

A Public Health Failure: The Lack of Disability Clinical Care and Competency Training of Medical Professionals

National Council on Disability

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National Council on Disability (NCD)
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Contents

Acknowledgments 3

Acronym Glossary 4

Introduction 6

The Effect of Lacking Disability Clinical Care Training on Health Care Providers 8

The Effect on Patients' Lives 10

Fundamental Barriers 12

Applicable Law, Standards, and Examinations 14

- US Department of Health and Human Services 14
- State Laws 15
- Nongovernment Organizations 16

The Current Status of Health Care Provider Education in Medical Training 20

- Harvard Medical School 20
- University of Illinois Chicago Medical School 21

Correlation Between Clinical Confidence and Changes in the Care Provided 23

- Cost-Effectiveness 23

Conclusion and Recommendations 25

Endnotes 27

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Acronym Glossary

AAMC	Association of American Medical Colleges
ACGME	Accreditation Council for Graduate Medical Education
ADA	Americans with Disabilities Act
AMA	American Medical Association
COCA	Commission on Osteopathic Accreditation
IDD	intellectual and developmental disability
JC	Joint Commission
HHS	US Department of Health and Human Services
LCME	Liaison Committee on Medical Education
NCD	National Council on Disability
NIH	National Institutes of Health
TBL	team-based learning
UIC	University of Illinois Chicago
USMLE	United States Medical Licensing Examination



"The secret of the care of the patient is in *caring* for the patient."

—*Dr. Francis Peabody*

"Only roughly half of physicians 'strongly' agreed that they would welcome patients with disability into their practices."

—*Health Affairs* (Iezzoni et al.)[1]

Introduction

The National Council on Disability (NCD) has consistently emphasized that good health, including mental, physical, and overall well-being, is the foundation for a person's ability to not just live but also to thrive. However, for many of the more than 61 million people with disabilities in the United States,[2] achieving and sustaining good health have been hindered by a health care system that has not adequately welcomed or served them. Simply put, the health care providers that many people with disabilities see for examination and treatment are largely untrained to do so. This phenomenon is driven by a persistent failure to integrate disability clinical care and competency training into medical, nursing, and other health professions curricula. Even federally financed medical, nursing, health care professional, and allied health professional schools, as well as postgraduate residency and fellowship programs, do not, for the most part, incorporate disability clinical care into curricula or training. Perhaps because of being ill-prepared, many clinicians choose not to treat patients with disabilities at all.[3]

[G]ood health, including mental, physical, and overall well-being, is the foundation for a person's ability to not just live but also to thrive.

This deficiency in medical training among medical professionals can perpetuate discrimination in health care against people with disabilities and, in conjunction with traditional didactic teaching that frames disability as a medical problem needing treatment, helps preserve negative bias against people with disabilities.[4] People with disabilities report higher dissatisfaction with the quality and accessibility of the medical care they receive and are more likely to experience unmet health needs and worse health outcomes than those without disabilities.[5] Certainly, the lack of comprehensive disability clinical care and competency training contributes to the disparate health outcomes of people with disabilities. In 2023, the National Institute on Minority Health and Health Disparities of the National Institutes of Health (NIH) recognized people with disabilities as one of five NIH-designated populations with health disparities.[6]

[T]he lack of comprehensive disability clinical care and competency training contributes to the disparate health outcomes of people with disabilities.

In 2022, NCD developed a *Framework to End Health Disparities of People with Disabilities*[7] that encompassed five core recommendations, including (1) designating people with disabilities as a Special Medically Underserved Population under the Public Health Services Act; (2) designating people with disabilities as a Health Disparity Population under the Minority Health and Health Disparities Research and Education Act (subsequently designated in September 2023); (3) requiring the use of accessible medical and diagnostic equipment (required as of July 2024); (4) improving data collection concerning health care for people with disabilities across the lifespan; and (5) requiring comprehensive disability clinical care curricula in all US medical, nursing, and other health care professional schools and requiring disability competency education and training of medical, nursing, and other health care professionals.

In an effort to further address the recommendation concerning necessary disability clinical care and competency education and training, NCD has conducted extensive research; solicited input through its Requests for Information[8]; received public comment through its public meetings held across the United States; and conferred with stakeholders, including industry experts and government and nongovernment organizations empowered to enact policy in this space. This policy brief summarizes NCD's additional findings and provides recommendations for legislation and policy updates. Undoubtedly, disability clinical care training is a solution to an obviously significant problem that is currently underused and inconsistently applied in US health care education and training, with the vast majority of institutions lacking comprehensive programs. This must be remedied.

The Effect of Lacking Disability Clinical Care Training on Health Care Providers

Fundamentally, many clinicians are not properly trained to even communicate with people with disabilities who might express themselves differently or know how to communicate with caregivers only when appropriate. Additionally, they are not trained to know how to support independent decision making by people with disabilities, nor do they understand how disabilities that begin in childhood can change throughout adulthood. It is profoundly unsustainable that people with disabilities have no choice but to see health care providers who were never trained to properly treat the patients in front of them.

Several studies have examined the impact this issue has had on health care providers, as well as the health of people with disabilities, the results of which shock the conscience. Providers often do not know the basic civil rights that patients with disabilities have when walking into a doctor's office. As reported in one study, when asked about their knowledge of the Americans with Disabilities Act (ADA), nearly all physicians reported having little or no training on the law and its implications for their practices. One study participant who is a specialist said, "I know they offer conferences and lectures, but this is a personal choice if you want to take it or not."[9] In general, physician attitudes about the ADA conveyed in the study were apathetic and even adversarial. Many physicians expressed explicit bias toward people with disabilities and described strategies for discharging them from their practices.[10] Another survey of 714 practicing US physicians (primary care physicians and subspecialists) found that only 41% reported that they were "very confident" about their ability to provide the same quality of care to people with disabilities as those without, and just 57% strongly agreed that they welcomed people with disabilities into their practices.[11]

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Diagnostic Overshadowing

If physicians do welcome people with disabilities into their practices, there is a risk that these untrained physicians may misdiagnose them, assuming a person's disability is causing new symptoms instead of considering the potential of a new disease or medical issue. This is called diagnostic overshadowing.

Relatedly, and because of a lack of training and familiarity, people with disabilities are sometimes viewed as asexual.[12] These assumptions may contribute to the finding that women with disabilities undergo colon cancer screening at similar rates as their nondisabled peers but experience disparities in breast cancer and cervical cancer screening.[13] The sexual health of women with intellectual disabilities is particularly ignored in terms of screening for breast and cervical cancers.[14] These training shortcomings and their corresponding diagnostic overshadowing contribute significantly to unequal health outcomes and unsafe care.

The Effect on Patients' Lives

Three specific examples help illuminate the effect that the lack of disability clinical care and competency training of medical professionals has on people with disabilities.

In the first example, provided by a faculty member of Harvard Medical School, a 72-year-old man with quadriplegia goes to a hospital for the placement of a kidney tube in January and again in June. He can speak loudly and clearly but is paralyzed from the neck down. He is lying on a gurney and has a surgical mask on to prevent infection. In January, of the three staff caring for him, none asked the patient what position was most comfortable, how best to position him, or what information he might like to know. The patient was rolled into a position for the procedure without giving permission and was not repositioned for hours after the procedure. He developed a large pressure ulcer and a fear of the health care system. In June, three different staff members happened to see the patient. This time, the staff spoke to him at eye level and asked what position was most comfortable, how best to position him, and what information he would like to know. The patient was relaxed and engaged and was positioned appropriately during and after the procedure. In the lead-up to the next appointment, the patient was left with anxiety and uncertainty as he wondered which team he would get on his next visit. Good clinical care should not be left to chance. Mandatory disability training for all health care trainees helps ensure patient-centered care for every patient during every visit.[15]

NCD received the second example as a public comment by an individual with a family member with an intellectual and developmental disability (IDD). The family member with IDD was admitted to a clinic and was tazed three times while admitted. The family was not made aware that their family member with IDD had been tazed or that the admitted individual was given, they believe, the wrong medicine. Tragically, the disabled family member passed away while admitted at the clinic. It is the family's belief that it was the improper prescription that killed him.[16]

Finally, the last example comes from the lived experience of one of NCD's own council members, who shares:

> As a 52-year-old, quadriplegic, speech impaired woman with cerebral palsy, I've constantly faced healthcare providers with little knowledge/training about disabilities, in addition to patronizing, dismissive attitudes. I've encountered barriers to routine healthcare, like mammograms and colonoscopies at recommended ages, even with a family history of breast and colon cancer. My expertise (and my

family's), based on lived experience, was repeatedly dismissed when I developed non-Hodgkin lymphoma (tumor pressing against my esophagus) in 2013. I checked into a university hospital for five days of chemo (to be repeated every 21 days for six rounds) but didn't leave for five months. I'd been belatedly diagnosed (after months of coughing) by a hospital urgent care doctor who not only treated me like a child but declined my request for an x-ray since I "probably" had allergies. Coughing made it hard to eat, so I'd lost 10 lbs. (from 95 lbs.) and was aspirating while eating when finally admitted. Speech therapists insisted on an Nasogastric Intubation tube, even though I said it would make me cough more, which it did. (I needed a stomach tube, which I soon got anyway.) My chemo floor didn't have orderlies to get me out of bed every day (as I'd always done), so I developed my first ever pressure ulcer in the first 10 days from all the extra coughing, sitting up at a 90-degree angle to try to alleviate that, and not getting out of bed into my wheelchair. I wasn't told I had a pressure ulcer until weeks later, and it progressed to stage four, so my final round of chemo had to be canceled because I was more at risk of dying from the ulcer than the cancer. I was overfed through the tube and that made me cough more (reflux) even after the tumor was reduced, and caused chronic, explosive diarrhea, which risked further wound complications. Extra hospital days meant lost lifetime Medicare hours, loss of promised weeks of rehab, and my family had to fight to keep me in the hospital until they felt able to deal with the wound at home. (They lived nearby, and visited every day, but the hospital wanted to discharge me to a facility 45 minutes away that was also inadequate for my needs.) We struggled to get them to hear and respond to our warnings/suggestions rooted in four decades of experience.[17]

These examples speak for themselves.

Fundamental Barriers

Several fundamental barriers hinder the provision of essential disability clinical care and competency training for medical professionals; among them is the shortage of faculty with training and experience on the topic. It is this shortage of equipped trainers that can and does result in a detrimental circle of untrained students who in turn become instructors themselves who are likewise incapable of providing the training that they themselves lacked.[18] This cited barrier is self-perpetuating absent a change in curricula.

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Another barrier often cited is the time constraints in health care programs' existing intensive curricula. As a result, any disability clinical care and competency training that is provided is either brief and lacking in depth and hands-on training or is in the form of optional electives rather than comprehensive competency development. The question of time constraint, however, is simply a matter of proper prioritization. The more comprehensive programs with built-in disability clinical care and competency training that do exist are often a result of individual faculty members who choose to champion and prioritize such training within their institution. However, these "one-offs" are not even necessarily sustainable because the programs inclusive of disability competency training may not persist after these particular faculty members retire or move on.

[T]here would be more faculty and student buy-in of disability clinical care and competency training if more of these types of questions were to appear across more medical professional state licensing exams.

According to responses received to NCD's Request for Information on the topic, limited faculty and student buy-in is a central challenge for medical schools and other medical professional schools in adopting disability clinical care and competency training into their curricula.[19] In connection with perceived time constraints with existing curricula noted

previously, instructors spend their instructional time training on the information known to be on state licensing exams. It therefore stands to reason that there would be more faculty and student buy-in of disability clinical care and competency training if more of these types of questions were to appear across more medical professional state licensing exams. It also stands to reason that more educational and training programs would presumably provide the necessary education and training as a means of "teaching for the test"—if not explicitly to improve treatment of people with disabilities, then for the benefit of helping their students pass the test.

Insufficient investment in accessible clinical infrastructure also acts as a barrier. Many training environments currently lack essential accessibility features such as height-adjustable examination tables, wheelchair-accessible weight scales, mobile diagnostic equipment, and examination rooms designed to accommodate wheelchair users, although new regulations from the US Department of Health and Human Services (HHS) and the US Department of Justice require adoption of accessible medical equipment.[20] Combined with barriers in the built environment and inaccessible medical equipment, often it is not until a physician encounters a patient with a disability and faces his or her own lack of confidence in properly treating that patient, including lacking the equipment to do so, that the gap in training and infrastructure is clearly recognized.

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Finally, limited guidance and expectations from accreditation bodies, as well as the absence of explicit guidance by regulatory bodies, also hinder the nationwide implementation of necessary disability clinical care and competency training. Absent a clear requirement for disability-specific content from health professional schools, training programs, and accreditation bodies, essential disability clinical care and competency training of medical professionals typically does not happen.

Applicable Law, Standards, and Examinations

US Department of Health and Human Services

Section 5307 of the Patient Protection and Affordable Care Act provides the legislative authority for the Secretary of the HHS to fund the development of and to disseminate model curricula for cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs.[21] Section 5307 does not, however, require adoption and implementation of such curricula.

Separately, the HHS Office for Civil Rights published a final rule, *Nondiscrimination on the Basis of Disability in Programs or Activities Receiving Federal Financial Assistance*, which became effective July 8, 2024. It updates, clarifies, and strengthens HHS' implementing regulation for Section 504 of the Rehabilitation Act of 1973.[22] Provided this rule is implemented and enforced, these revisions should help to improve the quality of health care that people with disabilities receive. According to the revised rule, within the context of health care provided to people with disabilities, recipients of federal financial assistance cannot deny or limit clinically appropriate treatment to a qualified individual with a disability when the denial is based on bias or stereotypes, a belief that the individual will be a burden on others, or a belief that the life of an individual with a disability has a lesser value than the life of a person without a disability. (This rule continues to apply during the adoption of different standards for the allocation of scarce resources during emergencies, commonly referred to as "crisis standards of care."[23] [24]). Recipients are prohibited from using any measure that discounts the value of life extension based on disability to deny or afford an unequal opportunity to qualified individuals with disabilities[25]; recipients are prohibited from discriminating against people with disabilities through the use of inaccessible medical and

> *...[R]ecipients [of federal financial assistance] are prohibited from discriminating against people with disabilities through the use of inaccessible medical and diagnostic equipment ; and ...must take appropriate steps to ensure that communications with individuals with speech, hearing, and vision disabilities are as effective as communications with others.*



diagnostic equipment[26]; and recipients must take appropriate steps to ensure that communications with individuals with speech, hearing, and vision disabilities are as effective as communications with others.[27]

Although the revised rule does not explicitly state that medical schools and residency programs receiving federal financial assistance must proactively incorporate disability clinical care and competency into their training programs, it is NCD's position that Section 504, along with the ADA, in their nondiscrimination provisions, should be read as requiring medical professional teaching programs to include disability clinical care and competency training.[28] Hence, **NCD recommends that HHS clarify Section 504 to make disability clinical care and competency training in medical care professional training explicitly required. NCD further recommends that HHS also establish guidance to that end.**

[I]t is NCD's position that Section 504, along with the ADA, in their nondiscrimination provisions, should be read as requiring medical professional teaching programs to include disability clinical care and competency training.

State Laws

State medical licensing boards establish requirements for physician licensure and may require continuing medical education or other

professional development as a condition of maintaining licensure. However, they generally do not establish detailed disability-related clinical care or competency requirements for medical school curricula or residency training programs; these requirements are primarily established through medical education accreditation standards (as set by organizations such as the Liaison Committee on Medical Education [LCME] and the Accreditation Council for Graduate Medical Education [ACGME]) and individual educational institutions. It is thus worth noting that in Massachusetts, the Massachusetts Department of Public Health is now legally required to establish a voluntary certification program for educational institutions that offer specialized training on caring for people with IDDs, including autism.[29] Although this singular state law is a step in the right direction, it is nonetheless voluntary for educational institutions. **NCD recommends that states pass laws mandating disability clinical care and competency training of medical students and professional trainees.**

There is currently no standard by the LCME that specifically requires all medical schools under its authority to train students in disability clinical care and competency training.

Nongovernment Organizations

In July 2023, NCD held a panel discussion at its quarterly public meeting, where it engaged in discussion nongovernment organizations with authority in the space of disability clinical care and competency training (or at least some influence). The leaders of these organizations left with a better understanding of the need, and NCD has continued to follow up. The following represents the current status of relevant organizations, with continued recommendations from NCD.

The Liaison Committee on Medical Education

The LCME serves as the official accrediting body for Medical Doctor degree granting medical education programs in the United States and Canada. The organization is jointly sponsored by the Association of American Medical Colleges (AAMC) and the American Medical Association (AMA). It consists of 21 voting members: 17 professional members who are medical educators and/or practicing physicians, 2 public members, and 2 medical students.[30] To attain and maintain accreditation, a program must meet the accreditation standards of the LCME.[31] LCME accreditation allows medical schools and their students to qualify for certain federal funding opportunities, such as Title VII programs administered by the US Public Health Service, and permits students to sit for the United States Medical Licensing Examination (USMLE). In addition, most state licensing boards require graduation from an LCME-accredited program for physician licensure. Graduates of these accredited schools are also eligible to enter residency programs approved by the ACGME.[32]

There is currently no standard by the LCME that specifically requires all medical schools under its authority to train students in disability clinical care and competency training.[33] **NCD recommends that the LCME establish a disability clinical care and competency standard in its *Standards for Accreditation of***

Medical Education Programs Leading to the MD Degree.

Accreditation Council for Graduate Medical Education

The ACGME oversees the accreditation of residency and fellowship programs in the United States, following medical school. It sets and monitors voluntary professional education standards. The mission of the ACGME is to improve health care and population health by assessing and enhancing the quality of resident and fellow physicians' education through advancements in accreditation and education.[34] The ACGME participated in a panel composed of policymakers and stakeholders that NCD hosted on disability clinical care and competency training.[35] The ACGME has made considerable efforts to draw attention to the fact that "physicians need to be better trained in how to care for patients with disabilities" (including through its 2025 Summit on Fostering Disability-Inclusive Care in Resident Education).[36] At present, though, the ACGME has elected to not establish a standard requiring graduate medical programs to train physicians in how to care for patients with disabilities. **NCD recommends that the ACGME establish a standard requiring graduate medical programs to train physicians in how to care for patients with disabilities.**

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Commission on Osteopathic College Accreditation

The Commission on Osteopathic Accreditation (COCA) is the accreditor of colleges of osteopathic medicine in the United States. COCA accreditation signifies that a college has met or exceeded the Commission's standards for educational quality.[37] There is currently no standard by the COCA that specifically requires all medical schools under its authority to train students in disability clinical care and competency training.[38] **NCD recommends that the COCA establish a disability clinical care and competency standard in its *Continuing Accreditation Standards*.**

There is currently no standard by the COCA that specifically requires all medical schools under its authority to train students in disability clinical care and competency training.

The Joint Commission (on Hospital Accreditation)

The Joint Commission (JC) is an independent, nonprofit organization that accredits and certifies participating health care organizations and programs in the United States. Its primary mission is to improve health care quality and safety by setting rigorous standards and conducting onsite evaluations. JC standards must meet or exceed the federal Medicare standards established in the Conditions of Participation.

The JC participated in a panel discussion with other policymakers and stakeholders that NCD hosted on disability clinical care and competency training.[39] In recent years, the JC

has updated its hospital accreditation standards whereby it can potentially better serve people with disabilities. The updated standards include a new requirement that requires accredited organizations to identify and reduce disparities in care. Although the standard applies broadly, it can potentially benefit people with disabilities by requiring organizations to identify populations experiencing poorer outcomes or barriers to care, improve access to services, and develop action plans accordingly.[40]

The JC's position on disability clinical care and competency training, however, has stopped short of requiring training.

The JC's position on disability clinical care and competency training, however, has stopped short of requiring training. **NCD recommends that the JC require disability clinical care and competency training of providers in the health care organizations that it certifies.**

American Medical Association

The AMA is a professional organization whose mission is to promote the art and science of medicine and the betterment of public health.[41] The AMA participated in a panel composed of policymakers and stakeholders that NCD hosted on disability clinical care and competency training.[42] The AMA's position concerning disability clinical care and competency training is that it supports the integration of comprehensive disability clinical care and competency training into medical education. Although the AMA is a co-sponsor of the LCME, it does not have direct authority over the LCME's decisions regarding accreditation standards. Nonetheless, in 2022, the AMA House of Delegates adopted Policy H-90.968, "Medical Care of Persons with Disabilities." Among other provisions, the policy states: "Our AMA encourages the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement a curriculum on the care and treatment of people with a range of disabilities." The policy further states that the AMA "encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with a range of disabilities."[43] NCD fully supports and commends the AMA for this policy.

The AMA's position... is that it supports the integration of comprehensive disability clinical care and competency training into medical education.

Association of American Medical Colleges

The AAMC aims to "advance academic medicine by leading and serving medical schools, academic health systems and teaching hospitals, and academic societies."[44] The AAMC participated in a panel discussion with policymakers and stakeholders that NCD hosted on disability clinical care and competency training.[45] The AAMC's position on required disability clinical care and competency training is that it recognizes the importance of including disability and accessibility in its mission to support the disparate needs of patients, including curriculum

design in medical education.[46] However, like the AMA, although the AAMC is a co-sponsor of the LCME, it does not have direct authority over the LCME's decisions regarding accreditation standards. The AAMC has promoted disability-related competencies and educational resources for undergraduate medical education[47] but has not formally called on the LCME or the ACGME to establish disability clinical care and competency training standards. Although the AAMC does not have direct authority over the LCME, **NCD nonetheless recommends that the AAMC explicitly recommend that the LCME develop a disability clinical care and competency training standard. NCD further recommends that the AAMC explicitly recommend that the ACGME does the same.**

The AAMC's position on required disability clinical care and competency training is that it recognizes the importance of including disability and accessibility in its mission to support the disparate needs of patients, including curriculum design in medical education.

Licensing Examinations

The USMLE is a three-step examination for medical licensure in the United States. It "assesses an examinee's ability to apply knowledge, concepts, and principles, and to demonstrate fundamental patient-centered skills."[48] "These skills constitute the basis of safe and effective patient care."[49] However, research indicates that of the six Core Competencies on Disability on Health Care Education (created by the Alliance for Disability in Health Care Education in partnership with the Ohio Disability in Health Partnership,[50] all six of which match six of NCD's eight Core Competencies[51]), two competencies were present in the USMLE exam content outline, with the word "disabilit(y/ies)" appearing three times.[52] According to the study done, on average, health professions licensure exams (including for the professions of allopathic physicians, osteopathic physicians, registered nurses, clinical social workers, occupational therapists, speech language pathologists, physician assistants, and physical therapists), as proxied by their content outlines, addressed only half of the Core Competencies on Disability, typically in a limited, particular way. **NCD recommends that state licensing examinations be revised to reflect robust testing of each of NCD's Core Competencies,[53] which also encompass the six Core Competencies on Disability created by the Alliance for Disability in Health Care Education.**

The Current Status of Health Care Provider Education in Medical Training

Although some medical schools and residency programs include disability clinical care and competency in their training, the majority do not. As it did in its *Framework to End Health Disparities of People with Disabilities*,[54] **NCD again recommends the creation of a model comprehensive disability clinical care competency curricula by HHS that encompasses the framework we set forth below** for use and adoption by schools that do not have the capacity to develop their own curricula. For schools that endeavor to create their own curricula, they should also encompass the following framework.

Model Disability Clinical Care Competency Curricula Framework[55]

- Competency 1: Contextual and Conceptual Frameworks on Disability
- Competency 2: Professionalism and Patient-Centered Care
- Competency 3: Legal Obligations and Responsibilities for Caring for Patients with Disabilities
- Competency 4: Teams and Systems-Based Practice
- Competency 5: Clinical Assessment
- Competency 6: Clinical Care over the Lifespan and During Transitions
- Competency 7: Effective Communication
- Competency 8: Advocacy

Of the minority of schools that voluntarily include disability clinical care and competency training in their programs, positive role models stand out for schools with no such programs.

Harvard Medical School

At Harvard Medical School, all students engage in a mandatory integrated disability curriculum across their four-year trajectory to steadily develop a disability lens in their approach to patient care and work environment, informed by reflection on personal and systemic biases, development of clinical and communication skills, and direct experiences learning from individuals living with disabilities.

The School provides a four-pronged, multilevel approach to disability education, including (1) a mandatory integrated longitudinal disability curriculum that spans every medical student's full four-year medical school trajectory; (2) engagement of community resources and advocates in the design, implementation, and evaluation of all curricular elements; (3) faculty development to inform the school's medical educator and clinician community; and (4) a structured



approach to incubating future leaders in disability in health care.

Content is delivered through a partnership of disability experts (students, house staff, faculty, community members) and the course directors for every course in which the disability curriculum is embedded. Prior to graduation, students' communication skills are assessed with a patient who communicates nonverbally and their caregiver in an Objective Structured Clinical Examination format, giving every student the opportunity to practice and reflect on their skillset and review it with a faculty preceptor directly observing the interaction.[56]

University of Illinois Chicago Medical School

At the University of Illinois Chicago (UIC) Medical School, students must demonstrate sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation. Their guiding principle in incorporating disability is described as presenting conceptual framework sessions and following up with application exercises or sessions in core cases and team-based learning (TBL).

UIC Medical School's current roadmap of its disability curriculum includes:

Phase 1: preclinical material (all of M1 [first year] and half of M2 [second year]): 1. stand-alone conceptual framework sessions (1–2 hours, often with small group discussions); and 2. disability content integrated into relevant TBLs/core cases (about 20-30 minutes of content is embedded in 2-3 hours of materials).

In M1, Block 1, Foundational Knowledge (Body Systems and Homeostasis), the students study a core case on prenatal genetic testing. They have a follow up session, 80 minutes in length, that involves small group work in which the students appreciate the history of eugenics, ethical issues in prenatal genetic technologies, the historical (mis)treatment of people with Down syndrome, and changing medical terminology that has been used to describe people with intellectual disabilities. The session ends with a discussion of current trends and concepts around community integration and supported decision-making for people with IDD.

In M1, Block 3, Musculoskeletal and Dermatology Systems, the students have a conceptual framework session called "Intro to Disability" (110 minutes: 50 minutes plenary, 50 minutes small groups). The goals are to develop a basic conceptual understanding of disability, including the various definitions and models; explore the stigma, bias, discrimination, and barriers people with disabilities face in health care settings; and learn some strategies for creating disability competent care services. In this session, the students interact with a panel of people with disabilities.

In M2, Block 6, Brain and Behavior, the students have a conceptual framework session on "Toward an Understanding of Personhood and the Moral Relevance of Disorders of Consciousness" (110 minutes: 50 minutes plenary, 50 minutes small groups). The students explore the ethical parameters of various types of brain injuries, classic legal cases involving brain injuries, and the various perspectives of people who live with brain injuries and their loved ones.

In M2: Transition to Clerkships (TTC), "The Basics: What you Need to Know to Work with Deaf and Hard of Hearing Patients." (60 minute session)[57]

Correlation Between Clinical Confidence and Changes in the Care Provided

Limited clinical confidence in treating patients with disabilities may lead to provider avoidance, reliance on diagnostic assumptions, uneven patient interactions, and unnecessary variation in care delivery costs.[58] Disability competency training helps students feel more prepared to care for patients with disabilities and can thus foster more inclusive, patient-centered attitudes. As previously noted, research has found that many practicing physicians are unaware of their legal responsibilities to ensure accessible care for patients with disabilities, including the requirement that health care facilities bear the cost of necessary accommodations. As a result, patients with disabilities may be denied care or treated without appropriate accommodations, potentially compromising care quality and further reducing clinicians' confidence in their ability to deliver effective, high-value care.[59] It is clearly more beneficial that providers are equipped with the training they need, which in turn benefits the system of care as a whole.

Disability competency training helps students feel more prepared to care for patients with disabilities and can thus foster more inclusive, patient-centered attitudes.

Cost-Effectiveness

Providing medical professionals with disability clinical care and competency training has the potential to improve preventive care and reduce medical errors and health care disparities.[60] Similarly, clinicians who are trained to communicate effectively with and appropriately assess patients with disabilities are better equipped to recognize health concerns promptly, facilitate earlier intervention, and reduce barriers that can contribute to preventable complications and the unnecessary emergency care. Routine preventive care and accessible screenings, for instance, can help reduce complications such as infections, pressure injuries, falls, and uncontrolled chronic diseases that often lead to hospitalization. Providing accessible screenings and preventive care is far less expensive than treating patients with advanced conditions after complications arise.

Improved disability competency may also reduce unnecessary health care spending by limiting diagnostic errors and excessive testing. As previously noted, patients with disabilities are often affected by "diagnostic overshadowing," the phenomenon in which health care providers mistakenly attribute new symptoms to an existing disability rather than exploring other possible medical causes. This can result in

repeated appointments, delayed diagnoses, unnecessary procedures, and worsening health outcomes. Providers with disability-specific training are more capable of conducting accurate assessments and distinguishing disability-related characteristics and unrelated medical conditions, leading to more efficient care and fewer wasted resources.

Additionally, disability competency training can strengthen patient-provider relationships by fostering respectful, accessible, and patient-centered care, which may increase patients' trust in the health care system and encourage greater use of preventive and primary care services. Patients who feel respected, understood, properly treated, and appropriately accommodated may be more likely to seek care promptly rather than delaying treatment until their conditions worsen and require emergency or hospital-based care. Because emergency department visits and inpatient hospitalizations are among the most expensive health care services, reducing avoidable use through timely, effective outpatient care has the potential to generate substantial cost savings across the health care system.[61]

Although implementing disability competency training and improving accessibility may involve initial financial investment, these efforts can generate long-term economic benefits and most importantly, patient health. Reduced hospital readmissions, better chronic disease management, fewer preventable complications, and more efficient use of health care resources all contribute to lower health care expenditures. As disability prevalence continues to grow alongside an aging population, incorporating disability clinical care competency into medical education is both a public health necessity and a cost-effective health care policy strategy.

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Conclusion and Recommendations

A person seeking medical care will only get good-quality care if the provider they are seeing is trained to treat them, which in turn increases the confidence the patient has in the care they are receiving and the willingness of the provider to see the patient. Considering that there are tens of millions of people with disabilities in the United States, including those who become disabled as they age, disability clinical care and competency training should not be merely an elective in countless medical schools as opposed to mandatory training nationwide. Furthermore, because people with disabilities certainly show up in the offices of every specialist, it stands to reason that disability clinical care and competency training should be incorporated into every residency program. Accordingly, NCD recommends the following:

Recommendations

Recommendations to the US Department of Health and Human Services

1. NCD recommends that HSS revise Section 504 regulations to make disability clinical care and competency training in medical care professional training a specifically expressed requirement.
2. NCD further recommends that HHS establish guidance to this end.
3. NCD recommends the creation and dissemination of model comprehensive disability clinical care competency curricula by HHS that encompasses NCD's Model Framework.

Recommendation to State Lawmakers

4. NCD recommends that states pass laws mandating disability clinical care and competency training of medical professionals.

(continued)

Recommendations, *continued*

Recommendation to the Liaison Committee on Medical Education

5. NCD recommends that the LCME establish a disability clinical care and competency standard in its *Standards for Accreditation of Medical Education Programs Leading to the MD Degree*.

Recommendation to the Association of American Medical Colleges

6. NCD recommends that the AAMC recommend that the LCME and the ACGME develop disability clinical care and competency training standards.

Recommendation to the Association of Graduate Medical Education

7. NCD recommends that the ACGME establish a standard requiring graduate medical programs to train physicians in how to care for patients with disabilities.

Recommendation to the Commission on Osteopathic College Accreditation

8. NCD recommends that the COCA establish a disability clinical care and competency standard in its *Continuing Accreditation Standards*.

Recommendation to the Joint Commission (on Hospital Accreditation)

9. NCD recommends that the JC establish a standard whereby accredited hospitals are required to train professional medical staff in how to care for patients with disabilities.

Recommendation Concerning Medical Professional State Licensing Examinations

10. NCD recommends that medical professional state licensing examinations be revised to reflect robust testing of each of NCD's Core Competencies, which encompass the six Core Competencies on Disability created by the Alliance for Disability in Health Care Education.

Endnotes

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