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CONCEPT PAPER

Making emergency medicine accessible for all: The what, why, and how of providing accommodations for learners and physicians with disabilities

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Abstract

Individuals with disabilities comprise a substantial portion of the U.S. population but make up only a small subset of medical students and health care providers. Both the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education have called for increased diversity in the physician workforce, to more closely represent the U.S. patient population and provide culturally effective care. Yet the barriers to disclosure and inclusion for individuals with disabilities in health care are significant, including attitudinal barriers such as stigma and bias, organizational barriers in policies and procedures, and environmental barriers such as resources and physical space. Lack of experience providing accommodations and a lack of knowledge of both what is legally required and what is possible also prevent programs from creating access. Realizing inclusion for individuals with disabilities in a diverse workforce requires emergency medicine programs to be proactive and deliberate in their approach to recruiting, accommodating, and retaining students, residents, and faculty with disabilities. Such efforts are likely to provide benefits that extend beyond those who receive the accommodations.

INTRODUCTION

Individuals with disabilities comprise 25% of the U.S. population[1] and 19% of undergraduate students in the United States,[2] yet they represent only 4.6% of medical students[3,4] and 3% of practicing physicians.[5] A survey of emergency medicine (EM) program directors in 2019 found a prevalence of disabilities in EM residents of 4.06%,[6] with 26% of programs reporting currently having a resident with a disability and 13% of programs reporting currently having a faculty member with a disability. This constitutes an increase from the only prior study of prevalence in EM residents, a 2002 program director survey that found a prevalence of 1.3%.[7] Potential reasons for this increase include a more inclusive definition of disability and increasing recognition of the importance of diversity and inclusion in providing culturally appropriate and equitable care.[8,9] Despite modest improvements in the number of medical providers with disabilities, the percentage of those with disabilities in medicine still fails to mirror the population we serve due to barriers related to inclusion and disclosure. Those barriers include attitudinal barriers, such as stigma and bias, but also structural barriers in the mechanisms by which students or trainees may request accommodations.[10-12] This is evident when comparing medical students' self-reported rate of disability from an anonymous graduation survey (7.6%)[13] to the rate of students' disclosures to their schools (4.6%).[3] It is possible that some students with disabilities make the decision not to notify

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their schools because they feel their learning environment is already providing an adequate degree of support for their needs. Even with endorsement of a diverse physician workforce to foster culturally effective care by governing educational bodies (Association of American Medical Colleges [AAMC] and Accreditation Council for Graduate Medical Education [ACGME]), the barriers to disclosure, access, and inclusion are substantial.[14-16]

Adults with disabilities constitute an often unrecognized health disparity population that experiences substantial organizational, attitudinal, and socioeconomic barriers to health care.[17] Inclusion of individuals with disabilities within our health care workforce has the potential to reduce the health disparities experienced by our patients by combating barriers and creating more accessible and inclusive environments.[18] Studies suggest that the experiences of medical students and physicians with disabilities may lead to greater empathy for their patients.[19] Patients with disabilities may feel more comfortable when they have doctors who can better understand their experience and may be more likely to discuss their health issues and/or limitations without the pressure to explain.[18]

The benefits of inclusion reach beyond the clinical realm and into the education setting and the community. A well-reported phenomenon, the "curb-cut effect,"[20] is likely to apply to health professions education in currently unknown ways. In response to the Americans with Disabilities Act (ADA), equitable access to sidewalks, buildings, and public places was required. This led to the cutting of curbs and construction of gently sloped ramps to facilitate the independent mobility of those in wheelchairs. Soon others who were not the targets of the law benefited from this accommodation, such as parents pushing strollers, travelers wheeling luggage, or sporting travelers on bicycles or skateboards.[21]

In didactic or clinical educational spaces, diversity and inclusion in medical student education has demonstrated potential benefits for all students in the class, even those who identify with the majority group, when compared to a similarly matched cohort without representation.[22] For example, White students whose schools ranked in the top quintile for achieving diversity metrics indicated an increased perceived ability and intention to care for a more diverse patient population compared to those whose schools were in the lowest quintile.[23] Additionally, the presence of individuals who have diverse characteristics yields increased representation from underrepresented groups.[24] An example of the "curb-cut effect" in the classroom setting would be the addition of open captioning during didactic sessions aimed at a person with a significant hearing loss. Others in the audience may benefit, particularly those whose hearing is diminishing due to age, those whose first language is different than the language of the presentation, and those who prefer visual learning or find themselves in an area with significant background noise. In EM, the 2019 program director survey found that the presence of faculty or residents with disabilities was associated with a greater number of hours dedicated to education on caring for patients with disabilities, overall greater confidence in providing accommodations for learners and trainees with disabilities, and longer term attitudinal and environmental changes.[6]

METHODOLOGY

On behalf of the Academy for Diversity and Inclusion in Emergency Medicine (ADIEM) Accommodations Committee of the Society for Academic Emergency Medicine (SAEM), we developed a didactic session for the general membership for the SAEM21 annual meeting. Our goal was to provide educators, administrative leaders, academic faculty, and learners with an up-to-date overview of best practices for creating an inclusive environment, including reviewing applicable disability laws and organizational obligations, particularly those that relate to education and the workplace, and discussing strategies to facilitate recruitment and retention of students, trainees, and faculty with disabilities in the academic setting.

The authorship team consists of four faculty with expertise, leadership, and advocacy experience surrounding individuals with disabilities at the departmental, institutional, and national levels. We performed a comprehensive literature search using PubMed, Google Scholar, and Congress.gov[25] to inform a comprehensive appraisal of existing laws, barriers to inclusion, and current best practices surrounding the approach of individuals and institutions in accommodating those with disabilities in the settings of the health care workplace and training environment. Each of the four authors researched a unique component of this work and presented it to the group for input, critique, and real-time group editing for the didactic. A similar process was followed for this article, with all authors providing critical review. In addition to the informational component that was conceived by the authorship team, we invited panelists (with life experience and/or professional experience with accommodations) to answer questions related to real-world examples of their experiences surrounding disability accommodations practices in the medical workplace during the live didactic session. We have incorporated their points of view in this work when appropriate. This work did not involve human subjects and, thus, was not presented to an institutional review board.

POLICIES AND STANDARDS

To better understand the next steps for EM education and training programs, it is critical that programs have a clear background in the legal obligations, policies and procedures that impact inclusion for individuals with disabilities. These include institutional policies developed in consultation with the ADA, technical standards for admission to medical school, and competency-based assessments of performance during education, training, and practice.

ADA

The legislation that most impacts accommodations for individuals with disabilities are section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities (and its Amendments) Act (ADA; 1990 and 2008). Both the AAMC and the ACGME defer to individual

institutions to create policies in line with these. In 2019, the ACGME updated the common core requirements for graduate medical education (GME) programs to include a new provision, "The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents." A key point related to accommodations is noted in IV.H.4: "The Sponsoring Institution must have a policy, not necessarily GME-specific, regarding accommodations for disabilities consistent with all applicable laws and regulations."[26]

The ADA defines disability as "a physical or mental impairment that substantially limits one or more of the major life activities of the individual"[27] (see Table 1). Section 504 and the ADA protect otherwise qualified individuals from discrimination on the basis of disability. For an applicant or employee to have this protected legal status, they must meet the criteria as defined by the ADA: having a disability or a record of disability or be regarded as having a disability.[29] Having a record of a disability, such as proof of having received accommodations in prior educational or work settings, can be used as evidence of requiring current accommodations, although it does not guarantee the granting of accommodations that are sought in the new setting. There are some rules at every stage of the interactive process: an employer is not allowed to ask if a person is disabled or ask about the nature or severity of the disability, but the employer can ask if a person can perform the duties of the job with or without reasonable accommodation.[29] If an accommodation is needed, the disabled individual generally has the responsibility for disclosing that need during the application process or at the onset of the disability. It is the disabled person's responsibility to initiate the interactive process and the employers' responsibility to engage in that interactive process and make determinations in line with legal guidance. If the employer has no knowledge of the employee's disability, and the person is unable to perform their job, then termination or discipline based on the employee's misconduct or poor work may proceed according to the place of employment's due process and is not typically held to violate the ADA.

What does it mean to be "otherwise qualified?" To be otherwise qualified one must have "the requisite skill, experience, education and other job-related requirements of the … position" such that "with or without reasonable accommodation, one can perform the essential functions" of the job. The employee must not pose a direct threat in the workplace. As an example, if an employee's condition is remedied by medication that eliminates his potential harm to himself or to others in the workplace, he cannot be considered a threat. Conversely, if an employee's medication causes somnolence or other side effects such that his ability to perform the job safely is impaired, then he may be said to pose a direct threat.[30]

The ADA also places the onus upon the employer to provide reasonable accommodations. The employer is entitled to request supporting documentation that conceptualizes the best ways to overcome the worker's limitations, and barring undue hardship, the employer must engage in good faith in an interactive process with the employee to identify reasonable accommodations. Possible suggested accommodations are, but not limited to, time off, modified work schedules, room modifications, increased supervision and guidance, provision of a job coach, and job restructuring.[31] In interpreting this, it is important to understand that the employer is not obligated to restructure essential job functions or transfer major job responsibilities to a different worker.

TABLE 1 The Americans with Disabilities Act (ADA)

The ADA defines disability as
A. A physical or mental impairment that substantially limits one or more of the major life activities of [the] individual;
B. A record of such an impairment; or
C. Being regarded as having such an impairment.[27]
To recover on a claim of discrimination under the Act, a plaintiff must show that:
1. They are an individual with a disability;
2. They are "otherwise qualified" to perform the job requirements, with or without reasonable accommodation; and
3. They were discharged solely by reason of their disability.[28]

Technical standards and competency-based assessments

Admission to undergraduate and graduate medical programs is based on a combination of academic achievement, qualifying board scores, extracurricular experiences, interview skills, and the ability to meet certain technical standards. Traditionally, the AAMC has defined technical standards as the minimum physical and mental (nonacademic abilities) standards required for admission to, retention in, and graduation from an academic program or to function as a physician (see Table 2).[32-34] The AAMC leaves the definition of these technical standards up to the school. The AAMC, in compliance with Section 504 of the Rehabilitation Act of 1973, has also prohibited discrimination against those with disabilities but fails to provide specifics as to what a school should provide to accommodate learners with disabilities.[35]

Residency programs are required by the ACGME to adhere to strict evaluative measures when considering the developmental advancement of their trainees.[36] Technical standards and core competencies are often conflated and this can lead to exclusion of persons with disabilities from admission to a medical program.[37] For example, clear communication is often listed as a technical standard for admission; however, communication with patients is actually a skill that is developed during a medical training program. As a standard, this may deter a Deaf or hard-of-hearing person, or someone with another communication-based disability, from applying to a program, but as a competency or professional activity, the Deaf person has the opportunity to develop communication with patients alongside his/her hearing counterpart, with or without accommodations.

In light of changing medical practice, team-based approaches to care, and programs' focus on measuring achievement, some schools have adopted functional technical standards, as opposed to the aforementioned (organic) technical standards, in an effort to focus

TABLE 2 Organic technical standards[32-34]

Observation	Using senses (hearing, vision, touch) to obtain information and assess a patient
Communication	Communicate in English to elicit information or detect changes in clinical status
Motor	Perform physical exam and diagnostic maneuvers and perform or guide emergency treatment
Intellectual/conceptual	Assimilate, synthesize, and disseminate complex medical information using problem solving skills, reasoning, and analysis
Behavioral and social	Possess the emotional health to demonstrate compassion and develop mature and sensitive relationships with patients
Ethics and professionalism	Understand and possess moral behavior to deliver care that is within the ethical and legal practices of medicine

TABLE 3 Functional technical standards[34,38]

Acquiring knowledge	Able to learn through a variety of modalities
Developing communication skills	Demonstrate interpersonal skills to evaluate patients verbal and non verbal communication; demonstrate effective and clear communication with a team and patients
Interpreting data	Able to assimilate, interpret, and understand complex medical information
Integration of information to establish clinical judgement	Able to perform physical exam and diagnostic maneuvers to form accurate and comprehensive assessments of patient health while adhering to appropriate safety standards and universal precautions
Developing professional attitudes and behaviors	Must exercise good judgment and be able to form mature, sensitive, and effective relationships with patients within the ethical and legal practices of medicine; must display compassion, integrity, and professionalism during patient interactions regardless of gender identity, race, sexual orientation, religion, disability, or any other protected status

on people's abilities and promote inclusivity. These standards, suggested by Reichgott in an AAMC meeting address in 1995, place an emphasis on what needs to be achieved and not how it is achieved (see Table 3)[34,38] In implementing these strategies, we choose to focus on the most inclusive ways for all to achieve a specific competency (or standard) instead of only thinking about traditional ways to meet these standards, which by default eliminates any new possibilities.

IMPLICATIONS/RECOMMENDATIONS

In creating a framework for promoting inclusion and providing appropriate accommodations, there is no single construct that can be applied to all; however, there are best practices that foster the proactive development of an accessible and inclusive environment. Meeks et al.[39] outline a clear plan for GME programs to promote inclusion, which can be adapted to create access and inclusion for students and faculty as well. Key components of this program include understanding institutional obligations and promoting the benefits of inclusion, as discussed above. Additionally, developing transparent processes and policies and identifying a knowledgeable disability expert to aid in the creation of accommodation processes are important.[39]

A crucial part of creating an inclusive environment for individuals with disabilities in EM is being proactive in practices related to disclosure and planning accommodations

Most EM program directors surveyed in 2019 reported offering accommodations and knowing the process for obtaining accommodations, yet 77% reported that they are not proactive in asking residents about whether they need accommodations.[6] When accommodations were provided, programs reported having greater confidence in providing accommodations for ADHD, learning disabilities, and chronic health conditions,[6] which suggests that the experience of providing accommodations improves confidence and comfort for future encounters.

Proactive preplanning demonstrates dedication to inclusion and allows for thoughtful and collaborative decision making while avoiding last-minute, reactionary decisions that may not provide the needed benefit and feel compulsory to all parties. Preplanning should be in collaboration with the individual requesting accommodations and experts in providing accommodations, such as your institution's accommodations office and/or disability expert. Additional resources may include experts by experience or someone who has already learned the successes and barriers—faculty, residents, or students. If an accommodations office does not exist in your institution, consider contacting national advocacy groups (e.g., ADIEM) and seek out professionals with the background that meets your needs. While in the planning phase, implement the principles of universal design in education by creating instructional goals, methods, materials, and assessments that work for all learners. For example, make closed captioning or recorded audio/visual lectures for watching at a later time available for all. This process also eliminates after-the-fact disability accommodations, emphasizes the importance of inclusion, and allows for maximal accessibility.[34] Proactively asking learners about a need for accommodations demonstrates a commitment to inclusion and promotes a safe environment where disclosure is not only possible but encouraged. Knowing about a disability or need for accommodation proactively enables programs to plan ahead.

Inclusive language regarding a program's commitment to disability as an aspect of diversity creates an environment of safety and support

This language as well as information on available accommodations should be explicitly demonstrated in all aspects of recruitment and training. This includes residency brochures, recruitment documents, and resident handbooks and on websites and social media.[39] For example, websites should comply with standards for color contrast for visually disabled applicants and forward-facing materials should contain multiple methods for establishing contact with the programs (e.g., phone, text, email). Other potential resources for programs are case studies that have been published on providing successful accommodations for students in the ED.[40,41] These real-world examples could serve as a starting point for enacting accommodations for students and residents in the future and may also help to demonstrate a program's commitment to equity and inclusion.

More research is needed to specifically understand the current experience of individuals with disabilities in EM, to eliminate barriers and foster a supportive environment. Current data suggest that medical students with disabilities may be discouraged from pursuing certain procedural or physically demanding specialties, such as EM, due to erroneous assumptions or beliefs regarding the student's abilities and/or the range of possible accommodations.[19] Given this, it is critical that EM as a specialty takes concrete steps to reduce stigma and promote access for individuals with disabilities in EM education and practice.

CONCLUSION

Creating access and reducing barriers for people with disabilities in EM is necessary to realize a diverse workforce that will benefit our health care community and our patients. Organizations such as the AAMC and ACGME require that programs have policies to facilitate accommodations, but much is left to individual entities to develop. An understanding of the ADA and other relevant policies and procedures, as well as the benefits of inclusion, are imperative for creating an equitable environment. Programs can promote inclusion of students, residents, and faculty with disabilities by being proactive and explicit in policies and procedures, including specifically asking about disability or need for accommodations, collaborative preplanning with universal education design strategies, and utilizing inclusive language. Implementing these best practices is a key step toward disability equity in EM.

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CONFLICTS OF INTEREST

The authors have no potential conflicts to disclose.

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