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Disability in Medicine: Inclusion and Mentorship

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Stanford MEDICINE | Teaching and Mentoring Academy | Stanford Medicine Alliance Disability Inclusion Equity | SOCIETY OF PHYSICIANS WITH DISABILITIES | MSDCI

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Agenda

Part 1: Didactic (30 min)

1. Introduction to disability as an underrepresented minority in medicine
2. Overview of the Disability in Medicine Mutual Mentorship Program (DM3P)
3. Accessibility best practices
4. Research findings of DM3P's impact on participants

Part 2: Group Discussion (30 min)

5. Breakout rooms for case-based discussions
6. Debrief in main room

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Learning Objectives

1. Define ableism and provide examples of its presence in medicine.
2. Explain importance of disability inclusion in policies that promote diversity across medical institutions.
3. Know and implement meaningful accessibility and disability inclusion practices in medical education, classrooms, laboratories, and clinics.

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Definitions: Disability

- Disability (ADA): having physical or mental **impairment** that substantially limits one or more **major life activity**
  - Impairment: can be *constant*, *episodic*, or in the *past*
  - Major life activity: eating, sleeping, speaking, learning, seeing, hearing, walking, self-care…

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Definitions: Disability and Ableism

- Disability (ADA): **Impairment + Limitation**

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Definitions: Disability and Ableism

- Disability (ADA): **Impairment + Limitation**
- Ableism: (Lewis 2022): A **system** of **assigning value** to people's **bodies** and **minds** based on societally constructed ideas of normalcy, productivity, desirability, intelligence, excellence and fitness.
  - Assumes superiority of "normal" minds/bodies
  - Intersectional - underlies other prejudices
  - *You do not have to be disabled to experience ableism*

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Disability Civil Rights Laws (United States)

Americans with Disabilities Act (ADA) and ADA Amendment Act (ADAAA):
- Prohibit discrimination based on disability in employment, public venues, transportation, etc.

Section 504 of the Rehabilitation Act of 1973:
- Prohibits discrimination based on disability by organizations with federal funding (including Stanford!)

Patient Protection and Affordable Care Act (ACA):
- Designates disability status as a demographic category.
- Mandates assessment of health disparities among persons with disability (PWD)
- Mandates accessible preventative screening equipment for PWDs

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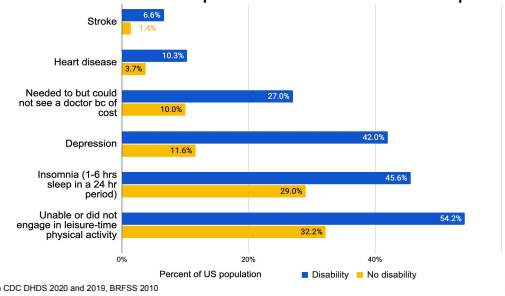
Disabled Patients Experience Healthcare Inequities



Data from CDC DHDS 2020 and 2019, BRFSS 2010

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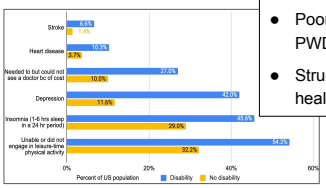
Disabled Patients Experience Healthcare Inequities



Why persistent inequity?

- Clinicians' ableist attitudes
- Poor physician training to treat PWDs
- Structural barriers to accessing healthcare

Data from CDC DHDS 2020 and 2019, BRFSS 2010, NIHS 2008, Iezzoni 2021, WHO World Report on Disability 2011, Iezzoni 2006, Lagu and Iezzoni 2014, Iezzoni 2022

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Medicine Needs More Disabled Clinicians To…

- Translate their lived experiences as patients into culturally competent care.
- Humanize PWDs to other doctors through interactions with colleagues.
- Encourage PWD patients' greater adherence to and satisfaction with care.

Sources: Iezzoni 2016, Meeks and Jain ed AAMC Report 2018, Traylor Schmittdiel et al 2010

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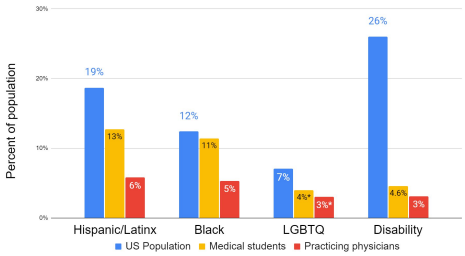
Disability is an Underrepresented Minority in Medicine



Data from 2020 census, 2021 AAMC enrollment data, 2021 State Physician Workforce Data Report, 2018 AAMC Workforce Study, 2022 Gallup, 2016 CDC Report, 2019 Meeks, Sweenor et. al., 2021 Nouri, Meeks et. al.

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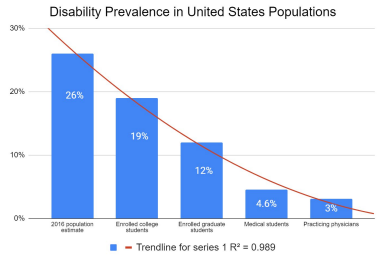
Disability is an Overlooked Underrepresented Minority in Medicine



Why the Attrition?

- Structural and attitudinal barriers against professional advancement
- Likely not attributable to age
- **Lack of disability-specific mentorship**

Data from CDC 2016, Postsecondary National Policy Institute 2022 Fact Sheet, Meeks ant Swenor et al 2019, Nouri and Meeks at al 2021

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Disability in Medicine Mutual Mentorship Program (DM3P)

- Virtual mentorship program for and by disabled clinicians and trainees
- 90 min. Zoom meetings (didactic component + discussion/Q&A)
- Unstructured social time for community building and networking
- Private Discord and LinkedIn groups for asynchronous mentorship
- Website containing resources from past events

***Mutual* mentorship:** participants assemble in groups to help each other navigate professional and personal life with a shared marginalized identity

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Accessibility Best Practices Used in DM3P

- Routinely asking participants what accommodations they need to fully participate
- Live captioning provided at all meetings
- Speaking slowly and clearly
- Introducing oneself with a short visual description
- Formatting emails for neurodivergent participants
- Centering cultural humility

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Supplemental Research Study

Mutual Mentorship Program for Persons with Disabilities in Medicine

Purpose and Design

Purpose: To understand the **impact** of a mutual mentorship program for persons with disabilities in medicine, by evaluating participants' **experiences**.

Design:
(1) Qualitative, one-on-one interviews with participants

(2) Quantitative survey examining domains including professional self-efficacy, sense of belonging, attrition ideation. (Analysis ongoing)

If we were to boil the findings down…

Ableism in the Medical Field

Feelings of belonging and support are necessary

Qualitative Study Findings (n = 18 participants)

1. **Apprehension to disclose disability status with institution**,
   " a culture of not being open"
   and
   very sensitive topic for lot people… you don't want to disclose"

2. **Barriers to disability accommodations**,
   ""...the existence of disabled people…was an afterthought. Their disability office was in an inaccessible building (laughs)"

Qualitative Study Findings (n = 18 participants)

3. **Culture in medicine is inherently ableist.**

   "...Like it's made up or (you are) choos(ing) to be lazy... There's still stigmatization even within our community…so that can… almost make it seem like there's lack of a competency as a physician because of their disability."

4. **Disability imposes limits on medical career.**

   "It became very difficult. I had to step down"

Qualitative Study Findings (n = 18 participants)

5. **Disability is intersectional.**

   "I also think that race and, gender and all these other things play a big factor….I don't think (these) can be fully ignored either."

6. **Multiple sources of support is important.**

   "...part of the reason why I picked this (MD) program other over other schools was because I knew the disability service would be a better ally to me during my time as a medical student than at other places, even if those other institutions had strengths, but I knew that it would be a huge, huge help to have someone who's on your side and advocating."

Qualitative Study Findings (n = 18 participants)

7. **Mentorship program has good diversity of participants.**

   "We get people there so many different stages of acceptance of their disability…We have people who have had disability for all their lives are well versed in the in their rights as a person with disability…and we have some people that have (recently) acquired a disability, and they're struggling with understanding and integrating themselves."

6. **Positive impact of program upon participants.**

   "...I feel greater belonging in medicine because of the mentorship program"

Case Discussions (Breakout Rooms)

Case 1: Rising M3 with health problems seeks guidance from academic advisor about how to approach clinical rotations.

Case 2: Clinical phase med student discusses accommodations with clerkship director.

Discussion Questions:

1. What is your opinion on how this interaction was handled?
2. Did you ever identify with either the trainee or the preceptor? If so, how?
3. Did any part of the conversation trigger discomfort in you? Which part, and why?

Captioner will be in breakout room #1

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Case #1

Kavita, a second-year medical student, has noticed a decline in her health over the past year. She has unintentionally lost 10% of her body weight and no longer has the stamina to keep up her usual study schedule. Her doctors have not yet given her a diagnosis but suspect an autoimmune disease. She is due to start her M3 year and clinical rotations, and she worries that she may have difficulty keeping up with the long hours and rapid pace. She seeks out her advising dean Dr. West for guidance. She hopes to learn strategies that other chronically ill medical students have used to excel in the clinic and whether any adjustments can be made to her schedule.

On hearing Kavita's story, Dr. West sympathizes with her predicament but states that no adjustments can be made to her education, as this would be unfair to her classmates. He suggests that if she has concerns about keeping up, she should consider taking a leave of absence and returning when she is healthy and whole. When Kavita explains that her condition may be chronic and that she may not ever be healthy in the traditional sense, Dr. West encourages her to leave the MD program. He concludes the meeting by scheduling a follow-up appointment to brainstorm alternative professions for Kavita.

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Case #2

Jamal, a third-year medical student, meets Dr. Brown, the internal medicine clerkship director, to discuss how his accommodations will be implemented when he takes the clerkship next month. His accommodations, as written by the disability resource professional from the office of accessible education, include (1) placement at Community Hospital as opposed to other clerkship sites, (2) one afternoon off a week for healthcare appointments, (3) written objectives and expectations for the rotation, broken down by the week, (4) weekly feedback delivered both orally and in writing by faculty preceptors, (5) permission to wear headphones while working on notes and case presentations, (6) a private room and 1.5X extra time on the shelf exam, and (7) wheelchair accessible assignments.

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Case #2, Continued

On reading the accommodations letter, Dr. Brown frowns and says, " I don't think this will work. You won't be able to keep up with the team on this rotation if you need to use a wheelchair."

"Actually," says Jamal, "my power wheelchair can travel faster than most people can run. I won't have a problem keeping up."

"Even so," Dr. Brown continues, "I don't understand your other accommodations. Why do you even need them?"

Jamal replies, "They will help me succeed on this rotation."

"But how?" Dr. Brown asks. "What diagnosis requires you to take one afternoon a week off?"

"If that's a problem, is there a way I can make the time up?" asks Jamal.

"It's best to be honest about these things, Jamal," says Dr. Brown. "I could help you much more effectively if you were transparent about your situation."

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Case #1 Take Home Lessons

Case 1 situation: Rising M3 with health problems seeks guidance from academic advisor about how to approach clinical rotations.

1. Recognize disclosure, even if your student does not use the word "disability." Disability can take many forms, including acute or chronic illness, and this discussion should trigger recognition that the Americans With Disabilities Act (ADA) applies.
2. Always direct students you suspect may have a disability to the Office of Accessible Education (OAE).
3. Accommodations are not special treatment. They provide an equitable training environment for students with disabilities.
4. While a leave of absence (LOA) may be appropriate for some students, it should not be the first and only solution for a struggling disabled trainee. Many students with a disability thrive in medical training with proper support, including adequate accommodations.
5. Disability does not preclude a medical trainee from being in medicine. Dismissal from the MD program should only be a last-resort solution.

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Case #2 Take Home Lessons

Case 2 Situation: Clinical phase med student discusses accommodations with clerkship director.

1. Refrain from assuming an accommodation precludes a student from your learning experience. Lack of information and biases may underlie such assumptions.
2. It is inappropriate to pressure trainees to disclose their health information. Period. Doing so is a violation of professional boundaries.
3. Accommodations never need justification. If an accommodation seems unreasonable, address questions to the accessibility office, i.e., the OAE.
4. Clerkship directors should help disseminate approved accommodations to preceptors. Students should not bear the burden of presenting accommodations to each and every supervisor.

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Disability Inclusion Resources

1. Stanford Medicine Alliance for Disability Inclusion and Equity (SMADIE): https://med.stanford.edu/smadie.html
2. Office of Accessible Education (OAE): https://oae.stanford.edu/
3. Disability in Medicine Mutual Mentorship Program (DM3P): http://disabilitymedmentors.org (website coming soon!)

Further Reading on Disability Inclusion in Medicine

- "Effect of Disability-Specific Education on Student Attitudes Toward People With Disabilities." (2021)
- "Beyond Technical Standards: A Competency-Based Framework for Access and Inclusion in Medical Education." (2021)
- "What Should We Teach about Disability? National Consensus on Disability Competencies for Health Care Education." (2020)
- "Emergency Medicine Resident Education on Caring for Patients With Disabilities: A Call to Action." (2020)
- "Perioperative Clerkship Design for Students with Physical Disabilities: A Model for Implementation." (2022)
- *Disability as Diversity: A Guidebook for Inclusion in Medicine, Nursing, and the Health Professions.*
- *Disability As Diversity: A Case Studies Companion Guide*
- *Access for Students with Disabilities: The Guide for Health Science and Professional Education. 2nd edition.*
- "Accessibility, Inclusion, and Action in Medical Education: Lived Experiences of Learners and Physicians With Disabilities." AAMC. 2018

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