    • or dealt with a less-than-ideal work environment
      o worried they would be seen as ‘trouble makers’ at work if they requested accommodations, which contradicted the desire to be perceived as an ‘ideal’ worker (175)

-Feelings of stigma associated with disabilities:
  o Interpersonal interactions often reflect the institutional climate and set the tone for how welcome nurses and physicians feel at work.
    • Influence of administrations and supervisors significantly affected participant’s view of work environments.
    • Culture of organization reflected in the attitudes and behaviors of supervisors and peers was critical for success or failure at work. (175)

o Reactions to workplace disability-related challenges run an emotional spectrum from anger and grief to resilience and optimism.
• “There’s something about a physician dealing with a physical impairment, physical disabilities—they are supposed to be perfect.” (176)
  • Participants tried to maintain their own self-confidence, despite feeling undervalued by others. (176)
  • Participants often felt forgotten or invisible within their professions. (176)

-Overall:
  o feelings of “being treated as less than fully competent” because of diagnoses (176)
    • negative and isolating experiences (176)
  o also had feelings of resilience—“experienced the struggles of ‘proving’ their competence despite their disabilities” (176)
  o Researchers surprised—“participants seemed either unaware of the legal protections in the workplace for employees with disabilities or fearful of pursuing this option” (176)

-OppORTunities:
  o Institutions and health care organizations can create a more welcoming atmosphere and supportive environment by:
    • promoting the retention of qualified and needed physicians and nurses
    • demonstrating to patients and the community-at-large that PWDs are a diverse group valued by the organization for the important contributions that they make
    • valuing and highlighting the critical perspectives that they bring (176)
    • offering necessary accommodations for PWDs that do not require major structural changes to the health profession work setting
      • adjusting shift schedules and creative solutions to conducting procedures that can be reviewed and implemented
    • raising awareness widely needed
    • formal and informal training of staff = important first step (177)
      • making “steps toward recognizing that health care professionals with disabilities contribute critical thinking skills and intellectual ability” (177)
      • support networks for health care professionals to help with navigating “isolation at work and invisibility within the profession” (177)
  o Findings suggest that health care organizations and professional schools need to “play a proactive role in educating all health care professionals both those with and those without self-identified disabilities, regarding ADA mandates in addition to establishing procedures for requesting accommodations while preserving privacy and confidentiality.” (177)
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