How to Bring Disability into Medical School Curriculum?

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Disability and Health

- Disability was once considered incompatible with health.
- Public health now recognizes that “disability” and “health” are not mutually exclusive.
- Healthcare providers need to receive that message.
- Beyond disability as a negative health outcome, disability as a demographic.
How should we teach medical students?

BIG “D” OR LITTLE “d”? 
Case for big D

- Need for disability content in undergraduate medical education – *undifferentiated* students
- Prevalence = large community population
- Disability as demographic – cultural competence
- Healthcare barriers are similar across disability groups
Making the Case
Epidemiology of Disability

Prevalence

• ~ 20% of population over the age of 5 has a disability (~54 million Americans)
Disability prevalence is increasing

- Increase in number of people with chronic disease
- Increased survival of those with trauma
- Increased number of elderly and frail elderly
- Advances in health care and survival of people with disabilities across the lifespan (VLBW babies, adults who are chronically critically ill, etc.)
Disability is part of Community

• 54 million Americans have a disability, 52 million (over 96%) live in the community while only 2 million live in nursing homes or other longer-term care facilities.
• People with disabilities seek healthcare from community providers

US Census Bureau 2002
“Disability is a universal experience that affects nearly everyone at sometime in their lives.”

Significance of Definitions of Disability

The definitions *and* the view of disability that we have...

- Determine who is eligible for services and what services are allowed
- Affect our attitudes, views, and perceptions of people with disabilities
- Influence how we interact with and treat people with disabilities in all education, clinical practice, and community sites and settings
- Influence how we teach others about disability-related issues
“Disability” is an umbrella term for impairments, activity limitations or participation restrictions.

Focus moved away from “consequence of disease” to one on health and factors that affect health.

A person’s functioning / disability is seen as a dynamic interaction between health conditions (diseases, disorders, injuries, etc.) and contextual factors (personal and environmental factors) that affect health.

Disabilities vary in type

- Disabilities vary in type (physical, sensory, developmental)
- In severity (from inconvenience to survival)
- And in visibility
Without training, healthcare providers…

• Tend to underestimate the abilities of patients with disabilities.
• Grossly underestimate the quality of life of patients with disabilities.
• Minimize the patient’s capacity to contribute to their own care.
• Minimize the extent and importance of patient’s expertise in own condition.
• Believe that PWD cannot be healthy
Disability Training Lacking
(Holder, Waldman & Hood 2009)

• In a survey of medical schools,
  - Over 50% deans reported that disability training was not a high priority and 61% reported their graduates were competent to treat
  - 81% of medical students reported no clinical training
  - Seniors and graduates expressed inadequate competency in the care of patients with disabilities
Health Disparities: National Statistics

2006 Medical Expenditures Panel Survey
(Reichard, Stolzle, & Fox, 2011)

- Arthritis
- Asthma
- Heart disease
- Diabetes
- High blood pressure
- High cholesterol

Legend:
- Green: No Disability
- Red: Cognitive Limitation
- Blue: Physical Disability
Preventive Screenings: National Statistics

2006 Medical Expenditures Panel Survey
(Reichard, Stolzle, & Fox, 2011)
Special Olympics Athletes
(Corbin, Malina, Shepherd, 2005)

- Disparities in healthcare access:
  - **Eye exam**: 1/3 required prescription eyewear; more than 25% had never been screened
  - **Hearing tests**: more than 3/10 failed hearing tests
  - **Dental screening**: more than 1/3 of participating athletes had obvious tooth decay
  - **Foot screenings**: more than 75% had gait abnormalities
Recommendations to Improve Health of People with Disabilities

Two Surgeon General reports (2002, 2005), one Institute of Medicine Report (2007), the National Council on Disability Report (2009), and the WHO World Report on Disability (2011) recommended several key actions to improve the health of people with disabilities:

1. Improve public recognition that people with disabilities can live long, healthy and productive lives and reduce stigma and discrimination;

2. Improve knowledge, skills and attitudes of health care providers to improve care;

3. Improve accessibility of health care, including insurance, facilities, equipment, transportation;

4. Improve opportunities for health promotion, safety and wellbeing;

5. Improve data on disability populations, and research on disability-related health disparities and interventions.
What to teach?
Essential Understandings..

- Help providers understand the nature and prevalence of disability
- Understand health and healthcare disparity
- Address resonance with patient-centered care and medical home models
- Explore disability as a demographic in context of cultural competence or diversity
- Role of physician in preventing secondary conditions and improving quality of life
How to teach?

- Didactic instruction (knowledge and etiquette)
- Patient panel (discuss healthcare experience)
- Standardized patient (do NOT feign disability)
- Clinical experience (rehab, VA, Shriner’s)
- Formative exam (transfer, communication)
- Home visits/ community service (informal)
  - Challenge assumptions & Appreciate family milieu
  - Value of preserving function and lifestyle
  - Witness patient/family as expert in condition – shift the power balance
Cultural Competence

- Health care training programs increasingly add content to curricula to prepare culturally competent providers.
- Attempts are being made to expose students to “diverse” patient populations.
- Disability should be considered among cultures that can influence an individual’s perspective of health and healthcare.
- Disability as Diversity at OSU.
Liasson Committee on Medical Education

HOW TO TAKE IT TO SCALE
New Accreditation Standard
ED-19-A Approved

• At its February 2013 meeting, the LCME approved the following new accreditation standard:

**ED-19-A: The core curriculum of a medical education program must prepare medical students to function collaboratively on health care teams that include health professionals from other disciplines as they provide coordinated services to patients. These curricular experiences include practitioners and/or students from the other health professions.**

This new standard will become effective July 1, 2013, and will appear in the medical education database for schools with a full accreditation survey in the 2014-2015 academic year.
ED-21. The faculty and medical students of a medical education program must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments.

Instruction in the medical education program should stress the need for medical students to be concerned with the total medical needs of their patients and the effects that social and cultural circumstances have on patients’ health. To demonstrate compliance with this standard, the medical education program should be able to document objectives relating to the development of skills in cultural competence, indicate the location in the curriculum where medical students are exposed to such material, and demonstrate the extent to which the objectives are being achieved.
The LCME and CACMS believe that diversity is key to...

- Basic principles of culturally competent health care.
- Recognition of health care disparities and the development of solutions to such burdens.
- The importance of meeting the health care needs of medically underserved populations.
- The development of core professional attributes (e.g., altruism, social accountability) needed to provide effective care in a multidimensionally diverse society.
- The institution should articulate its expectations regarding diversity across its academic community.
- The institution should consider in its planning elements of diversity including, but not limited to, gender, racial, cultural, and economic factors.
- The institution should establish focused, significant, and sustained programs to recruit and retain suitably diverse students, faculty members, staff, and others.
ED-22 cultural bias

• ED-22. Medical students in a medical education program must learn to recognize and appropriately address gender and cultural biases in themselves, in others, and in the process of health care delivery.
The objectives for instruction in the medical education program should include medical student understanding of demographic influences on health care quality and effectiveness (e.g., racial and ethnic disparities in the diagnosis and treatment of diseases). The objectives should also address the need for self-awareness among medical students regarding any personal biases in their approach to health care delivery.
And admissions...

• MS-31. In a medical education program, there should be **no discrimination** on the basis of age, creed, gender identity, national origin, race, sex, or sexual orientation in any of the program’s activities.

• Standards for Accreditation of Medical Education Programs May 2012
Should we campaign for a LCME standard on disability?
Photos courtesy of Florida Office on Disability and Health, National Center for Physical Activity and Disability, Kansas Disability and Health, and Public Access Images Obtained from FODH and other sources
Toward Healthcare Parity

We hope that training medical students and healthcare providers will improve the availability, access, and appropriateness of healthcare for people with disabilities.
For more information...

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