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Institutional Accountability for Students With Disabilities: A Call for Liaison Committee on Medical Education Action

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Abstract

Medical educators and leaders have called for greater diversity among the physician workforce, including those with disabilities. However, many students with disabilities are precluded from entering and completing medical training due to historically restrictive technical standards and poor internal practices to protect student privacy. This limits the possibilities for growing this part of the workforce and making progress toward the ultimate goal of having a physician workforce that better represents the patients it serves. To achieve diversity among the physician workforce, medical education must create environments that allow students with disabilities to apply to, flourish in, and feel well supported in medical school.

Recent additions to Accreditation Council for Graduate Medical Education requirements have helped to catalyze work in the area of disability inclusion by incorporating disability-focused mandates into graduate medical education accreditation standards. However, similar mandates for undergraduate medical education have not yet materialized. In this article, the authors call for the Liaison Committee on Medical Education (LCME) to elevate disability as a valued part of medical school diversity in its accreditation standards and to include protections for disabled students. The authors propose that the LCME can take 5 actions to promote institutional accountability toward students with disabilities: (1) define disability as diversity, (2) mandate disability support, (3) protect from conflicts of interest, (4) protect privacy, and (5) verify schools’ technical standards comply with the Americans with Disabilities Act. By adopting these recommendations, the LCME would send the powerful message that students with disabilities bring welcome expertise and value to the medical community.
Medical educators and leaders emphasize the value of increasing diversity among the physician workforce, including individuals with disabilities, who bring uniquely informed experiences to the practice of medicine.\textsuperscript{1–19} Indeed, students with disabilities report increased compassion and understanding for their patients’ experiences, along with improved communication skills.\textsuperscript{1,3,20–23} Moreover, clinical teachers perceive that while these students may experience barriers to completing their medical training, their life experience made them more mature and empathic learners overall.\textsuperscript{23}

Ongoing institutional efforts to improve diversity have focused on the recruitment and training of physicians who better represent the patients they serve.\textsuperscript{2} Disability remains part of this representation, and it is believed that the inclusion of physicians with disabilities may improve health care delivery and medical education through multiple mechanisms, including well-informed care for patients with disabilities and lessons on cultural humility for peers and trainees.\textsuperscript{2,13,24–28} Well-informed care is necessary as patients with disabilities often experience health care disparities that are grounded in misinformation, stereotyped assumptions about living with a disability, and barriers to accessible, informed health care.\textsuperscript{29–32} Moreover, training in cultural humility allows nondisabled providers to center aspects of identity important to the person they are treating, which often includes a wealth of knowledge about managing a disability. In doing so, they reframe lived experience with disability as a form of expertise, both in their patients and their colleagues with disabilities who continue to face stigma and exclusion in the profession.\textsuperscript{3,12}

Despite these institutional efforts, many medical students with disabilities experience barriers to entering and completing medical training due to historically restrictive technical standards and poor internal practices to protect student privacy.\textsuperscript{1} This limits the possibilities for growing this
part of the workforce and for making progress toward the ultimate goal of having a physician workforce that better represents the patients it serves. To achieve diversity among the physician workforce, medical education must create environments that allow students with disabilities to apply to, flourish in, and feel well supported in medical school.

In an effort to increase the number of trainees with disabilities in graduate medical education, the Accreditation Council for Graduate Medical Education (ACGME) recently added disability-focused institutional and program mandates into accreditation standards for residency programs and expanded its definition of diversity to include disability. The ACGME institution-level requirements mandate that training programs maintain a disability policy, while the program-level requirements mandate that training programs provide accommodations to trainees. These initial changes have helped to catalyze work in the area of disability inclusion and, importantly, impose consequences for training programs and institutions that fail to meet basic standards.

To date, the Liaison Committee on Medical Education (LCME) has not included similar actions for undergraduate medical education, relying on medical schools to determine the process for integrating students with disabilities into their programs. Moreover, the LCME does not explicitly include disability in their definition of diversity. While the LCME requires schools to develop technical standards that comply with federal laws there is evidence that schools do not adhere to these requirements and that technical standards remain a substantial barrier to the inclusion of disabled students. Currently, meeting the LCME’s requirement is perfunctory for schools. They must publish a set of technical standards (standard 10.5), that adhere to the law, but this adherence is not well scrutinized. Many schools attempt to meet legal requirements through a nondiscrimination statement, however, nondiscrimination is not equivalent to creating a culture of inclusion.
Given that accreditation standards substantially influence the allocation of support services and the development of policy in medical education and, in turn, a school’s culture and climate, the omission of disability-focused guidance risks excluding qualified students from the profession. To protect the efforts toward disability inclusion in medical education and the recruitment and training of students with disabilities, in this article we call for the LCME to elevate disability as a valued part of medical school diversity in its accreditation standards and to include protections for disabled students. This can be accomplished by adding requirements for disability policies, accommodations practices, privacy policies, protections against conflicts of interest, and by verifying that schools’ technical standards are nondiscriminatory and follow best practices. Importantly, efforts to elevate disability inclusion must be informed by individuals with disabilities who are working in medical education and have experienced barriers themselves.

**Barriers to Disability Disclosure and Requesting Accommodations**

Any accreditation standards designed to support disability inclusion must consider barriers to disability disclosure and requesting accommodations in medical education. Students with disabilities often avoid disclosing their disability and requesting accommodations due to fears of bias, stigma, and misperceptions about performance. Indeed, students and physicians with disabilities self-report experiencing stigma and encountering ableist perspectives on their ability to practice medicine. Recent data support these claims, suggesting that higher numbers of students self-disclose a disability status when asked in anonymous surveys (9% and 7.6%) versus when they are asked to disclose directly to their institutions (4.6%). The resulting gap of ~2–4% suggests that for some students, disclosure and request for accommodation is either not possible due to a myriad of known barriers or not needed.
Known barriers include concerns regarding the lack of a disability policy and transparency around disability disclosure and accommodation requests. Additionally, as part of accommodation requests, students must substantiate their disability by submitting confidential documentation to an institutional representative. Collectively, these issues raise students’ concerns about privacy and the use and sharing of their personal health information. These concerns increase when the accommodations process requires a review of documentation by individuals with a conflict of interest or by those who hold an evaluative role in the students’ education or promotion. When these conflicts exist, or when processes lack transparency, many students opt to navigate medical school without any accommodations, not trusting that their sensitive information will be held in confidence. Students face further barriers when an institution’s forward-facing messages, including those embedded in technical standards, suggest that students with disabilities are incapable of completing medical school or are discouraged from applying altogether. Broadly, these institutional policies and the forward-facing messages often fail to communicate that the school considers disability as a valued part of diversity. The language used and the lack of a policy on disability accommodation, therefore, implicitly signal to students that disability should remain hidden, perpetuating stigma and encouraging nondisclosure. To support the inclusion of disabled students in medical education, we propose that the LCME take 5 actions to promote institutional accountability toward students with disabilities: (1) define disability as diversity, (2) mandate disability support, (3) protect from conflicts of interest, (4) protect privacy, and (5) verify schools’ technical standards comply with the Americans with Disabilities Act (ADA; Table 1).
Define Disability as Diversity

The LCME mandates that schools “recognize the benefits of diversity” through standard 3.3, while standard 3.4 mandates an antidiscrimination policy on the basis of disability. However, the glossary of terms for LCME accreditation standards and elements defines the “benefits of diversity” and “mission-appropriate diversity” with specific references to many marginalized groups—but not to individuals with disabilities. To make clear that students with disabilities are, in fact, underrepresented and a priority for inclusion in medicine, we propose that disability status be included in all places within the LCME standards and elements where marginalized groups are enumerated, similar to changes recently implemented by the ACGME.

Mandate Disability Support

The LCME must recognize the need for specialized guidance around providing accommodations and services for students with disabilities. Much like the standards set forth by the LCME requiring schools to maintain access to appropriate student services, such as wellness supports, tutoring, and career advising, we propose that the LCME add an element specific to disability. This element could be added within standard 11 and codified to specify the requirements and expectations associated with providing equal access to students with disabilities, including the guidance discussed in the Association of American Medical Colleges report, “Accessibility, Inclusion, and Action in Medical Education: Lived Experiences of Students and Physicians With Disabilities.”

Protect From Conflicts of Interest

Currently, LCME standard 12.5 forbids conflicts of interest in wellness services, requiring that “the health professionals who provide health services, including psychiatric/psychological counseling, to a medical student have no involvement in the academic assessment or promotion
This protection from conflicts of interest should also hold true for institutional personnel adjudicating accommodation decisions for students with disabilities. Therefore, we propose that standard 12.5 be amended to include disability support services, applying the same standards to the provision of disability accommodations and the professionals who adjudicate these decisions.

**Protect Privacy**

Privacy must be a priority in creating an environment where students feel safe disclosing disability-related information and requesting accommodations. LCME standard 12.5 specifies the privacy of all health records for students, including, for example, those who engage in mental health counseling, stating “a medical school ensures that medical student health records are maintained in accordance with legal requirements for security, privacy, confidentiality, and accessibility.” In keeping with this standard, we propose that the LCME include disability records in these privacy requirements. The main focus of this action would be to avoid the unnecessary sharing of disability-related documentation with medical school faculty and administrators.

**Verify Schools’ Technical Standards Comply With the ADA**

Technical standards outline the criteria and abilities required for admission to, and successful completion of, medical school programs but remain a known barrier for students with disabilities. LCME standard 10.5, titled Technical Standards, requires that medical schools “develop and publish technical standards for the admission, retention, and graduation of applicants or medical students in accordance with legal requirements.” Despite this requirement, research shows that many schools maintain technical standards that do not comply with legal requirements, yet they remain accredited. We propose that the LCME ensure that
medical schools maintain technical standards that comply with legal requirements and that the LCME conduct a robust review of medical schools’ technical standards as part of the reaccreditation process. This review should ensure that technical standards are nondiscriminatory, do not uniformly denounce the use of any specific accommodation (e.g., interpreters or intermediaries), and include a statement about the ability of students with disabilities to meet the standards with or without accommodations, all of which are in keeping with legal requirements and best practices. This review should be completed and certified prior to a school being reaccredited.

Conclusions

Meeting the calls for the inclusion of disability as a valued part of diversity in medical education will require institutional accountability to create a culture where students feel safe disclosing their disabilities and requesting accommodations. We believe the LCME is well positioned to support these efforts. The above recommendations serve to protect the privacy of students with disabilities, avoid conflicts of interest in disability adjudication, ensure that technical standards are nondiscriminatory, and regulate infrastructure, which, in turn, may collectively encourage students to disclose that they have a disability and request accommodation if needed. Importantly, enacting these recommendations could increase the consistency of services and protections for students with disabilities in LCME-accredited programs, contribute to ongoing efforts toward disability inclusion in medical education, and provide a system of accountability for the provision of disability-related services in medical schools. By adopting these recommendations, the LCME would send the powerful message that students with disabilities bring welcome expertise and value to the medical community.
References


### Table 1
Disability-Focused Recommendations for the LCME

<table>
<thead>
<tr>
<th>Goal</th>
<th>Recommendation for the LCME</th>
</tr>
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<tbody>
<tr>
<td>Define disability as diversity</td>
<td>• Include disability status in all places within the LCME standards and elements where marginalized groups are enumerated to specify that students with disability status are part of diversity and inclusion efforts.</td>
</tr>
<tr>
<td>Mandate disability support</td>
<td>• Add an element within standard 11 to codify the requirements and expectations associated with providing equal access to students with disabilities.</td>
</tr>
<tr>
<td>Protect from conflicts of interest</td>
<td>• Amend standard 12.5 to include disability support services within this protection against conflicts of interest.</td>
</tr>
<tr>
<td>Protect privacy</td>
<td>• Amend standard 12.5 to include disability records within the student health records privacy requirements.</td>
</tr>
<tr>
<td>Verify schools’ technical standards comply with the ADA</td>
<td>• Verify medical schools have technical standards that are in compliance with the ADA before reaccreditation.</td>
</tr>
</tbody>
</table>

Abbreviations: LCME, Liaison Committee on Medical Education; ADA, Americans With Disabilities Act.