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JUSTICE THROUGH COMMUNITY POWER

Testimony of Christopher Schuyler, Senior Staff Attorney
New York Lawyers for the Public Interest, Disability Justice Program
To the New York City Council, Hospitals Committee
Regarding Resolution 512 Calling on New York State to Require Medical Schools to Train All Students about "Implicit Bias" (September 18, 2019)

Patients with disabilities experience greater barriers to health care than patients without disabilities. Among the reasons for this disparity are the implicit biases held by medical providers. Training medical students in identifying implicit bias, as called for in Resolution 512, is a critical step to elevate the quality of medical care available for patients with disabilities.

Good afternoon. My name is Christopher Schuyler and I am a Senior Staff Attorney with the Disability Justice Program of New York Lawyers for the Public Interest (NYLPI).

I. Patients with disabilities face myriad barriers to medical care

People with disabilities experience greater barriers to health care than people without disabilities.[1] Generally speaking, "people with disabilities are 2.5 times more likely to have unmet health care needs than their non-disabled peers and are more likely to suffer from a terminal condition that may have been detected earlier through disease prevention screening."[2] Particularly affected, however, by the disparity in access are women with disabilities, especially in the area of cancer screening.[3] To give a sense of numbers, 61.4% of women with disabilities reported having mammograms while 74.4% of women without disabilities received this test.[4] For pap tests, 64.6% of women with disabilities received pap tests compared to 82.5% of women without disabilities.[5] Such significant lack of access to critical services leads to poorer health outcomes for women with disabilities, including higher mortality rates.[6]

It is also suggested that racial minorities with disabilities experience disproportionate barriers to health care. While "relatively little is known about the health status of individuals with disabilities who are also members of racial or ethnic minorities [], reports from the CDC on the health status of people living with disabilities along racial lines show that people of color present with poorer health at a higher frequency than Caucasians, and

racial and ethnic minorities have historically been and continue to be disproportionately impacted by health disparities.[7] Inaccessibility to health care affects people with disabilities on every level of their lives: socially, psychologically, physically, and economically.[8]

II. Negative impact of structural-environmental barriers to medical care for patients with disabilities

There are two primary causes for the disparity in health care faced by persons with disabilities: structural-environmental barriers and process barriers.[9] Structural-environmental barriers include types of services offered, accessibility of provider offices and diagnostic equipment, and insurance coverage.[10] Process barriers include medical provider implicit bias and their lack of knowledge in treating minority patients.[11] We strongly support the fact that Resolution 512 addresses process barriers, as "[c]onscious and unconscious biases held by health care providers are another underlying aspect of identified barriers to health care access for people with disabilities as well as other marginalized groups, such as racial and ethnic minorities. Negative stereotypes held by health care providers translate into lower quality and fewer services provided as well as contributing to poorer health outcomes for these groups of people."[12] However, Resolution 512 makes no mention of the equally critical structural-environmental barriers, notwithstanding the fact that such barriers present significant and continuing impediments to receiving appropriate health care.[13] We urge the immediate addition of language acknowledging and condemning such structural-environmental barriers.

III. Training medical students to recognize bias will improve medical access for people with disabilities

Adding implicit bias trainings to medical school curriculums will, first and foremost, start a valuable discussion about treating patients with disabilities. Simply bringing awareness to medical providers about the challenges people with disabilities face in accessing health care is significant, as:

> physicians have not received training on the fundamental aspects of working with people with disabilities. In a 2007 survey of primary care physicians, 91% of them revealed that they had never received training on how to serve people with intellectual or developmental disabilities. According to a national study of physicians, only 2.6% of respondents demonstrated specific awareness of the ADA [(Americans with Disabilities Act)]. Another survey of more than 500 physicians revealed that nearly 20% of respondents were unaware of the ADA and more than 45% did not know about its architectural requirements. Moreover, less than a quarter of the respondents had received any training on

physical disability issues in medical school, and only slightly more than a third had received any kind of training on disability during their residency. However, nearly three quarters of the physicians surveyed acknowledged a need for training on these issues.[14]

Such trainings will also lead to increased awareness of medical equipment and procedures for people with disabilities. There is a significant correlation between knowledge about accessibility and the provision of accessible equipment in health care clinics. Yet, in one study only 46% of health care administrators in clinical practices knew that accessible equipment existed, and only 25.4% were able to describe accessible equipment. While 44% of administrators had considered purchasing accessible equipment at some point, only 22% knew of the federal tax credit program that assists businesses in complying with the legal mandates to do so.[15]

Moreover, open discussion of implicit bias at medical schools will encourage future medical providers to publicly identify as people with disabilities. Medical professionals are hesitant to identify as people with disabilities for fear of stigma and damaging their career prospects.[16] Having bias training in the curriculum will set the stage for medical professionals to identify as people with disabilities, and in turn, take a larger role in advocating for medical access issues concerning disability.

Trainings on implicit bias will also increase "disability literacy," or making one's language, knowledge, and interactions reflective of understanding disability experiences and disability etiquette.[17] Increasing the level of disability literacy among medical providers in turn will lessen the barriers to medical access for people with disabilities.

IV. Recommendations

NYLPI respectfully requests that the NYCC Hospitals Committee modify Resolution 512 as follows:

- Add people with disabilities to the list of "traditionally marginalized communities" in the first paragraph.
- Add a paragraph summarizing the statistical disparities faced by people with disabilities, with an emphasis on structural environmental barriers, as set forth above.
- Mandate training regarding removal of structural-environmental barriers.

V. Conclusion

Thank you for the opportunity to testify about these key issues affecting appropriate medical care to patients with disabilities. Please feel free to contact me to discuss further.

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About New York Lawyers for the Public Interest
For over 40 years, NYLPI has been a leading civil rights and legal services advocate for New Yorkers marginalized by race, poverty, disability, and immigration status. Through our community lawyering model, we bridge the gap between traditional civil legal services and civil rights, building strength and capacity for both individual solutions and long-term impact. Our work integrates the power of individual representation, impact litigation, organizing, and policy campaigns. Guided by the priorities of our communities, we strive to achieve equality of opportunity and self-determination for people with disabilities, create equal access to health care, ensure immigrant opportunity, secure environmental justice for low-income communities of color, and strengthen local nonprofits.

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[1] Independence Care System & New York Lawyers for the Public Interest ("ICS & NYLPI"),
Breaking down barriers, breaking the silence: Making health care accessible for women with disabilities (2012), p. 1. Available at: https://www.nylpi.org/images/FE/chain234siteType8/site203/client/breakingbarriers.pdf. *See also*, ICS & NYLPI, at 1.
[2] Onyeabor, Sunny. (2015). Addressing Health Disparities at the Intersection of Disability, Race, and Ethnicity: the Need for Culturally and Linguistically Appropriate Training for Healthcare Professionals. Journal for Racial and Ethnic Health Disparities. 3. 10.1007/s40615-015-0140-9.
[3] Yee, S., et al., Compounded disparities: Health equity at the intersection of disability, race, and ethnicity, The National Academies of Sciences, Engineering, and Medicine (2016). *See also*, ICS & NYLPI, *supra* at 1.
[4] Altman, B. M., & Bernstein, A., Disability and health in the United States (2008), 2001-2005.
[5] Mudrick, N. R., & Schwartz, M. A., Health care under the ADA: A vision or a mirage? Disability and Health Journal, 3(4) (2010), 233-239. Available at: doi:https://doi.org/10.1016/j.dhjo.2010.07.002.
[6] ICS & NYLPI, at 1.
[7] Onyeabor.
[8] ICS & NYLPI, at 5. *See also*, Neri, M. T., & Kroll, T., Understanding the consequences of access barriers to health care: experiences of adults with disabilities. Disability and Rehabilitation, 25(2) (2003), 85-96. Available at doi:10.1080/0963828021000007941, "Social consequences have to do with one's relationships, social role, and social participation. Psychological consequences often involve depression, frustration, and stress along with experiences of stigma. Physical consequences may lead to a deterioration in one's health due to limited or skipped diagnostic and health screening procedures and related limitations in activities of daily living. Economic consequences involve potential lost wages, financial strain, and additional health service expenditures one has to undertake. With regards to independence, barriers to health care access can lead to a greater dependency on others than individuals would require otherwise."
[9] Kroll, T., Jones, G. C., Kehn, M., & Neri, M. T., (Barriers and strategies affecting the utilisation of primary preventive services for people with physical disabilities: a qualitative inquiry, Health & Social Care in the Community, 14(4) 2006), 284-293. Available at: doi:doi:10.1111/j.1365-2524.2006.00613.x. *See also*, ADA National Network, Health Care Access and the ADA: An ADA Knowledge Translation Center Research Brief (2019). Available at: https://adata.org/publication/health-care-access-and-ada. This report finds that the challenges faced by people with disabilities can be categorized as [margins] environmental, attitudinal, and policy barriers.
[10] *Id.*
[11] Kroll, *et al.*

[12] ADA National Network, *supra* note 8. *See also*, Yee, et al and ICS & NYLPI at 7, 15. Research shows that bias and misinformation, including stereotypes, negatively affect the quality of care patients with disabilities receive.
[13] ICS & NYLPI at 5.
[14] ICS & NYLPI, at 7 (internal citations omitted).
[15] Pharr, J., Accessible medical equipment for patients with disabilities in primary care clinics: Why is it lacking? Disability and Health Journal, 6(2) (2013), 124-132. Available at: doi:https://doi.org/10.1016/j.dhjo.2012.11.002.
[16] Steinberg, A. G., Iezzoni, L. I., Conill, A., & Stineman, M., (Reasonable accommodations for medical faculty with disabilities. JAMA, 288(24) 2002), 3147-3154. Available at: doi:10.1001/jama.288.24.3147. *See also*, Matt, S. B., Nurses with Disabilities: Self-Reported Experiences as Hospital Employees, Qualitative Health Research, 18(11) (2008), 1524-1535. Available at: doi:10.1177/1049732308325295.
[17] Yee. *et al.* (2016).