

Helping Physicians Help Us

BY CAROL HAYWOOD

Do Doctors Care About People with Disabilities?

It's no secret: medical training is arduous. Over the course of no less than seven years of post-baccalaureate training, physicians learn how to care for the human body. Initial, preclinical education provides a foundation for understanding body functions and systems. Then medical students go on to clinical clerkships for applied learning. After graduating from medical school, physicians complete at least three years of residency, and some go on to specialize in a particular area of practice through additional years of residency or fellowship. Throughout this process, we come to generally accept that physicians are experts in health and health care. Yet there seems to be a glaring omission in these years of training: how to care for individuals with disabilities, including hearing loss.

At least one in four adults in the U.S. reports having a disability related to mobility, hearing, vision, mental health or cognitive skills. Hearing loss specifically affects communication and daily life for at least half of people older than age 60, and exponentially more are affected later in life. People with disabilities, including hearing loss, report more difficulty accessing health care, poorer quality of care and lower satisfaction with care than people without disabilities. People with disabilities also often have high health care needs and experience more severe disease. Inequities in health and health care for people with disabilities have been particularly searing throughout the COVID-19 pandemic, as entire health care systems have rationed care based on misguided assumptions that people with disabilities have lower quality of life than people without disabilities.

Recent research to examine physician attitudes about caring for people with disabilities has exposed a complicated web of barriers to the advancement of health equity for this population. Such barriers include inaccessible physical environments and exam equipment; ineffective strategies for alternative communication; gaps in provider knowledge, experience, and skills to care for people with disabilities; structural discrimination, including financial disincentives for providers; and negative attitudes about people with disabilities.

Breaking the Cycle of Bias by Raising Consciousness

In a nationwide survey of physicians, less than 60% of respondents strongly agreed that they welcomed people with disabilities into their practices, and only about 40% were very confident in their ability to provide the same quality of care to their patients with and without disabilities. Furthermore, many of the physicians who lacked confidence in their ability to care for people with disabilities also reported having limited knowledge of the Americans with Disabilities Act (ADA), which in part, establishes requirements for equal access to health care for people with disabilities. Physicians have a responsibility not only to understand how disability co-occurs with other health conditions and needs but also how to accommodate patients with disabilities in their clinical practices.

Gaps in disability-specific training can perpetuate bias, hesitation, and discrimination in care for someone with a disability. This is apparent in the U.S. health care system, where physicians aren't given the time and equipment necessary to provide good quality health care for someone with a disability. This leads to a vicious cycle where medical students are not provided with opportunities to become comfortable working with people with disabilities, and therefore, when presented with an option to focus on disability, many physicians choose to avoid it. Inequities in health care access expand and negative ideas about disability grow in a complicated landscape where physicians lack confidence, training, and resources to welcome people with disabilities into their clinics.

Medical Students and Disabilities

Misguided ideas about disability have also led to poor matriculation of medical students who have disabilities. Many medical schools have admissions criteria and technical standards that necessarily exclude individuals who would require accommodations to practice medicine. Research has also shown that medical students with disabilities are fearful of disclosing their disability status and accommodation needs while in training. The burden for medical students with disabilities to succeed in their training is heavy and, too often, we

are missing opportunities to support a more diverse and impactful generation of physicians who themselves have a disability and/or have the preparation and commitment to work with the growing numbers of people in the U.S. who do.

The Squeaky Wheel Gets the Grease

It's easy to feel discouraged by this research, but the passion and commitment of advocates brings us hope. We must continue to examine medical education as a source of bias, as well as an opportunity to address it, when it comes to health care for people with disabilities. We must also consider other opportunities to advance the knowledge and skills of physicians to prepare them to work with people with disabilities. Improving health care for people with disabilities requires relentless advocacy at every level, including in clinics, where we actively seek care. As patients, we can have a leading role in helping physicians fill gaps in their training by advocating for our own needs. In doing so, we ultimately pave the way for improved partnerships and health care for all. **HL**

Carol Haywood, Ph.D., OTR/L, is an occupational therapist and health services researcher. Her work focuses on understanding patients' experiences and maximizing the effectiveness of health services, especially for individuals and their families who have experienced trauma and/or acquired disability, particularly among populations marginalized by race and ethnicity, socioeconomic status or geographic location. Dr. Haywood completed her doctoral studies in occupational science at the University of Southern California and postdoctoral training in health services and outcomes research at Northwestern University. She is currently a research assistant professor in the Department of Medical Social Sciences at Northwestern University.



News and Notes

The strategic team continues to work on multiple important projects. We invite you to visit our website at hearingloss.org/programs-events/communication-access-in-health-care/ for an update on recent activities.

To receive a quarterly release of the Health Care Communication Access column and occasional email messages about important developments, we invite you to join our stakeholders email list at communication-access-health-care.gr8.com.

Time for a Change

BY ZINA JAWADI

I'm a medical student. One day I received a call from a resident, whom I'll call Sally, who had a problem. "We have a new patient on our service who is deaf and blind. Her hearing aid is not working, and we are unable to communicate with her," she told me. "Can you help?"

I went with Sally to the patient's room and introduced myself using fingerspelling.

I realized that the patient had a cochlear implant, rather than a hearing aid, and that the battery had died. We replaced the battery, oriented her, spoke slowly and closely to her implanted ear, and held her hand with permission.

Afterward, we developed a plan to ensure that she was receiving proper accommodations by notifying the nursing team, printing a sign that we placed over the patient's bed and adding information to her records.

However, the unfortunate reality is that most medical schools do not train students about ways to communicate with and accommodate people who have disabilities, including hearing loss. It may not be obvious how someone's chronic illness or disability can negatively impact the health care they receive, but it can — and often does.

Raising Consciousness Results in Change

One of my proudest moments in clinical rotations is witnessing the progress of my teams during my brief time in their service, and I have already seen positive transformation in the accommodation of hearing loss.

The above example is a testament to the rapid growth and improvement that have taken place in such a short period of time, thanks to education, representation and advocacy. Sally not only actively thought about the patient's hearing loss but also sought solutions. She recognized that, while treatment of hearing loss was not the reason the patient was admitted, the patient's hearing loss was still negatively impacting her care, and something needed to be done.

It is superbly rewarding to play even a minor role in improving the care of patients with hearing loss. It motivates me throughout my rotations and reminds me daily of why I went to medical school. **HL**

Zina Jawadi received her Bachelor of Science and Master of Science degrees from Stanford University and is a medical student at the University of California, Los Angeles, David Geffen School of Medicine. She serves on the HLAA board of directors.

