

## MEDICINE AND SOCIETY

### Why Increasing Numbers of Physicians with Disability Could Improve Care for Patients with Disability

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#### Abstract

Erroneous assumptions among health care professionals about the daily lives, preferences, values, and expectations of persons with disability can contribute to documented health care disparities, faulty communication, and substandard quality of care affecting this heterogeneous population. Efforts to reduce racial and ethnic disparities have focused on expanding diversity in the physician workforce. Would expanding the numbers of physicians with disability benefit patients with disability? Increasing the number of physicians who identify as “disabled” is one strategy for proactively confronting disability-related barriers affecting patients, but such efforts will likely face substantial challenges. Nonetheless, physicians who require accommodations to practice (e.g., a height-adjustable examination table) could plausibly benefit patients needing similar accommodations and perhaps be well-positioned to provide patient-centered care to persons with comparable disability.

#### Introduction

Able-bodied images, such as “walking tall” and “seeing is believing,” suffuse our language. Although it has several variants, one popular aphorism typically asserts: “You can’t really understand another person’s experiences until you’ve walked a mile in their shoes.” Recognizing irony in this ambulatory metaphor, many persons with disability might nonetheless endorse this sentiment, even when considering health care. Health care professionals’ erroneous assumptions about the daily lives, preferences, values, and expectations of persons with disability—a diverse population encompassing people of all ages—can reduce the quality of the health care that persons with disability receive [1]. In particular, frequent misconceptions about persons with disability can contribute to troubling health care disparities, especially an underemphasis on health promotion [2]. For example, clinicians might not think that persons with disability are interested in exercise or that women with certain types of disability are sexually active and thus put the latter at risk for human papillomavirus exposure and cervical cancer development. According to the *World Report on Disability*, this problem of erroneous assumptions extends globally, as stigmatized views of disability infiltrate patient-physician communication and can compromise patients’ care [3].

Little is known about whether increasing the numbers of physicians with disability would reduce health care disparities and improve quality of care among patients with disability. Some suggest that increasing racial and ethnic diversity of the physician workforce can reduce both health disparities and health care disparities for racial and ethnic minorities [4]. One strategy for reducing racial and ethnic disparities in health care involves increasing [physician-patient concordance](#) with respect to race and ethnicity. Research suggests that racial and ethnic concordance between patients and physicians can significantly enhance cross-cultural communication and patients' health care experiences, participation in clinical decision making, intentions to adhere to clinicians' recommendations, and satisfaction with care [5, 6]. Perhaps concordance improves these outcomes because many minority patients distrust clinicians from racial or ethnic backgrounds who do not share their daily experiences—that is, who have not “walked in their shoes” [7]. Could concordance in disability status between physicians and patients eliminate disparities in health status, access to health care, and quality of health care, and generate better health outcomes?

Empirically, this question has not yet been addressed. Indeed, some might be puzzled or troubled by the notion of having a substantial number of physicians with disability in the physician workforce [8, 9]. Historically, physicians with recognized disability have been persons with singular personal qualities (such as having an attractive demeanor or personality, being highly personable, or having extraordinary intellectual gifts or professional achievements) who have found mentors who have recognized their talents and intervened or advocated for them [10]. Approximately 57 million Americans (almost 20 percent) currently live with disability [11], and finding sufficient numbers of physicians with disability to serve even a small fraction of this growing population would be difficult. Increasing the workforce of physicians with disability would require major changes in medical training programs and, for physicians who become disabled during their careers, systematically providing reasonable accommodations so they could continue productive practice. Improved accommodations for medical students who are [deaf or hard of hearing](#) appears to have contributed to the number of physicians serving persons with hearing disability, which will likely dramatically improve patient-physician communication for this underserved group [12]. However, benefiting large and heterogeneous populations of patients with disability would require two major steps: (1) expanding the number of physicians with disability and (2) ensuring that their practices actually enhance care for patients with disability.

### **Motivating Change**

Both steps face considerable challenges. As Melnick argues, increasing the number of physicians with disability requires recognizing the absolute primacy of patient safety [8]. But there are other challenges to increasing the number of physicians with disability. One might wonder, *how much and what kind of concordance is needed?* Indeed, achieving

disability status concordance between physicians and patients is illusory for some disability types. Given the cognitive, professional, and personal demands of medical practice, expanding the physician workforce to include persons with significant intellectual and cognitive disability, major communication disorders, and some mental illnesses, particularly if untreated, is likely unrealistic. However, depending on clinical practice demands, reasonable accommodations are now possible to support safe and productive practice by physicians with vision, hearing, mobility, or mental health disability. Below, I discuss challenges to expanding the number of physicians with disability and possible effects of physicians' disability on their attitudes toward and care of patients with disability.

### **Challenges to Expanding the Number of Physicians with Disability**

Expanding the number of students with disability matriculating at and graduating from medical schools confronts several challenges, as does retaining physicians who acquire a disability during their career.

Despite the 1990 passage of the Americans with Disabilities Act (ADA) [13], medical schools and practice settings have been slow to recognize their legal obligations to make reasonable accommodations for persons with disability [10, 14]. Most notably, accommodations are not explicitly supported in many schools' technical standards [15]. In 1979, the Association of American Medical Colleges Report of the Special Advisory Panel on Technical Standards for Medical School Admission specified five categories of skills required for medical school matriculation and graduation: observation; communication; motor; conceptual, integrative, and quantitative; and behavioral and social [16]. These technical standards have changed little since 1979 and—especially the standards for motor and sensory skills—have effectively prevented qualified students with disability from becoming physicians [14-16]. Not surprisingly, young adults with disability are underrepresented in medical schools, and their graduation rates are lower than those of students without disability [16]. Nonetheless, more deaf and hard of hearing applicants [8] are entering medical school today than before passage of the ADA.

Keeping physicians who acquire disability later in life in the practitioner workforce also poses important challenges. Physicians experience the same potentially disabling disorders over their life course as others do, with prevalence increasing with [age](#). Given the potentially career-ending consequences of some disabilities, whether and when physicians recognize or openly acknowledge disability raises several questions, including about ensuring safe practice [10]. In some situations, physicians might be "in denial" about whether they can practice safely [9]. They "appear reluctant to identify themselves as disabled or use available accommodations, in part out of fear of reprisal" [17]. State licensure boards, which ultimately make determinations about whether health care professionals can practice safely, might not yet fully understand ADA requirements, such

as whether it is permissible to ask questions about physical or mental health that have no bearing upon professional competence [18]; the ADA prohibits such questions. Safe practice deliberations can be complex: “Resolving the tension between protecting the public and protecting the rights of impaired individuals [i.e., physicians with disability] requires Solomonic wisdom” [19]. As Altchuler observed, medical licensure boards must walk a fine line between identifying physicians with impairments that compromise their abilities to practice safely with the boards’ obligation to uphold ADA provisions by limiting investigations to topics relevant to professional competence and not imposing an undue burden on physicians with disability [9].

### **The Effects of Physicians’ Disability on their Attitudes toward Patients with Disability**

The small group of physicians with pre-existing disability who graduated and trained since the ADA went into effect and the much larger group who age into disability likely approach caring for patients with disability differently.

Young physicians who explicitly needed to invoke their rights under the ADA or who received specific accommodations during training can carry a disability identity [20] that informs their clinical practice, giving them more disability cultural competence [21-23] or empathic understanding of disability experiences. This is one potential benefit of disability concordance in patient-physician relationships that could motivate good outcomes or health care experiences for patients.

In contrast, older physicians who have developed chronic disabling conditions might not identify as “disabled” or might even actively deny their limitations [10]. It is unclear whether a clinician’s denial of disability might affect his or her views of patients with disability. Today’s aging physician workforce—and some physicians’ erroneous assumptions about the values and preferences of their patients with disabilities [1, 2]—are two factors partially responsible for current health care disparities. Health care disparities are exacerbated by discriminatory structural features of health care delivery systems (e.g., inaccessible facilities and equipment) and the health care system as a whole (e.g., inadequate insurance coverage). It is unclear whether these older physicians will significantly alter and improve their current practices or become more knowledgeable about their legal obligations to accommodate patients with disability if and when they become disabled themselves.

### **How Physicians with Disability Can Affect Health Care**

Patients report that many physicians “just don’t get disability”—they have little understanding about living with disability or the consequences for daily life or health-related behaviors [1, 3, 24, 25]. A question is whether one can assume—based on disability concordance—that physicians with disability will proactively “get it” and thus improve care for this population. In particular, will physicians with disability be more likely to provide patient-centered care—a “true North” to guide improvements in health

care quality [26, 27]—to patients with disability? After all, “nothing about me without me,” a key maxim defining patient-centeredness [28], precisely echoes one rallying cry of the disability rights movement: “nothing about us without us” [29].

Certainly, if physicians themselves need accommodations—for vision correction, being deaf or hard of hearing, or mobility disability, for example—those very accommodations could help their patients with the same disabling conditions. For example, physicians who use wheelchairs would benefit from height-adjustable examination tables, which automatically raise and lower. Their patients with mobility disability would also find that “high-low” tables improve accessibility (i.e., a physician who lowers a height-adjustable exam table to facilitate his or her performance of physical exams would similarly position the table’s height to best assist patients in getting on and off the table). However, height-adjustable examination tables are not yet widely available. A study of 2,389 California primary care facilities found that just 8 percent had a height-adjustable examination table [30]. Another study conducted a telephone survey of 256 practices in four US cities to assess the willingness of subspecialty clinicians to care for a fictional patient with hemiparesis (weakness on one side of the body) and obesity who used a wheelchair and could not self-transfer onto an examination table [30]. The researchers reported that 22 percent of practices could not accommodate the patient and 18 percent of practices could not transfer the patient onto an examination table [31]. One striking finding among clinicians who refused to accommodate this fictional patient was that they failed to recognize that their refusal was illegal under the ADA [13] and Section 504 of the Rehabilitation Act [32]. Most importantly, practices staffed by physicians with mobility disability would probably have accessible equipment and better understand their legal obligations to serve patients with mobility disability.

Other factors that contribute to disparities and poor care—and that possibly could be contravened by physician-patient concordance—are [erroneous assumptions](#) and stigmatized attitudes about the lives, preferences, values, and expectations of persons with disability. These explicit and implicit negative biases do vary by disability type (e.g., often persons with intellectual disability generate the most negative perceptions) [33-35], and physicians can share these prejudices [36-38]. However, physicians’ attitudes toward persons with mobility disability can improve with greater experience with these patients, especially through interacting with wheelchair users whose full lives and extensive daily activities contradict stereotypes about the limitations imposed by wheelchair use [39]. In 1994, a seminal study of three Level I trauma centers compared the attitudes of 233 physicians, nurses, and emergency medical technicians toward treating persons with spinal cord injury (SCI) with responses of people with SCI from a previous study [40]. Among clinicians, 22 percent reported they would not want life-sustaining treatment if they had a SCI; 18 percent imagined being glad to be alive after SCI; and 41 percent felt that staff in their emergency departments tried “too hard to resuscitate or save” persons with new SCIs [41]. In contrast, 92 percent of respondents

with SCI said they were glad to be alive. Physicians who themselves have SCI—or exposure of physicians to colleagues or patients with SCI—could likely dispel these negative impressions.

## Conclusion

Plausible scenarios do exist that suggest why increasing the number of physicians who actively identify as having a disability and who require accommodations to practice could improve health care experiences and outcomes for patients with disability. Increasing the representation of physicians with disability in the clinical workforce will be challenging for reasons explored here but could potentially offer benefits to the growing population of patients with disability [42]. However, physicians with disability should not be burdened by unrealistic expectations about what they can accomplish. As a physician who became deaf wrote:

The single most important insight I have gained from being a disabled doctor is that I really have no idea what life is like for my patients.... The disability I know best is deafness. The profession I know best is medicine. So I accept that I've no idea how life is for, say, an accountant with cerebral palsy. But I do at least know what not to do if I should meet such a person. I won't automatically assume that they can't do certain things—nor will I blithely reassure them that they can. I'll ... try to build up a picture of a more complex reality. Above all, I will let them tell me how it is [43].

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