Despite a recent explosion in research related to diversity, equity, and inclusion in the physician workforce, there have been relatively few studies focused on the experiences of physicians with disabilities. It is encouraging to see this starting to change, albeit slowly. This new study by Pereira-Lima et al evaluated the prevalence of reported disability among first-year medical residents and the frequency of disability accommodations requests and identified residents’ reasons for not requesting accommodations. Pereira-Lima et al found that 11.9% of surveyed first-year medical residents reported having at least 1 type of disability, including chronic health conditions, mental health conditions, and physical disability. Although 48.0% of residents with disabilities (weighted number, 83) reported needing accommodations, more than half (50.6%; weighted number, 42) did not request them. The leading causes cited by residents for not requesting accommodations included fear of stigma or bias and a lack of clear institutional processes.

Fear of stigma and bias against disability in the medical profession is justified. Physicians with disabilities are subject to stigmatizing attitudes throughout their careers. One of the us (M.R.O.) is a neurology resident living and working with a neuromuscular disease and feels the most damaging of these prejudices often come from physician colleagues and health care administrators.

The ingrained culture of ableism in medicine is particularly damaging to trainees, including resident physicians, who are a uniquely vulnerable population because their ability to complete training and find employment in their chosen field often mandates working up to (and at times, in excess of) 80 hours per week. They are in the unique position of being both learners and employees but seem to have the protections of neither. Concerningly, residency programs across the nation continue to demonstrate low rates of adherence to disability-focused recommendations laid forth by the Accreditation Council for Graduate Medical Education (ACGME); a 2020 study found that only 68% of graduate medical education handbooks included a disability policy, and only 59% of handbooks maintained a clear process for disclosing disabilities and requesting accommodations.

Pereira-Lima et al postulate that to increase resident comfort with accommodation requests, medical education programs should create inclusive environments that recognize disability in physicians as an important form of diversity that enriches patient care. One key barrier to creating those environments is physicians’ biases about disability and chronic illness. The disability paradox describes the disconnect between physicians’ perceptions of disability and the lived experiences of individuals with disabilities. Although 82.4% of physicians believe individuals with disabilities have a worse quality of life than those without disabilities, more than half of individuals with moderate or severe disability report having a good or excellent quality of life. A 2021 multispecialty study found that most physicians felt patients with disabilities were treated fairly in the health care system, yet fewer than half of physicians reported feeling confident they could provide high quality care to patients with disabilities. Thus, physicians’ misconceptions about quality of life for patients with disabilities are compounded by physicians’ self-reported inability to adequately care for those patients. Bringing physicians’ beliefs in line with the realities of the experiences of both patients and colleagues with disabilities is critical for making positive change.

The findings highlighted by research in this field are reflected in the lived experiences of resident physicians with disabilities. In keeping with findings by Pereira-Lima et al, it took a year after M.R.O.’s diagnosis to establish reasonable accommodations, due to a lack of clear processes and
procedures. M.R.O. has found that although most accommodation requests made by her or her coreidents are more than reasonable, including limiting work shifts to no more than 24 hours without rest and having 1 day off per week, they are sometimes challenged as “unreasonable” or overlooked in day-to-day practice. It is worth noting these requests are the bare minimum that all residents deserve, let alone individuals with disabilities or chronic illness. Even after accommodations are established, there are inevitably feelings of guilt and self-doubt when attending physicians, who care for patients with disabilities and chronic illness, falsely believe reasonable accommodations are negatively impacting learning and are unfair to other residents. Even with supportive program directors (correctly highlighted by Pereira-Lima et al1 as critical allies in this process), it can take years to educate colleagues regarding the nature of disabilities and accommodations and to establish clear boundaries when legally protected rights to accommodations are challenged. The need to continuously self-advocate to exist and practice safely within a workplace comes at a high cost in terms of time and energy and can negatively impact learning and well-being far more than any disability accommodation. 5 Disability accommodations are a legally protected right; the preferences of the generations of physicians that came before do not outweigh current trainees’ needs as human beings.

Adding to this harmful ableist culture is the design of health care spaces that are inaccessible to some patients and employees. M.R.O. pays more than $700 per year for the “privilege” of handicapped parking, and the resident facilities, such as the lounge, gym, and many of the call rooms at her hospital, are inaccessible to residents with mobility limitations because they are on a floor with no elevator. As long as health care policies and spaces continue to actively exclude those with disabilities and chronic illness, the shadow of ableism in medicine darkens even the greatest aspirations and the most eloquently worded promises of inclusion. The time has come for health care institutions to step up and ensure that their day-to-day practices align with their words and with the policies that the ACGME has set forth regarding the inclusion of residents with disabilities. Continuing education for attending physicians and administrators, hiring of designated disability professionals, a commitment to accessible workplace design, and active recruitment and retention of diverse faculty and trainees are all critical for achieving a truly inclusive workplace for physicians with disabilities.

ARTICLE INFORMATION
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