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Black Ice

Five ways to counter ableist messaging in medical education in the context of promoting healthy movement behaviours

Cinq façons de contrer le discours capacitiste en éducation médicale dans le contexte de la promotion de comportements sains en l'activité physique

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Abstract

One in five Canadians have a disability and there are well-documented gaps in care for this equity-deserving group that have roots in medical education. In this paper, we highlight the unintended consequences of ableist messaging for persons living with disabilities, particularly in the context of promoting healthy movement behaviours. With its broad reach and public trust, the medical community has a responsibility to acknowledge the reality of ableism and take meaningful action. We propose five strategies to counter ableist messaging in medical education: (1) increase knowledge and confidence among physicians and trainees to optimize movement behaviours in persons living with disabilities, (2) perform personal and institutional language audits to ensure terminology related to disability is inclusive and avoids causing unintended harm, (3) challenge ableist messages effectively, (4) address the unmet healthcare needs of persons living with disabilities, and (5) engage in efforts to reform medical curricula so that persons living with disabilities are represented and treated equitably. Physicians and trainees are well-positioned to deliver competent and inclusive care, making medical education an opportune setting to address health inequities related to disability.

Résumé

Un Canadien sur cinq souffre d'un handicap. Cette population subit des inégalités bien documentées sur le plan des soins de santé, une situation qui une situation qui découle en partie de l'éducation médicale. Dans cet article, nous mettons en évidence les conséquences involontaires du discours capacitiste véhiculé dans le contexte de la promotion de l'activité physique pour les personnes vivant avec un handicap. Compte tenu de l'influence de la communauté médicale et la confiance que lui témoigne le public, elle se doit de reconnaître. Nous proposons cinq stratégies pour contrer les discours capacitistes en éducation médicale : (1) renforcer les connaissances et la confiance des médecins et des stagiaires pour leur permettre d'optimiser les comportements kinésiques chez les personnes vivant avec un handicap, (2) effectuer des vérifications linguistiques pour garantir que la terminologie liée au handicap qu'emploient les personnes et les établissements est inclusive et n'entraîne pas de préjudices involontaires, (3) contrer efficacement le discours capacitiste, (4) répondre aux besoins de santé non satisfaits des personnes vivant avec un handicap, et (5) participer aux efforts de réforme des programmes d'études médicales afin que les personnes vivant avec un handicap soient représentées et traitées équitablement. Les médecins et les stagiaires occupent une position privilégiée pour offrir des soins compétents et inclusifs, ce qui fait de l'éducation médicale un cadre opportun pour combattre les inégalités en matière de soins liées au handicap.

Introduction

An estimated one in five Canadians over the age of 15 have a disability.[1] The United Nations define disability as any "long-term physical, mental, intellectual, or sensory impairments which, in interaction with various barriers, may hinder full and effective participation in society on an equal basis with others."[2] Persons living with disabilities (PLWD) use more health care services and access primary care more frequently than the general population.[3] Unfortunately, some health care providers report lacking the necessary knowledge and confidence to competently care for PLWD.[4,5,6] Thus, while medical trainees will undoubtedly care for PLWD frequently, they require better preparation to deliver that care.

Given that a lack of knowledge can produce social biases and negative attitudes, medical education may

unintentionally foster ableism.[5] Fundamentally, ableism refers to the differential valuation of abilities in society, which leads to discrimination towards PLWD.[6] In the medical world, ableism may take insidious forms; for example, the underestimation of quality of life for PLWD,[8] or lack of exposure to bodies with disability in case-based learning.[9] Further, non-inclusive language used in medical education can have unintended consequences for PLWD that amount to ableism.[10]

One area where ableist messaging is pervasive in medical education is in discourse about movement behaviours (i.e., physical activity, sedentary behaviour, and sleep). Non-inclusive messages target people who are not living with disabilities and exclude those outside what would be considered 'normal.' For instance, prevalent messages like "sitting is the new smoking" or "sit less" not only overlook PLWD but are also discriminatory by disfavouring any person that cannot easily avoid sitting. When sitting is demonized or its negative impact on health is mischaracterized, the message is harmful to individuals who cannot stand (i.e., wheelchair users).[11] It is equally important to be cognizant of those who can only manage a certain level of activity before chronic fatigue or pain sets in (e.g., persons with fibromyalgia), or those who find sitting beneficial for their well-being (e.g., persons with developmental disabilities).[11] While consistent health messaging is important, consistently exclusionary messaging is counterproductive. Widespread public awareness and acceptance of popular messages are not excuses for normalizing ableism, particularly when popular messages can penetrate medical education and, subsequently, the lexicon of physicians and trainees.

It is important to acknowledge that ableist messaging may often be inadvertent. However, it is possible for us to simultaneously call attention to what harm has been done while affording one another the opportunity to learn and do better. At all stages of medical education, trainees are taught to communicate with patients in a way that conveys empathy and builds trust. Adopting more inclusive messaging in undergraduate medical courses offers a valuable opportunity to shape the language that trainees will use with future patients, including PLWD. Language matters and is a powerful tool that continues to evolve, with a positive trend towards eliminating prejudice and discrimination. This paper highlights the "black ice" of ableist messaging in medical education, and how to end the harmful pattern of undermining healthy movement behaviours in PLWD and the consequent worsening of health outcomes.[12]

The strategies offered in this paper can be used to shift the tone of movement behaviour messaging in medical education. As part of broader efforts to enhance equity, diversity, inclusion, and accessibility, it is also the authors' hope and objective that this paper will serve as a call for systemic change to medical education as it relates to disability.

Strategies to counter ableist messaging in medical education

1. Increase knowledge and confidence

As trusted sources of health information,[13] physicians are well-positioned to offer counseling about movement behaviours; however, many medical professionals report a low level of confidence to do so.[14] When disability or chronic health issues require special considerations for physical activity, this may present an added challenge for physicians that contributes to the underutilization of counseling.[15] Institutions must ensure its physicians and trainees have disability-specific knowledge about how to engage in physical activity and the associated benefits related to participation among PLWD.[12] Gaining this knowledge starts with recognizing that people move in different ways, and that all movement counts and is beneficial.[16] When movement behaviours are discussed in the context of disease prevention or management, PLWD should be explicitly recognized. Neglecting to do so may imply that disability precludes an individual from accessing the benefits of movement, which is harmful and untrue. Indeed, despite the well-established physical and mental health benefits associated with physical activity and reduced sedentary time,[17] PLWD are 16-62% less likely to meet physical activity guidelines when compared to the general population.[12] A simple step towards inclusivity is to learn and share knowledge about movement in non-standing postures (e.g., stationary cycling, seated resistance training), examples of which can be incorporated into medical education where applicable.[18] Resources are available to aid physicians in supporting physical activity among PLWD.[19]

2. Audit language to ensure inclusivity

In Canada, "person-first" language is considered most inclusive when communicating about disability, where the focus is shifted away from the medical condition and onto the individual (e.g., "person with a disability" rather than

"disabled person").[20] The personal preferences of PLWD and the communities of which they are a part should also be considered (e.g., many individuals prefer to be referred to as "autistic" rather than "a person with autism"); however, certain terminology will always be inappropriate in a medical setting. Case in point, it is important to avoid language that causes harm, which includes derogatory terms (e.g., "crippled" instead of "person with a physical disability"), labels that define what is normal (e.g., "able-bodied" instead of "person without a disability"), and phrases that are overly emotional and stigmatizing (e.g., "suffering from" instead of "experiencing" or "wheelchair bound" instead of "wheelchair user"). A common mistake in the context of movement behaviours is to equate sitting and sedentary behaviour. Sedentary behaviour is defined by an energy expenditure ≤1.5 metabolic equivalents and may occur in a seated posture; however, physical activity can also be done in a seated posture.[21]

A practical approach that physicians and trainees can use to audit their language is to (1) compare their language to a reputable standard,[18] (2) create opportunities to apply inclusive language in clinical settings, and (3) remain adaptable as inclusive language evolves. Institutions, on the other hand, have the authority to set standards and the responsibility to guide members to achieve those standards. For instance, the Faculty of Health Sciences at Queen's University has developed a "Style Guide" to promote the use of equitable and inclusive language when discussing disability and other identities.[22] Other organizations have developed similar resources that academic institutions could also use in lieu of creating their own guide.[23] While such initiatives undoubtedly represent progress, they must be paired with strategies to maximize uptake. It is frankly not enough to create resources that are widely touted but seldom put into action–physicians and trainees should be strongly encouraged to view the use of inclusive language as an imperative. Institutions should also consider implementing requirements for all educational and public-facing materials to follow an inclusive language standard.

3. Challenge ableist messages

The message "get out of your chair, it's killing you"–presented during a pre-clerkship lecture in medical school–was the provocation for this paper. The attitudes that such messages convey have no place in medical education or practice, and change will not come without advocates who challenge ableist messaging. When confronting ableism on an interpersonal level, advocates should make the messenger aware of their use of non-inclusive language, acknowledging it may have been inadvertent. Then, alternative language that is inclusive and reasons why the change in language matters should be shared.[11] Health institutions and research groups also have a platform to shift the status quo of ableist messaging. For example, during formative research in the development of Canada's 24-Hour Movement Guidelines for Adults, the tagline "Move more. Sit Less. Sleep Better." was found to best foster confidence among Canadian adults and, thus, was highly favoured to be used in all public-facing materials.[24] However, the final tagline used to promote the guidelines was "Move more. Reduce sedentary time. Sleep better." to lessen stigmatization towards those for whom sitting is essential or beneficial for their well-being.[24] It is these difficult yet necessary choices that will make movement behaviour messaging more universal.

4. Meet the needs of PLWD

Movement behaviour messaging is useful to illustrate ableism in medical education and practice, but does not capture the breadth of inequities facing PLWD in health care. Adults with disabilities are three times more likely to report unmet health care needs when compared to the general population in Canada.[3] Unmet needs can be explained in large part by structural issues that demand policy-level solutions, but this does not absolve physicians and trainees of their responsibilities at the point of care. Trainees should be aware that PLWD are more likely to feel rushed and dismissed during clinical encounters and should be taught strategies to mitigate these feelings and preserve the confidence PLWD have in the quality of their care.[3] Increased clinical exposure to PLWD, particularly where it might require adaptations of the typical approach to a history and physical examination, would also be beneficial.[5] These efforts, which will combat ignorance about disability and prevent the formation of negative attitudes, are integral to addressing this 'unmet needs' problem.

5. Engage in curricular reforms

The care of PLWD deserves significantly more attention in undergraduate medical education and continued professional development than it is currently receiving, and a key to progress on this front is curricular reform. One approach to developing a medical curriculum to improve disability education has been described in detail by Symons et al. (2009) and its implementation was reported to be successful.[4] The curriculum is goal-oriented, focusing on (1) building knowledge, (2) fostering positive attitudes, and (3) teaching skills (e.g. communication skills, assessment of

physical functioning).[4,25] It includes classroom-based, community-based, clinical, and research components to facilitate a comprehensive experience for learners, and is evaluated across a range of outcomes.[4] The attitudinal survey and formative feedback provided during Objective Structured Clinical Examinations are feasible ways for any institution to monitor its progress towards equity for PLWD, especially as it relates to inclusive language.[4]

Closing remarks

Medical schools are under increased scrutiny and pressure to improve their curricula with equity, diversity, inclusion, and accessibility as central tenets.[26] The objective of this paper was to argue that reform relating to disability education should be a top priority. Importantly, this is not a call to fit additional material into an already over-extended curriculum,[27,28] but rather a proposal of five strategies for embedding inclusivity towards PLWD into the current model of medical education. Ableist movement behaviour messaging has gone unnoticed as "black ice" and, for that reason, it has merited emphasis in this paper; however, the entire landscape of disability-related medical education must change. Physicians and trainees are well-positioned to deliver competent and inclusive care, making medical education an opportune setting to address health inequities related to disability.

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