

A Student's Perspective: Medical Education on Caring for Patients of All Abilities

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• health disparities • patient-centered care

The experience of evaluating a patient with a neurocognitive disability during an early clinical rotation truly stands out in my mind as one of the least prepared moments of my life. The pediatrics team I was rotating with as a part of my inpatient clerkship during my second year of medical school was notified of a patient in the emergency department. The patient was a young man with cerebral palsy who did not use verbal language to communicate, and I was tasked with gathering information pertinent to the patient's admission into the hospital. Without much time to think or prepare, the senior resident and I were on our way to see the patient.

I had made the trip down the elevator to see patients many times before, clipboard in hand and stethoscope on my neck, but this time, questions swirled in my head about what to do during the encounter. Do I direct my questions toward the patient? Or to a caregiver if they are present? What if he isn't very interactive with me? How do I pivot? How should I go about performing a physical exam on him? What if I offend the patient? I tried to reflect on prior education I had received on patient encounters and realized that I was simply unprepared. I had no training to fall back on for this situation.

Within minutes, I was standing in front of the patient and his mother. Without hesitation and after a very brief introduction, I began taking a history as I had been taught in my hundreds of hours of clinical courses and instruction from my preceptors. Before long, I could feel the tension build as I awkwardly and rapidly bounced between topics and who I was directing my questions toward in that moment. My anxiety continued to rise, my mind blurred, and after just a few minutes, I could not think of anything else to say even though I had hardly gathered any necessary information. The patient's mother looked at me with concern. She was rightfully worried that her son was in the hands of a vastly underprepared student. The resident, observing my discomfort and struggle, stepped in and finished the encounter. I felt embarrassed and ashamed that I was unable to offer more in this moment.

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This was not the only encounter that caused me to feel unprepared during my clinical training. In the heart failure clinic a few months later, I saw a man in his mid-40s who relied on a wheelchair to get around. As I was listening to his heart in the various locations and positions, I realized that I had *never* performed a physical exam on a patient in a wheelchair until that moment. I didn't know if he would be able to sit at the appropriate angle to auscultate his heart, and I was also unsure of how to ask him to move or help position him in a thoughtful and safe way. Again, questions raced through my mind, similarly to the patient during my pediatrics rotation, and I realized I still lacked many answers. I returned to the uncomfortable reality of the glaring gaps in my education around treating individuals of all abilities. I could not believe that this trial-and-error methodology was the best way to learn how to provide patient-centered care. I had come to realize that we are taught at length how to ask and gather information about disease processes but are not fully trained in asking and gathering information from individuals of all abilities to help them feel most comfortable and respected in the therapeutic process.

Prior to beginning my time as a member of healthcare teams in the clinical space and working with real patients, the only training I received on caring for patients who have disabilities was a 2-hour didactic session in my first year of medical school. No specific skills were taught, and there were no opportunities to practice any patient-centric language or alternative physical exam positioning in a safe and protected space. During required clinical rotations, there was no follow-up or formal educational session on this topic. My learning about how best to care for patients who have disabilities has largely come from trial and error, anecdotes from members of my community, and occasional brief conversations with other trainees and supervising physicians about patient-specific needs. Nothing, besides the pre-clinical session, has been organized or structured, which leaves great room for variation among student experiences, impacting the care that we will provide as physicians in the future.

This topic is immensely important. Twenty-six percent of adults in the United States have some form of disability.¹ The lack of medical education on providing care for individuals of all abilities has complicated roots and continues to exacerbate the disparities faced by this population. Healthcare has a distressing history regarding its care of patients with disabilities, including proven discriminatory policies and even unnecessary institutionalization and forced sterilization.²⁻⁴ Though these practices have been discontinued for decades, the cultural sentiment remains, and patients who identify as having disabilities have a right to remain skeptical of healthcare providers given the trauma that communities have endured. This scarred healthcare relationship will not be mended by the currently and often-taught "medical model of disability," which views disability as a deviation from normal and proposes to "fix" it, assuming that an individual's disability affects all aspects of their life in a negative manner. Today, patients with disabilities report frequently needing to educate medical staff on basic aspects of disability, and many providers report feeling unprepared to provide care for patients with disabilities.⁵

Physicians are expected to be experts in caring for patients of all ability levels within their respective settings — the pediatric emergency department and heart failure clinic are no exception. Yet how are we able to improve the care we provide for patients with disabilities if we are only relying on lessons and teachings that are passed down from one generation to the next through informal conversations that have not corrected misunderstandings and beliefs? More formal education and opportunities for hands-on instruction are needed, especially in pre-clinical and early clinical education within medical school systems.

Interventions to develop more robust medical education consist of better inclusion of patients with disabilities within standardized patient encounters. This method has been shown to be highly effective by a variety of different training programs.⁶ Additionally, online-based modules have been developed and studied. These have been shown to improve medical students'

understanding and attitudes toward patients with disabilities and can be combined with flipped classroom techniques and a variety of clinical placements or exposures,⁵ modalities of learning that are especially important in medical schools.

The need is clear. Medical education must include specific preparation and learning dedicated to the care for patients who identify as having disabilities. Interventions for change have been developed and studied and are available to be implemented across the country. For the sake of our patients, I am hopeful that future generations of medical students will not endure the same trial-and-error method of learning how to care for patients with disabilities that I did.

References

1. CDC. Disability impacts all of us. Centers for Disease Control and Prevention. Published March 8, 2019. Accessed July 24, 2022. <https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html>
2. Marini I. The history of treatment toward people with disabilities. In: Marini I, Graf NM, Millington MJ, eds. *Psychosocial Aspects of Disability*. 2nd ed. Springer Publishing Company; 2021. Accessed July 25, 2022. <https://connect.springerpub.com/content/book/978-0-8261-8063-6/part/part01/chapter/ch01>
3. Johnson E. Disability, medicine, and ethics. *AMA J Ethics*. 2016;18(4):355–358.
4. Trent J. *Inventing the Feeble Mind: A History of Intellectual Disability in the United States*. Vol 1. Oxford University Press; 2017. doi:10.1093/med/9780199396184.001.0001
5. Keller MA. Doctors and disability: improving inclusion in medical education. *HCA Healthc J Med*. 2022;3(3). doi:10.36518/2689-0216.1393
6. Crane JM, Strickler JG, Lash AT, et al. Getting comfortable with disability: the short- and long-term effects of a clinical encounter. *Disabil Health J*. 2021;14(2):100993. doi:10.1016/j.dhjo.2020.100993

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