BRIEF
REPORTS

Disability Policies and Practices in Family Medicine Residencies: A CERA Study

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BACKGROUND AND OBJECTIVES: Increasing the diversity of family medicine residency programs includes matriculating residents with disabilities. Accrediting agencies and associations provide mandates and recommendations to assist programs with building inclusive policies and practices. The purpose of this study was (1) to assess programs' compliance with Accreditation Council for Graduate Medical Education (ACGME) mandates and alignment with Association of American Medical Colleges (AAMC) best practices; (2) to understand perceptions of sources of accommodation funding; and (3) to document family medicine chairs' primary source of disability-related information.

METHODS: Data were collected as part of the 2019 Council of Academic Family Medicine Educational Research Alliance Chairs' Survey. Respondents answered questions about disability policy, disability disclosure structure, source of accommodation funding, and source of information regarding disability.

RESULTS: Half (56%) of responding chairs reported maintaining a disability policy in alignment with ACGME mandates, while half (52%) maintain a disability disclosure structure in opposition to AAMC recommendations. Funding sources for accommodation were reported as unknown (32.9%), the hospital system (27.1%), or the departmental budget (24.3%). Chairs listed human resources (50.7%) or diversity, equity, and inclusion offices (23.9%) as the main sources of disability guidance.

CONCLUSIONS: The number of students with disabilities in medical education is growing, increasing the likelihood that family medicine residency programs will select and train residents with disabilities. Results from this study suggest an urgent need to review disability policy and processes within departments to ensure alignment with current guidance on disability inclusion. Department chairs, as institutional leaders, are well positioned to lead this change.

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Disability is espoused as a critical part of diversity in medical education. Indeed, as the second largest specialty in the United States, family medicine residency programs will undoubtedly train learners with disabilities, adding to the diversity of our physician workforce. Given this importance, accrediting agencies and associations maintain requirements and offer best practices for improving workforce diversity efforts that include disability.[1-9] For example, in 2018, the Association of American Medical Colleges (AAMC) report on disability identified barriers to the inclusion of residents with disabilities in graduate medical education (GME) and highlighted facilitators of access, including a list of best practices for disability inclusion.[4] Simultaneously, the Accreditation Council for Graduate Medical Education (ACGME) introduced new institutional and program requirements related to residents with disabilities including maintaining institutional policies on disability,[7] and programmatic

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requirements to accommodate residents with disability that follow relevant laws and regulations.[8] In addition to disability-specific requirements, the ACGME added a set of Common Program Requirements that directly impact diversity and inclusion including:

> that the program in partnership with its sponsoring institution must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents...[9]

Efforts to increase diversity suggest that institutional mission statements must align with program efforts and messaging (Table 1).[4, 7-8]

A recent study suggests that the majority of GME sponsored institutions neither fully comply with requirements, nor align with current recommendations,[10] while a similarly-focused commentary offered best practice for inclusive policies in GME.[5] As the number of medical students with disabilities grows,[11] the disconnect between the potential applicants for residency and residency preparedness may serve as a barrier to the stated goals of increasing diversity in GME.

To our knowledge, no study exists that examines family medicine training programs disability-related policies or practices. In this study our aim was to (1) assess programs' compliance with ACGME mandates and alignment with AAMC recommendations, (2) identify main sources of accommodations funding, and (3) document chairs' primary source of information regarding disability-related guidance.

Methods

The disability questions were part of a larger omnibus survey conducted by the 2019 Council of Academic Family Medicine Educational Research Alliance (CERA).[12] The CERA survey was emailed to 200 department chairs of family medicine using SurveyMonkey. One email bounced back, and six opted out, resulting in a sample of 193 family medicine department chairs. The American Academy of Family Physicians Institutional Review Board approved the study.

Survey Questions

Family medicine department chaires answered questions about themselves, their medical schools, disability policy, funding structures for accommodations, reporting structure for disclosing disability and their preferred sources for further guidance on disability inclusion.

Analysis

Descriptive statistics summarized the demographic questions and all of the residency program and disability practices questions. We used IBM SPSS Statistics Version 26 for the data analysis for this study.

Results

One hundred-five of 193 (54.4%) family medicine department chairs responded to the CERA survey. Descriptive statistics for study variables are summarized in Table 2. Of the 71 department chairs who responded to questions about policy, primary contact for disability disclosure, and sources of guidance regarding

Table 1: ACGME Mandates and AAMC Guidance on Disability

ACGME Mandates on Disability	
Institutional requirement IV.H.4.	Maintain a policy "regarding accommodations for disabilities consistent with all applicable laws and regulations
Common Program requirement I.D.2.e.	Programs must provide, as part of their resources, "accommodations for residents with disabilities consistent with the Sponsoring Institution's policy
AAMC Report on Disability	
Barriers to GME	• Unclear policies and process • Forced disclosure to supervisor • Lack of understanding regarding legal obligations for the inclusion of people with disabilities and the cost for accommodation
Facilitators of disability inclusion	• Providing professional development training on the topic of disability inclusion • Hiring faculty, administrators, and clinicians with disabilities • Employing someone with knowledge of disability, disability rights law and accommodations in a clinical setting to facilitate the interactive process • Understanding responsibility and obligation for accommodations • Developing and disseminating a clear understanding of the financial obligation to provide accommodations, and ensuring that accommodations are adequately funded • Integrate disability into diversity initiatives, efforts, and language

Abbreviations: ACGME Accreditation Council for graduate Medical Education; AAMC, Association of American Medical Colleges; GME, graduate medical education.

Table 2: Summary of Residency Program Type and CERA Disability Questions

Variables	n (%)
Residency Program Type	**Respondents=71**
Medical school based	35 (49.3)
Community based	31 (43.7)
Other	5 (7)
Availability of Formal Written Policy for Disability Disclosure	**Respondents=71**
Yes	40 (56.3)
No	5 (7)
I don't know	26 (36.6)
No Response	32
Primary Funding Source for Accommodations	**Respondents=70**
Departmental budget	17 (24.3)
Centralized-specialized fund for all GME	8 (11.4)
Hospital system	19 (27.1)
Medical school	3 (4.3)
I do not know	23 (32.9)
Contact Person for Disability Disclosure	**Respondents=71**
Program directors	37 (52.1)
Human resources	5 (7)
Resident affairs office/GME office	11 (15.5)
ADA coordinator for hospital	2 (2.8)
Do not know	16 (22.5)
Source for Information About Disability Disclosure	**Respondents=71**
ABFM	1 (1.4)
ACGME	9 (12.7)
AAMC	1 (1.4)
Diversity, equity, and inclusion office of your institution	17 (23.9)
Human resources of your institution	36 (50.7)
Office of general counsel of your institution	2 (2.8)
I am not sure	5 (7)

Abbreviations: CERA, Council of Academic Family Medicine Educational Research Alliance; ADA, Americans With Disabilities Act; GME, graduate medical education; ABFM, American Board of Family Medicine; ACGME, Accreditation Council for Graduate Medical Education; AAMC, Association of American Medical Colleges.

disability inclusion, 40 (56.3%) affirmed they maintain a formal written policy for disability disclosure; 37 (52.1%) listed the residency program director as the primary contact for disability disclosure. Most chairs listed human resources (50.7%) or diversity, equity, and inclusion offices (23.9%) as their main source of disability information and guidance.

Seventy chairs responded to the question about accommodation funding; 23 (32.9%) did not know their institutions' primary funding source for accommodations; 19 (27.1%) listed the hospital system, while 17 (24.3%) listed the departmental budget.

Discussion

While associations and accreditors are working to facilitate disability inclusion, our findings suggest a disconnect between national guidance and the practices in family medicine training programs. When asked where department chairs would seek guidance on disability-related issues, most listed campus-based offices rather than national associations and accreditation bodies, potentially out of need for local legal precedence.

Our results suggest that while half of family medicine programs align with accreditation mandates for maintaining a disability policy, a third were unable to confirm whether they were in compliance.

Approximately one-quarter of chairs were unable to identify the funding structure for accommodations in their department. When asked about the structure for disability disclosure, over half of the department chairs reported a structure in opposition to AAMC guidance, failing to recognize the potential for conflict of interest in reporting to a direct supervisor.

Our findings highlight the urgent need for the review of disability policy and process within departments of family medicine. Chairs, while fiscally constrained, must align practices with educational mandates or efforts towards diversity goals will go unrealized. In addition, the potential conflicts of interest related to program director's role in the management of accommodations requires further attention/discussion. The need for professional development on the topic of disability inclusion for chairs and their departments is further evidenced by a detailed examination of the barriers reported.

Conclusion

These findings add to our understanding of policy compliance and practices for disability inclusion in family medicine. As the number of students with disabilities in medical education grows,[11] it is likely that family medicine residencies will select and train residents with disabilities.

Residency program efforts to meet diversity goals will require aligning organizational and institutional mission statements with program efforts and messaging and comport with current guidance.[13] Programs that neglect these efforts, may unintentionally disincentivize disability disclosure, fail to meet accreditation requirements, and create structural barriers for resident training.

Programs might reflect on their internal policies to ensure their practices comport with stakeholder mandates and national recommendations. Family medicine chairs as institutional and departmental leaders are well placed to lead/support this change.

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