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Dismantle Ableism, Accept Disability: Making the Case for Anti-Ableism in Medical Education

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ABSTRACT: There currently exists an exciting impetus for increased diversity among medical trainees and improved equity in medical care received by patients. Yet, inclusion of disability within these efforts is often forgotten, allowing the current cultural narrative of ableism to shape medical training. National structural challenges as early as medical school admissions and ableist barriers throughout the educational pipeline have yielded 1) a concerningly low prevalence of medical students and physicians in the US who identify as disabled and 2) propagation of systemic misunderstandings on disability in our healthcare system. This perspective addresses the need for a re-evaluation of diversity in medicine which includes ability status and a commitment to anti-ableism as a critical part of the conversation. We propose reforms and important considerations that could have meaningful implications necessary for improving the culture of disability inclusion in medical education.

KEYWORDS: disability, inclusion, medical education, diversity, ableism, equity

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Simple statements have lasting impacts, small actions make a world of difference. We are taught this early in our medical training, even during our first year of school. We learn to make eye contact with patients when they are describing the reason for their clinic visit. We are given appropriate phrases to say in response to difficult situations or experiences being described. And yet, it is in this same environment of medical education that ableism thrives, and in some instances, can even be taught.

In its simplest definition, ableism refers to a framework of thought and action that prefers certain types of bodies and minds over others. This form of discrimination centres a notion of "normal" within a hierarchy of value[1] whereby "abled" is superior to "disabled." Yet, a definition fails to capture the breadth of ableist tendencies that are prominent not only in society but within our medical system. Ableism exists in a myriad of forms from inaccessible website design for COVID-19 vaccines, to failing to provide reasonable accommodations in clinic spaces. As current trainees, we speak from a place of humility, recognizing all we have to learn, but also personal experience, identifying as a passionate advocate and ally for persons with disabilities and a proud disabled woman and manual wheelchair user following a spinal cord injury. Our team of perspectives allows for confirmation of the concerning bias that perpetuates society and medicine – "You have a very impressive application, but I just don't think the lab is a place for a wheelchair" – while also providing necessary allyship required for positive change.

It takes minimal effort to identify instances of the widespread medicalization of disability within the framework of medical training. Such instances innately imply affected individuals require "fixing" to restore their full potential. Statements are heard over and over that affirm a "less than" status – "I hope this (gesturing to wheelchair) isn't permanent" – for those identifying as disabled. Beyond being hurtful, they ostracize persons with disabilities from the practice of medicine, binding them to the "bed" never allowed to reach the "bedside." The startling reality that over 80% of physicians perceive patients with disabilities to have a lower quality of life than patients without disabilities highlights ableism as a systemic healthcare concern.[2] Importantly, those identifying as disabled do not share the same view. Such disparate perspectives and negative opinions held by an overwhelming majority of physicians in this study highlight the magnitude of the problem. Eighty percent should force us to take pause and ask why.

The emerging and necessary practice of anti-racism encourages us to recognize the value of diversity within the medical profession. In a country of growing minority populations, bolstering the spectrum of identities represented by physicians improves patient-provider relationships and enhances cultural humility between providers. The growth of diversity in medicine nationally largely comes from change at the medical school level,[3] and it is clear schools are intentionally striving to recruit and support diverse cohorts. Yet, recruitment efforts have primarily focused on underrepresented groups with respect to race and ethnicity. While such inclusion is long overdue, this lens of diversity does not consider the multidimensional nature of humanity and the many intersectional identities, such as ability status, gender identity, or socioeconomic status, that profoundly affect how an individual experiences the world.[4]

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The study of disability in trainees and clinicians has been a dearth in medical education literature. A 2019 study found that only 4.6% of medical students identify as having a disability, with related evidence that disclosure of a disability was dependent on openness of medical institutions.[5,6] Relatedly, a first of its kind study in 2021 identified the prevalence of providers with disabilities as 3.1%.[7,8] This is stark underrepresentation compared to the prevalence of disability, which has most recently been identified as 26.7% of the US popultation.[9] We hold that disability is underrepresented across the United States in the current medical school system due to systemic and biased misunderstandings about disability that continue to propagate throughout society and are reflected in medical education frameworks.

As it stands, US medical school curricula do not comprehensively address disability in pre-clinical or clinical training, allowing the hidden curriculum and chance interactions with more senior providers (and unexpecting patients) to provide disability-related training.[3] In some ways, this incomplete and unstructured disability education increases potential for spread of harmful and repetitive ableist themes including worthlessness, objectification, and emphasis on supposed limitations. It should be noted that individual medical schools are trying to address such concerns--introducing disability education in specific lectures, small group discussions, or requiring a rotation in Physical Medicine and Rehabilitation which allows for increased exposure to patients with disabilities.[10] However, the impetus for each laudable effort currently rests with the institution itself as no requirements for disability education by central governing bodies exist aside from a single mention of disability under an umbrella of health disparities.[11]

As trainees, we are intimately familiar with the demands of a medical school curriculum and acknowledge the universal challenge of delivering required content efficiently and effectively. However, we are also disability advocates, recognizing that training is an opportunity where we either begin to expose and address our bias, implicit or explicit, against disability or reinforce the harmful societal narrative. We should not and cannot let medicine rest here any longer. As we re-evaluate what diversity means in medicine and construct anti-racist frameworks, it is critical to understand and address how racism and ableism unmistakably rely and uphold each other as connected forces, especially overlapping in discussions of intersectionality.[12] We are in a special state of flux where we have both agency and current to build a more equitable and supportive medical system with respect to a wide range of minoritized identities in a connected and collaborative way.

Addressing the current culture of disability inclusion in our national medical education system is the clear gateway to meaningfully addressing ableism in our profession.[13] All medical schools must be required to uphold an explicit commitment to admit and support students with disabilities.[14] Formation of a network of peer mentors and physicians with disabilities would help instruct prospective trainees about accommodations while providing support.[15] Revising restrictive and organic technical standards into inclusive and functional ones, with annual updates to honor improvements in accommodative technology would remove unnecessary barriers.[16,17] We should work to focus on the end goal of skill mastery, not on how such skills are mastered, mirroring universal design. Within medical training, related changes should rebuild a stronger, more inclusive foundation where what is "normal" is learning about how to combat ableism to provide equitable care to all. Persons with disabilities could serve as educators of their own lived experience, debunking unrelenting quality of life myths.[18]

Discussions of the models of disability including medical and social models and the intersection of disability across all specialties and clerkships would provide clinically relevant knowledge to improve care for this population. Integration of persons with disabilities in clinical skill examinations and objective written assessment is a critical top-down initiative to complement changes in the learning environment and support networks.[19] In proposed anti-ableism initiatives, partnering with the existing generation of practicing clinician and staff champions who are committed to improving inclusion of disability in medical education will facilitate change.[20–22] It is important to recognize that these ideas and this piece is far from the first call to action for mandating nationalized curricular competencies on disability education in healthcare. Thorough guidelines which provide a structured framework for disability education in healthcare have been created and published by the Alliance for Disability in Healthcare Education and scholar activists and yet we still wait for meaningful change.[23,24]

In this time when we commit to prioritizing equity in medical education, ability status must occupy more space in the conversation. If intentions are genuine, unprecedented recommendations are necessary–just as our health systems begin to champion anti-racism as described by Dr Ibram Kendi, we make the case for anti-ableism in our profession.[25] Anti-ableism requires us to not just reject ableism, but to actively implement actionable change in our national admissions and curricular approaches to positively impact the culture of disability inclusion in medicine. "Being creative" and "learning to adapt" are necessary skills for those of us within the ranks of disabled Americans, and now, it is our turn as trainees and physicians to apply this same creativity and adaptation to the lens in which we approach medical training. If not now, when? It is time to dismantle ableism and accept disability.

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Trial Registration

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