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Reasonable Accommodations for Medical Faculty With Disabilities

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MANY ACADEMIC INSTITU-tions seek and celebrate diversity, and this quest holds special relevance for medical schools. Graduates practice within communities, where providing optimal care often requires in-depth appreciation of complex interplays among health, sociodemographic factors, cultural beliefs and practices, and community values.[1-5] Medical school faculties and student bodies that reflect communal diversity offer important opportunities for enhancing that understanding.[6-11]

By unspoken consensus, the word "diversity" has evolved a specific meaning centered around gender, race, and ethnicity. Women and racial and ethnic minorities made significant inroads in professional schools only after landmark civil rights laws were enacted starting in the mid-1960s. Although women and minorities remain underrepresented, especially in leadership positions,[12-18] their inclusion has generated increasing attention in the last decade. However, today's academic diversity movement has yet to embrace individuals targeted by our nation's latest civil rights mandate, the 1990 Americans with Disabilities Act (ADA).[19]

Disability differs importantly from gender, race, and ethnicity; for example, these latter traits can be counted. The Association of American Medical Colleges tracks these characteristics in its annual report entitled *US Medical*

An unknown number of medical school faculty have disabilities, and their experiences have generally escaped notice and scrutiny. Although most medical schools offer long-term insurance and extended leaves of absence for disability, relatively few have policies explicitly addressing accommodations for faculty with disabilities as they perform teaching, research, and clinical duties. We discuss accommodating active medical school faculty with disabilities, drawing on University of Pennsylvania School of Medicine initiatives exploring the concerns of faculty with sensory and physical disabilities. Anecdotal reports suggest that many faculty, fearing reprisals, resist seeking job accommodations such as those mandated in the 1990 Americans with Disabilities Act (ADA). Although some faculty with disabilities have found supportive academic mentors, others report that lax institutional enforcement of ADA requirements, including physical access problems, demonstrates a tepid commitment to disabled staff. Potentially useful job accommodations include adjusting timelines for promotion decisions; reassessing promotions requirements that inherently require extensive travel; improving physical access to teaching, research, and clinical sites; and modifying clinical and teaching schedules. Faculty with disabilities bring identical intellectual and collegial benefits to medical schools as their nondisabled counterparts. In addition, they may offer special insights into how chronic illness and impairments affect daily life.

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School Faculty.[20] Some medical schools monitor their progress toward gender, racial, and ethnic diversity, but faculty members with disabilities remain uncounted. Without the compelling evidence of numerical data, they are thus largely invisible, and their experiences have generally escaped notice. Nevertheless, medical school faculties do include persons with disabilities who contribute daily to teaching, research, and clinical care.

Most university policies include standard language governing equal employment opportunity, encompassing persons with disabilities. In addition, according to the Association of American Medical Colleges, most medical schools offer long-term disability insurance and have policies governing extended leaves of absence for disability.[21] However, relatively few medical school policies explicitly address procedures and processes for accommodating faculty members with disabilities as they perform their jobs.

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Box 1. Definitions of Disability

Social Security Administration

"The inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months."[35]

Americans with Disabilities Act, Section 3

" . . . (A) a physical or mental impairment that substantially limits one or more of the major life activities . . . ; (B) a record of such impairment; or (C) being regarded as having such an impairment."[19]

World Health Organization

Disability is an "umbrella term for impairments, activity limitations, or participation restrictions" (p 3); "a person's functioning and disability [represent] a dynamic interaction between health conditions (diseases, disorders, injuries, traumas, etc.) and contextual factors," including environmental, social, and personal attributes (p 8).[40]

Accommodating active medical school faculty members who have disabilities is the topic of this article. Given the paucity of systematic evidence, our examples are anecdotal. We also use insights gained through an initiative undertaken in 1999-2000 by the Medical Faculty Senate Steering Committee at the University of Pennsylvania. As part of its "Faculty 2000 Project," which examined promotion and quality of life issues for junior and mid-level faculty,[22] a Subcommittee on Faculty with Disabilities specifically explored concerns relating to physical and sensory disabilities. These included identifying the following: (1) physical and nonphysical barriers in areas such as advancement and promotions, work satisfaction, and right to privacy vs the need for and fear of disclosure; (2) accommodations that would provide equal opportunities for faculty with disabilities; and (3) ways of improving recruitment, retention, and promotion of faculty with disabilities. The subcommittee did not explicitly address mental health problems, such as depression and bipolar disorder, which commonly cause work-related disability.[23] Subcommittee members spoke confidentially to 20 medical school faculty with disabilities identified through personal referrals and outreach. The anecdotes recounted below come from these interviews and from faculty at a half dozen other medical schools, who shared their stories with us.

Definitions of Disability

Disabling conditions are diverse in their causes, nature, timing, pace, and societal implications. Some are congenital, others acquired. Some occur suddenly, with injury or accident; others arise slowly, with progressive debility. Some gradually limit but do not threaten life; others hurry death. Some are visible to outsiders; others remain hidden. Some engender stigmatization and blame; others prompt pity and paternalism. Some are seen primarily as "diseases" (eg, cancer, emphysema), even when profoundly disabling. Unlike gender, race, and ethnicity—virtually immutable traits—anyone can become disabled. All medical faculty face the possibility of developing a serious illness or disability during their careers.

Identifying individuals as disabled is complex, with multilayered personal, institutional, and societal ramifications. Since the 14th century, disability has marked individuals meriting societal assistance including alms, food, shelter. However, "because physical and mental incapacity are conditions that can be feigned for secondary gain..., the concept of disability has always been based on a perceived need to detect deception."[24] Since the 19th century, distinguishing "deserving" from "undeserving" disabled persons fell to physicians using theoretically objective tools, such as stethoscopes, ophthalmoscopes, and radiographs. Over the last 30 years, however, many have countered that disability results from discriminatory social attitudes and physical environments that fail to accommodate persons with differing physical, sensory, cognitive, or emotional attributes.[25-29] This new "social model" demanded that societal and environmental barriers be removed, allowing persons with disabilities to participate fully in daily life throughout communities and workplaces. Seen as ensuring basic human rights, this perspective galvanized the ADA.[30-34]

Depending on the context, definitions of disability differ; **BOX 1** shows 3 examples. The Social Security Administration determines adult eligibility for Social Security Disability Insurance based on medical evidence of being unemployable,[35] although these standards frequently are applied subjectively.[36] Through 3 recent cases,[37-39] the US Supreme Court is constraining the ADA's reach, largely by delimiting "major life activities." The World Health Organization places disability within a broad "biopsychosocial" perspective, integrating the medical and social models.[40] This approach highlights the need to eliminate environmental barriers to facilitate full participation by persons with disabilities in daily life.

As the Supreme Court cases demonstrate, passionate disputes can arise about whether individuals are disabled, especially when employment accommodations are at stake. Some individuals fear reprisals and keep potentially disabling conditions, such as progressive vision or hearing loss, hidden. Self-identification as "disabled" depends on the context. Many individuals who are born deaf, for example, use American Sign Language and see themselves as members of a distinct Deaf culture, not as disabled.[41] Almost 20% of adult manual wheelchair

users nationwide do not perceive themselves as disabled.[42] Nevertheless, deaf persons and wheelchair users could legitimately request job accommodations under the ADA.

Defining medical faculty members as disabled thus resides within broader, unresolved societal debates. A subtle but critical factor for medical faculty is that they are surrounded by physicians, the putative arbiters of true impairment. Colleagues or supervisors may think their medical training gives them special insight into the faculty member's abilities and needs. But these colleagues or supervisors may have inaccurate perceptions or limited knowledge about specific diseases or disorders; they may thus harbor overt or hidden biases or misconceptions. For instance, a concerned senior surgeon described serving on an oral board examination committee for a young surgeon, a rising star at a prestigious institution but recently diagnosed with multiple sclerosis. The examinee tripped while entering the room and briefly joked about it, then answered the questions flawlessly. The committee's deliberations, however, focused on whether the joke signalled emotional lability from the multiple sclerosis, making the young surgeon unfit to practice. Many years later, the examinee, now using a wheelchair, is a respected teacher and role model.

Disability Accommodations

Beyond lack of formal recognition, disability differs from gender, race, and ethnicity in ways significantly affecting employment. Anyone can become disabled by injury or disease, and employers may perceive accommodating employees with proven accomplishments who become disabled differently from newly hiring persons with disabilities. Further, persons with different disabling conditions often fail to see themselves as sharing common experiences and interests, impeding their effectiveness in working together toward increased accommodations.

The nature of physical, sensory, cognitive, or emotional impairments may legitimately preclude individuals from performing certain jobs. In some situations, the accommodations required to permit job performance can be expensive and logistically challenging, even infeasible. These concerns underlie the concept of "reasonable accommodations," pioneered by Section 504 of the 1973 Rehabilitation Act.[31,34,43] Section 504, applicable only to entities receiving federal funds, generated several Supreme Court challenges to define "reasonableness." The court found that disabilities, jobs, and potential accommodations are too diverse to yield a single standard. Individual solutions are necessary. The ADA adopted this practical, individualized framework.

Title I of the ADA bars discrimination against persons with disabilities in employment—hiring and firing, advancement, compensation, training, and benefits.[44] The law requires employers to provide reasonable accommodations that do not cause them "undue hardship" (significant difficulties or expenses or fundamental redefinitions of jobs). Reasonable accommodations include ensuring physical access, restructuring jobs or work schedules, adjusting training procedures, acquiring assistive devices, and reassigning individuals to other jobs.[43,45] As stated by Young[32]:

The ADA is unique in the context of civil rights legislation because it requires that businesses and government do more than just cease discriminatory actions. They must also take proactive steps to offer equal opportunity to persons with disabilities commensurate with their economic resources.

Thus, beyond preventing discrimination, the "ADA requires that some affirmative steps . . . ensure that the particular impediments faced by individuals with disabilities are overcome."[46] Some worry about fueling resentment among coworkers without disabilities who feel that their needs are ignored.[47] But despite the ADA's moral authority[46,48] and the booming 1990s economy, unemployment among persons with disabilities remained high 10 years after its passage.[49-51] After all, Title I of the ADA does not require affirmative action in hiring disabled workers. Employers intent on rejecting applicants with disabilities can find ways to deny employment without risking lawsuits.[49]

These ADA mandates apply equally to medical schools, but academic medicine presents several special considerations. The Hippocratic tradition and "do no harm" ethos hold patient well-being sacrosanct. The cognitive, communication, and physical technical skills required to practice medicine are nonnegotiable: patients must always come first when counterbalanced against the needs of faculty members with disabilities. Many medical schools have academic clocks, governing promotion and tenure decisions. Some medical schools explicitly allow delays to accommodate faculty with disabilities, but others do not.[21] Finally, as academic medical centers seek efficiency and cut costs, clinicians can feel stretched to their limits,[52] with fewer support staff. Faculty members with disabilities may be particularly affected by sparse support staff. Some accommodations for faculty members with disabilities (eg, limiting working hours, arranging coverage, hiring American Sign Language interpreters, ensuring physical access) carry financial ramifications.

Experiences of Medical School Faculty With Disabilities

No systematic evidence exists about the experiences of medical school faculty with disabilities. A study from the late 1980s of 155 physicians with physical disabilities found that 83% continued to practice full-time,[53] but no current information is available. We therefore relied on anecdotal information from interviews with faculty from 7 medical schools around the country. Since the majority of these faculty still hold academic positions, these reports may reflect a positive bias.

Perceived Attitudes of Colleagues and Supervisors

Demanding academic environments challenge almost all faculty members. Most individuals want respect, appro-

bation, and acceptance from their peers and supervisors. For faculty members with disabilities, achieving this recognition and acceptance occurs within broader societal contexts that historically stigmatized and marginalized persons with disabling conditions.[25-29] Although public views have improved over the last 30 years, sometimes even celebrating disability, pockets of negative perceptions persist.[33,34]

Medical school faculty with publicly known disabilities report mixed experiences concerning the acceptance of their peers and supervisors. Almost uniformly, the backdrop involves medical schools that appear largely disinterested in disability, besides pro forma compliance with basic equal opportunity employment provisions. Some faculty believe that lax institutional enforcement of ADA requirements, including physical access, demonstrates a tepid commitment to disabled persons. Although medical schools may support faculty committees addressing barriers to gender, racial, and ethnic diversity, disability is not discussed. Some individuals see few ways to improve institutional attitudes toward disability since "neither medical school faculty nor students are expected to have disabilities." Some believe that they must work harder than their nondisabled colleagues to gain recognition. Because of these institutional views, as well as the absence of identified peers with disabilities, some faculty describe their experiences as "a silent and lonely tenacity."

On an individual level, some faculty with disabilities have found supportive supervisors who recognize their talents and provide chances to succeed. Sometimes, academic careers would have ended abruptly without active intervention and advocacy from these critical mentors. A few describe assistance by nondisabled peers, believing that their nondisabled colleagues carry more clout in changing administration policies and combatting environmental barriers than they do. When an academic division relocated, one chief gave the largest office with a private bathroom to a disabled faculty member rather than to himself.

Occasionally, faculty members with disabilities find themselves called "heroes," although their supervisors sometimes question why they would choose careers stressful even to those without disabilities. Despite its flattering intent, the "hero" moniker can raise unattainable expectations and carry problematic messages[54]: "You have a disability . . . but you are not suffering . . . Why not? It must be because you are brave, courageous, plucky, extraordinary, superhuman."[55] At a social function, the department chairperson of one wheelchair user patted her on the head. The chairperson had strongly supported her promotion, and the wheelchair user believed the pat was fondly meant. But it nevertheless symbolized paternalism, imposing a childlike dependence.

Some faculty members say they consciously overcompensate to thwart doubts about them. As a student, one wheelchair user started "making up for any inability to perform physically by knowing more than the other students. . . . Attending physicians would say I was doing really well and that I would find a great job." Nonetheless, obtaining an academic position proved difficult. Ostensibly to protect her health, her department chairperson did not offer a potentially stressful tenure track position but instead provides year-to-year contracts. Some faculty members refuse accommodations because they perceive they must demonstrate toughness, trying to "prove themselves" at the expense of their health. Negative attitudes can have subtle manifestations. Several wheelchair users report being continually mistaken for patients. As described previously,[56] one wheelchair user reported that when rolling through corridors, physicians and unfamiliar faculty members seldom meet her eye; in contrast, on trips through the basement, cleaning staff routinely smile and nod.

Finally, some faculty fear reprisals so they do not reveal a hidden or new disabling condition. They fear requesting accommodations, worrying about harming their careers. One person described institutional perceptions that physicians are easily replaced; thus, physicians expressing needs may become expendable. Such faculty will reveal impairments only when hiding becomes impossible and they anticipate that accommodations, if any, will be inadequate. Even persons at high academic rank voice these fears.

Accommodating Physical Access

Universities, their medical schools, and affiliated teaching hospitals are often among the oldest local institutions. Their facilities are frequently physically inaccessible, including clinical sites, libraries, office buildings, and social or ceremonial settings. Title III of the ADA requires that facilities be physically accessible but invokes a "readily achievable" standard. If renovating existing structures is technically infeasible or too costly, they need not be modified. However, organizations must find other ways to make services physically available.

Faculty with physical disabilities report needing to enter campus buildings through loading docks and finding themselves trapped in locked buildings after hours, unable to access library stacks, stuck on ramps deep in snow, struggling with heavy doors, and unable to locate accessible toilets. Modifications to enhance access, such as ramps and automatic door openers, are sometimes poorly maintained; wheelchair access routes are often not clearly marked. Due to space constraints, old buildings sometimes house academic departments, despite having neither wheelchair access nor elevators. Colleagues must therefore travel to wheelchair users' offices for meetings, a generous action but one breeding an awkward indebtedness. Wheelchair lifts on university shuttle buses, if present, are often unreliable. Anticipating transportation glitches, faculty with physical disabilities must schedule extra time to reach every out-of-office appointment. One wheelchair user was repri-

manded for arriving late to an important meeting even though city workers were repaving surrounding streets, blocking physical access.

These access issues mirror problems wheelchair users confront elsewhere in the built environment and are not unique to medical schools. Nonetheless, continually facing obstacles, inconveniences, and dangers in the workplace is exhausting and demoralizing. One university hosts celebratory events in a gracious but poorly accessible building. Wheelchair users must enter this old structure through subterranean labyrinths of basements and kitchens. One honoree arrived at an outside entrance with stairs. Finding her stranded, the chairman of medicine carried her wheelchair up the steps, while others assisted her. At her reception, the honoree avoided all refreshment because the building had no accessible bathroom.

Other Accommodations

Faculty report numerous other concerns raised by their disabling conditions. Those seeking promotion as investigators face timelines often difficult for faculty without disabilities, although certain medical schools explicitly permit tenure delays for illness.[21] Medical schools can demand evidence of national or international reputations for promotion to associate and full professor. This requires traveling to give lectures, or to serve on committees or as a visiting professor. When traveling, faculty who use wheelchairs expend many extra hours (eg, to meet preflight airline requirements and organize ground transportation) not spent by nondisabled colleagues. Obtaining accessible lodging is also challenging.

Destinations may be inaccessible. One wheelchair user described arriving at a hotel to give a speech and asking for directions to the elevator. She was told to wait. Minutes later, 3 men in gray janitor uniforms arrived, reporting they planned to carry her down the stairs because the conference facility had no elevator. Another wheelchair user spent many hours one night locked in an empty conference center;

nondisabled attendees had left on buses, but the wheelchair-accessible van never materialized.

Numerous smaller accommodations become necessary but are often absent. For example, cavernous amphitheaters and meeting rooms are rarely equipped with acoustic paneling or devices to assist persons who are hard of hearing; Braille signage is often missing. Helpful technologies include telecommunication devices for the deaf, voice-activated controls on elevators, voice-activated computer systems and software, enlarged print written materials, and hands-free telephones and dictating equipment.[57] Extra secretarial assistance for persons with physical disabilities or low vision is especially critical when confronting tight deadlines, such as writing grants or time-sensitive publications.

Active clinicians must negotiate accommodations not only with their medical schools but also with their practice sites (ie, affiliated hospitals and clinics). This may involve redefining one's clinical job, such as no longer performing certain tasks. Other accommodations include modifying clinical schedules, obtaining more practice assistance, and having an automatically adjustable examination table. Obviously, improving physical access within clinical settings will also help patients.

Seeking New Academic Positions

Once individuals are recognized as disabled, seeking jobs elsewhere, either for personal reasons or career advancement, is difficult. Often, however, negative experiences are too subtle to support claims of discrimination. One physician who walked with crutches reported interviewing for an academic position at a prestigious institution. The morning of the interview, the search committee chairperson parked in the nether regions of the garage rather than dropping the candidate off at the front door. "I knew by 9:00," reported the candidate. "They were marching me back and forth from one building to another just to prove to me it was the wrong place for me."

Recommendations for Accommodating Faculty With Disabilities

Based on reviews of existing policies, interview findings, other faculty reports, and internal deliberations, the Subcommittee on Faculty with Disabilities of the University of Pennsylvania School of Medicine Faculty 2000 project produced recommendations for actions concerning disabled faculty (BOX 2). Some recommendations target physical access considerations relevant to other environments, while others apply specifically to medical schools. Potential reasonable accommodations include modified work schedules, flexible leave policies, moving to part-time status, negotiated time for medical appointments, providing assistive technologies, and staff support. The subcommittee urged disabled faculty members and their supervisors to discuss openly discomforts either might have about negotiating accommodations.

Academic promotion for faculty with disabilities must meet the same rigorous standards as for nondisabled faculty. Nevertheless, the subcommittee recognized the challenge of removing attitudinal barriers to fair advancement of faculty with disabilities. While they must demonstrate not only competence but also achievement, faculty with disabilities must not be held to standards irrelevant to their actual responsibilities. Predicating promotion on technical skills or abilities outside the faculty member's specific job is inappropriate.

The ADA requires that persons with disabilities request accommodations. However, the subcommittee recognized that some faculty with disabilities fear revealing their conditions and hesitate requesting accommodations. Without necessary accommodations, faculty members may fail to achieve, let alone excel. Academic leadership must encourage open communication by first recognizing the legitimate fears of disclosure. Alternative paths for assistance, such as an ombuds office, should be available for faculty fearing retribution within their departments.

Box 2. Recommendations to Improve Access to Academic Medicine for Faculty With Disabilities, Subcommittee on Faculty with Disabilities, University of Pennsylvania

Nonphysical Barriers

Senior faculty (including chairs of departments), members of committees on appointments and promotions, and ombudsperson should be exposed to basic information about disabilities including rights to voluntary disclosure, preemployment equities, conducting an effective job interview with persons who have visible disabilities, reasonable accommodations, and appropriate adaptive strategies for individuals who have a disability.

Affirmative action offices should maintain a database of faculty who have disclosed their disabilities and given permission to include that information. These data will provide information about the recruitment, retention, and promotion of faculty with disabilities.

Outreach should occur at various professional organizations to ensure that there is no bias against the recruitment of persons who have disclosed disabilities.

Enhancement programs should be developed to recruit, promote, and retain "minority" faculty with disabilities, eg, incentive scholarships, mentoring program, counseling, and support.

A formal mentoring program should be established for junior faculty among senior faculty who have an understanding of disabilities.

Physical Barriers

Ramps need to be present at all central locations in positions aesthetically equal to able-bodied entrances. Loading docks and service entrances do not constitute equal access and foster a huge divide. Ramps must be accessible in all weather conditions: leaves, mud, puddles, and snow pose formidable obstacles even to motorized wheelchairs. Partial clearing of ramps is equivalent to no clearing, and represents a particular hazard as individuals may attempt to gain access and sustain injury.

Cars should be ticketed and towed promptly if blocking an access ramp.

Automatic doors should be checked for operation regularly. A clear avenue needs to be established for reporting mechanical failures and for fixing them quickly; a central maintenance telephone number should be posted in clear view near the automatic opener, and a mechanism to obtain immediate assistance should be devised.

Shuttles around campus and from hospitals to train or bus stations should all be wheelchair accessible, eg, faculty with disabilities should have equal access to shuttle and other intrafacility transportation services, rather than be limited to the single accessible shuttle's schedule.

Internal doors and bathroom doors should have push rather than pull handles.

At least 1 bathroom stall on each floor should be wheelchair accessible; the office of a faculty member with a disability should be located preferentially in close proximity to the accessible facility.

A faculty member with a disability should be a permanent member of the institution's committees involved with architectural planning, plants, and operations.

Different Pathways in Evaluations and Promotions

The need for accommodations for the disability should have no relevance to the evaluation and promotions decisions.

A mechanism for a faculty member with a significant disability or chronic disease to petition for an extension of the probationary period should be described. A review process should be outlined. Professional documentation as well as personal correspondence from the faculty member describing the need for an extension (and the duration of the extension) given the individual circumstance should be reviewed. A faculty ombudsperson should assist the faculty member in this petition.

The inflexible adherence to standard technical skills should be avoided, instead, skill competency assessment should be limited to the stated responsibilities of the faculty member. The institution must be assured of the physical and mental competence to practice in the specialty of choice.

Faculty with disabilities should be held to the same academic standards as others.

Reasonable Accommodations

Reasonable accommodations should be sought to provide equity in the work place. When adaptive technologies or accommodations are required to allow the individual to perform essential job functions, assistance for procuring equipment might be made through the University Office of Affirmative Action programs for persons with disabilities. A small proportion of university budgets should be set aside for the purchase/rental of such equipment.

Disability leave policies at some academic centers can promote premature, speedy, and complete departures. While onset of a disability may not imply complete inability to work, remaining employed can place the faculty at risk of loss of employment and benefits. If one chooses full disability retirement, remaining a vital member of the medical community becomes a real challenge that must be addressed thoughtfully.

Assuming there are provisions for part-time status at a university, competent persons with disabilities contemplating disability retirement should be advised that they may elect to work part time under the same rules and regulations applicable to all faculty.

Support for the equal recruitment and retention of persons with disabilities should be clearly stated in the mission statements of universities, the medical schools, and departments in language that is similar to that used for minorities and women.

Financial and administrative support should be provided, perhaps through the University Offices of Affirmative Action, or a central resource for persons with disabilities. Building an infrastructure throughout the academic institution for providing the necessary service and support for faculty with disabilities is an attainable goal.

Although reasonable accommodations are ultimately crafted for individuals, improving accessibility throughout academic institutions sends important messages of recognition and respect.

Recommendations of the Subcommittee on Faculty with Disabilities have begun to produce policy changes to accommodate faculty with disabilities. In response to the Faculty 2000 initiative overall, the University of Pennsylvania School of Medicine hired someone to address promotion and quality-of-life issues for all faculty, including persons with disabilities. The Standing Committee of Department Chairs invited subcommittee members to present their findings; subcommittee members also met with the chair of the Committee on Appointments and Promotions. These meetings raised the interest of academic leaders in improving accessibility and opportunities for faculty with disabilities, prompting consideration of the dissemination of information about disability accommodations, and the allowance of extensions in promotion timelines. Several presentations by faculty with disabilities have further heightened awareness. An examination of architectural barriers is scheduled during upcoming fall and winter months to develop strategies to enhance access.

Welcoming Faculty With Disabilities

Discussions about medical school faculty with disabilities occur within the broader context of the health care delivery system. Over the last half century, medical interventions have increasingly shifted from curing acute illness toward palliating chronic conditions, assisting persons to live longer with better quality of life[58]: "The basic struggle in chronic disease is not against death; it is against disability."[59] Using a broad definition, *Healthy People 2010*, which sets national health priorities, asserts that 54 million Americans have disabilities.[60] The report notes troubling disparities in the services they receive, especially an "underemphasis on health promotion and disease prevention."[60] For example, per-

sons with severe difficulty walking receive significantly fewer mammograms, Papanicolaou smears, and tobacco queries than other individuals.[61] Women with disabilities are diagnosed with breast cancer at later stages than other women.[62] *Healthy People 2010* concludes that, "as a potentially underserved group, people with disabilities would be expected to experience disadvantages in health and well-being compared with the general population."[60]

In its report *Unequal Treatment*, addressing racial and ethnic disparities in health care services, the Institute of Medicine recommended increasing the proportion of underrepresented racial and ethnic minorities among health professionals.[63] This recommendation drew from studies suggesting that greater racial and ethnic diversity among providers strengthens relationships with patients and improves care.[6,8-11] Parallel arguments concerning physicians with disabilities may be imperfect; accepting and accommodating persons with disabilities in medical training raises special questions (eg, about students' abilities to perform "essential functions"[64]).

Nonetheless, some faculty believe their disabilities enhance their rapport with many patients, improving patient-physician relationships, enhancing patients' responsiveness to clinical recommendations, and sometimes offering patients hope by their example. Even patients' negative responses can provide important therapeutic insight.[65] Some faculty feel that their disabilities heighten their empathy for patients. Combining these various clinical and personal observations can make them better teachers. More thought is therefore needed about encouraging persons with disabilities to apply to medical school and accommodating medical curricula, thereby providing these individuals with opportunities to become excellent clinicians, teachers, and researchers.

Welcoming faculty with disabilities could thus enrich academic medicine's understanding of an ultimate target of its various missions—improving the lives of persons with chronic disabling conditions. By their ex-

ample, disabled faculty can implicitly teach others not only how to live gracefully with impairment, but also how to achieve against tremendous barriers. However, enlisting the special insights of faculty with disabilities must proceed realistically. Some may choose not to participate, pursuing interests just as varied as among nondisabled faculty. Some may feel uncomfortable being "role models" or fear becoming the disability "poster child." Constant interactions about disability can be exhausting, diverting people from academically productive efforts. But some will relish challenging others to remove social and environmental hurdles that daily impede academic lives.

Accommodating medical faculty with disabilities and welcoming them fully into the academic community therefore raises many complex issues—personal, professional, institutional, financial, legal, societal, and ultimately moral. Academic medicine should identify the scope of these issues and initiate systemwide changes in policies and procedures. Disability must be discussed openly, thoughtfully, and productively, recognizing potential intellectual, professional, and interpersonal benefits from fully including diverse and valued colleagues. Although ADA mandates may motivate this examination, doing the right thing is another impetus. Accessible, welcoming academic medical environments convey a powerful message and benefit everyone, not only faculty with disabilities but also students, patients, staff, and communities at large. Academic medicine's response to faculty with disabilities speaks volumes about its values, empathy, compassion, and heart—a prelude to how we, as individuals, may be treated in the future.

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