Accreditation Council for Graduate Medical Education

Proceedings of the 2025 ACGME Summit on Fostering Disability-Inclusive Health Care in Resident Education

MARCH 2-4, 2025

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EXECUTIVE SUMMARY

Consider practicing physicians who treat patients with disabilities with respect and empathy, who value their patients' lived experience and right to direct their own care, who are knowledgeable of and compliant with the Americans with Disabilities Act (ADA) and related regulations, and whose care settings have the equipment and technologies needed to examine and communicate with all patients. Such physicians should be the norm rather than the exception, agreed the 90 invited participants in the Accreditation Council for Graduate Medical Education (ACGME) Summit on Fostering Disability-Inclusive Health Care in Resident Education.

During two and a half days of presentations, robust discussions, breakout sessions, and informal conversations, these leaders of graduate and undergraduate medical education and experts in the care of patients with disabilities convened both to assess current challenges in educating and training physicians to provide disability-inclusive care and to develop effective, actionable solutions. Representing several specialties—from family medicine, internal medicine, and pediatrics to neurology, obstetrics and gynecology, physical medicine and rehabilitation, psychiatry, and general surgery—the Summit attendees listened to and participated in panel discussions on current practices related to disability in medical education. They then broke into small groups to share and synthesize their ideas, which were later reported to the plenary gathering.

INTRODUCTION

Recognizing that physicians need to be better trained in how to care for patients with disabilities, 90 medical education leaders and disability education champions convened in Chicago, Illinois on March 2-4, 2025, for the ACGME Summit on Fostering Disability-Inclusive Care in Resident Education. These invited participants included designated institutional officials (DIOs), who oversee multiple residency and fellowship programs; residency and fellowship program directors and associate program directors; graduate medical education (GME) and medical school faculty members; residents and fellows; practicing physicians; and others with an interest in disability-inclusive care. The Summit-goers represented several different specialties, mostly primary care specialties and those with a population base consisting largely of people with disabilities: family medicine, general surgery, internal medicine, pediatrics, obstetrics and gynecology, neurology, psychiatry, and physical medicine and rehabilitation. Although the focus was on GME, organizations centered on undergraduate medical education (UME) and specialty board certification took an active part in the event, including the Association of American Medical Colleges (AAMC), the American Association of Colleges of Osteopathic Medicine (AACOM), the American Board of Medical Specialties (ABMS), and the American Osteopathic Association (AOA). Other national health care organizations—such as the American Medical Association (AMA), the American Academy of Developmental Medicine and Dentistry (AADMD), the American Association on Intellectual and Developmental Disabilities (AAIDD), and the Alliance for Disability in Health Care Education (ADHCE)—were represented as well.

A significant proportion of the attendees had disabilities themselves, both visible (such as using a wheelchair or cane) and invisible (such as having attention-deficit/hyperactivity disorder [ADHD]). The ACGME provided captioning and American Sign Language interpretation for panel

discussions, breakout groups, and break times. Materials were provided in advance to allow participants to review information at their own pace, prepare for presentations, and access materials in formats that best suited their needs. For the benefit of attendees with limited vision, speakers were asked to briefly describe their appearance before beginning their presentations. A sensory room was reserved for those who needed space in the case of overstimulation. The ACGME Department of Communications and Public Policy organized the two-and-a-half-day event, with the assistance of more than two dozen ACGME staff volunteers.

The Summit kicked off on Sunday evening, March 2, with a reception, opening remarks, and a keynote address. On the remaining two full days of the event, the attendees listened to and participated in panel discussions, brainstormed ideas and prioritized suggestions during facilitated breakout sessions, and ultimately developed work plans for bringing their recommendations and goals to fruition. The gathering was also an excellent networking opportunity for the participants. Although many of the attendees already knew each other, new connections and friendships were forged, suggesting that the sharing of ideas and resources will continue long after the end of the event.

BACKGROUND

In the United States, 28.7 percent of adults aged 18 to 64 and 43.9 percent of adults aged 65 and older have a disability of any type (CDC 2024b), while one in six children has a developmental disability (CDC 2024a). Nearly 35 years since the passage of the ADA, individuals with disabilities still do not experience equitable health care in the US. For example, people using wheelchairs often encounter physicians in outpatient settings who do not have the equipment or skills needed to give them a proper physical examination. Disabled individuals sometimes are asked to forgo critical diagnostic tests because flexible-height imaging equipment (for mammography, for instance) is not available (NCD 2025). People who are Deaf or have hearing loss face communication difficulties if their physicians are unaware of their obligations under the ADA; in fact, hard-of-hearing individuals experienced tremendous frustration during the COVID-19 pandemic, when the widespread use of masks muffled voices and made lip-reading impossible. Adults with intellectual disabilities, executive function difficulties, or sensory issues can be overwhelmed by the process of making and keeping health care appointments and navigating often sprawling medical campuses, as well as hospitals that have bright lights and shiny, reflective surfaces. Such barriers and unpleasant experiences can cause people with disabilities to avoid seeking care.

Indeed, in the 16 years since the National Council on Disability (NCD), an independent federal advisory agency, published *The Current State of Health Care for People with Disabilities* (NCD 2009), health disparities between people with disabilities and their nondisabled counterparts have not significantly improved (NCD 2025). In part because they often have unmet medical and prescription needs, people with disabilities are three times more likely to have a heart attack and five times more likely to have a stroke (NCD 2025). These are just two of many such disparities described by the NCD in its *Framework to End Health Disparities of People with Disabilities*, a report updated in 2025 (NCD 2025).

Recent research, moreover, has shown that the vast majority (82.4 percent) of physicians believe people with disabilities have a lower quality of life than nondisabled individuals (Iezzoni et al. 2021).

With firsthand knowledge that disabled individuals' health care needs were not being adequately addressed, the late NCD Chair Andrés J. Gallegos, a paraplegic civil rights attorney, held a council meeting in July 2023 that was essentially a call to action for health care professions to end disparities in care. John R. Combes, MD, chief communications and public policy officer for the ACGME, was among those in attendance. That NCD meeting, along with Dr. Combes' subsequent conversations with Mr. Gallegos on the need for disability-inclusive education and training of residents, inspired the ACGME's decision to host the Summit on Fostering Disability-Inclusive Health Care in Resident Education. The purpose of the Summit was to come up with solutions for improving physician education and training to enable practicing physicians to deliver the best possible care to individuals with disabilities.

OPENING REMARKS

During his opening remarks, Timothy P. Brigham, MDiv, MS, PhD, the ACGME's chief of staff and chief education officer, explained why residency is the critical period for inculcating disability awareness and empathy in physicians. Citing the most recent book by medical education historian Kenneth M. Ludmerer, MD, *Let Me Heal: The Opportunity to Preserve Excellence in American Medicine* (2015), Dr. Brigham said, "The most potent time for physician identity formation is in residency."

Training new physicians on the path to mastery is "almost an alchemical process" of transformation, Dr. Brigham continued. Thus, residency is the right time to instill the values, knowledge, and skills needed to provide optimal, inclusive care for patients with disabilities and to combat attitudes of ableism (discrimination in favor of able-bodied people). Residency needs to be reinvigorated so that patients who have disabilities can count on physicians for "kindness, safety, trustworthiness, and the highest quality of care," he said. "We have to make sure that patients who deserve the best quality care aren't disregarded, aren't having their health care need just peripherally met."

> Residency is the right time to instill the values, knowledge and skills needed to provide opitmal, inclusive care.

KEYNOTE ADDRESS

The keynote address was moderated by Oluwaferanmi O. Okanlami, MD, MS, director of student accessibility and accommodation services at the University of Michigan in Ann Arbor, where he is also a professor of family medicine, physical medicine and rehabilitation, urology, and orthopaedic surgery. Before introducing the keynote speaker, Dr. Okanlami emphasized that while the needs of the disability community are no different than the needs of non-disabled people, society has become accustomed to not meeting them.

Lisa I. Iezzoni, MD, MSc, professor of medicine, Harvard Medical School, based at the Health Policy Research Center and the Mongan Institute at Massachusetts General Hospital, gave the keynote address. Dr. Iezzoni is a full-time wheelchair user who was diagnosed with multiple sclerosis (MS) in her first year of medical school and was denied the opportunity to serve an internship or residency after earning an MD from Harvard Medical School in 1984. Dr. Iezzoni's remarks focused on two high-impact articles published in the journal *Health Affairs* (See Appendix C):

- "Physicians' Perceptions of People with Disability and Their Health Care" (Iezzoni 2021).
- "US Physicians' Knowledge About the Americans with Disabilities Act and Accommodation of Patients with Disability" (Iezzoni 2022).

Through her capstone research project, Dr. Iezzoni conducted a nationwide survey of physicians in outpatient practices in seven specialties: family medicine, general internal medicine, neurology, obstetrics and gynecology, ophthalmology, orthopaedic surgery, and rheumatology. Of the 714 physicians who completed the survey, 82.4 percent responded that individuals with significant disability have worse quality of life than nondisabled people; only 40.7 percent of the respondents said they were very confident about their ability to provide equal quality care to patients with disability; and just 56.5 percent strongly agreed that they welcomed disabled people into their practices (CDC 2024a).

The statistic that really "leapt off the page" for Dr. Iezzoni, who was conducting research during the height of the COVID-19 pandemic, was that slightly more than 82 percent of physicians believe that people with disabilities have worse quality of life than other people. "I don't mean to imply that the quality of life for people with significant disabilities cannot be really difficult," Dr. Iezzoni continued. "However, the vast majority of us with disabilities learn how to get along … Having had MS for 48 years, there are aspects of my life every day, every hour of the day, that are difficult. But that doesn't mean that my quality of life is worse. And I think that a lot of doctors have trouble understanding that."

Dr. Iezzoni's second *Health Affairs* article (2022) on the survey of 714 physicians focused on physicians' knowledge of their responsibilities under the ADA. Of the respondents, 35.8 percent reported knowing little or nothing about their ADA-related legal responsibilities, while 71.2 percent answered incorrectly a question about who determines reasonable accommodations (CDC 2024b). "The major point is that the patient—the person with a disability—should be involved in making that decision," she said.

Approaching the end of her talk, Dr. Iezzoni stressed that disability needs to be integrated into all of medical education, starting with UME. Disability education should not be treated as if it's something that's distinct, that needs to be separated from other aspects of medical education. For example, many cases that medical students study incorporate some aspect of the social determinants of health (socioeconomic factors, such as income, food, housing, and employment insecurity). "Why can't the cases also have some disability twist in them?" she asked her audience. That way, talking about disability is not regarded as some trending topic tacked onto the curriculum. Dr. Okanlami agreed, adding that although disability education should be integrated into UME, this isn't occurring consistently at medical schools. "The GME level," he said, is "that last stop before [physicians] are out on their own."

CURRENT INITIATIVES TO INTEGRATE DISABILITY INTO THE CONTINUUM OF MEDICAL EDUCATION

Insights from the Panel Discussions

The first full day of the Summit (March 3) began with a series of panel discussions. These presentations highlighted current initiatives to integrate disability into the continuum of medical education and called the audience's attention to some available resources. While some of these disparate initiatives are robust, the panels underscored the need for a comprehensive approach to incorporating disability-inclusive care into physician education and training.

Common Domains of Competency

The first panel discussion, "Common Domains of Competency," featured two speakers: Laura Edgar, EdD, CAE, the ACGME's senior vice president, competencies, Milestones, and faculty development; and Susan M. Havercamp, PhD, director of health promotion and healthcare parity at the Ohio State University (OSU) Nisonger Center. Their presentations provided insight into promoting competence in disability-inclusive care.

EXISTING DISABILITY CONTENT ACROSS ACGME SPECIALTIES/SUBSPECIALTIES

Dr. Edgar pointed out that five ACGME specialties or subspecialties have subcompetencies directly related to the care of patients with disabilities:

1. Physical medicine and rehabilitation
2. Spinal cord injury medicine (a subspecialty of physical medicine and rehabilitation)
3. Brain injury medicine (a subspecialty of neurology and physical medicine and rehabilitation)
4. Neurodevelopmental disabilities (a subspecialty of neurology)
5. Pediatric rehabilitation medicine (a subspecialty of physical medicine and rehabilitation)

This list should come as no surprise, she said, because these subspecialties and physical medicine and rehabilitation serve a patient population consisting primarily of people with disabilities. When Dr. Edgar dug deeper into the specific milestones applicable to each of the 140 ACGME specialties and subspecialties, however, she found that 135 of them included language around disability, though the term *disability* isn't necessarily used. Altogether, there are 662 disability-related examples across the six Core Competencies.

ADHCE Core Competencies on Disability in Health Care Education

Dr. Havercamp, a professor of psychiatry and behavioral health at OSU, was a leading contributor to the ADHCE Disability Competencies for Health Care Education (ADHCE 2019). Setting the stage for the rest of the Summit, she framed the core disability competencies as essential to providing quality care to patients with disabilities:

COMPETENCY 1

Contextual and Conceptual Frameworks on Disability: Introduces disability as a demographic characteristic as opposed to a negative health outcome. This competency is a challenge to teach and master, according to Dr. Havercamp. It requires people to shift their thinking from a biomedical model of disability, in which disability is part of the individual, to a biopsychosocial model. Under a biopsychosocial model, disability is recognized as an interaction between a health condition and an environment that doesn't accommodate the functional limitations of the condition. This separation of disability from health allows the physician to focus on health and appreciate that people with disabilities can be healthy.

COMPETENCY 2

Professionalism and Patient-Centered Care: Addresses professionalism and the need to mitigate implicit bias against people with disabilities. Through this competency, the learner demonstrates mastery of general principles of professionalism, communication, and respect for patients and recognizes optimal health and quality of life from the patient's perspective.

COMPETENCY 3

Legal Obligations and Responsibilities for Caring for Patients with Disabilities. The learner will understand and identify legal requirements for providing health care in a manner that is minimally consistent with federal laws, such as the ADA, the Rehabilitation Act, and the Social Security Act.

COMPETENCY 4

Teams and Systems-Based Practice: The learner will engage and collaborate with team members within and outside their own discipline to provide high-quality, interprofessional team-based health care to people with disabilities.

COMPETENCY 5

Clinical Assessment: Clinical assessment for people with disabilities requires the integration of functional status in clinical decision-making to develop a coordinated care plan. Learners will collect and interpret relevant information about the health and function of patients with disabilities and engage in creating a plan of care that includes essential and optimal services and supports.

COMPETENCY 6

Clinical Care over the Lifespan and During Transitions: Clinical care for people with disabilities requires the integration of functional status and life course transitions in clinical decision-making to develop a coordinated care plan. Learners will demonstrate knowledge of effective strategies to engage patients with disabilities in a coordinated plan of care with needed services and supports.

These competencies remained top of mind for the Summit participants during their subsequent discussions on what physicians need to learn to provide better care to individuals with disabilities.

Competency-Based Medical School Curriculum to Meet the Needs of People with Disabilities

Moderator Nethra Ankam, MD, a professor of rehabilitation medicine at the Thomas Jefferson University Sidney Kimmel Medical College in Philadelphia, Pennsylvania, offered insights before introducing the two panelists: Lisa Howley, PhD, AAMC's senior director for transforming medical education, and Mark Speicher, PhD, AACOM's senior vice president of research, learning, and innovation.

CURB-CUT EFFECT APPLICABLE TO EDUCATING AND TRAINING PHYSICIANS

"As we design a curriculum to teach the knowledge, skills, and attitudes [needed] to care for people with disabilities, we are actually teaching universal concepts that will help all of our patients. All of our patients want care teams that can take histories and perform physicals in an adaptive way. Everyone wants health care that is coordinated, collaborative, interprofessional, team-based, person-centered, goal-directed, and trauma-informed," said Dr. Ankam. In addition, she continued, all patients want physicians who can produce an appropriately broad, differential diagnosis without the following errors in reasoning that often occur in the care of patients with disabilities:

- *Anchoring bias*—the focus on a single, often initial, piece of information when making clinical decisions without sufficiently adjusting to later information
- *Diagnostic overshadowing*—a phenomenon in which the symptoms of one health condition are mistakenly attributed to another, pre-existing condition or to a person's disability, leading to an underdiagnosis or misdiagnosis of the true underlying health problem

"As we universally design [a more inclusive medical education curriculum] and think about our discussions, we are truly creating the curb-cut effect," Dr. Ankam said. "When we design for people with disabilities, we make things better for everyone."

> "As we design a curriculum to teach the knowledge, skills, and attitudes [needed] to care for people with disabilities, we are actually teaching universal concepts that will help all of our patients."
>
> *— Dr. Nethra Ankam*

INVOLVING THE DISABILITY COMMUNITY IN IMPROVING PHYSICIAN EDUCATION AND TRAINING

Dr. Howley noted that AAMC focuses on four pillars: medical education; health care; medical research; and community collaboration. The fourth pillar, community collaboration, was added because better health outcomes can't be achieved unless physicians are effectively collaborating and working with our communities, she said. The need to involve the disability community in improving physician education and training was emphasized throughout the Summit.

KEY RESOURCE: AAMC'S MEDEDPORTAL

After reviewing the six Foundational Competencies for UME, Dr. Howley shared information on AAMC's MedEdPORTAL®, an open access journal of teaching and learning resources in the health professions. Dr. Howley encouraged Summit participants to submit content on disability-inclusive medical education to the journal. MedEdPORTAL, she said, includes not just information on schools that have integrated some disability-inclusive education into their curricula, but also tools that medical educators can use to add disability content to their own curricula, classes, clerkships, and GME programs.

KEY DISABILITY-FOCUSED CURRICULUM: NICHE-MED (FOR IDD)

Dr. Speicher used his talk to highlight NICHE-MED, the largest inclusive curriculum initiative that focuses on people with intellectual and developmental disabilities (IDD). NICHE-MED awards medical school partners $15,000 grants to implement curricular enhancements that address gaps in education regarding patients with IDD. Dr. Speicher urged attendees to learn more about NICHE-MED and about how excellent curricular models already are effectively and meaningfully integrating disability care into medical education.

Roadmaps for Curricula: What to Teach Residents/Fellows to Support Disability-Inclusive Care

Before introducing the four panelists, moderator Michael Stillman, MD, assistant dean for undergraduate medical education and academic affairs at the Thomas Jefferson University Sidney Kimmel Medical College, presented statistics on disability:

- Approximately 6.5 million Americans have intellectual and developmental disabilities, according to the Centers for Disease Control and Prevention (CDC) (CDC 2019).
- Each year, more than 795,0000 Americans have a stroke (CDC 2024c).
- Just under one-third of a million Americans are living with a spinal cord injury (National Institutes of Health 2025).
- About 3.6 percent of Americans are deaf or have substantial hearing loss (National Deaf Center on Postsecondary Outcomes 2024), and approximately 2.5 percent of adult Americans have a significant visual disability (US Department of Justice 2020).

Dr. Stillman observed that the prevalence of disability goes up with age, with about eight percent of people under the age of 15 but nearly three quarters of those older than 80 having disabilities. And yet, very few medical schools and very few residency programs offer comprehensive education and training in comprehensive care for patients with disabilities. “This educational dearth has real clinical consequences for people in this country living with disabilities,” said Dr. Stillman.

The four speakers on Dr. Stillman’s panel were:

- Mary M. Stephens, MD, a professor of family and community medicine and co-director of the Jefferson FAB [For Adolescents and Beyond] Center for Complex Care at Thomas Jefferson University
- John Harris, MD, an assistant professor in the Department of Obstetrics, Gynecology, and Reproductive Sciences, and the director of the Center for Women with Disabilities at the University of Pittsburgh Medical Center (UPMC) Magee-Women’s Hospital
- Mike McKee, MD, MPH, a professor in the Department of Family Medicine and co-director of the Center for Disability Health and Wellness at the University of Michigan Medical School/Michigan Medicine
- Kara Ayers, PhD, the associate director of the Center for Excellence in Developmental Disabilities at the University of Cincinnati

KEY DISABILITY-FOCUSED GME PROGRAM (FAMILY MEDICINE AND PHYSICAL MEDICINE AND REHABILITATION): JEFFERSON FAB CENTER FOR COMPLEX CARE

The Jefferson FAB Center for Complex Care focuses on the transition of care from pediatrics to adult medicine, “but we realize that life is full of transitions,” said Dr. Stephens. The Center provides disability training to both family medicine and physical medicine and rehabilitation residents, who are immersed in the care of individuals with complex childhood-onset conditions. This immersion includes “a lot of mentorship, meeting the patients where they are, recognizing them as experts in their own journey and condition,” Dr. Stephens said.

KEY DISABILITY-FOCUSED GME PROGRAM (OBSTETRICS AND GYNECOLOGY RESIDENTS): MAGEE WOMEN'S HOSPITAL

Dr. Harris noted that obstetrics and gynecology care is one of the settings in which individuals with disabilities face the most barriers. Disability-inclusive education and training at Magee Women's Hospital focuses heavily on developing in residents the communication skills needed to discuss with empathy what might be traumatic experiences for individuals with disabilities (for example, individuals with IDD are more likely to be victims of sexual abuse). Residents also learn to approach topics such as genetic counseling and pregnancy care with sensitivity and with awareness of historic ableism in the specialty of obstetrics and gynecology.

KEY DISABILITY HEALTH CARE INITIATIVE: MDISABILITY AT MICHIGAN MEDICINE

MDisability is a collaborative Michigan Medicine family medicine program focused on improving the primary care of people with disabilities through medical education, research, clinical care, and community partnerships. MDisability established a two-week Disability Health Elective for third- and fourth-year medical students, who rotate among different clinics specializing in disability-based care (e.g., deaf health, adaptive sports medicine, spinal cord injury, cerebral palsy, low vision). Students are introduced to elements of disability theory, clinical practice, disability law, and implications for policy.

KEY DISABILITY-FOCUSED GME PROGRAM: MICHIGAN MEDICINE DISABILITY HEALTH FELLOWSHIP

Dr. McKee also led the development of the first-ever Michigan Medicine Disability Health Fellowship. This 12-month clinical fellowship provides fellows with the opportunity to improve their clinical skills in caring for patients with physical, intellectual, or developmental disabilities. The fellows also learn about disability-relevant policy, teach medical students and residents about disability-inclusive care, and do research to advance the field.

KEY FEDERAL INITIATIVE: LEADERSHIP IN EDUCATION AND NEURODEVELOPMENTAL DISABILITIES (LEND) PROGRAM

Dr. Ayers highlighted opportunities to influence education and training through her role as a faculty member in the Cincinnati Leadership in Education and Neurodevelopmental Disabilities (LEND) program. The mission of the LEND program is to improve the health of infants, children, and adolescents with disabilities. LEND prepares learners to assume leadership roles in their respective fields and helps ensure high levels of interdisciplinary clinical competence in the care of patients with neurodevelopmental disabilities. "If I had one wish for that program, it's that we would be able to integrate more residents," she added.

EXAMPLES OF EDUCATIONAL PRACTICES: METHODS FOR TEACHING RESIDENTS/FELLOWS TO PRACTICE DISABILITY-INCLUSIVE CARE

The final day of the Summit, March 4, included a panel discussion in the morning, followed by two rounds of breakout sessions and report-outs to the full gathering. This was a time for prioritizing recommendations and mapping out implementation plans.

Roadmaps for Curricula: What to Teach Residents/Fellows to Support Disability-Inclusive Care

Margaret Turk, MD, a distinguished service professor of physical medicine and rehabilitation, pediatrics, and public health and preventive medicine at the State University of New York (SUNY) Upstate Medical University, moderated the final panel discussion of the Summit. Throughout the discussion, Dr. Turk emphasized the need for program assessment—that should measure the performance of physicians in practice who have participated in disability-inclusive GME education and training.

Dr. Turk introduced the three panelists, who are involved in educating and training residents in disability-inclusive care:

- Leslie Rydberg, MD, an associate professor of physical medicine and rehabilitation and medical education at the Northwestern University Feinberg School of Medicine, and associate program director at the Shirley Ryan AbilityLab
- Nabil Abou Baker, MD, an associate professor of internal medicine and pediatrics at University of Chicago Medicine, and associate program director of the internal medicine-pediatrics residency program
- Alex Schoenberger, MD, MDEd, a fourth-year internal medicine-pediatrics resident at the University of Cincinnati College of Medicine

KEY DISABILITY-FOCUSED GME PROGRAM: SUPPORTIVE COMMUNICATION PATHWAY AT THE NORTHWESTERN UNIVERSITY FEINBERG SCHOOL OF MEDICINE

Dr. Rydberg noted that she enjoys her "dual role in medical education" as someone who works at both the UME and GME level in the department of physical medicine and rehabilitation. In the GME program, she said, "training our residents to care for people with disabilities [is] intrinsic to what we do in our mission and the patient population we serve." PGY-2 residents in the program are immersed in inpatient rehabilitation and work with people who have various neurologic conditions. "Communication skills are so very important when we're thinking about cognitive communication disorders and medical decisions in an inpatient setting," she said.

> "... training our residents to care for people with disabilities [is] intrinsic to what we do in our mission and the patient population we serve."
>
> *— Dr. Leslie Rydberg*

For the past three years, speech therapists have helped with the training of residents in the "supportive communication pathway" for adults with aphasia—instruction that learners now receive in their first week of residency. This training includes a lecture on aphasia and the supportive communication pathway, followed by hands-on training that involves role-playing, with cases that are similar to those the residents will encounter on their stroke rotation. "That way, everyone is ready to jump in on day one, so they're not learning about this on the job and having to figure it out as they go along," said Dr. Rydberg.

KEY DISABILITY-FOCUSED GME PROGRAM: MANAGING CARE TRANSITIONS AT UNIVERSITY OF CHICAGO MEDICINE

At University of Chicago Medicine, Dr. Abou Baker oversees a rotation focusing on the management and transition of pediatric patients with chronic childhood conditions that is open to internal medicine and pediatrics—and required of combined internal medicine-pediatrics—residents. Content on health care transitions and the care of individuals throughout their lifespans is also integrated into grand rounds and didactic lectures. “My main focus regarding disability is the care of children with chronic childhood conditions and disabilities, and the transition between pediatrics and internal medicine. There are a lot of health disparities that exist in that realm,” he said. To help bridge that gap, internal medicine-pediatrics program directors have successfully lobbied for changes at the national level for all pediatrics and internal medicine-pediatrics residency programs to integrate content on health care transitions in residency program requirements.

KEY DISABILITY-FOCUSED GME PROGRAM: MANAGING CHILDHOOD-ONSET COMPLEXITY AT UNIVERSITY OF CINCINNATI COLLEGE OF MEDICINE

Dr. Schoenberger noted that the internal medicine-pediatrics residency program where she is training has integrated content on disability and health care transitions into its curriculum after a survey of residents revealed that only 32 percent of residents were comfortable caring for patients with childhood-onset complexity. Despite this pervasive discomfort, 96 percent wanted to learn more about caring for this patient population; in response, the program developed learning objectives covering topics such as medical technology, autonomic dysfunction, communication, guardianship, and goals of care.

“From there, we developed a series of didactic lectures, high-fidelity mannequin simulations, and some small group-based learning sessions,” she explained. To aid resident learning and promote patient safety, they also developed a series of one-pagers on managing emergencies involving medical technology (such as gastrostomy tubes, baclofen pumps, and shunts), outlining what to look for, what to do, and whom to call. Addressing Dr. Turk’s question about program evaluation, Dr. Schoenberger noted that her program conducts pre-and post-surveys of learners to assess their experiences and the effectiveness of the content, and is in the process of doing a larger year-long assessment of its curriculum.

BREAKOUT SESSION INSIGHTS: THE ATTITUDES, KNOWLEDGE, AND SKILLS NEEDED TO PROVIDE DISABILITY-INCLUSIVE HEALTH CARE

For the first breakout session, the Summit attendees answered this central question: **What core knowledge, skills, and attitudes (cognitive, communication, clinical) should be taught in GME to prepare residents to care for patients with disabilities?**

Reflecting a modified version of the world café method for stimulating purposeful dialogue, the breakout groups were further divided into three discussion tables of six or seven participants, each assigned one of three topics to start:

KNOWLEDGE	**What do residents need to *know*?**
SKILLS	**What do residents need to *know how to do*?**
ATTITUDES	**What *perspectives* should residents develop?**

The following is a summary of the collected insights of all breakout groups.

KNOWLEDGE

What do residents need to know to provide quality care for patients with disabilities?

Residents must develop a comprehensive understanding of disability to provide effective, empathetic care. This includes knowledge of medical or clinical, legal, ethical, and communication considerations pertaining to patients with disabilities.

MEDICAL OR CLINICAL KNOWLEDGE

- Understand the common comorbidities and medical complications related to different types of disabilities. For example, for patients with IDD, be aware of the "fatal five"—aspiration, dehydration, seizures, constipation, and sepsis.
- Understand how a disability (especially a congenital, childhood-onset, or young adult-onset disability) will evolve over the course of a person's life.
- Recognize that diagnostic overshadowing and anchoring bias often occur in diagnosing illness in people with disabilities, with physicians likely to attribute new symptoms to the disability rather than rigorously considering other potential underlying health conditions. Implement measures to ensure thorough differential diagnoses when providing care to disabled patients who have new illness symptoms.
- Understand the challenge of health care transitions for patients with disabilities (from pediatric to adult care, for example) and how to ensure smooth, successful transitions.
- Be familiar with community resources, social programs, and home- and community-based services for patients with specific disabilities.
- Know where to find guidelines for routine care specific to different disabilities.

KNOWLEDGE OF LEGAL, ETHICAL, AND FINANCIAL CONSIDERATIONS

- Understand physicians' roles and responsibilities under the ADA, the Affordable Care Act (Sections 1557 and 4302), and Section 504 of the Rehabilitation Act.
- Be knowledgeable about patient rights, guardianship, and supported decision-making.
- Be knowledgeable about disability-related documentation, such as those required for the Family Medical Leave Act (FMLA), work capacity, and long-term disability.
- Understand how to document medical necessity for equipment and referrals.

CULTURAL AWARENESS AND UNDERSTANDING OF SOCIAL DETERMINANTS OF HEALTH

- Be knowledgeable about disability history and culture.
- Understand the biopsychosocial model of disability, in which disability is viewed as a complex interaction among biological, psychological, and social factors and is influenced by individuals' health status, personal experiences and beliefs, and the social and environmental contexts in which they live.

- Recognize how disability intersects with other social determinants of health.
- Understand the value of patients' lived experience and their right to determine their own care.
- Recognize the need for non-stigmatizing documentation in the electronic health record.
- Understand the importance of engaging with the disability community.
- Understand disability etiquette.

SKILLS

What do residents need to know how to do to provide quality care for patients with disabilities?

Residents need to develop practical, adaptable skills to communicate with and care for patients with disabilities. In addition to clinical know-how such as physical examination skills, physicians need to learn how to interact with disabled patients in a sensitive, effective manner that builds trust and maximizes patients' confidence and sense of safety.

CONDUCTING ACCESSIBLE, ADAPTABLE PHYSICAL EXAMS AND CLINICAL PROCEDURES

- Adapt physical exams and clinical procedures to meet patients' needs, as indicated.
- How to use accessible examination tables, medical equipment, and imaging machines.
- How to use adaptive equipment and adaptive surgical procedures (wheelchairs, augmentative and alternative communication [AAC], feeding tubes, tracheostomies, and so on).
- Perform comprehensive physical exams while considering medical equipment and devices (such as wheelchairs, feeding tubes, and communication devices). Arrange for the safe transfer of patients from wheelchairs to exam tables.
- Troubleshoot when physical exams, procedures, and diagnostic tests cannot be performed as usual, without entirely forgoing them.

COMMUNICATING WITH PATIENTS

- Obtain disability-relevant histories from patients.
- Develop patient-centered communication skills, including speaking directly to the patient rather than to caregivers.
- Use adaptive communication devices, sign language interpreters, and translators when needed.
- Practice disability etiquette (Disability:IN).
- Practice trauma-informed care to create a safe environment.
- Ask the patient, "What do I need to do to make you more comfortable?" during a physical exam or other health care encounter.
- Recognize nonverbal signs of pain and distress.
- Learn de-escalation techniques for patients with behavioral challenges.

PUTTING LEGAL, ETHICAL, AND FINANCIAL CONSIDERATIONS INTO PRACTICE

- Apply ADA requirements and disability right laws to clinical practice.
- Advocate for patient accommodations in health care settings.
- Discern when and how to make appropriate referrals for disability-related care.

- Navigate insurance, benefits, and coverage for disability-related services.
- Write letters of medical necessity and fill out FMLA and disability forms.
- Recognize and address bias to prevent disability-related stereotypes from influencing medical decisions.

PROVIDING COMPREHENSIVE, COLLABORATIVE, INTERDISCIPLINARY CARE

- Provide flexible care plans that are tailored to individuals with disabilities.
- Work effectively within interdisciplinary teams to manage complex care.
- Coordinate with behavioral health professionals, social workers, community organizations, and others as needed.
- Proactively address discharge planning and suggest solutions to potential barriers faced by individuals with disabilities.
- Facilitate care transitions and follow up with patients, serving as an advocate for robust continuity of care.
- Access community resources to help patients with disabilities.
- Involve and support caregivers as a vital part of the care team.

ATTITUDES

What perspectives should residents develop to provide quality care for patients with disabilities?

Physicians in training need to cultivate humility, flexibility, and appreciation for the patient's expertise in order to provide equitable and respectful care to patients with disabilities. GME should emphasize patient autonomy, inclusive communication, and the value of lived experience.

VALUING PATIENT EXPERIENCE AND AUTONOMY

- Recognize and trust patient and caregiver expertise in managing the patient's condition(s).
- Avoid hubris by validating lived experiences rather than assuming that medical knowledge is always superior.
- Understand that learning about disability is ongoing—there is no "one-size-fits-all" approach.
- Understand that disability is not something to "fix" but an essential part of identity.

AVOIDING ABLEISM

- Recognize that disability does not equate to a lower quality of life.
- Actively reflect on biases about disability and their impact on clinical decision making.
- Be humble and (appropriately) curious when interacting with patients with disabilities.
- Avoid assumptions about a patient's abilities and independence.
- Understand that health care has historically been a source of harm for many disabled individuals.

DEVELOPING FLEXIBILITY AND ADAPTABILITY

- Accept uncertainty and be open to creative problem-solving when standard approaches don't work.
- Recognize that patients' needs and accommodations may change over time.
- Understand that disability-inclusive care requires adaptability in clinical practice.
- Be open to learning from patients and applying their insights to improve care.

ADVOCATING FOR DISABILITY-INCLUSIVE HEALTH CARE

- Support colleagues with disabilities and ensure that they receive appropriate accommodations in medical education and training.
- Incorporate patients with disabilities into clinical education and training.

TABLE TALK: KEY TAKEAWAYS

Breakout Session Insights

Facilitated by Priya Chandan, MD, MPH, PhD, a clinical associate professor in the division of physical medicine and rehabilitation at the University of Louisville School of Medicine in Louisville, Kentucky, this phase of the Summit saw attendees assigned to small groups to reflect on the prior discussions and come up with specific, prioritized takeaways. The participants were tasked with answering four questions:

1. What are the most practical, scalable things we can do to improve GME in disability care?
2. What are the highest-value/highest-impact things we can do to improve GME for people with disabilities?
3. What questions remain?
4. What are the most important points or key insights that emerged in your discussion?

Questions One and Two are addressed below.

What are the most practical, scalable things we can do to improve GME in disability care?

The Summit-goers agreed that the following measures would be among the most leverageable:

Establish shared competencies.

Develop disability care competencies applicable across specialties. Advocate for clear, specific requirements for disability education and training, including the Milestones-based learning objectives and observable Entrustable Professional Activities (EPAs).

Create a centralized repository of resources.

Establish a centralized repository of existing disability-inclusive resources and curricula, success stories, and adaptable resources, ensuring that all specialties have tools to incorporate disability care into GME.

Enhance faculty engagement and development.

Cultivate faculty champions for disability-inclusive care by providing faculty development opportunities that don't add measurably to faculty members' existing workload and by offering continuing medical education (CME) credits for training.

Integrate disability care into education and training.

Integrate disability-related education into existing curricula, clinical experiences, standardized patient cases, and longitudinal care, ensuring that both hospital and ambulatory care settings are included.

Leverage lived experience and community partnerships.

Engage individuals with disabilities in GME, and collaborate with disability-related community partners for experiential learning.

Improve residents' disability-related clinical skills and knowledge of accessibility requirements.

Train residents on legal requirements related to accessibility and develop learners' hands-on clinical skills, such as the ability to examine all patients (including those who use wheelchairs full time) on an exam table.

Foster institutional and cross-disciplinary collaboration.

Break down silos by promoting cross-disciplinary collaboration, facilitating resource sharing among institutions, and working with professional organizations to prioritize the care of patients with disabilities.

Develop objective measures for impact assessment.

Create objective performance metrics for assessing learners and for measuring the success of the disability-related training experiences and instruction.

What are the highest-value/highest-impact things we can do to improve GME for patients with disabilities?

The Summit participants also came up with a list of longer-term measures that would have the greatest impact on educating and training physicians to better care for individuals with disabilities:

Integrate people with disabilities as educators.

Proactively hire disabled individuals as paid educators to provide firsthand knowledge of their lived experience, ensuring that disability identity, culture, and pride are embedded in GME to drive cultural shifts alongside clinical knowledge.

Encourage disability education and training across the continuum of medical education and across specialties.

Promote disability education across specialties and across the medical education continuum.

Enhance experiential learning and hands-on practice.

Mandate experiential training with standardized patients, skills-based learning, and direct interaction with people who have disabilities to improve clinical competence and reduce ableism.

Define outcomes and measure impact.

Implement longitudinal tracking of patient outcomes for physicians trained in disability care to assess the effectiveness of disability-related GME curricula.

Create lasting, systemic change.

Advocate for the purchase and use of accessible medical diagnostic equipment, and ensure institutional compliance with all ADA and other disability-related legal requirements.

TOP PRIORITIES

In the final round of breakout sessions and report-outs to the plenary gathering, the Summit attendees refined and voiced their top priorities. For example, the participants agreed that because many institutions have already integrated aspects of disability care into GME and even UME, there needs to be a shareable national repository of disability education resources. That way, programs won't waste time "reinventing the wheel" and can adapt and build on what other programs have done.

To counter ableism, training in disability care must address the historical context of disability in medicine, as well as disability identity and culture, the Summit-goers said. It is also critical to include experiential learning with people with disabilities to ensure that learners have direct interaction with those who have lived experience. In addition, residents need considerable education and training in performing physical examinations on people with disabilities; using assistive technologies and accessible diagnostic equipment; and communicating in a clear, empathetic manner, using adaptive communication technologies or interpreters, if needed.

As was reiterated throughout the Summit, the effectiveness of disability-related education and training will need to be measured—in the short run through faculty and resident surveys and observations and in the long run through patient outcomes. In the future, implemented changes to education and training could be evaluated through another large-scale survey of physicians like that conducted by Dr. Iezzoni.

Above all, disability care must be reframed as a routine and expected part of health care education. Curricular changes need to be mandated to ensure universal adoption and long-term sustainability.

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APPENDIX A: SUMMIT PLANNING COMMITTEE

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APPENDIX B: RESEARCH AND RESOURCES RELATED TO EDUCATING MEDICAL LEARNERS IN PROVIDING DISABILITY-INCLUSIVE CARE

The following are resources shared by Disability Summit participants for purposes of this appendix.

Association of Academic Physiatrists. 2025. "Disability Education Network." Last reviewed May 2, 2025. www.physiatry.org/resource/disability-education-network/.

The Disability Education Network is designed to help medical educators integrate disability education into medical curricula through tools for the pre-clinical and clinical stages of training, including interactive modules, clinical cases, small group activities, and journal club article recommendations.

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