

Medical Education and Disability Studies

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Abstract The biomedicalist conceptualization of disablement as a *personal medical tragedy* has been criticized by disability studies scholars for discounting the difference between disability and impairment and the ways disability is produced by socio-environmental factors. This paper discusses prospects for partnerships between disability studies teaching/research and medical education; addresses some of the themes around the necessity of critical disability studies training for medical students; and examines a selection of issues and themes that have arisen from disability education courses within medical schools globally. The paper concludes that providing there is a commitment from senior management, universities are well positioned to apply both vertical and horizontal approaches to teaching disability studies to medical students.

Keywords Disability studies · Medical education · Social relations of disability · Disability narratives

Introduction

Since the Age of Reason, medicine and a biomedicalist stance have played a critical intervening role in the lives of people with disability and people with anomalous bodies or mentalities. Medicine has operated as the primary paradigm not only for the treatment of disabled bodies but has also shaped the way decision makers, legislators, families and society in general *think* about and *sense* disability. This article addresses some of the themes around the necessity of critical disability studies training for medical students and medical practitioners. Secondly, it will explore a selection of issues and themes that have arisen from disability education courses within medical schools globally. There is a discussion

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around issues or tensions identified in the literature in undertaking disability education as well as the author's own experiences of teaching disability studies to human services and allied health students both in Australia and in Sri Lanka. The article concludes that providing there is a commitment from senior management, universities are well positioned to apply both vertical and horizontal approaches to teaching disability studies to medical students.

The 'problem'

The knowledge of doctors and other health professionals has significant impacts not just on the medical decisions made but also on the kinds of access to information that disabled people are given, the impetus for new and responsive health technologies and the utilization of preventative health care programs especially by disabled women. Research on women with disabilities has consistently shown persistent poor access to health care, especially reproductive services.¹ The World Bank has noted the urgency for research on HIV/AIDS and disability as disabled people are at increased risk for every known risk factor for HIV/AIDS.² Individuals with intellectual disability are reported to experience an excessive amount of unrecognized and poorly managed medical conditions.³ Hollins⁴ reports that people with intellectual disability are fifty-eight times more likely than the population as a whole to die before the age of fifty.⁵ Surprisingly, allied health professionals and human service workers are insufficiently trained.⁶

Medical professionals have been accused of contributing to discrimination experienced by disabled people. The most serious assertion is that doctors represent one of the disabling professions, which contributes to the social exclusion and dependence of disabled people.⁷ Biley⁸ suggests that, far from being user-friendly, hospitals may be particularly hostile to disabled people and lead to 'hospital-induced dependency'. Duff, Houghan and Scheepers⁹ find possible bias and discrimination towards people with a learning disability accessing a range of health screening and intervention programmes. They argue that the root of the problem for people with a learning disability lies in the lack of quality structured training in medical aspects of these people's care in the medical curriculum. Indeed, medical and other health care professionals often report feeling deskilled when working with disabled people.¹⁰ Loeser & Sullivan¹¹ in the USA argue that physicians need much more education about human behavior and the highly variable relationships among disease, distress, and disability. Patients and third party payers (insurance companies) expect physicians to identify damage or disease as the cause of pain and disability although often there is no damage or disease that can be identified. Doctors can fall hostage to the predictive frameworks of assessment instruments such as the euphemistically termed *table of maims*.

The medical profession still plays a powerful role in the lives of disabled people. As lezzoni reminds us, all active doctors can expect to have people with disabilities as part of their practice.¹² Armed with the power of *authorizing knowledges*, doctors even at the level of general practice, act as gatekeepers to specialist services¹³ and more broadly to social security and compensations systems. Doctors are regarded by medical associations and governments alike as authorized experts having the power of disability certification in ways of which allied health professionals can only dream.¹⁴ This begs the question as to whether medicine is monolithic or has a consciousness? Allowing for differences within medicine at the levels of specialization, practice and education, well over 30 years ago Engels¹⁵ noted the propensity of medicine to conceptualize humans as biological reductions and proposed instead a biopsychosocial approach to medicine. I am in agreement with Bishop¹⁶ who argues that even though medicine would deny it, medicine operates on a metaphysics of efficiency, asking "how to manipulate it [the world] to get the facts that we desire." Medical

practices, organized around the medical model, presume the doctor's task is to diagnose diseases, discover their causes and symptoms, and design treatments. Any knowledge standpoint of the patient is diminished.

The metaphor of the “elephant in the room” has been used to describe the experiences of disabled people with the medical profession—she is “present but unnoticed.”¹⁷ Martin & Rowell *et al*¹⁸ find that medical students generally had limited knowledge about cerebral palsy and displayed negative attitudes toward people with it. Discourses around medical research and practices contain implicit narratives of disability as a *personal medical tragedy*. It is also found that males have less positive attitudes than females and that students educated mainly in Asia have less positive attitudes than students educated mainly in Australia (more on that later). These negative attitudes, implicit in relations of ableism, are effectually illness inducing in the lives of disabled people.¹⁹

Given the significance of the role that doctors play in the lives of disabled people, the small numbers of studies on doctors' attitudes reveal a coherent and gloomy picture. Ormond *et al* surveyed Chicago-based health professionals' attitudes regarding disability and genetic screening and pilot-tested it on a sample of medical students, residents, and genetic counseling students.²⁰ Their study also addresses the underlying views of health care providers regarding quality of life (QOL) and critical correlates of genetic disability. Consistent with other studies, most health care trainees focus on the medical or functional aspects of disability when assessing QOL and over half of the participants equate disability with suffering. Student responses regarding what defines QOL impacted on advice when offering prenatal diagnosis and influenced parental decisions when faced with prenatal diagnosis of disability. This is clearly in contrast to research emanating from rehabilitation and disability studies researchers, as well as many people with disabilities that report QOL is related to personal and social relations, such as personal well-being, degree, and control over life choices, definition of self, and social status. The failure to notice the differing realities in disabled peoples' lives is not just about ignorance but is a failure to ask about differences and it is a failure to acclimatize to a different phenomenological world view that might conceive professional intervention as oppressive.²¹ Kuper argues that medical education rarely appreciates that there are multiple “truths” in the patient care environment.²² Kvalsvig, a doctor with disability, points to the critical task of suspending the impulse to guess what a person's difficulties and needs are. Doctors, she suggests, are challenged to embrace the management of uncertainty,²³ a tall order given the reluctance of doctors to voice their own illness experiences and to seek occupational care.²⁴

In Melbourne, Australia, Martin & Rowell *et al* find that nearly half of their surveyed students disagreed with the statement that “having a child with cerebral palsy would be better than having no child at all.”²⁵ Many of these students saw the disabled body in terms of burden rather than capacity to be productive. Such “private” values become dangerous without adequate consciousness raising and could influence intervention options and information given the families. Doctors are often called to provide expert testimony on tort cases around issues of “loss,” “burden,” and the “value of life” (e.g. wrongful and end-of-life cases) as well as engage in health care ethics debates (e.g. the separation of conjoined twins or intellectually disabled persons' access to transplantation or self-demand amputation). The notion of disability as intrinsically negative has also crept into the research design of some disability attitudes surveys beyond the commonly constructed deficit based functional style questionnaire structure. Nigerian research published by Owoeye in *Disability and Rehabilitation*, opens with a pre-determined and confounding assumption: “Blindness and deafness are important, and possibly, the *least redeemable deficits*” (emphasis added).²⁶ This statement is neither elaborated nor substantiated. The

questionnaire developed to elicit students views on blindness, deafness and deaf/blindness already has a negative presumption of disability build into it as “there is handicap worse than blindness ... there is handicap worse than deafness ...” and so on.²⁷

Most health care providers, whether in a general or speciality medical practice, receive little formal education regarding disability or genetics, and that training usually consists of interspersed lectures and short-term optional clerkships. For example, in a recent study of genetic counselors, although 99% of respondents reported some disability training, only 50% took a formal course on disability issues. Most genetic counselors surveyed report that more training is needed to improve sensitivity toward persons with disabilities.²⁸ It is unclear whether this training takes a diagnosis functionalist approach to impairment or attempts to explore the creation of disability sociologically.

Similarly a survey conducted by Margaret Byron from Bristol, U.K. of disability word association amongst medical students found that they associate disability predominantly with depersonalized or negative words,²⁹ but the introduction of short disability courses appears to change such associations. Byron’s innovative approach to probing medical student attitudes regarding disabled persons suggests that their attitudes confirm the view of disability theory, that professionals’ outlook on disabled people is strongly influenced by the medical model of disability and is dominated by issues of disadvantage and dependence. Viewing disability as a problem means that doctors are hindered in being able to imagine disabled people having full, varied, interesting and individual lives.³⁰ This conclusion finds support in the US study by Tervo *et al* who conclude that the attitudes of medical students in the USA and Canada towards disabled people are less positive than normative data (the general public).³¹ However, it can be argued that limited attention has been given to the *enduring effects* of the medicalized approach to disability that sees disability in terms of burden and damage. The use of case studies and personal testimony from disabled people uncritically can result in storytelling and scenarios that merely reify and perform notions of disability as tragic suffering that can or has been overcome. Medicalization has been fused in the mindsets of doctors and people with disability alike.³²

What I have tried to capture with this brief thematic review is that biomedicalism has created a distorted and incomplete picture of the disablement experience. Instead of turning the organism in on itself (focusing on what has biologically gone wrong), medical education can shift the gaze outward and explore more phenomenological insights of disablement, such as the different proprioceptive ways that deaf, blind, paralyzed and intellectually disabled people experience materiality and relations. Since the introduction by the UN of the ICF (*International Classification of Functioning, Disability and Health*) and its subsequent incorporation in the definitional and planning apparatus of member states, medical students and allied health professionals are beginning to be exposed to new ways of thinking about disability through training. The new *Convention on the Rights of Persons with Disabilities* provides an impetus to re-ground disability medical education. The *Preamble* of the Convention describes:

...disability [a]s an *evolving concept* and that disability *results from the interaction* between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others (emphasis added).³³

Whilst many of the barriers to inclusion are *external* to the disabled person (laws, resources, environmental, educational), barriers also exist that are *internal* to the person (self-image, internalization of negative views of disability, learned helplessness, and the

legacies of incarceration). The next section will outline and critically appraise medical education programs on disability.

The Programs

The orientation of many medical schools has focused on didactic learning and examination based assessment. In recent times, many schools have revised their curricula to focus on problem-based learning (PBL) with summative and formative assessment pieces. In 1991, the UK General Medical Council Education Committee recommended that disability education be included in the medical curriculum.³⁴ A global scan of the literature of disability education reveals a fragmented system of implementation, poor communication among medical schools and conceptual confusion as to the meaning and goals of disability education for medical students; interventions are usually horizontally incorporated into the curriculum, limited in scope and short in duration. The vast majority of disability education is still primarily functional and clinical in orientation, occasionally drawing upon the expertise of other allied health professionals such as physiotherapists and occupational therapists. This education does not seem to demonstrate an awareness of competing conceptual understandings of disability and knowledge of disability studies as an education centre. The one exception is the flagship program spearheaded by Bristol University in the UK which has been operating in different forms since 1993 and is based on a social model of disability conceptualization aimed at attitude formation and change.³⁵ This program is now part of the *Partners in Practice* project, a tri-collaboration between the University of Bristol, the University of the West of England and the Peninsula Medical School who have developed curriculum frameworks for medicine, nursing and allied health studies.

The research suggests that negative attitudes towards disablement held by doctors and medical students are more significant than a mere lack of knowledge of resources and services. That attitudinal issues are not taken seriously in the first instance indicates a core problem in acknowledging among the profession and teaching faculties that there *is* a problem in the first place. As the *Partners in Practice* report states: “For professionals that consider themselves founded on principles of caring and service, it is uncomfortable to have to acknowledge the reality that healthcare is endemically disablist.”³⁶ Most programs use a combination of theoretical and practical lectures which have significantly improved the attitudes of those participating.³⁷ In the United States, the process of simulation is extended having medical students being interviewed as disabled people.³⁸ In some instances, students leave the hospital or university setting and visit families in their own homes or at disability centres.³⁹ In Croatia (Split) a 10 day disability education course is taught in the context of medical rehabilitation, and whilst some attention is paid to psychosocial aspects of disability, the seminars and lectures focus on the functional aspects of disability, specific diagnostic rehabilitation and is delivered by other specialist doctors and a physiotherapist.⁴⁰ An alternative focus on a metaphysics of disability would examine the power of memory and resilience in the psychic lives of disabled people.

The length of a course does not seem to be an indicator of quality or the impact of challenging and shifting the attitudes of medical students. At Tulane University in New Orleans, a three-hour “disability awareness and skills training” workshop is conducted with senior medical students, as part of an overall strategy by the School of Medicine to raise awareness of disability. The school has hosted an art exhibition and a promotional book display about disability and social issues. A commitment to interdisciplinarity is a feature of the training with staff drawn from the broader university, a disability advocacy centre and

an independent living organization. The intensive course covers legislative issues, speakers with disabilities discussing advocacy, culture, communication, mobility issues, and families with a child with disability.⁴¹ The authors of the study note that whilst information about resources is important, the matter of attitudes of students needs addressing, that there is "... a significant decline in students' attitudes to people with disability and chronic illness from year 1 to the end of the 3rd year of medical school."

Kahtan *et al*'s survey of British medical schools found that teaching on this topic appears fragmented and inadequate, but a number of interesting innovations are identified, including: a drama workshop at St George's Medical School run by a group whose members mainly have learning disabilities, student-directed learning at the University of Dundee and structured teaching programmes at the Universities of Leeds and Edinburgh. Recommendations arising from the findings of the survey include the integration of disability and rehabilitation into clinical teaching, a teaching focus on those types of disability which are common in the community, a greater emphasis on functional assessment in teaching the physical examination, and the wider use of standard assessment instruments: for example, activities of daily living, cognitive impairment and locomotor disability. Additionally, improved communication between medical schools to facilitate the spread of educational activities on this topic is required. Within medical education, some programs have moved to concentrate on narrative medicine which is about encountering disability through simulation and working alongside 'real' disabled people in training.

Maria Crotty, *et al* (2000) report on the introduction of a new postgraduate medical course at Flinders University of South Australia in 1996 which incorporates the development of a new topic on disability and rehabilitation.⁴² In this course, disability is understood within the context of rehabilitation. Over a four-week period, students undertake four activities. First, they follow a particular disabled person in an inpatient rehabilitation setting to learn about the multidisciplinary approach to rehabilitation. Secondly, they each visit two people with a disability living in the community to assess their physical, mental, functional and social status. Thirdly, they each visit a service which supports those people in the community. Finally, they simulate having a disability which is randomly allocated to them. The simulation exercise plays a significant role in the evaluation program despite that fact that such exercises have been significantly critiqued by several disability studies scholars as not only individualizing (privatizing) the experience of disability but inculcating negative and false attitudes about the lived experience of disablement.⁴³

May *et al* describe a teaching programme that is part of a behavioral sciences course, in which small groups of students are introduced to a similar number of people with learning disabilities, and they are encouraged to talk to each other, initially in pairs.⁴⁴ There is no introductory lecture; the seminar focuses on getting to know each other. The participants with learning disability are prepared to some extent. This experience resulted in positive changes in attitude. However, there is a danger of using people with disabilities in 'real time' when some disabled people may have unreflected attitudes towards disability as well as vulnerable self-esteem, reinforcing ambivalent attitudes that the education program, seeks to challenge. In contrast, meeting a group of people with learning disabilities who have positive images of themselves helps students avoid equating disability with illness.⁴⁵ Monash University (Victoria, Australia) introduced a short two-hour intensive communication skills workshop where the tutors have intellectual disability. The format was twofold: a brief information session and an opportunity to interact with the person with intellectual disability. According to Tracey, these sessions effected a change in attitudes.⁴⁶ We may wish to query how sustainable is attitudinal change, and does this attitudinal shift impact on workplace cultures and regimes ultimately affecting how things are done? In 2005, the UK

based Health Council of the Disability Partnerships produced a framework, the “*Learning Journey for Health and Social Care Professional who work with Disabled People*” based on the notion that understanding disability is a lifelong requirement. This framework has been adopted by some teaching bodies for teaching guidance and as a competency check.⁴⁷ A recent French study that examines the impact on attitudinal change on 4th year medical students who undertake a seventeen hour course on disability and work in a physical medicine rehabilitation department found, in contrast to UK and US studies, that there had only been a *modest* change in attitudes compared with students who had not undertaken these initiatives.⁴⁸

Tensions: theory (which theory) or practice (what practice)?

A survey of programs and initiatives detailed in this article identify several orientations of a theoretical nature or oriented towards disability “exposures” i.e. in the form of a practicum placement, usually although not exclusively at a medical rehabilitation facility or by way of a site visit to a disability service, special school or family with a disabled child. A number of the studies place importance on the impact of the experiences of the medical student when exposed to disability outside of a classroom/hospital setting. None of these surveys, however, due probably to the quantitative nature of their research design, critically appraise the hermeneutics of experiences, which is the framework students draw upon to interpret or make sense of their exposure. Whilst experience-centered learning is important, Joan Scott reminds us of the difficulties of an experience-based paradigm:

[it is] not individuals who have experience, but subjects who are constituted through experience. Experience in this definition then becomes not the origin of our explanation, not the authoritative (because seen or felt) evidence that grounds what is known, but rather that which we seek to explain, that about which knowledge is produced.⁴⁹

In order to process disability experiences, students also need a prior exposure to the different ways that disability concerns are conceptualized, including the strengths and weaknesses of different approaches and the range of questions and orientations that each theoretical paradigm generates. Disability studies scholars have criticized the biomedicalist conceptualization of disablement. A social constructionist approach distinguishes between disability and impairment in the same way that early feminist writing distinguishes between gender and sex.⁵⁰ This approach understands disability as socially produced or a neologism wrapping around and over impairment. Even though there have been debates over the efficacy of the social model from a range of disciplines over the past 30 years, the notion of disability as a relational and cultural concept is now well established. The insights of disability studies have shown that the disability idiom has a history before biomedicalism; indeed, this is a history where the reckoning of bodily and mental differences is both culturally, locally and historically contingent.⁵¹

In terms of best practice it is critical that medical schools, instead of bypassing these developments as being ideologically irrelevant, need to embrace and enter a space of dialogue. This can be facilitated by broader teaching and research engagements with disability studies, as medical sociology has shown itself to be reluctant to engage with critical disability issues outside a health paradigm. Richards *et al*, study indicates the necessity to challenge medical student prejudices about disability that consider “disabled

people as bearers of deficiency which calls into question their competence to collectively cure”⁵² and focus on the mechanisms of prejudices. Richards, *et al* asks:

What are the relevant educational tools to achieve this? If the attitude towards disabled people is first and foremost a matter of concepts, an awareness of the mechanisms of discrimination and social prejudice, the course must then find a place in the corpus of the humanities and introduce an ethical discussion of the medical and social models of disability, along with other forms of discrimination, reflecting on attitudes in medical decisions. If the behavior is the final result of attitudes and experience, including contacts with experiences of people with disabilities, the theoretical and practical aspects of physical medicine & rehabilitation (MPR) can, and should probably be changed [my translation].⁵³

These complexities and flashpoints can be witnessed in a heated disagreement in the journal *Medical Education*,⁵⁴ initially in response to a piece by Crotty (2000)⁵⁵ about the postgraduate disability and rehabilitation course taught at Flinders University, Australia. The Bristol group argues that the South Australian course does not challenge students’ attitudes enough, nor does it get students to examine their own preconceptions.⁵⁶ The choice of a predominantly medical team of teachers results in emphasizing a medical model approach to disability. They argue that the Bristol course which vertically cuts across the 5 year medical program is predominantly delivered by the “best people to teach medical students,” that is by disabled people. In response to this charge, Crotty *et al* argue that “delivery” by disabled people occurs “as a direct consequence of the interaction between student and people with disability.”⁵⁷ The source of the difference is whether medical culture(s) should be challenged especially if disability education causes discomfort and alienation to both students and faculty. Surprisingly then, Crotty *et al*, move to dismiss these significant debates over pedagogies by reducing the disagreement to one of “internal wrangling and name calling” and characterize the whole debate in the last 30 years about the medical model and the social models as some kind of semantic brawl. They conclude that “we should put away our models and our ideologies and get on with the task of helping students to deal effectively with people who have chronic disease [*sic*].”⁵⁸ It is exactly this kind of resistance to take seriously knowledge claims from other disciplines and the voice of grassroots disability constituencies that invokes a fundamental need for disability education for medical students to gain some conceptual clarity based on a social model of disability or at least work through the purview of a critical disability studies paradigm. Learning from the experiences in multicultural education in medicine, a humanities frame enables an interrogation of broader social relations of disability and difference in order to ascertain the place of medicine. Following Wear’s⁵⁹ work on cultural competency, a disability studies framework can help educators refocus away from the minoritization of disability towards an exploration of the impact of disablement on self-image, unequal access to power and resources that “allow some groups but not others to acquire and keep resources, including the rituals, policies, attitudes, and protocols of medical institutions.” Hence this avoids any patient or doctor blaming (in the doctor-patient relationship) towards focusing on the social production of inequality and privilege.

Medical education needs to recognize its impulse to usurp other knowledge forms in simultaneously incorporating the social but at the same time leaving the medicalization of human experience unproblematized. Otherwise disability education runs the risk of lapsing into a sole preoccupation with an individualized biomedical, functionalist approach to disability that reinforces the very negative attitudes toward disability which these courses

purport to oppose. The Bristol program remains at the cutting edge and will confront the academy particularly in the area of knowledge standpoint, as Wells, *et al* puts it: “our experience indicates that, from an educational point of view, recognition of the disabled person’s own expertise and the idea of partnership is only fully realized when the disabled person is introduced as ‘the teacher’.”⁶⁰ Interdisciplinarity is not as some studies suggest, merely about working with other allied health professionals side by side (although this is a worthy task). Rather, interdisciplinarity involves the *deprivileging* of medical episteme and having a preparedness to encounter different and divergent viewpoints gained from a different relationship to disability and professional training.

Recently, another disability studies approach to medical education and the allied health professions (speech and language therapy and audiology) has been developed at the University of Kelaniya, Sri Lanka. The design has been as much an accident of chance as well as a pragmatic response to existing university structures and severely limited resources. The Faculty of Medicine is housed on a separate campus from the rest of the university with a teaching and military hospital nearby. In 1995, the Disability Studies Unit (DSU) was established in conjunction with the University of Uppsala (Sweden) to teach community rehabilitation courses. These courses, due to a lack of skilled homegrown personnel and funding, waned over time. The DSU was approached during this “down time” by a UK institution to provide Sri Lanka’s first Speech and Language program. The Director of the Unit, although trained in Rehabilitation Medicine, had a commitment to extending the knowledge base of the Faculty to more sociological understandings of disability. In 2006, he invited an Australian Sri Lankan disability studies academic to establish a new disability studies program under a new proposed Department of Disability Studies. What makes this Department unique is all current and future training of the professions (e.g. speech therapy, audiology, orthotics and prosthesis, deaf communicators) under its auspice are to have their curriculum *underpinned by a disability studies paradigm*, where all teaching places the perspectives of disabled people at the centre of study. The DSU is also committed to interdisciplinarity and multi-methodological approaches to the study of disability and encourages the employment of disabled people as teachers.⁶¹ The DSU is to commence course training with the Faculty of Medicine, and this new way of doing things is already creating waves with faculty colleagues who work in close proximity, especially pediatricians and neurologists. Already the medical faculty has entered into tentative research engagements with disability studies scholars, and the author is supervising research projects of speech and language therapists.

The School of Human Services and Social Work at Griffith University (Australia) has been teaching a disability studies major at undergraduate and postgraduate levels for over 10 years, and disability studies has been a core component in the curriculum for the education of rehabilitation counselors. One course, *Disability: Theory & Philosophy*, focuses on introducing a critical appraisal of the shifts in the ways disability is conceptualized in both the natural and social sciences that impact on assessment, interventions, social policy, community and practitioner attitudes. The companion course titled *Disability Studies* (recently rebadged at undergraduate level as *Difference & Disability*) is concerned with the lived experience of impairment. Until 2002, the course *Disability Studies* reflected the dominant understanding of disablement that sought to equip students with clinical and enumerative understandings of disability. Any course content related to social context was often confined to aspects of disablement related to the functional performances of activities of daily living within family and vocational contexts. This clinical orientation to the study of impairment has meant that, pedagogically, this course was structured around a diagnostic framework of five impairment categories: an ‘impairment type a week’. The lived experiences and ‘voice’ of the disabled person

remained at the periphery of the teaching and learning experience. Modalities of disablement were mediated through the ‘voice’ and practices of professional experts.

Increasingly a dissonance has emerged between the course objectives, structure and pedagogical approaches and contemporary understandings of disablement drawn from the social sciences. Human service students would usually not be working as clinicians or in medicalised environments, yet the emphasis of the course is on these clinical and functional aspects. Furthermore, the functionalist approach to the study of disablement does not expose students to the ways that impairments interact with environments (built, cognitive, economic and social), nor the ways that similarly situate impairments maybe lived and experienced differently. Invisible is the residual impact of living with impairment in a world that devalues disablement. During 2001–2003, the responses to pedagogic shortcomings were limited and measured – in the sense of *modifying* some of content and assessment tasks, whilst *preserving* the overall structure of impairment categorization. Based on annual student course evaluations and my own reflections upon teaching, it became evident that the teaching and learning approach in *Disability Studies* was flawed in two *significant* ways:

- 1) there was an inbuilt conflict between the ideology and rhetoric that gave primacy to the lived body and social constructionist notions of disablement and the ongoing usage of an impairment/diagnostic based schema to study disability which reinforced a form of biomedicalism;
- 2) students undertook their ‘tour of impairments’ (looking in and gazing fleetingly on the five impairments categories) but did not really engage in a deep reflection on the realities of impairments and the effect of that knowledge on professional practice.

In response to my own and students’ frustration about the ‘package tour’ approach and the course’s seeming reinforcement of diagnosticism, the emphasis and objectives of the course were overhauled. It was felt that structured opportunities were required for students to focus on the experiences of disability in order to reinterpret their own experiences and taken-for-granted attitudes and practices. The course has taken a different direction with weekly themes being divided into tropes of disablement rather than a diagnostic orientation, borrowing some of pedagogical strategies adopted in the teaching of literary studies. The content of this course is intended to provide students with an experiential understanding of living with impairment to enhance reflective professional practice. This course has sequenced knowledges of impairments within the more dynamic scaffolding of *thematic tropes* of disablement – childhood, acquisition, ambivalence, punishment, activism, sexuality, relationality, and intersectionalities, to reflect upon how individuals *make sense* of their experiences - the impacts of life stories on opportunities and challenges. The course is heavily reliant on good facilitation and the usage of materials from YouTube, autobiographies, independent documentaries, life writings and occasionally a guest speaker. Assessment consists of a 13 week reflective journal on the materials, a poster exhibition and a dedicated critical review of an autobiography. Students from rehabilitation counseling, disability studies, nursing, psychology and human movement are now benefiting from this perspective. The revised approach is more in keeping with the notion of disability as an evolving concept as stated in the UN *Convention on the Rights of People with Disabilities*.

Conclusion: integral commitment or “add disability and stir”?

An overview of program offerings around disability education in medical schools suggests that the existence of disability studies orientated initiatives has been dependent upon the

enthusiasm of particular staff rather than a planned response to policy. Indeed, I am in agreement with Lennox *et al*, who argue that the shape of these programs, in terms of the range of content, teaching and theoretical orientation is driven by the motivation and perspectives of a particular individual than specific guidelines.⁶² Melville in surveying the English and Scottish scene points to a shift from discrete course offerings to embedding disability as an aspect throughout the curricula across the year levels.⁶³ Tufts University School of Medicine, in Boston, for instance, incorporates disabled people as *standardized* patients in medical interview simulations for third- and fourth-year students, bringing together common primary care concerns with disability related issues.⁶⁴ Horizontal embedding, however, needs safeguards to ensure that there is a consistent approach to conceptualizing the production and effects of disablement in order to avoid students receiving mixed messages about the meaning of disability. Overall, this paper suggests that a comprehensive medical curriculum about disability, including personal and clinical contact with individuals affected by a disability, can significantly alter the knowledge, attitudes, and self-awareness of medical students provided that disability is interpreted through the lens of the lived body that is located within and shaped by cultural, ontological and economic forces.

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