Whereas, Liaison Committee on Medical Education (LCME) standards explicitly include disability as a protected category subject to discrimination and requires medical schools to develop policies on defining, reporting, and responding to mistreatment, but no universal definition or reporting protocol for mistreatment exists; and

Whereas, medical students with disabilities comprise 7.6% of allopathic and 4.27% of osteopathic medical school classes, and disability-related mistreatment may include denial of reasonable accommodations, exclusion from training opportunities based on disability, ableist remarks, and lower evaluations or grades due to evaluator judgments of student disability; and

Whereas, LCME collects data on medical student mistreatment using the American Association of Medical Colleges’ Medical School Graduation Questionnaire, which explicitly includes mistreatment based on race, ethnicity, gender, and sexual orientation, but not disability; therefore be it

RESOLVED, that our American Medical Association work with the Association of American Medical Colleges (AAMC) and other relevant bodies to encourage data collection of medical student mistreatment based on disability as a protected category in internal and external mistreatment surveys, including the AAMC Medical School Graduation Questionnaire. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 09/11/2023

REFERENCES

RELEVANT AMA POLICY

D-615.977 Advocacy for Physicians and Medical Students with Disabilities
Our AMA will: (1) establish an advisory group composed of AMA members who themselves have a disability to ensure additional opportunities for including physicians and medical students with disabilities in all AMA activities; (2) promote and foster educational and training opportunities for AMA members and the medical community at large to better understand the role disabilities can play in the healthcare work environment, including cultivating a rich understanding of so-called invisible disabilities for which accommodations may not be immediately apparent; (3) develop and promote tools for physicians with disabilities to advocate for themselves in their own workplaces, including a deeper understanding of the legal options available to physicians and medical students to manage their own disability-related needs in the workplace; and (4) communicate to employers and medical staff leaders the importance of including within personnel policies and medical staff bylaws protections and reasonable accommodations for physicians and medical students with visible and invisible disabilities. [BOT Rep. 19, I-21]

D-90.990 Evaluate Barriers to Medical Education for Trainees with Disabilities
1. Our AMA urges that all medical schools and graduate medical education (GME) institutions and programs create, review, and revise technical standards, concentrating on replacing “organic” standards with “functional” standards that emphasize abilities rather than limitations, and that those institutions also disseminate these standards and information on how to request accommodations for disabilities in a prominent and easily found location on their websites.
2. Our AMA urges all medical schools and GME institutions to: a) make available to students and trainees a designated, qualified person or committee trained in the application of the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, and ,available support services; b) encourage students and trainees to avail themselves of any needed support services; and c) foster a supportive and inclusive environment where students and trainees with disabilities feel comfortable accessing support services.
3. Our AMA encourages the National Board of Medical Examiners (NBME), National Board of Osteopathic Medical Examiners (NBOME), and member boards of the American Board of Medical Specialties and the American Osteopathic Association to evaluate and enhance their processes for reviewing requests for accommodations from applicants with disabilities in order to reduce delays in completion of licensing and initial board certification examinations. This should include an assessment of the experience of those applicants and the development of a transparent communication process that keeps applicants informed about the expected timeline to address their requests. These processes should require neither proof of accommodation nor proof of poor academic performance prior to the time at which a need for accommodation was requested.
4. Our AMA encourages research and broad dissemination of results in the area of disabilities accommodation in the medical environment that includes: the efficacy of established accommodations; innovative accommodation models that either reduce barriers or provide educational approaches to facilitate the avoidance of barriers; impact of disabled learners and physicians on the delivery of health
care to patients with disabilities; and research on the safety of established and potential accommodations for use in clinical programs and practice.

5. Our AMA will collaborate with the NBME and the NBOME to facilitate a timely accommodations application.

6. Our AMA recommends adherence to the ADA recommendations in section 36.309 that requires the documentation requested by a testing entity to evaluate a request for testing accommodations be both reasonable and limited to only the information needed to determine the nature of an examinee’s disability and their need for the requested testing accommodations, as noted by the Civil Rights Division of the Department of Justice in their 2014 interpretation of this ADA provision.

7. Our AMA will collaborate with key stakeholders to raise awareness regarding the process for applying and preparing for examinations, inclusive of requests for accommodations. [CME Rep. 2, I-21, Appended - BOT Action in response to referred for decision: Res. 314, A-21]

H-295.955 Teacher-Learner Relationship In Medical Education

The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

CODE OF BEHAVIOR

The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.

A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher.

In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty.

Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behaviors can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual’s work; intentional neglect or intentional lack of communication.

On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals’ rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.

While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a
private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling. Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively. Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients. [BOT Rep. ZZ, I-90, Reaffirmed by CME Rep. 9, A-98; Reaffirmed: CME Rep. 2, I-99, Modified: BOT Rep. 11, A-07; Reaffirmed: CME Rep. A-13, Reaffirmed: BOT Rep. 9 I-20]