

## The Resident With Disabilities

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The training of residents with disabilities is becoming increasingly important for residency program directors. As Losh and Church<sup>1</sup> indicate in this issue of *Family Medicine*, the number of requests by college students for accommodation in the application process for the Medical College Admission Test is increasing significantly. Some of these applicants will gain admission to medical school and subsequently apply for residency training.

What should our response be when faced with the possibility of admitting a resident with a disability into our programs? As noted by Losh and Church, the Americans With Disabilities Act (ADA), the vehicle through which applicants may apply for accommodation, places specific requirements on employers to ensure that applicants are not subject to discrimination because of their disability. Residency training programs, however, have unique characteristics that make application of ADA principles challenging.

We speak from personal experience. Dr Pearson is a family practice

residency director working with a resident who has a physical disability. Dr Smith is a residency faculty member who is disabled.

### Preplanning

Preplanning is the key to maintaining high standards in our residency programs, as well as maintaining compliance with ADA regulations. The first step in the ADA planning process, as suggested by Losh and Church, should be development of a clear job description for all residents.

The description need not be all encompassing. Rather, it should reflect the minimal expectations placed by the program on all residents. In addition, it should be based on objective criteria, whenever possible. It would be a serious mistake to craft a job description based on "the way we always did it." Nor should personal biases about "the way things should be done" be allowed to color the job description. Often, creative solutions can be found to allow residents with disabilities to complete the educational requirements of the program in unique, but perfectly satisfactory, ways.

In our particular program, the lack of a list of essential job functions led to considerable difficulty when confronted with concerns about job performance of a resident disabled by a serious visual impairment. At the same time, our open-

ness to exploring alternate ways to accomplish what later became recognized as essential job functions allowed for many satisfactory solutions. For example, obtaining PAP smears using a single finger and cytobrush, a technique used routinely by Dr Smith in the care of women with developmental disability, was an acceptable alternative for use by our visually impaired resident.

### Goal Setting

An active assessment of the training goals of a resident with disabilities is an important next step in the planning process. The program director should be prepared to discuss the resident's goals and assist in determining whether or not these goals are realistic. More than a single step, this is an ongoing process of discovery for the resident and faculty that is based on individual limitations, skills, and experience. It should not be an unending process, however, and timelines should be established within which goals should be attained. This planning process, as with any resident, should occur in focused sessions with the director and/or advisor.

From a personal perspective, this process of goal setting was particularly difficult for me (Dr Smith), having become disabled as an established physician because of a lower-extremity amputation. It took a long time before I was able to

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acknowledge that there were things I couldn't do. I can't stand for long periods of time. I can't climb stairs well. I fatigue easily, and my balance is poor. I hated making "reasonable accommodations" for myself. I eventually learned to examine patients mostly from a seated position. I pace myself differently; I see patients for half-day sessions only, and I provide less pregnancy care. Although reality continues to change, it is important to learn to accept and adapt to those changes. Similarly, it is important for both the disabled resident and a residency program to accept and adapt to those changes necessary for pursuit and continuation of the resident's career.

### **Reasonable Accommodation**

The program director and faculty must assess whether the program is flexible enough to accommodate the resident (and the resident's goals) without seriously compromising the educational process. Because significant costs may be incurred in meeting the ADA requirements, a program may be ill equipped to take on this challenge. Some programs will not be able to accommodate a resident who may need altered scheduling, additional space to store equipment (eg, ambulation aids), or various types of special assistance. The challenge and experience of providing this assistance, however, can be enriching and educational for all involved. Further, addressing issues such as unimpeded access to areas of the office or hospital is likely to benefit patients and staff as well.

Access is not something that the able-bodied consider often. For example, my first office was on the second floor of a building with no elevator. Installing a railing made it possible for me to pull myself up and ease myself down the stairs. Sometimes, residents know what they need; at other times, residents require time to brainstorm with faculty and colleagues to achieve a

mutually acceptable solution. It is a process of discovery and asking for help, mixed with lots of waiting and sometimes disappointment.

### **Mobilizing Resources**

Support resources can be vital in assisting programs and residents to identify and obtain the needed equipment and services to perform the job. These resources include governmental agencies, support groups, and volunteer organizations. Over the course of her training, our visually impaired resident was able to obtain a typewriter, books and papers translated into Braille, a voice-activated computer, and funding for a sighted reading assistant. Timing, however, was never ideal, and it was not unusual to wait 6 months for the needed equipment.

While some of the equipment could be anticipated in advance, certain needs were not identified until problems arose. For example, it became clear that the time delay in having a dictated note reach the chart was often unacceptable, and a typed note was needed in addition to the brailled note documenting the visit. This meant that a portable typewriter was needed on site during office encounters—something we had not anticipated in advance.

Although invaluable in providing direct aid and support, the above services may not cover all the needs encountered in training the disabled resident. There will be additional costs borne by the program and the individual, and these costs should not be minimized (for example, the cost of a reading assistant for our resident). In addition, since much of the support happens as a result of trial and error, the full capabilities of the support services may not be realized. Further, the assistance offered by such agencies is not always acceptable to the resident, for various reasons.

### **Reaching Consensus**

Constituent groups (faculty, fellow residents, and administrators) should be consulted to assure that all potential problems are discussed in an open, objective manner. While the applicant has the right to confidentiality regarding their disabling condition, aspects of that condition that affect others' ability to work, resource allocation, and/or workload need to be shared with others.

After reaching consensus with the constituents, the resident's rotations should be carefully planned as far in advance as possible. During planning, specific goals and objectives should be discussed with the resident, keeping in mind the general curricular guidelines for the program. The resident should be actively involved in this process, including doing the legwork for planning whenever possible. It is often important to approach support staff and nurse managers so that issues, including prejudice, assumptions about the disabling condition, and concerns, can be shared and solutions identified.

Coping with people's assumptions can be a painful and frustrating experience for someone with a disability. For example, being an amputee (Dr Smith), people naturally assumed that I played basketball and could downhill ski (based on the few television images of amputees). The contrast between these encouraging sentiments and my reality were frustrating at best.

On the other hand, the resident with a disability may be forced to accept assistance where none is needed and be prevented from obtaining a full experience on his/her rotations. If the resident will not be allowed, for example, to perform procedures that other residents learn to perform, an alternate training experience must be sought or expectations for completing the rotation adjusted. It is essential that these attitudes be uncovered early and addressed. Exploring underlying assumptions and prejudices will

help us guard against serious impediments to training and growth of all residents, including those with disabilities.

### **Documentation**

It is crucial to keep records as problems arise, noting the issues, discussions, decisions, and time lines. Clear delineation of the individual resident's goals and documentation of achieving those goals is critical to the process of ensuring the resident's eligibility for program completion and board examination. In addition, continued documentation is helpful as a reminder for how recurring problems were solved the last time. Clear documentation of the processes involved with accommodation serves to protect both the resident's and the program's interests as questions arise over time.

### **Growth, Understanding, and Awe**

It is sometimes difficult to step back and appreciate the process and results of residency training with all of the detail that goes into adapting training to individual resident needs. Most programs have experienced the difficulties of adapting schedules and rotational experiences for residents who are injured or develop complications of pregnancy. Somehow, assisting our learners through these crises gives us a better perspective and a sense of having shared something special. We are stronger, more humane, more loving. Working day to day with a resident who has permanent disabilities has been a humbling experience. It is with awe that we watched her struggles and successes. Her strengths, her sensitivity to the nuances of speech, her

patience and understanding of the individuals and families under her care, and her tremendous courage are inspiring qualities.

As teachers of family medicine, we need to assist ourselves and our students and residents in adjusting and adapting to disability. We do this, not because it is the law, but because it is the right thing to do, and, in doing so, we enrich our lives and our programs.

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### REFERENCE

1. Losh DP, Church LL. Provisions of the Americans With Disabilities Act and the development of essential job functions for family practice residents. *Fam Med* 1999; 31(9):617-21.