

# Why accessibility should be part of equity, diversity, and inclusion initiatives

## Ableism remains a barrier to care and dignity in medical settings



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I am reminded of the persistence of ableism—discrimination against people with disabilities—every day. Though many family physicians seem increasingly aware of systemic racism and sexism in medicine and health care, in part due to initiatives to promote equity, diversity, and inclusion (EDI), fewer seem cognizant of ableism and the barriers those with disabilities encounter.

As a physician with disabilities, I consider the need to improve care for those with disabilities an urgent one. I envision a focus on accessibility as one way to do this, by mitigating ableism in medicine.

### Family physicians as agents within structural ableism

My family medicine residency exposed me to the policies and structures of ableism in my preceptors' clinics. As a patient, my own physicians' clinics serve as regular reminders.

The lone elevator in one new clinic is clearly an afterthought; it is not large enough to turn around in with my wheelchair, and it barely fits more than one person. During residency I found most waiting rooms had few chairs for larger people, and too many clinics still have oppressive flickering fluorescent lighting and no space for people using mobility devices.

During medical training I saw few clinic rooms large enough to accommodate service animals, strollers, or mobility devices and even fewer with height-adjustable examination tables. Though my current physicians' rooms are often larger, their tables remain largely inaccessible.

Navigating our health-care systems, as a physician and as a patient, is endlessly frustrating for me.

Referrals by my residency preceptors were made without consideration of whether a person could actually attend the appointment, let alone in a dignified manner. This continues for me today: I have been referred to practitioners accessible only by stairs, imaging facilities in which I must change out in the open as I am unable to fit into their tiny cubicles with my wheelchair, and interventions in which nurses and technicians openly question whether someone like me even merits their efforts.

I am part of the diverse, heterogeneous community of people living with disabilities, who make up the largest minority group in Canada and around the world.<sup>1,2</sup>

I am also a physician and professor, and as such I experience both incredible privilege and intense marginalization. Both my race and socioeconomic status

provide protection, and I have advantages and options that others lack.

However, as a woman with disabilities who uses a wheelchair I am marginalized, and the sexism and ableism I encounter often outweigh the cachet of my title and privileges.

I am constantly reminded that I exist in a world that was not created for me. I am excluded by policy and by design. I am discriminated against in medicine and beyond.

I vacillate between being a willing activist and advocate for accessibility and wishing previous professional work I have done to advance equity and social justice would progress faster. I often resent how I must reinvent access and plead my case with each new health care professional I visit.

### Physicians do not want patients with disabilities

Though I often choose not to disclose the multitude and extent of my disabilities, I usually cannot avoid disclosing my use of a wheelchair during in-person encounters. It goes with me wherever I go, and it is often what people—especially physicians—notice first. Too frequently this one factor is their focus, unduly influencing the care I am offered and the manner in which it is provided.<sup>3</sup>

Multiple studies have demonstrated that physicians do not want patients with disabilities in their practices,<sup>4,5</sup> and I am acutely aware of this in interactions with colleagues. Countless times it has been shared with me that disabled people are to be judged, pitied, and fixed rather than listened to or supported.

Physicians have lamented that those with disabilities are burdensome and not worth the effort. Multiple doctors have related to me that disabled people do not need access to every place and space, and that it is not a problem that their clinic is not accessible, as “those people” should just go to the hospital.

In online forums with fellow physicians, I have seen cringe-worthy comments written that would be considered bigoted and discriminatory if the disabled people they targeted were replaced with individuals belonging to gender, racial, or sexual minority groups.

Such underlying beliefs, made clear when such comments are made, stereotype and stigmatize people with disabilities and lead to discriminatory action, design, and policy. Not seeing the humanity and personhood of people with disabilities leads to individual ableism by

physicians and to systemic ableism within medicine and health care.

Patients with disabilities, me included, are not offered the same standard of care as those without disabilities, as we are often not deemed worthy of such care.<sup>6</sup> We receive less preventive care because we are offered fewer screening tests. When care is offered, it is often inaccessible to us.

Perceptions of quality of life for those with disabilities are skewed when physicians' assumptions and assessments are compared with what people living with disabilities themselves report.<sup>7,8</sup> Often, physicians frame their understanding of disability as an individual problem with and within me.<sup>9</sup> However, I find disability to be the interplay of context and the interaction of the environment with me.<sup>10,11</sup>


My wheelchair is not the problem. It is often the solution. It is the lack of ramps and elevators that is the issue and the assumptions that lead to this lack of inclusive infrastructure.

The centring of disability as an individual problem is especially prevalent in medicine, where we are taught to see any difference from an arbitrary norm as a deviance to be fixed. From medical school onward we are taught binary labels of sick versus healthy, patient versus physician, and so we have difficulty reconciling multiple identities within a person. Often the challenge of my disabilities is not from impairment or divergence in function but from the limited, narrow way in which culture is constructed and society is set up.

### Family physicians can facilitate accessibility

Ramps and elevators are often obvious markers of accessibility. They are one way to accommodate those with disabilities and to begin to include us. Accessibility measures, and clear communication about them, can be advocated for and implemented by family physicians. You can add a line to your communication material about your clinic's accessibility today, and with that simple action improve accessibility and inclusion.

We know EDI initiatives can lead to improvements in patient care, stronger patient-physician relationships, and more resilient health care professionals.<sup>12</sup> People with disabilities—physicians and patients alike—need to be included in EDI strategies to ensure the benefits of EDI are realized for everyone.<sup>12,13</sup>

Family physicians are known for seeing the whole person and not just one facet of a patient's identity, such as a diagnosis or a disability. We have the expertise and opportunities to broaden the concept of EDI to *IDEA*—inclusion, diversity, equity, and accessibility. We can speak out about the lack of accessibility in medicine, the ableism it perpetuates, and the importance of inclusion of all. 

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#### Competing interests

None declared

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