The need for active allies: A narrative analysis of disabled medical students' perspectives of their medical school

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Abstract

Introduction: Providers of medical degree programs need to ensure that graduates represent the diverse communities they serve. Disabled students face barriers to accessing and completing medical programs. As the call for a more inclusive and supportive medical education culture grows internationally, it is essential to understand the perspectives of disabled medical students in Australasia. To inform the ongoing discussion concerning inclusive medical education, this study aimed to describe disabled medical students' experiences regarding the inclusive culture of a medical degree program at a University in New Zealand.

Methods: Semi-structured interviews and a "writing" story-elicitation activity were conducted with five participants who self-identified as experiencing disability and who were enrolled in a medical degree program. Interviews were between 1 and 1.5 hours, transcribed verbatim and subject to narrative analysis.

Results: Data are presented through three archetype participant narrative summaries preceding three overarching themes. Participants generally reported experiencing passive allyship regarding disability and received support from staff, students and disability support services. However, they also recounted instances where their disabilities were negatively framed and stigmatised as hindrances. These experiences led to a reluctance to disclose further needs, with participants feeling that accommodating their disabilities was solely their responsibility. They expressed a desire for the medical school to proactively create opportunities and spaces to normalise and validate the needs of disabled students.

Conclusion: Findings illustrate how medical programs can better position themselves as proactive allies by creating opportunities for disabled students, thereby better reflecting society's diversity.

Keywords: medical education; students; disability; identity formation; diversity; qualitative research

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Background

Medical education is a critical focus for disability inclusion. While national disability rates range from 10–20% (WHO, 2011), fewer than 5% of doctors experience disability—with estimates being 4.6% in the US (Meeks et al., 2019), 4.1% in the UK (Mogensen & Hu, 2019) and only 2% in Australia (Mogensen & Hu, 2019). Disabled people are, therefore, under-represented in the medical workforce. Disabled people face numerous structural and cultural barriers to accessing medical education programs, which are often governed by policies that frame disability as a risk and potential educational burden for schools, however, despite this, schools are required to adapt practices to meet legal requirements (Mehta et al., 2020; Shrewsbury et al., 2018). For example, the Medical Deans of Australia and New Zealand (MDANZ) (2017) inherent requirements document deems it necessary that individuals have a certain level of fine motor skills (alongside equivalently sufficient vision and hearing abilities) to enter and practise medicine in Australasia.

Structural and cultural barriers can include faculty having a lack of prior knowledge about the students' conditions, a lack of dialogue between students and teachers about possibilities for adaptation, an underestimation of disability, a lack of approach to disability in the curriculum and a lack of accessible structures in teaching spaces (de Oliveira et al., 2021; Doherty, 2022; Meeks & Neal-Boylan, 2020). Furthermore, the socialisation of disabled people in medical education presents unique challenges, particularly concerning identity. Medical students with self-identified disabilities reported that institutions often implicitly and explicitly framed "wellness" as a means to optimal academic performance (Stergiopoulos et al., 2018). Jain (2020b) has suggested such instances reflect a detrimental cultural logic: *the capability imperative*, whereby a deficit-based conceptualisation of disability conflicts with the hyper-ability culture of medicine.

Jain (2020b) argues for a universally designed medical education system that values disabled medical professionals, reconceptualises notions of capability and fosters positive disability conceptualisations into identity formation. In April 2021, the Medical Deans of Australia and New Zealand (MDANZ) released a guidance document to help medical schools support disabled students (Issakhany & Crampton, 2023). Motivated in part to challenge the MDANZ's 2017 inherent requirements document, this framework suggests identifying and considering necessary adjustments or supports for disabled students. However, Jershua Mather (2021), a neuroscience PhD candidate and disabled individual, critiques the document for failing to address the discrimination faced by disabled applicants throughout the medical school application process and provide specific solutions to increase access and address structural changes needed for the inclusion of disabled individuals.

Providers of medical degrees need to ensure that graduates represent the varied communities they serve, including disabled people. Disabled people actively and effectively contribute to the medical workforce in front-line roles (Fitzmaurice et al., 2021; Morrow, 2010), and community members have reported the lived experience of disability can promote genuine empathy in doctors (Mogensen & Hu, 2019). Creating inclusive medical education institutions requires a shift towards a more proactive, strengths-based approach to inclusion (Clarke, 2022; Rastogi, 2021), focusing on the context, practice and social relations of medical education rather than an individual's impairment (Jain, 2020a; Tweed & Wilkinson, 2022) and critically reflecting on regulatory policy in relation to evolving social approaches to disability (Issakhany & Crampton, 2023; Mehta et al., 2020).

There is a growing body of international research focusing on disabled medical students (Rastogi, 2021; Shahaf-Oren et al., 2021; Stergiopoulos et al., 2018). However, despite the recent MDANZ guidelines to establish a more inclusive and representative medical education culture, there is a current lack of literature in Australasia regarding first-hand experiences of disabled medical students. This study aims to fill the literature gap by providing insights into the inclusive culture of a medical educational program in New Zealand (hereafter "the program"), thereby contributing to the broader discourse on disability inclusion in medical education. This study focused on three specific research questions (RQ):

> RQ1: How do students feel their experience of disability is acknowledged, supported and valued within the program?
>
> RQ2: What teaching and learning practices, administrative and organisational policies and procedures within the program best facilitate (or do not) the empowerment, capacity and capability of disabled students?
>
> RQ3: How does the program support the disability identity of students as they move through the program and into clinical practice?

Method

We employed a narrative inquiry qualitative approach (Clandinin & Huber, 2010; Lyons et al., 2019). Clandinin (2006) suggests that the ontology of narrative inquiry is based on John Dewey's pragmatic theory of human experience and that, as humans, we "individually and socially lead storied lives" (p. 45). From an epistemological perspective, coming to know these experiences can be through narrative inquiry (e.g., listening and interpreting the living out of people's stories) (Clandinin, 2006; Clandinin & Huber, 2010). Narrative inquiry was appropriate to interpret and articulate detailed perspectives regarding how participants' disabilities were acknowledged, supported and valued within the program (RQ1) and how practices within the program facilitate (or not) the empowerment, capacity and capability of participants (RQ2). A particular strength of narrative inquiry is the ability to engage in identity negotiation within the education sector (RQ3) (Lyons & Roulstone, 2018). This research was grounded in critical realism, which acknowledged the mediating influence of various sociocultural influences on participants' reality (Shakespeare, 2014; Williams, 1999), namely, the organisational, social and cultural context of medical education (Meeks & Neal-Boylan, 2020). The

Otago Human Research Ethics Committee (Health) provided ethical approval for the study (H22/092).

Procedure

Participants

Inclusion criteria for participants were medical students currently studying within the medical education program who self-identified as having a learning, psychological or physical impairment or disability. We purposefully employed a broad definition of disability due to the exploratory nature of our research. Our research focused on eliciting detailed and rich data from a small sample of participants. Small samples are justified in qualitative inquiry when the focus is on interpreting a rich account of a specific context (Braun & Clarke, 2013, 2022; Sebele-Mpofu, 2021).

Setting

Most students enter the program in Year 2, after a first-year health sciences program. The balance enters as graduates (about 20–25% of entrants), with about 10% entering under an alternate entry category after work or life experience. Years 2 and 3 are an integrated clinical science and practice program at one campus. Years 4 and 5 are structured around clinical placements in three geographically dispersed campuses. Year 6 is a "trainee intern" year with students fully embedded in clinical teams.

Recruitment

Following ethics approval, an invitation email was sent to all current program students (all degree phases, all campuses). Study invitations were also sent to medical students registered with the university's Disability Information and Support Service by the office staff. Potential participants contacted a research assistant (RA) via the invitation and had an opportunity to ask questions. The RA organised an interview time convenient for participants and obtained written informed consent. We aimed to purposefully recruit a small sample of participants, including disabled Māori (Indigenous people of New Zealand), if possible.

Data collection

Data were collected between December 2022 and March 2023. We focused on the narrative inquiry data collection method of "story eliciting", whereby participants were asked to tell their stories using semi-structured in-depth interviews (Lyons et al., 2019). Participants were interviewed once by the RA and then invited to complete a "writing" story-elicitation activity requesting brief answers to three questions about (1) a time their disability was valued as a medical student, (2) a time their disability was undervalued or positioned as a barrier and (3) ways they felt the program could be improved to value and include disabled people. Having a writing exercise allowed participants to critically reflect and, ideally, share more nuanced information about their experiences. Interviews were conducted online and recorded using the university-supported Zoom videoconferencing software (Zoom Video Communications Inc., Version 5.16.10). This helped close the geographical gap between researchers and participants and ensured participation was accessible. We used the Otter.ai transcribing software (Otter.ai Inc, California), with the RA reviewing each transcript for accuracy.

Data analysis

We analysed data from a narrative inquiry stance—for example, what was said, what happened, who participated—and interpreted this from the standpoint of the teller (Lyons et al., 2019). For this study, we focused on analysing story content that could be used to identify and report patterns within data for each participant before exploring how these experiences were shared between participants (Lyons et al., 2019; Lyons & Roulstone, 2018). Both inductive and deductive analyses were performed using thematic analysis (Braun & Clarke, 2013, 2022; Gale et al., 2013). Deductive analysis was guided by creating a coding matrix. The rows represented the specific topics explored during the interview, and the column provided space to summarise the key aspects of each participant's narrative (Gale et al., 2013). Using this matrix, our analysis was guided by the flexible process of thematic analysis (Braun & Clarke, 2006, 2013), first, by reading each participant's transcript and inductively interpreting the codes in relation to the predetermined topics. Next, each participant's transcript was uploaded to NVivo, and the RA created an individual file for each of the above codes. Each file was then populated with text data from all participants. Third, RM read through each file and developed a draft narrative exploring key themes across all participants and the three research questions, supported by illustrative quotes from the interview data. Fourth, the team met to discuss, debate, refine and verify the coherence within and between codes, themes and narratives against the original research questions. Lastly, a report was written explaining each theme with examples and ensuring a coherent flow connecting all themes.

In addition to our analysis process regarding the three research questions, we also prepared three narrative summaries representing participant experiences. The narrative summaries aim to present examples of distinct participant experiences within the medical education system, which can serve to illustrate how organisational allyship can be shaped to different student circumstances.

Research team reflexivity

Research team reflexivity (i.e., considering and acknowledging the values, skills and experience that every researcher brings to a research study) was enacted by examining and reflecting on the individual and collective influences of the research team during regular team discussions. For example, two members of the research team (JC and JB) are males who have lived experience of disability (spinal cord impairment), enabling a certain (but not comprehensive nor extensive) degree of shared experience with participants. JC has worked as a research assistant on several projects with the other authors. JB, who has a

PhD in health sciences and extensive experience in conducting qualitative research, led the data analysis. RM and RG are both extensively experienced in conducting clinical research. RG is also a medical doctor and Professor of Medicine and Associate Dean of Medical Education at Otago University. A collective decision was made within our team to use the identity-first terminology of "disabled person" to recognise it is often modifiable societal attitudes and structures that disable people (Best et al., 2022).

Reporting

The method of reporting this study is consistent with the consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines (Tong et al., 2007). In reporting, all quotes below are from interviews unless attributed to the "writing activity".

Results

Semi-structured interviews with the five participants were held between December 2022 and January 2023. Two participants also contributed short written activities. Interviews lasted between 1 and 1.5 hours. Most participants were female (n = 4) and had at least 3 years of experience enrolled in the program (Table 1). Most participants (n = 4) had an invisible impairment, for example, a neurodiverse diagnosis or learning disability.

Table 1

Demographic Characteristics of Participants (n = 5)

Characteristic	N
Age (years)	
16–24	1
25–34	2
35+	2
Gender	
Male	1
Female	4
Ethnicity*	
NZ European	2
NZ Māori	2
Pacifica	1

Characteristic	N
Years in the program	
1–2	1
3–4	2
4–5	1
5+	1
Impairment type	
Learning	4
Physical	1

* More than one option could be selected.

We present the three archetype participant narrative summaries before the more descriptive findings to sensitise readers to imagine these archetypal human stories before the broader description of their experiences.

Narrative summaries

Three narratives were written using data from all participants (including the phrasing they used in italics) to illustrate three different disabled medical students' experiences:

the student who flies under the radar (Table 2), the student who is a strong self-advocator (Table 3) and the student who is fearful of the unknown (Table 4). The bold text at the end of each narrative is a potential recommendation written by the authors. These narratives draw on various participant data to illustrate certain shared experiential narrative identities, how identities were either supported or contested by others and the connection of these personal stories with broader cultural narratives. These narratives have been developed to stimulate discussion about how medical education providers might move from passive allyship towards active allyship.

Table 2

Narrative Summary 1: The Student Who Flies Under the Radar

I have worked hard and feel fortunate to have entered medical school. However, I also experience self-doubt, often needing to reassure myself that I am capable when I make mistakes or experience challenges. *I do need to get over my attitude towards [my disability] every time I make a mistake. Like, I'm in medical school; I'm not dumb.* Nevertheless, I still require extra time and effort to maintain my level of learning at an expected level.

Additionally, I have been accepted into the medical program based on policies aimed at achieving equity and diversity within the medical profession, and therefore, I need to perform at an even higher standard to prove myself. *I just feel like everyone would judge [me]. Because I feel like, already, I'm [in one of the prioritised groupings]. I feel like adding disability and my special assessment conditions doesn't really do me any favours.*

Therefore, I try hard to fly under the radar, *not make too much noise about it*, and not draw attention to the challenges I am experiencing on a day-to-day basis. I aim to *go the subtle route and not be a nuisance.* This results in me feeling that I am *not really seen* and that I *am alone.*

I tend to take on the burden of actioning any required accommodations within my study contexts and clinical placements. *I'll put the extra work in. I've always been very reluctant to actually ask for and say what I need.* I believe I will experience *stigma* if I *ask for additional assistance,* so instead, I decide to *do it the normal way.* This can also extend to an unwillingness to discuss my accessibility needs with my peers. I experience *awkwardness* and *discomfort* when I take accommodation or accessibility actions different from my peers, which further contributes to feeling like I am *effectively on my own.*

I am also concerned that I might be perceived as being given *an unfair advantage* if provided with learning or assessment accommodations. I *don't like being perceived as imperfect, and asking for an extension embodies that imperfectness.*

While engaging with disability support services is reassuring, I lack confidence in the general understanding and competence of teaching staff regarding my needs. Some learning accommodations have coincidentally happened due to the recent COVID-19 pandemic, including more online learning and pre-recorded lectures. These changes make learning *life changingly [*sic*]* better, but I am unsure if these opportunities will be maintained.

Increased attention to the social model of disability within the curriculum and teaching practices will help medical training programs move towards active allyship with this disabled medical student. These actions will include normalising and celebrating differences, ensuring that a broader range of *abilities are embraced and valued in terms of diversity*. This student needs to feel *valued*. However, they don't want or need their disability *to define them as a person*. Instead, they perceive themselves as *having other expertise* and want medical training programs to understand that lived experience is of value. This approach will contribute to the student feeling *empowered*, validated, acknowledged and accepted, like they are *part of the group and part of the cohort*.

Table 3

Narrative Summary 2: The Student Who Is a Strong Self-Advocator

I can clearly communicate my accessibility needs and preferences because I came to medical school with more life experience and am used to advocating for myself in a range of educational and workplace settings. One of the main reasons I have chosen medical training is to *push the boundaries with what people say and think I can do* and test what is possible for someone with my impairments: *proving to myself that I can do things, finding ways to deal with challenges and finding solutions.*

Another reason I want to be a doctor is that *I can see how the healthcare system is failing individuals and families* like me*. And there's something really special about actively trying to make a difference to future young people.* But I also feel *pressure* to prove myself and to ensure that I am forging an inclusion path for others to follow.

While I am committed to forging these new pathways, I am also tired and often frustrated because I need to *keep pushing and using my own willpower to get through different challenges.* It feels like a daily battle, and sometimes I wonder if it is worth it. While *I think I've got a relatively thick skin and I've got no qualms about pushing the point, . . . it's definitely not a comfortable process.* I especially don't like approaching the staff about my accommodation needs *unless I've got an idea for a partial solution. If I know how to make this work, then I'm quite happy to have that conversation. But when I don't know, it is quite challenging.*

My biggest concern is about the challenges the next clinical placement might present. I don't know what *reactions I'm going to get and the willingness of the clinical staff to accommodate my needs.* I'm concerned about navigating the different responses of staff and *not knowing how the medical school will react if I take a problem like that back to them. Whether that's something that will be supported or not.*

I have also really appreciated the times when I have been encouraged to draw on my personal experience to support peer learning opportunities or clinical interactions. *I've been able to know what's going on and use that to help. And it was really quite validating.* But sometimes, I feel that my experience is not valued and that I can be perceived as being *cocky and arrogant; knowing more than they do.* I find it very *empowering to know that there are healthcare professionals who want to do better, and they want to know what my opinions are as someone who's got lived experience.*

I have been raised as someone who can do anything as long as I put my mind to it. However, in medical school, *it's been really hard. You have people telling you you can't do this; you can't do that. And it's quite hurtful that it's coming from people who, you would think, have some appreciation of different conditions and how they impact life.*

Clarity and transparency of university and medical program processes make life a lot easier for me. It is really helpful to *know what is available to me*, but there is *often confusion* about what the expectations and requirements are. This helps me to feel like I am not *fighting the system* all the time.

This student would benefit from medical school staff initiating conversations about the student's accommodation needs and demonstrating curiosity about the disability experience. They want to feel safe knowing that the medical school is *willing to work through challenges* and can collectively *find solutions*. They also want staff to challenge expectations of what disabled doctors can achieve and require a consistent approach from all lecturers, tutors and clinical training spaces. If consistency of approach does not happen, then they need to know that the medical school will advocate for them. Ongoing *intentional recruitment of disabled students to diversify the medical workforce* is required*, with the intention of working with these students to break down potential and perceived barriers within the medical training and practising environment.*

Table 4

Narrative Summary 3: The Student Who Is Fearful of the Unknown

I am constantly wondering if someone will deem me unsafe to practise. *I worry they'll turn around and say, "Well, that's just what it is. You're going to have to make it work. And if you can't make it work, then you know that's it." There's always that worry in the back of my head.* This makes me feel unsafe and disempowered. But I don't know who to talk to about these worries, and I have an *underlying fear* that any conversations may be used to determine my competence in the future. *What's the consequence of me asking for that support?* I am worried they might think *I'm not fit to do the job.* And if there is an issue, *it often feels like I don't get support until after I've already failed.*

Accommodations in assessment contexts are framed as "black and white" situations. However, I know from my own experience that in a clinical situation, there are often ways around the challenges, including environmental adaptations, such as technology.

However, when I have been offered opportunities *to advocate for myself*, this has helped me *build my confidence. It's not something that I've fully nailed yet. I think that's a lifelong lesson for me to learn, how to deal with those situations.*

I found it especially difficult during the transition to another clinical training campus. *I thought there'd be more support, but they don't have any disability support for the students in the new town I moved to. And so, because of that, I haven't really been able to get any more support. It's kind of me being on my own for the last couple of years.*

This student needs safe places to talk about their concerns—support systems and *spaces where they can meet other medical students experiencing disability to acknowledge and share their experiences.* They also require opportunities to proactively co-negotiate what practice might look like, including the *opportunity for advocacy and the provision of situation- and environment-specific problem-solving support.* Proactive and safe facilitated conversations will result in lifelong learning approaches to problem solving for this student. Conversations could involve a designated contact person within the medical school—*that we know is there to support us and problem solve with us.* However, *an opportunity at the beginning of the year to have a very brief chat with tutors about specific needs* would also be very helpful. Transparent, linked-up supports across contexts (e.g., different training locations) would also help these students access the type of support they require across the whole of their training programs.

Descriptive findings

How do students feel their experience of disability is acknowledged, supported and valued within the program?

Generally, participants reported positive experiences in relation to their disability while enrolled in the program: "On the whole, it's been pretty positive" (Participant 1). For example, participants recalled receiving positive acknowledgement from staff, fellow students and disability support services. However, participants felt that the positive experience was perhaps better conceptualised as being "just not that bad" and that the value given to disability within the medical school could be improved. The main concern from participants was that the concept of disability attracted negative stigmatic connotations of being a deficit:

> I think there's a lot of progress to be made … It's quite stigmatising—the word disability—in some areas with some people in some specialities. There's a lot of room to improve. (Participant 2)

Because a majority of participants reported having an "invisible" disability, they were often faced with a choice about whether or not to reveal their disability. Due to the potential for stigma, participants felt uncomfortable disclosing their needs. There was an underlying concern that their ability to study and eventually practise medicine would be questioned and perceived detrimentally. For example, one participant reported:

> The worry that I have is: what's the consequence of me asking for that support? What are they [the medical school] going to say [to] that? Actually, if you can't do that, you're not fit to do the job. Therefore, why are you at medical school? … That's the underlying fear, I guess, behind that. (Participant 1)

Another participant had similar experiences, where disability was categorised as being incompatible with the concept of good health: "I think there's an emphasis on [me] as a med student; you should be healthy" (Participant 4). At worst, this narrative was reinforced by clear instances of ableism. For example, one participant who required a piece of assistance technology described an experience on clinical placement when a medical professional (not a medical school staff member) asked them to "hide" their device to avoid appearing "unwell" and potentially promoting a lack of confidence in patients:

> [The medical professional] effectively told me that I needed to cover up my [medical device]. I needed to put it away. … As a future doctor, I shouldn't be portraying to people that I am not well. (Participant 2)

However, instances of dismissive behaviour towards participants were more often subtle, including gestures or off-hand comments. For example, having student or staff "roll their eyes" (Participant 2) or being told to "limit" (Participant 3) their career expectations:

> I've had so many people say, oh, well, you will have to do GP [general practice] because that's the only speciality that you can set yourself [arrange your life] around. … It's quite hurtful that it's coming from people who, you would think, have some appreciation of different conditions and how they impact life. (Participant 2)

When experiencing such barriers, some participants felt bolder and more confident than others in being able to navigate and negotiate such instances, however they made it clear that they shouldn't have to act that way:

> I [have] kind of gotten used to just advocating for myself … [but for] someone who's maybe a bit younger … that would have been maybe more of an issue. … It's disappointing and frustrating for me that I'm still having to have those conversations. (Participant 1)

Other participants reported that they would need help asking for the necessary accommodations to make their participation more inclusive. However, participants reported that increased knowledge and/or access to support groups of others with similar experiences bolstered their confidence in addressing these barriers.

What teaching and learning practices, administrative and organisational policies and procedures within the program best facilitate (or do not) the empowerment, capacity and capability of disabled students?

Participants had mixed reflections on how the teaching and organisational practices of the medical school influenced their experience of disability. There were several positive experiences. For example, participants valued being able to watch lectures online. They specifically appreciated being able to rewatch, pause and have the option to absorb the information in a quiet space as opposed to a loud lecture theatre, which could be distracting and overstimulating:

> I have tutorials on Zoom, but I can just do it when I need to do it. … It's not distracting for anyone … being able to just turn my screen off and go for a walk even though I'm still listening is really good. … That's worked well for me. (Participant 2)

Another participant valued being provided with extra exam time and access to a low-distraction study room, which they found helpful:

> It was very easy to get extra time, and [for] the exam, it was very easy to get a low distraction room for the exams, which is great, and a low distraction room to study. (Participant 3)

A number of students also reported their appreciation for disability support services and how they not only provided valuable study options but also contributed to feelings of inclusion and validation:

> I found the Disability Support Services have been really, really good. They've been really proactive, really receptive. (Participant 1)

Participants were also encouraged by how classmates often reacted to any support participants requested:

> I think in terms of my classmates … [they've] mostly been really, really good about it if I explain, you know, what I need and tutorials and labs and things like that. They're really good at accommodating. (Participant 1)

In fact, participants reported that having supportive and curious classmates bodes well for the future cohort of doctors, who hopefully would learn and have a more rounded knowledge of disability, as one participant suggested:

> When I asked for things, and they [classmates] are curious, … to sort of learn and understand more. (Participant 1)

Likewise, another participant reported their peer group had been able to learn more about disability and diverse mobility issues:

> A lot of my peers and colleagues have learned a great deal about disability and about the nuances and mobility issues. And that's been really empowering, knowing that my life has helped them to have a greater understanding. (Participant 2)

Interestingly, one participant reported that the program was more inclusive than they thought it would be, and this was inconsistent with their view of such institutions:

> I just didn't know that there was support at the medical school. … It wasn't very promoted. … Now I know that … it was quite inclusive. And, you know, they do want us to be well-rounded people. (Participant 4)

While this inclusivity was welcomed, participants weren't always aware of what types of disability support services were available. They felt that having increased awareness of what supportive disability services were available would reduce the time and energy required of the student to find this out themselves:

> Just sort of knowing that there'll be people there that will do that and help me through a particular program [or] something like that. (Participant 5)

However, learning of the various supports available underscored participants' preference for discreet communication from support services:

> And maybe just sort of like for me, I mean, I … personally don't mind being singled out … but as long as it [contact] wasn't in front of … people—it was just like a discrete email or something. (Participant 5)

How does the program support the disability identity of students as they move through the curriculum and into clinical practice?

As only one participant was in the program's final year, this participant's perspectives should be considered in this context. Participants suggested that the program could be more proactive in supporting students who experience disability by taking a "front-foot" approach to acknowledging disability—taking away the onus of students having to disclose their needs and ask for help. The burden of advocating for themselves is not ideal or comfortable and is something that could be changed:

> [I've] kind of gotten used to just advocating for myself, and it's definitely not a comfortable process … to have one of the lecturers sort of rolling their eyes and things like that. But then, you know, actually, no, I need this [disability accommodation], otherwise I'll miss out on the content. (Participant 1)

Another participant reported the burden of ongoing self-advocacy: "Having to repeatedly advocate/request changes with constant rollover of teaching staff/colleagues is also energy consuming" (Participant 3, written activity).

Participants had suggestions for how the program could be more proactive. For example, acknowledging disability more generally through group activities and/or creating spaces for students to meet and share experiences. They felt that such efforts could be very beneficial to creating feelings of validation and inclusion:

> A space where you meet other medical students with a disability—that's just non-existent … so there's no real platform for wider acknowledgement or sharing of those experiences. (Participant 1)

It was suggested that creating a more proactive approach to disability inclusion and raising disability awareness could include inviting past medical students, in particular those with learning disabilities to speak:

> [In the past] we only had people that had physical difficulties come to speak … I feel like a lot of people have learning difficulties. So, it'd be good to, you know, get

> that knowledge. Because, I mean, obviously, we are dealing with a lot of people that have learning difficulties. (Participant 4)

Another participant highlighted that education focusing on diversity and cultural competency could be expanded to address disability:

> There're seminars where you have to go and learn about other cultures. You learn about appropriate gender labels, you know, I think [it] is really helpful because it keeps pushing through a new wave of awareness. (Participant 1)

One participant observed that the teaching on disability was very orientated to ageing, "meaning there is a lost opportunity to focus on the experience and value of younger persons with a disability" (Participant 1, written activity). However, some participants had a very positive experience while on clinical placement, particularly when the placement staff and environment were supportive:

> It's quite validating, knowing that I'm in a team that's also supportive, and it's also quite reassuring that I can be in a placement and if anything was to go wrong, I would be in an environment that is supportive; I would get the attention I needed. (Participant 2)

Overall, Participant 5 summed up how their disability identity had been less well supported by suggesting that the program needs to be more proactive in its advocacy for the rights of disabled students, suggesting:

> [It needs to change to] more of a communal attitude, and everyone does a lot more together. I feel like I have been released and burnt out and just alone, not really able to always feel comfortable.

This response highlights potential outcomes that can result when the burden and responsibility to ameliorate any consequences of a person's impairment falls on the individual.

Discussion

This study reports a novel narrative analysis of disabled medical students' experiences in a medical degree program in New Zealand. It highlights that while participants described their experience as primarily supportive, they reported making several decisions not to disclose their disability due to perceived stigma and apprehension about creating a negative impression. Participants in this study expressed concern that disclosing their disability might be perceived detrimentally by faculty teachers, peers and clinical placement supervisors as incongruent with being "healthy, competent" people and serve to compromise their perceived ability to succeed as a medical student and future doctor.

The presence of a negative stigma associated with disability in the context of medical education has been widely reported and discussed (Murphy et al., 2022; Rastogi, 2021;

Shahaf-Oren et al., 2021). While there is some evidence suggesting that disclosure of specific learning disability amongst medical and junior doctors has increased (Murphy et al., 2022), a 2020 British Medical Association survey reported that over three quarters of respondents were still worried about being treated unfavourably if they disclosed a disability to a place of study or workplace. From a theoretical perspective, Jain (2020b) proposes some explanation that can be found in the notion of *legibility*, which asserts that the way in which we come to "know" disability is a consequence of specific relational contexts. From this perspective, when medical students come to know their disability within such parameters of stigma and doubt, they are less likely to disclose their disability.

However, there is a growing shift towards recognising that disability is the cumulative result of various environmental, social, cultural, attitudinal and political determinants (Baird et al., 2009; Barnes & Mercer, 2010; Shakespeare, 2014; Shakespeare & Kleine, 2013). For instance, Fitzmaurice, Donald, de Wet and Palipana (2021) argue that applying the International Classification of Functioning and Disability model can demonstrate how individuals with specific impairments can be included and valued as legitimate, qualified medical professionals. This argument challenges the MDANZ's inherent requirements document, which deems it necessary that medical students have a certain level of fine motor skills (alongside equivalently sufficient vision and hearing abilities) to enter and practise medicine in Australasia. Fitzmaurice et al. propose an alternative entry framework that emphasises a supportive physical environment (e.g., self-opening doors, height adjustable tables) and more open, inclusive systems and culture. To illustrate, they highlight how Dinesh Palipana (who has a C6/7 spinal cord lesion and uses a wheelchair due to paralysis) completed his medical education and now successfully practises as a doctor in an emergency department despite him not meeting many of items listed in the MDANZ's inherent requirements document.

To potentially reduce stigma and reluctance to disclose disability, medical schools have an opportunity to create a culture and spaces to normalise and validate the needs of disabled students—in short, to become a proactive disability ally that values disability. Disability allyship can be described as recognising discriminatory practices and taking action to promote social change, equity and inclusion of marginalised groups (Feldner et al., 2022; Myers et al., 2013). Allyship recognises that disabled people cannot do all the work by themselves—nor should they have to—and that the role of allies is to support social change and make use of their privilege (Wolbring & Lillywhite, 2023).

To achieve positive allyship, articulate and detailed frameworks for creating more inclusive medical education systems have also been proposed (Jain, 2020a; Mehta et al., 2020). Jain (2020a) proposes a continuum of approaches, beginning with a strict compliance approach, which mandates creating an accessible system based on strict legal requirements of law and guiding policy. This approach is primarily motivated by minimising possible institutional risks rather than ensuring accessibility. The spirit of the law approach takes inclusion further and is characterised by a liberal interpretation of compliance policy. This approach also views the opportunity provided by disabled students' experiences as an opportunity for programs to evolve practices or environments. The end goal is the transformative approach, which moves beyond a retrofit of often inaccessible environments to the creation of medical education environments and curricula that reflect the diversity of humanity, creating a medical workforce more reflective of the people they serve. Indeed, in her argument to improve equity of medical education, disabled medical physician Suchita Rastogi (2021) suggests that equal access to medical education doesn't require lowering standards, and that "accessible" doesn't mean "less rigorous" (p. 887).

At an Australasian level, initiatives like the MDANZ (2021) *Inclusive Medical Education* guidelines are a step in the right direction. The MDANZ proposes that medical schools consider a range of elements relating to an inclusive culture, including but not limited to early engagement, open and constructive discussions and a range of reflective questions to assess their inclusiveness culture (Issakhany & Crampton, 2023; MDANZ, 2021). While the MDANZ guidelines are not without criticism (Mather, 2021), such approaches may serve as fertile ground to facilitate and enact the findings of our study. Furthermore, medical schools can enhance inclusiveness by integrating suggestions from the literature alongside those of our participants (Meeks & Neal-Boylan, 2020; Mehta et al., 2020). Strategies include offering diversity-related education and seminars, inviting former disabled medical students to share their experiences and creating spaces for students to discuss their challenges. Such initiatives start the transformation of medical schools to be proactive allies and foster a genuinely inclusive educational environment that embraces the lived experiences of disabled students (Meeks & Neal-Boylan, 2020). However, sustainability of any initiative is important, Issakhany and Crampton (2023) remind us, as the effort towards greater inclusiveness in medical education is ongoing.

Strengths and limitations

The aim of our research was not to sample a large number of participants or to reach saturation or generalisability (Sebele-Mpofu, 2020, 2021). Instead, we aimed to provide rich and sufficient detail, also known as "thick description" (Korstjens & Moser, 2018, p. 121) regarding the participant group, the context in which the research occurred and the processes involved in the data analysis so the reader may decide whether the results warrant being transferred to other settings (Drisko, 2024). For example, although our participants had specific impairments (which may not represent the experiences of other disabled students, such as those with visible impairments), we are confident that the context-specific knowledge of our sample provides valuable insight regarding the broader experience of disabled medical students' participation in medical school (e.g., see Meeks & Neal-Boylan, 2020). Lastly, we felt it was beyond the scope of our analysis to examine any intersecting experiences of underrepresented groups in medicine. Such a topic warrants the attention of future research in the Australasian context.

Conclusion

This study provides a narrative analysis of disabled medical students' experiences and highlights the critical role medical schools can take by positioning themselves as proactive allies for the inclusion of disabled students. Resourcing organisational support, alongside the creation of spaces and culture to improve opportunities for disabled students, can both better validate disabled students and reflect society's diversity.

Conflicts of interest and funding

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest. This project was funded by a grant from the Otago Medical Education Research Fund.

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Appendix A

Interview Guide

Thank you so much for agreeing to participate in the study. As we mentioned in the information sheet, the key aim of the study is to better understand disabled medical students’ experiences and perspectives regarding the inclusive culture of medical school. We have a list of questions we will ask you, but there are no right or wrong answers—you are the expert in your own experience, so these questions are just a guide.

In this interview, our primary interest is your experience as a disabled medical student. Before we start, we would also like to remind you that to keep your identity confidential, we will only use your pseudonym (remind participant of this); your real name will not be recorded anywhere where we present the results of the study. You also can stop this interview at any time without having to give a reason.

Do you have any questions before we begin?

Can I reconfirm you consent to participant in this study?

If you are ready, now we can begin.

1. To start things off, could you please tell me about your experience of disability?
2. What is your experience of being a disabled medical student?
3. Can you provide any examples of how your disability has been acknowledged and/or supported as a medical student?

Possible prompts: *In what ways? How was it useful and relevant to you? Did it address your <u>actual concerns</u> and questions? Could you think of an example? How did this make you feel then? How do feel about it now?*

4. Can you provide any examples of how your disability has been valued as a medical student?

Possible prompts: *In what ways? Could you think of an example?*

5. I am now interested in your day-to-day experiences of being a student in medical school. Tell me about your experiences of the following as they relate to your experience of disability.
    - Teaching practices
    - Use of technology
    - Organisational policies

Possible prompts: *Faculty, tutors, admin, placements? How did they impact your experience? Examples? How did this make you feel then? How do feel about it now?*

6. How do you describe other medical students' attitudes and acknowledgement of disability? How has this impacted your own experience of disability?
7. When thinking about your own experience, have you encountered any barriers inhibiting your full inclusion as a disabled medical student?

Possible prompts: *In what ways did it inhibit your participation? Could you think of an example? How did this make you feel then? How do feel about it now?*

Overall, how would you describe the inclusive culture at medical school?

8. Do you feel medical school reflects disability in health contexts and the community in general? In what ways?
9. In what ways do you feel this could be improved?

Possible prompts: *In what ways? Could you think of an example?*
