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Invited Commentary | Equity, Diversity, and Inclusion

Disability-Inclusive Accommodations in Nursing Education—Addressing Health Equity Needs

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The Accreditation Council for Graduate Medical Education (ACGME) and other medical associations have committed to the elimination of health care inequities by enriching and broadening the physician workforce. Through its Department of Diversity, Equity, and Inclusion, the ACGME works to provide tools for the graduate medical education community to build safe, inclusive, and equitable learning environments for physicians, including disability-inclusive practices.[1] This work has led to extensive data collection on, and increased representation of, medical students with disabilities.[2] However, there is a paucity of information regarding nursing students with disabilities.

Jackson et al[3] share groundbreaking findings establishing baseline disability data for US nursing schools. This cross-sectional study uses data from nursing schools to examine disability prevalence and types of didactic and clinical accommodations used in traditional prelicensure Bachelor of Science in Nursing programs. Nineteen schools responded to solicited invitations to participate in a survey, identifying 562 nursing students with self-reported disabilities. This is a prevalence estimate of 8.4% of total enrollment, which exceeds the current prevalence in medical schools of 5.9%. Prevalence estimates are accurate as the data are obtained from US nursing schools' federally mandated documentation of disability decisions. Disability accommodations services varied due to school size, from variations in admission practices, disability expertise, or resource allocation. The study identified the critical need to prioritize future research in psychological disabilities (3%) and attention-deficit/hyperactivity disorder (2.1%), as these were most prominent. In addition, the study captured the heterogeneity of self-identified disabilities and categorized the diversity of accommodations. The authors noted a scarcity of nursing students with mobility and sensory disabilities and called for future studies to address barriers for these students to enter and fully participate in the nursing profession. Finally, the authors called for further study of student performance and efficacy of accommodations.

The major limitation of the study by Jackson et al[3] is that the data are based solely on self-disclosed disabilities. Both previous studies of medical students with disabilities and this current study of nursing students with disabilities are limited by the exclusion of students who did not self-disclose. Some reasons for nondisclosure include ableism and the unique culture of medicine.

As we work toward equity in health professions education, we must look at ableism, and structural ableism in particular. Although there is no singular definition of ableism, it is generally, "stereotyping, prejudice, discrimination, and social oppression toward people with disabilities."[4,5] Similar to other forms of oppression, ableism describes valuing some attributes over others, including a reflexive preference for nondisability.[5] This system of preference is not only reflected in thoughts and actions of individuals but is also deeply ingrained within systems and structures. An analogy to understanding how ableism affects our culture is to understand how critical race studies recognize the importance of understanding Whiteness to better understand how racism operates.[5,6] Disability professionals provide services to people with disabilities in capacities such as health care professionals, educators, direct support staff, social workers, and liaisons in students disability services. They are often nondisabled individuals who are the gatekeepers of services for people with disabilities. Research indicates high levels of disability bias among disability professionals.[5] On an individual level, a disability liaison with an implicit or explicit bias in student disability services may negatively affect the experience of students with disabilities. On a larger scale, disability

professionals' attitudes can have implications well beyond their fields and affect public policy that can considerably affect the lives of people with disabilities.[5]

A systemic barrier to the inclusion of students with disabilities in the health professions is the unique culture and context of medicine itself.[7] Models of disability that need to be reconciled are the social and medical models of disability. The social model considers disability as a social construct through discrimination and oppression. In the medical model of disability, the focus is on the person's impairment rather than the needs of the person. Due to this medicalization, people with disabilities are often viewed as passive patients requiring care rather than a group with diverse human experiences who can legitimately contribute to and be a necessary part of the medical workforce. Given the ableism of disability professionals, it is understandable that that many medical applicants, students, and practitioners are hesitant to declare their disability, particularly when facing rigorous selection processes for medical education and professional practice.[7] By examining our attitudes of bias and ableism, we can improve rates of students' self-disclosure of disabilities and provide supports needed for all learners with disabilities in the medical profession.

The need for accommodating learners with disabilities to eventually produce a workforce of health care professionals with disabilities is evidenced by health care disparities encountered by people with disabilities worldwide. The World Health Organization's world report on disability states that people with disabilities have the same general health care needs as others but they are 2 times more likely to find health care professionals' skills and facilities inadequate, 3 times more likely to be denied health care, and 4 times more likely to be treated badly in the health care system.[8] Health care professionals from different countries report concerns about their ability to provide quality care for disabled patients. Singh et al[9] tackle these disparities by addressing taking into consideration the Convention of the Rights of People with Disabilities, Act 2016,[10] and by involving the 3 groups of stakeholders: disability rights activists, physicians and other health professionals with disabilities, and health profession educators. By incorporating disability-related competencies in medical education, we can avoid perpetuating the medicalization of diverse human experiences and lead to inclusion of health practitioners with disabilities, who will not only inform medicine but also reduce stereotypes.

Research has already shown that a diverse medical work force can benefit physicians, trainees, and patients. The current study by Jackson et al[3] serves as a starting point to help us discover how to encourage a more diverse nursing workforce and assist them to have successful careers. We need representation from professionals with disabilities to care for people with disabilities. We must form an inclusive environment or learning climate such that students feel comfortable disclosing their disabilities and have the proper structural support to ensure success. An ideal way to address this issue is to have disability professionals, including disability liaisons (such as people who work in the student disability services), who understand ableism to ensure that accommodations are being put into place to ensure educational goals to create a stronger, diverse, and more inclusive work force.

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