Whether, How, and Why Departments Should/Shouldn't Make Accommodations for its Members with Learning Disabilities

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Disclosures

I am not an expert in this area, but throughout my career in medicine as a Flight Surgeon, Clinical Competency Committee Chairperson, Fellowship Program Director, and Division Chief, I have had to deal with the impact of illness on the health of an individual as well as their career and personal identity.

The question of whether academic Departments of Anesthesiology should offer accommodations to individuals with learning disabilities requires that leaders understand the basic definition of disability, prevalence, impact, and means to offer assistance to our colleagues. The framework for these decisions must balance our quality and safety responsibilities to the patient, with compassion for the disabled individual[1]. Facilitating the entry of those individuals with learning challenges and others with physical, sensory, and motor disability will allow us to form a truly

inclusive and diverse cadre of healthcare providers, many of who, with appropriate accommodations, are able to deliver great care[2].

Prevalence and Background

The World Report on Disability notes that nearly 1 billion people worldwide suffer from some disability[3]. It is estimated that nearly 57 million American citizens are currently living with a disability, a number greater than the entire population of Canada. The number grows as the population ages. Approximately 8% of those under fifteen are disabled, but by the age of 65, nearly 50% have a condition that impairs their daily living[4]. The numbers are increasing[5]. Disabled individuals in society have lower levels of education and employment[6]. They have higher rates of poverty and are more likely to become victims of crime and domestic violence. Medically they suffer higher rates of depression, anxiety, and stress. This is coupled with higher rates of obesity and tobacco use. Disabled women are less likely to obtain Pap smears or have a mammogram[6].

Context

The motto of the American Society of Anesthesiology (ASA) is “vigilance”. Our practice requires that we have the cognitive ability to review conditions and make sound decisions, the physical ability to perform often delicate procedures with accuracy and efficiency, we must have senses that allow us to see and hear alarms, verbally communicate our concerns, summon help or respond and react or immediately in order to provide care. We must have the emotional capability of control in crisis. Thus, certain disabilities may potentially hinder our ability to perform.

The management of motor, sensory, cognitive, or emotional disabilites is rarely black and white, but more often is a very hazy shade of gray. Learning disabilities among graduate medical education have been more poorly studied than physical, sensory, and motor disabilities. Very little has been published on disability among anesthesiologists or residents in Anesthesiology[7,8,9,10].

Several questions must be answered in order to determine whether academic medical centers should make educational and professional accommodations to facilitate both training and clinical practice.

What is a Disability?

The Rehabilitation Act of 1973 was the first attempt to ensure opportunities including equal access to education for individuals with disabilities. This primarily focused on programs receiving *federal funding*. This resulted in a significant increase in the number of handicapped persons seeking higher education. The Americans with Disability Act of 1990 (ADA) expanded rights to the private sector. The ADA defined a disabled person as one who has a physical or mental impairment that substantially limits one or more major life activity. This includes people who have a record of such impairment, even if they do not currently have a disability. The ADA also makes it unlawful to discriminate against an individual based on that person's association with a person with a disability[11]. The ADA defines "qualified with a disability" as an individual who with or without reasonable accommodation, can perform the essential function of a position

[12]. The ADA Amendments Act of 2008 attempted to relax strict standards of proof that a disability actually exists.

The term 'major life activities' generally includes functions which are typically required for daily life and are performed independently such as walking, sleeping, eating, sitting, standing, learning, hearing, lifting, reaching, and working. Another means of classifying functional limitations includes *basic action difficulties* (movement, sensory, emotional, cognitive) or *complex activity limitations* (limitations in self-care, social interaction, or work)[5].

There is not a single universally accepted definition or a "disability". The World Health Organization, Social Security Administration, as well as the American Medical Association have all established terminology[13]. It is critical to understand that the presence of a condition does not imply a disability; in fact this is a social stigma that infiltrates physician-patient or even employer-employee relationships. This may lead individuals to feel compelled to conceal a medical condition and not ask for assistance.

Conditions that *may* involve a disability can be generally divided into physical (sensory and motor), cognitive, and emotional. Examples are provided in Table 1.

Table 1 – Examples of conditions that *may* result in a disability

Physical Disability	Cognitive	Emotional
Visual impairment Hearing impairment Multiple sclerosis Cerebral palsy Amputation Spinal cord injury	ADHD Dyslexia Dyscalculia Dysgraphia Language processing disorders Non-verbal learning disability	Substance Use Disorders (SUD) Anxiety Depression Bipolar disorder

Chronic pain Latex allergy Vertigo		

What is the incidence of disability throughout the spectrum of professional development including medical school, residency, and professional practice?

Several studies have examined the incidence of disability in US medical students. Wu et al. examined physical disability between 1987 and 1990[14]. Approximately 0.19% of over 33,000 students graduated with a physical disability. Nearly 50% of these individuals required some sort of device to facilitate their performance (wheelchair, cane, hearing aids, artificial limb, insulin pumps, electric carts, eye glasses). The vast majority of disabilities were present before admission to medical school. Moutsiakis et al noted an incidence of 0.15% between 2002 and 2005[15]. Eickmeyer et al reviewed medical school experience with disability between 2001 and 2010[16]. Less than 1% (0.56%) of students had a disability at matriculation and 0.42% upon graduation. Very little work has been done to determine the incidence of disability among physicians in graduate medical education. Takakuwa et performed a survey of directors of Emergency Medicine residency programs[17]. Sixty-two (62) of 4,644 residents were identified as having a disability (1.3%). The majority of disability were learning (29%) followed by depression/bipolar (12.9%), and musculoskeletal (9.7%). No article has been published that assessed the incidence of disability in the anesthesia community.

What impact does the presence of a disability have on a medical professional?

Searcy et al studied the course of medical school applicants that required additional time on the Medical College Admission Test (MCAT) and found that those applicants who required additional time had lower rates of passing Step examinations at each level and also graduated

from medical school at a lower rate than other colleagues[18]. Wu et al notes that the majority of medical students with a disability performed at an average or above average level[14]. Nearly 50% of the individuals required some sort of device to facilitate their performance (wheelchair, cane, hearing aids, artificial limb, insulin pumps, electric carts, eye glasses). Eickmeyer found that those medical students with a disability had a far higher rate of attrition from medical school than those without[16]. Takakuwa et al noted that 79% those residents in Emergency Medicine with a disability either graduated or were expected to graduate at the time of the study[17]. Individuals that disclosed a disability prior to matriculation were more likely to graduate.

Our discussion thus far had revealed that medical students with a disability graduate at a lower rate than peers without. Neal-Bolyn et al interviewed 20 medical professionals having a disability and five findings were noted (Table 2)[19]. Findings revealed that disabled healthcare providers rarely seek accommodations and often struggle with disclosure of their condition. They do not disclose their condition nor seek accommodations. They also experience emotional roller coasters from anger and grief to optimism.

Table 2 – Career Trajectory of the Disabled Practicing Healthcare Provider

Disability Impact	Manifestation
Narrow career choice and trajectory	Initial specialty choice, job changes
Disclosure of condition to employer or supervisor?	Individual struggles alone
Rarely seek legally guaranteed workplace accommodations	Do not receive assistance and workplace continues with environment not accepting of disabilities
Interpersonal interactions reflect institutional climate	Assumptions made that an individual cannot perform tasks
Reactions to work-place disability-related challenges run from anger, grief, to resilience and optimism	Feelings of being undervalued but have a high tolerance for compromise and negotiation at work

Neal-Boylan L, et al Acad Med 2012;87:172-178

What are the legal rights of an individual with a disability and what are the rights of an institution in managing a disability?

The legal rights of an individual with a disability are outlined well in the three key federal acts, Rehabilitation (1973), ADA (1990), and the ADA Adjustments Act (2008). Specific challenges have been brought to court made regarding decisions by institutions. *Jakubowski v Christ Hospital* (2010) resulted in the recognition that an employer has an obligation to participate in an "interactive process" to assess possible accommodations for a disability[20]. Legal challenges have specifically included medical training. These largely focus on the impact of management of a disability during training and the burden the program will have to accept to offer accommodations. *Doherty v Southern College of Optometry* addressed whether an examination that required dexterity should be waived for a disabled individual. The court held that a course that is "reasonable and necessary" does not need to be eliminated nor altered[21]. An example of "reasonable and necessary" in an anesthesiology residency would include the ability to perform intubation. *Wynne vs. Tufts University School of Medicine* determined that deference must be paid to an institution as long as that institution demonstrates that an effort was made to investigate alternatives to a particular activity[22]. *Southeastern Community College v Davis* (1997) made the key determination that an accommodation is "not reasonable" if it creates an undue financial or administrative burden, or that the accommodation would fundamentally alter the nature of the program[23]. The question of whether a trainee is afforded the protections of a student or whether they are considered an employee has been subject to litigation. The ADA requires that employees establish processes where individuals with disabilities have equal opportunities to (1) apply and work in a job for which they are qualified, (2) have the chance to be promoted, (3) have equal access to benefits offered to other employees, and (4) are not harassed because of a disability.

The employer has several rights, and accommodations are not simply requests that must be granted (Table 2).

Table 3 – Limitations on the obligation to provide accommodations

There is no obligation to provide an accommodation that would assist on and off the job (prosthetic limb)
No obligation to remove or alter essential job functions
No obligation to lower production or performance standards
No obligation to tolerate violations of conduct rules necessary for operation of business

What are "accommodations" in management of disability and how does a program implement them?

An accommodation is considered any modification or adjustment to a job or work environment that enables a qualified person with a disability to apply for or perform a job. The term also encompasses alterations to ensure that a qualified individual with a disability is afforded the rights and privileges in employment equal to those of employees without disabilities. In the simplest term, an accommodation is an activity to remove a *workplace barrier*. These barriers may be physical or administrative. The obligation to provide reasonable accommodations for job applicants or employees with disabilities is one of the key non-discrimination requirements in the ADA's employment provisions[24]. Accommodations are condition specific. Not all individuals with a certain condition may require accommodations and not all individual with a condition require the same accommodation. Some accommodations are general and apply to many conditions (Table 2). While others are more case specific.

Table 2 – Non-specific Accommodations

Sensitivity training for coworkers
Maintain open lines of communication
Allow communication with the individual's physician

Flexible medical leave
Breaks
Check-lists/"To do" lists/ Reminders
Part-time work
Assistance with development of strategies to assist with problems *before* they occur
Establishing mentoring programs with faculty that understand disability
Assessment of appropriate technical needs rather than rigid general standards

Should or shouldn't academic departments of anesthesiology offer accommodations to trainees and faculty members?

When considering whether academic departments of anesthesia should make not only basic but exceptional efforts to accommodate individuals with disabilities decision makers will need to balance their responsibility to three populations: the patient, the aspiring or attending physician, and the effect on society as a whole. Medical ethics has traditionally stressed that our primary responsibility is to assure the well-being, and more recently the safety, of the patient. The Accreditation Council for Graduate Medical Education (ACGME) has avoided specifics on disabilities in specific common program requirements but under the institutional requirements notes that, "The Sponsoring Institution must have a policy, not necessarily GME-specific, regarding accommodations for disabilities consistent with all applicable laws and regulations"[25]. A residency applicant or a current trainee is under no obligation to disclose a past, present, or even potential future disability at the time of application. Even if a disability has required accommodations in the past, this does not need to be disclosed. When an individual does request "modifications", accommodations, or chooses to disclose a disability, leadership is obligated by law to engage in an "interactive process" *with* the individual in order to determine whether accommodations are needed and whether those accommodations are reasonable. A mere superficial assessment without a concerted good faith effort may place the employer and others in legal jeopardy. Direct reference to the ADA or even the term "accommodation" is not

necessary, “plain English” may be used. Additionally a surrogate such as a friend, family member, health professional, or rehabilitation counselor may request specific accommodations[26]. The “interactive process” involves a good faith discussion between the individual and supervisor regarding what is needed. If the disability is not obvious then additional information may be requested but only enough to assist with the determination of appropriate accommodation. An employer may not request an entire medical record but may ask the employee’s physician for a description of how the disability will affect their position, how long they anticipate the impact, and recommendations for specific modifications to their routine tasks.

When determining whether an accommodation is “reasonable” two major factors are considered, cost and whether the essential function of the position must be modified. A cost-benefit analysis by the employer includes the cost of initiating the accommodation as well as the sustaining cost over time. It is the burden of the employer to determine whether an accommodation it too expensive. Many accommodations for the learning disabled resident are quite inexpensive considering the benefit that is obtained in both the short- and long-term (Table 3).

Table 3- Potential Reasonable Accommodations for the Learning Disabled Resident

Additional time on examinations
Explicit written instructions
Explicit feedback
Check-lists
Allowance for notes in the operating room
Individual tutoring
Extra examinations (practice)

Organizations are appropriately looking at diversity among their cadre. The majority of these efforts are focused on addressing barriers to gender, racial, ethnic, and sexual orientation, yet

disability is rarely discussed. Whether intentional or accidental, this manifests as underrepresentation of a portion of the population in the healthcare profession. The incidence of physical, sensory, cognitive, and emotional disabilities in medical students, residents, and practicing physicians is lower that than reported in society. Those individuals that are disabled but successfully navigate the training necessary to enter the healthcare profession often continue to face unnecessary physical and nonphysical barriers[27]. Healthy Persons 2020 established several goals applicable to medical education. These included expansion of disability and health training opportunities for public health and healthcare professionals as well as the inclusion of people with disabilities in all health promotion efforts[28]. Ultimately the question on whether or not to offer an accommodation must not lose sight of the delivery of excellent patient care.

Academic Departments of Anesthesia that wish to serve a growing diverse population must first obtain the skills and expertise for understanding the individuals, the contributions they make, and the needs they may have. There is no better resource than a practicing physician who has direct personal experience with a disability. A willingness to actively and openly work to remove physical and non-physical barriers, and to consider alternative educational options, will allow us to truly increase the representation of the disabled among our faculty. This increased representation will allow us contribute to the betterment of healthcare for disabled persons.

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