Canadian Medical Education Journal
Revue canadienne de l'éducation médicale

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Volume 15, numéro 2, 2024

URI : https://id.erudit.org/iderudit/1111574ar
DOI : https://doi.org/10.36834/cmej.78355

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Éditeur(s)

Canadian Medical Education Journal

ISSN

1923-1202 (numérique)

Découvrir la revue

Citer ce document

Clarke, Q., Taylor, K., Abu-Ghazaleh, N. & Beldick, S. (2024). The case for centralization of academic accommodations in undergraduate medical education. *Canadian Medical Education Journal / Revue canadienne de l'éducation médicale*, *15*(2), 107–109. https://doi.org/10.36834/cmej.78355

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Commentary and Opinions

The case for centralization of academic accommodations in undergraduate medical education

Arguments en faveur d'une centralisation des aménagements universitaires dans la formation médicale de premier cycle

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Published ahead of issue: Dec 14, 2023; published: May 1, 2024. CMEJ 2024, 15(2) Available at https://doi.org/10.36834/cmej.78355

Introduction

Medical students with disabilities are an integral part of the field of medicine. Their presence contributes to much needed diversity in medicine and therefore, helps the medical community to reflect the populations that it seeks to treat, namely society at large.

Clarke et al.[1] previously defined disability as "a product of the interaction between the social environment and an individual's health condition, in which a person with an impairment cannot fully participate in society due to an environment which is structured to favour able-bodied individuals." Per Saltes,[2] accommodations recognizes that "spaces and environments are not accessible to everyone and that modifications at the individual level may be required in order for some people to gain access and/or be able to fully participate."

Academic accommodations are imperative to provide medical students with disabilities an equitable experience as compared to their non-disabled peers. Although the prevalence of students requiring accommodations is increasing,[3,4,5] the process to acquire accommodations remain variable, complex, and burdensome.[6] These processes often require additional documentation, medical appointments, and personal statements that can take hours to days to collate and complete.[7,8]

Medical students have largely predetermined academic trajectories that include preclerkship, clerkship, licensing exams, and residency. Despite the predictability of one's medical education preceding clinical practice, the fulfillment of accommodations is not a streamlined process and often requires several independent and labour-intensive documentation requests. In the Canadian context, accommodation processes would be required at the medical school level for preclerkship and clerkship rotations, for the Medical Council of Canada's (MCC) Qualifying Examination Part I, for the Canadian Residency Matching Service R-1 Main Residency Match, and subsequently for residency; the American equivalents would include preclerkship and clerkship rotations, the United States Medical Licensing Examinations (USMLE), the National Residency Match Program, the San Francisco Match Program, and residency.

Although students with disabilities should be supported to obtain accommodations, Canadian health professionals with disabilities continue to express difficulty in securing accommodations.[9] They note limited institutional support with lengthy waiting periods for accommodation approvals, and an absence of an identifiable, accountable administrator responsible for overseeing accommodation.[9] This is troubling given that the consequences for students with disabilities and for the organizations in which they work not obtaining accommodations are significant.

Petersen et al. showed that 3% of students with disabilities who took the USMLE Part I without accommodations failed it and withdrew or were dismissed from their medical education program.[10]

We advocate for a centralization and standardization of the academic accommodations processes. Centralization of accommodations processes would most logically occur at the medical school level. Medical schools are the first point of contact for medical trainees and have the most sustained academic relationship with students. Temporally, students would require accommodations in that setting before obtaining accommodations through licensing examinations, the residency selection process, or in residency. Although the accommodations process will be centralized, personalization of medical students' accommodations will still be required. Further, implementation of these accommodations will need to occur through the various stakeholder bodies.

Standardization and centralization would benefit both students and stakeholder organizations by reducing the workload and time investment associated with processing accommodation requests. As previously mentioned, the prevalence of accommodations is rising which has increased the labour and resource costs required to evaluate these requests appropriately. By streamlining this process, the existing resources available would be used more efficiently and organizations such as the MCC and the USMLE could reallocate resources to other areas of education.

Centralization and standardization of accommodations processes would also reduce the labour required by medical students with disabilities when requesting and implementing their accommodation needs. Medical students with disabilities should not have to be burdened by hours of additional, unremunerated tedious labour on administrative tasks, not required by their peers, that distract from time better spent learning how to practice medicine.

It should be noted that learners with transient disabilities, such as those who require mobility aids secondary to healing fractures, may also benefit from a centralized documentation process. These students are less likely to be familiar with the processes involved in obtaining academic accommodations and may have more urgent requests if their condition occurs shortly before an examination or other academic demand.

By having a centralized accommodations body, efforts could be made to fill existing knowledge gaps among current staff and human resources departments, such as through the recruitment of dedicated disability resource professionals, and to ensure that programs are adherent to disability legislation. Efforts should be made to increase the transparency of accommodations processes and collect and analyze measures that could be utilized for quality improvement of these processes.

Current wellness initiatives such as the Association of Faculties of Medicine of Canada (AFMC) implementation of the Okanagan Charter should consider this a priority area for improvement. The Association of American Medical Colleges (AAMC) and AFMC should prioritize establishing a forum for stakeholders to meet to discuss how a centralized approach could be implemented and optimized.

If medical schools and stakeholder organizations intend to promote learner wellness and recruit a diverse group of physicians, then advocating for and committing to a centralized accommodation process should be established as a shared goal to promote equitable learning experiences. The removal of excessive and unnecessary administrative burdens on learners with disabilities would promote a more equitable learning environment. This in turn would have a positive impact on both the mental health and clinical learning goals of learners with disabilities. It is unreasonable to ask medical trainees to complete these administrative tasks and remain successful in their medical training with no effect on their learning goals or mental health.

Centralization and standardization of the accommodations process at the medical school level would serve to accelerate the inclusion, and highlight the value of learners with disabilities, and reduce administrative, emotional, and physical burdens on the individual and systemic levels.

Conflicts of Interest: The authors have no competing interests.
Edited by: Marcel D'Eon (editor-in-chief)

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