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Emily Johnson

University of Minnesota - Morris, joh11803@morris.umn.edu

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Emily Johnson
Honors Capstone
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Disability in Medical Spaces

Introduction

There are many existing definitions of disability, but a disability is generally considered to be any physical, intellectual, or developmental condition that limits someone's ability to take part in daily activities and interactions. ("Disability"). However, that is only one example. Disability can be broadened to include any disadvantage imposed by society, or reduced to include only specific impairments by the Americans with Disabilities Act (ADA) definition. The academic discipline of disability studies approaches disability from an interdisciplinary perspective and uses multiple theories to define and understand the disability experience ("What Is Disability Studies?") . First and foremost, disability studies rejects the idea that disability is an individual impairment that limits a person in their daily activities. Instead, the discipline posits that disability is a concept defined through social and cultural contexts. While most disability studies scholars do agree that membership in a group shapes a person's experiences in society, there is much disagreement in the field on how best to define disability. A primary goal of disability studies is to view disability through lenses other than the clinical, medical, or therapeutic perspectives. One of the best ways to explain disability studies is to explain what it is not: "It is not medicine, rehabilitation, special education, physical or occupational therapy, and professions oriented toward the cure, prevention, or treatment of disabilities," (Foley 2014). Disability studies utilizes many different models and lenses to explain difference, so there is no one universal way to define the core tenets of the discipline. Some scholars

support the social model, which focuses on the policies and barriers in society that are inherently disabling. Others dismiss this model because it overlooks the experiences of suffering that many people with disabilities experience. On the whole, disability studies addresses how disability is defined and represented in society.

The most pervasive way of understanding disability is the medical model. The medicalization of disability began in the nineteenth century in the United States, spurred by the desire of the newly freed colonies to differentiate between “fit” and “unfit” citizens (Nielsen 2012). Unsurprisingly, disability being viewed as a medical condition coincided with the rise of medicine as a profession. It was in this era that it became common for people with disabilities and their families to rely on the expertise of doctors, and physicians took it upon themselves to diagnose and treat physiological and intellectual differences. Although during this period, treatments varied greatly among doctors, and could be anything from bloodletting to immersion in cold water (Nielsen 2012). Over time, medicine and the treatments may have changed, but the idea that disability is a disease that ought to be cured has continued to be one of the most persistent views of disability in America. The treatment centered viewpoint has also greatly influenced the way people with disabilities are treated in medical spaces. The knowledge-power differential between a physician and patient allows for the physician to control the situation, and as a result forces the person with disabilities and their family members into a “sick-role” that is generally characterized by passivity and powerlessness (Hayes and Hannold 2007).

As the social and medical model of disability differ so greatly, disability studies is often seen as incompatible with medical spaces, because it challenges the idea that disabilities need to be “fixed.” By suggesting that it is society itself that needs to be fixed,

disability studies seeks to remove the barriers to inclusion that so many face. With this project, I am investigating what future physicians are taught about disability because I plan to attend medical school and I hope to foster better cooperation between the medical and social models. I hypothesize that by incorporating disability studies into medical practice, some of the power struggle would be removed from medical spaces, and medical school would become more accessible to people with disabilities. This would result in patients feeling more comfortable when visiting their doctor, improved communication between patients and their doctors, and an overall environment of mutual understanding and empathy.

Problems With Medical Spaces

People with disabilities are consistently stigmatized, perceived as less than whole in the minds of others. The medical model embraces the idea of “able-bodiedness” and “able-mindedness,” which in turn classifies people with disabilities as dysfunctional and in need of care. By defining the acceptable standards of health and designating which behaviors are beneficial or detrimental to health, doctors are able to create a narrative where people with differences are considered sick or unhealthy and are therefore in need of treatment, thus promoting the beliefs of the medical model. The use of specialized language, tools, and techniques make it difficult for the average person to have the same level of knowledge as someone with medical training, thereby enforcing the power difference. This is in high contrast with disability studies, which restores authority to people with disability and their own experiences. As the goal of the medical model is to “cure” the disability, the main focus of physicians when working with disabilities is the treatment of said disability. Historical

methods of treatment ranged from prescribing opium and alcohol to treat seizures in the early 1900's to using lobotomies to cure intellectual disabilities as recently as the 1960's ("Cures Exhibit"). More recently, researchers discovered the possibility of silencing the extra chromosome responsible for Down Syndrome (Fessenden 2013). This focus on a "cure" results in people with disabilities becoming the targets of medical discourse and practice (Hayes and Hannold 2007). People with disabilities are seen as a unique learning opportunity for medical students or residents. This results in the patients being used for the benefit of the doctors, not being treated for their actual health concerns. Not only is this problematic because of the continued attempts to "fix" disabilities, which can be upsetting to the person with disabilities, but it also leads to curt assumptions regarding the needs of people with disabilities and a lack of common courtesy when they enter a medical space.

When they enter medical spaces, many people with disabilities are not afforded the same privacy as a non-disabled person would be in the same situation. It was not uncommon for physicians working with patients, particularly children with a physical disability such as spina bifida, cerebral palsy, muscular dystrophy or brittle bone disease, to have the patient strip down to only their undergarments and display them in front of colleagues, residents, or other professionals to examine them. This practice, called "public stripping," was still common in some hospital settings as recently as the 1990s. In her account of the procedure, author Lisa Blumberg describes one woman's personal experience with public stripping: "No one ever explained to Anne why she had to be examined in front of a group. No one ever considered whether she found it embarrassing or upsetting to be viewed nearly naked by so many people. No one ever acknowledged to her that she was being used as a teaching tool. No one ever told her or her parents that she had

any choice in the matter,”(Blumberg 1994). This experience violates the patient’s privacy, promotes bad medical practice, and has lasting psychological effects. It also overlooks the most basic principle that a patient with a disability is just like any other person seeking medical advice. They deserve to be provided with medical care, not treated as a learning opportunity for physicians.

Another major problem with the medical model is that a unique focus on fixing, curing, or treating the disability, distracts from the actual desires of the person in question. For many disabled people, the disability is a part of their identity. Additionally, they might not have any desire to change themselves simply to be considered “normal” in today’s society. In the medical model, the goal of treatment is to enable the person with a disability to live as normal a life as possible, whether through therapy, medication, or the use of assistive devices. However, those treatments are often decided with minimal discussion . Medical professionals often adhere to the deficit model of disability, which functions on the assumption that a disability is a deficiency or abnormality. This leads them to simply assume that the person with disabilities would want to be cured of their disability. While it is reasonable for people with disabilities to have no interest in being “cured,” those people are often labeled unmotivated or noncompliant (Haegele and Hodge 2016).

When physicians become fixated on a person’s impairment, it can also lead to differential outcomes for the patient. Placing the focus on the disability, rather than the person as a whole, can lead medical professionals to overlook other symptoms and health issues. Studies have found that people with disabilities receive inferior health care, including disparities in mortality, morbidity, and overall quality of life (Krahn et al. 2006). People with disabilities have three times as many unmet healthcare needs as people

without (Kelsall 2016). Healthy People 2020, the government's health prevention agenda that sets national health priorities for 2010 to 2020, documented that people with disabilities were more likely than people without disabilities to experience difficulties or delays in getting the health care they need. They are more likely: not have had a mammogram in the past 2 years, not have had a Pap test within the past 3 years, not have had an annual dental visit, not engage in fitness activities, to use tobacco, to be overweight or obese, to have high blood pressure, and to experience symptoms of psychological distress ("Disability and Health"). For instance, only 3% of women with intellectual disabilities are reported to receive screenings for cervical cancer, as opposed to 85% of women in the general population (Marks 2006). People with intellectual disabilities are also more likely to be prescribed medication for psychiatric concerns, without corresponding psychiatric diagnoses (Krahn et al. 2006). In the past, people with intellectual disabilities have been given psychotropic medication to subdue them and control any perceived behavioral issues, and not to treat an actual mental illness. These results are alarming because they indicate that this practice is still occurring. These are only a few examples of the many ways that people with disabilities do not receive adequate health care due to a singular focus on disability that seems to undermine their dignity and worth as fellow people.

For people with mobility impairments, accessibility is another barrier to good healthcare. Healthcare facilities often report that they are unable to care for patients who use wheelchairs because they do not possess the appropriate accommodations, listing reasons such as inaccessible buildings or lack of height-adjustable exam tables (Lagu et al. 2013). A mobility impairment can also affect a patient's ability to climb stairs or onto an

examining table, use a restroom to provide a sample, or navigate halls in a wheelchair. A substantial distance from public transit or from the parking lot to the clinic can present a major barrier, as well. Many doctors might think their hospital or clinic is accessible, but their patients often disagree. A recent study in Ontario, Canada found that only 15% of clinics had an accessible examination room (Kelsall 2016). Be it physical or procedural, people with disabilities face many obstacles to receiving the healthcare they need.

Problems With Medical Schools

As the primary place of learning for future health professionals, medical schools and their practices play an important role in influencing how physicians interact with their patients. The way medical schools choose to teach their students about disability influences how those students will treat their future patients who have disabilities. If the medical model is emphasized, it could lead to students furthering the poor practices and ideations that occur in medical spaces. While it is not surprising that a medical institution, whether a hospital, clinic, or medical school, would be largely focused on diagnosing and treating patients, those methods can result in upsetting or even harming patients if their needs are not considered (Marks 2006).

Some medical schools do not have any curriculum available to train their students about caring for people with disabilities. Over half of the medical school deans surveyed in one study stated that their graduates are “not competent” to treat people with intellectual disabilities. The main reason for this alarming deficiency was “a lack of curriculum time or faculty expertise,” or that clinical training focused on people with intellectual disabilities is not a high priority. While many students expressed an interest in treating people with

disabilities in their career and nearly all administrators stated that they would implement a curriculum on the subject if given one, improvements will not be made unless explicit action is taken to create and actualize a comprehensive curriculum that can be used in a wide variety of situations (*Changing Attitudes*).

One corollary of these attitudes is a decided lack of physicians with visible physical differences. A possible cause of the shortage of doctors with disabilities is problems with accommodations in medical schools across the country. According to a report by the Association of American Medical Colleges (AAMC), there were no universal practices for the provision and review of disability accommodations in medical education, and no network was available to share information on successful or faulty practices until recently (Meeks and Jain 2018). As a result, most schools reported the problems were due to the absence of standardization in the disability disclosure and accommodation processes, inconsistent support from necessary offices and staff, and a lack of understanding of the ADA. This is all concerning, but there is hope for change: all the medical school administrators the AAMC interviewed while gathering this data reported a desire for guidance and to make any necessary improvements in order to be compliant with the mandates of the ADA (Meeks and Jain 2018).

Physicians with Disabilities

Due to the medicalization of disability, people with disabilities have historically been seen as unfit to pursue higher education, which hinders their ability to enter the medical field. While there is a problem with attrition in medical schools, this issue is present even at undergraduate universities. Studies have shown that only 16.4% of people

with disabilities who attend college finish with a 4-year degree, compared to the 34.6% for people with no disability (“People with a Disability Less Likely to Have Completed a Bachelor's Degree”). Problems with accommodations are not specific to medical schools, they are systemic and exist throughout society. However, the environment created in higher education is one that specifically excludes people with disabilities. As a result of this exclusion, although people with disabilities make up over 20% of the United States population, less than 3% of practicing physicians have disabilities (Meeks and Jain 2018). While this is an improvement over the 0.56% reported in 2010, there is still a great discrepancy. This is alarming, because representation is important: the greater the number of physicians with disabilities, the more the profession as a whole will be able to embrace differences, and work to change medical spaces to be more welcoming.

The largest and most disconcerting of the problems reported in the study by Meeks and Jain about medical school accommodations is the confusion surrounding the ADA. A 2016 study suggests that as few as 33% of schools had technical standards that specifically support disabilities as required by the ADA (Zazove et al. 2016). The same study found that most medical schools did not clearly state policy and lacked information about their responsibility for providing accommodations. Some attribute these problems to attempts to define core technical standards and competencies that have not kept pace with technological changes, diverse specializations, and changing practice options. Adjusting the technical standards required by medical schools would resolve many of the problems for medical students with disabilities. This is an example of the idea behind much disability studies research: it is societal views and practices, and not the impairment itself, that cause the problems for people with disabilities.

Another problem for people with disabilities trying to enter medical fields is that some physicians operate on a dependency model: they are the experts upon whom people with disabilities depend for help. The presence of competent disabled people in the medical field challenges the dependency model described above. People with disabilities often possess unique skills as a result of their experiences, such as increased empathy with patients. However, in order to take advantage of those skills and improve this situation, medical professionals would need to learn from their clients, which could compromise their authority and status. Despite this, in a 2008 study most physicians with disabilities describe their experiences with colleagues and other medical professionals very positively. The biggest difficulty the physicians with disabilities experience is a lack of understanding, with colleagues overlooking or forgetting their disabilities, leading to uncomfortable situations. Some of the people interviewed also struggle with the expectation that they would rotate through a wide variety of specialties, but this was not possible for all the doctors with disabilities. As a result, most people tried to specialize as early as possible. For example, a deaf physician said she avoided positions where she would need to work with large groups of people or a hospital with a big campus (French and Swain 2008).

Dr. Lisa Meeks, a professor at the University of Michigan medical school, has become a passionate activist for disability representation in health professions, working to inform policy and successful practices in the area of disability resources and accommodations. In 2013, she and Tim Montgomery founded the Coalition for Disability Access in Health Science and Medical Education, “a collaboration among peer institutions that aims to improve the student experience with disability accommodations in graduate health science and medical education programs,” (Meeks). Recently, the pair started the

“#DocsWithDisabilities” movement, a social media campaign where physicians can send in their stories about having a disability and being in a medical profession; the stories are then posted on Twitter or Instagram. The posts are usually only a few sentences, but they convey a lot of insight the doctors would like to share with others who may hesitate to pursue a medical career because of the barriers they may experience. For example, Dr. Chris Sterwald states “Starting out in medicine can certainly be daunting, but even when you’re the only one in the room with a disability know that you are not the first.” The testimonies are also beneficial to other physicians, helping them learn more about disabilities from the unique standpoint of those who have been both doctor and patient. Dr. Feranmi Okanlami shares “I have learned the value of independence through my struggle, and I have the empathy to understand it in my patients,” while Dr. Sarah Sternlieb says, “The practice of medicine needs to be less formulaic and more adaptive to allow people with disabilities to set their own limits,” (“Docs With Disabilities”). The goal of the #DocsWithDisabilities Project is to share stories about physicians, nurses, and medical trainees with disabilities and their professional experiences, in their own words. The movement features the real voices of physicians and health professionals with disabilities, including both their struggles and their successes, which will hopefully foster awareness, visibility, and a safe environment to support people with disabilities as both patients and physicians.

Current Practices in Minnesota

As a resident of Minnesota and future medical student, I am particularly interested in the practices of the University of Minnesota medical schools in the Twin Cities and

Duluth, especially because I am likely to attend one of the two. As of 2018, the Twin Cities campus does not offer courses in disability studies. However, in recent years, the University has started taking steps in the right direction. Last year, the medical school hosted a lecture with photographer and activist Rick Guidotti. Guidotti's activism began with a photographic exhibition, titled "Positive Exposure," that depicted individuals with a wide variety of genetic, physical, behavioral and intellectual differences. Since the exhibition, Guidotti has created a non-profit organization of the same name. As stated on their website, Positive Exposure "celebrates the beauty of human diversity, inclusive of ethnicity, religion, age, ability, learning style, gender identity, gender expression and sexual orientation," ("About the Program"). At the end of their first year Biochemistry and Genetics course, University of Minnesota medical students have the opportunity to attend a two-hour session with Guidotti. He most often brings along someone he has worked with who has a genetic disorder, and they discuss problems with the medical model, as well as challenges they have experienced in their life when entering medical spaces. More recently, in early March 2018, the student council arranged a week-long event with Guidotti, where families of children with genetic differences describe their personal experiences, and how physicians can make their interactions with people with disabilities more positive (Haas 2018). While this is definitely an important improvement to their curriculum, there is still work to be done in order for the students to more fully understand the importance of moving away from the goal of "curing" patients with disabilities, and instead focus on the immediate health needs of the patients.

In an interview with University of Minnesota Medical student and Morris alum Anne Gair, many of the same issues were discussed. Gair states that there is little to no

curriculum about people with disabilities. The medical school offers an optional lecture series about mental disability and how to interact with patients in ways that are more humane and focused on their needs at that time. As far as the actual required curriculum, disability is rarely discussed. Anne mentioned that there were a few lectures on the basic idea of patient centered appointments, where the patient is able to talk about their specific concerns, an important type of appointment because it is explicitly focused on the patient's goals. However, Gair says that most medicine does not utilize patient centered appointments. Especially in primary care, due to specific standards that need to be met according to the ADA and other regulations, the focus of appointments for people with disabilities is on preventive care. While that is obviously an important aspect of healthcare, it does not allow the patient to discuss their needs.

Anne also mentioned the activism of Rick Guidotti. She agreed that the opportunity was valuable to the medical students, but it left them feeling more frustrated than enlightened. The lecture brings to light many of the problems that exist in medical care for people with disabilities, and makes the students aware of the need for change. But when the lecture is over, attendees just return to their regular classes where disability is never discussed. Many of the students were upset that only one lecture in their entire time in medical school was about disability, and expressed a desire for more. It is unfortunate that the opportunity for better education about disabilities in medical spaces is not available now, but the fact that students want more is a promising step toward change.

Finally, Anne told a story that she thought highlighted a positive experience with a patient with disabilities that she had as a medical student. Anne was doing rotations in a hospital, and there was a patient who was fairly young, and had suffered a stroke in the

past which resulted in him using a wheelchair. He had also recently received a cancer diagnosis. He smoked a lot, and while he was in the hospital, that was prohibited. The patient asked a resident to take him outside to smoke, and she knew that it was bad for him, but she also knew that what he needed in that moment was to smoke, so she went outside with him. He then informed her that he did not have any cigarettes, and she went around to everyone standing outside the hospital to ask for a cigarette for him. Anne appreciated how the resident identified what he needed in that moment and focused on that. This story is an excellent example of taking a step back from the role of “doctor-as-healer” and allowing the patient’s wants and needs to come first (Gair interview 2018).

Future Directions

Although systemic pressures prevent the incorporation of disability studies into their practice, the coexistence of disability studies and medical education would have many beneficial effects. After just one 90 minute lecture, medical students felt more comfortable interacting with patients with disabilities, and demonstrated more considerate practices in the exam room (Graham et al. 2009). If such an improvement was present after only one lecture, one can expect that incorporating more disability studies into medical school curricula would have an even greater positive effect.

Two such programs have been implemented in the United Kingdom. In Leicester, medical students complete a one month placement entitled “Learning from Lives” during their third year. The program involves students attending a one-week orientation, where they are taught about the social and medical models of disability, as well as disability equality. The students then spend the rest of the month working within rehabilitation

settings, allowing them to be completely immersed in the lives of people with disabilities. At the end of the experience, one student reported “I have learnt that people who have an impairment should not be viewed as passive recipients but should be given tools to enable them to overcome that impairment and live as independent a life as possible,” (Marks 2006) At the University Bristol, a similar program, called Partners in Practice, was designed with input from people with disabilities. After participating in a pilot audit, students stated they felt more confident about communicating with people with a disability, and that the program would improve their future practice.

While programs such as these are extremely beneficial, not all medical schools have the funds or resources developed to dedicate to such a program. An alternative option is to use online resources to introduce the medical students to important concepts in disability studies. One excellent resource that could be used, especially as it expands its range of topics, is the website *healthtalk.org*. Managed by the charity DIPEX and the Health Experiences Research Group at the University of Oxford, the website provides accounts of people describing their experiences with a variety of medical conditions. Their aims are “to support patients and their loved ones, who may feel alone or ill-prepared for challenges ahead, to support healthcare professionals in providing patient-focused care, and to promote better communication between patients and health professionals” (“About”). For each topic covered on the site, a research team made up of people affected by the health issue, health professionals, academics, and staff from relevant charities create an advisory panel. The researchers then find between 40 and 50 people to interview about their story, pick out the common themes and write detailed summaries. Videos of the interviews are provided with the summaries to illustrate people’s experiences. The website currently only

has about 100 topics, but they span a wide range of illnesses, injuries, and disabilities. Medical schools could easily design a lecture series using the videos to demonstrate patient perspective. Research has shown that students taught using videos from the *healthtalk.org* site performed better on exams, expressed greater confidence while interacting with patients, and felt more comfortable responding to emotional reactions from patients (Rosamund et al. 2016). There are currently over 25,000 videos on the site, and if they continue to add more topics related to disability, it would be a simple way to teach medical students about interacting with patients disabilities from the patient perspective, an important change to the current model. The video-teaching method is also beneficial because there can be ethical concerns when asking a patient to disclose uncomfortable or upsetting situations to medical students in person, and that can be avoided with this method.

Another program that would be extremely beneficial if included in medical education is FRAME, created by Rick Guidotti. FRAME, or Faces Redefining the Art of Medical Education, is one of multiple projects Guidotti has created with his advocacy organization Positive Exposure. Since his original exhibition, Guidotti has continued to collaborate with various organizations to change the way people with perceived differences are viewed by society. FRAME is one such collaboration. Started as a collaboration with students at Sarah Lawrence College, it consists of a collection of educational films which will give future medical professionals a more complete understanding of the featured genetic, physical, intellectual and/or behavioral conditions. The videos model an attitude of respect for the humanity of patients, allowing viewers to see participants “talk, move, and smile, a departure from the ‘patient-as-a-specimen’ model

that most educational medical literature utilizes” (“FRAME”). The program presents individuals living with specific genetic conditions in a more humanizing way, avoiding the common temptation of medical spaces to reduce a person to their condition, instead capturing their unique beauty, as seen in Figure 1. In addition to the benefits FRAME provides in medical education, it could also be used by families, and as a transition tool for young adults with these genetic conditions that are transferring into the adult health care system.



Figure 1: Treacher Collins syndrome, a condition that affects the development of bones and other tissues of the face, as depicted in “FRAME.” *Positive Exposure*, positiveexposure.org/frame/. Photo by Rick Guidotti

While changing the way future physicians are educated is extremely important to improving care for people with disabilities, it is also important for doctors to have all the

best options available to provide the most quality care for their patients. One practice that has become especially problematic is genetic counseling. Parents who opt to do genetic testing during pregnancy are often counseled about the results, particularly if results indicate that the child is likely to have any sort of disability. Prenatal genetic testing is concerning to disability advocates because they believe it is eugenic, in other words, that it contributes to the disappearance of disability. For example, as many as 90% of women terminate their pregnancy due to prenatal tests that indicate their child could have Down Syndrome (Don't Screen Us Out 2016). These numbers have been steadily increasing as genetic testing becomes more safe and readily available. Studies also show that most genetic counselors have a more negative perspective on disabilities than those whose lives are affected by them, and this prejudice impedes their accurate representation of disabling conditions while counseling families about their options (Madeo et al. 2011). When families of people with disabilities participated in a survey about quality of healthcare, one of the largest complaints was the physician's unwillingness or lack of resources to touch with other parents. Most parents agreed that the general care provided by their physician was very good, but they were left wanting more information and connections with other people in the disability community (Liptak et al. 2006).

Many online groups have been started in order to help families of children with disabilities share knowledge and resources. Websites such as *Stone Soup Group* and *Parents Reaching Out* exist to assist parents find resources and support. They also have opportunities to meet with other parents and families. At no cost to the family seeking support, the *Stone Soup Group* offers help from a parent navigator: another parent of a child

with disabilities who has experience and is familiar with the resources available in Alaska (where the organization operates), (“Connect”).

Someone receiving genetic counseling has likely not yet found and utilized those resources, and would benefit from the opportunity to speak with someone who can explain their situation, rather than a physician who conveys only its medical implications. It would be extremely positive to have physicians connect families encountering similar situations, in order to allow them to help each other discuss the information that physicians cannot provide. Physicians could introduce their patients and families to these websites, or provide the services themselves. It may be as simple as having each family they meet with complete a survey asking if they would be comfortable meeting other families with similar experiences, and then keeping a small database of those who are willing. This is a simple, short term solution that would be easy for hospitals and clinics to implement, and patients would feel much more informed and comfortable as a result.

Conclusions

Many advances have been made in recent years to improve medical spaces and make them more welcoming and understanding of people with disabilities. Moving away from the medicalization of disabilities and becoming more accepting of difference will go a long way in improving health care for people with disabilities, as well as for the population as a whole. The skills that medical health professionals will gain as a result of this change, such as increased empathy and patient-centered care, will result in better healthcare for everyone, not only people with disabilities. Changing the way medicine views disability will also pave the way for more representation of people with disabilities in health professions.

Incorporating disability studies into medical school curriculum, either as a course or by utilizing one of the many resources available online today, will change the way medical practitioners view the world. Specifically, physicians having a better understanding of difference would reduce stigma for all parties, promote self-acceptance and healthy identity formation in people with disabilities, promote interdependence over heroism, build trust and candor, and produce better health outcomes for patients. It will take time, but starting with a few small, simple changes could catalyze a greater shift in the views of disability in medicine and in society, overall.

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