A Lifeline for Disability Accommodation Planning:
How Models of Disability and Human Rights Principles Inform
Accommodation and Accessibility Planning

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Dedication

This work is dedicated to my students and colleagues who seek to examine assumptions rigorously in pursuit of equity; and to my parents, who inspired my passion for equal opportunity.
Abstract

Implementing the legal mandate to accommodate students with impairments in higher education, particularly in fieldwork settings, poses a significant challenge to retaining academic integrity (Pardo, 1999). Currently, there is no consistent way of determining which academic requirements are “bona fide” (OHRC, 2004), and might not be altered for students with disabilities, and those which can be accomplished using a different method. Situating accommodation and accessibility within the Environmental Factors domain of the World Health Organization’s International Classification of Function, Disability and Health (ICF) as a theoretical framework, a set of questions are presented to determine whether academic requirements in fieldwork can be accommodated or not, and why. Combining an occupational therapy perspective on the importance of task analysis (Ashworth, 1995) with the means of identifying discrimination laid out in the human rights case law provides the required tools for such an analysis.

This dissertation examines the intersection of legislated mandates for accommodation and academic integrity, by applying human rights legislation to higher education. Using the three-step test of discrimination set out in Meiorin (1999) and an additional question based on Granovsky (2000) to analyze academic tasks and requirements of fieldwork, bona fide requirements can be determined. The resulting model for determining accommodation for students with impairments is applicable to accommodation of disability in primary and secondary education, as well as in the employment sector and accessibility planning, and contributes to standards of practice
in academic accommodation planning, a need identified by Reed, Lund-Lucas, & O'Rourke (2003). Following the introduction, six distinct chapters explore 1) the background of accommodation in post-secondary education, 2) the weaving together of models of disability with legislated requirements and curricula, 3) the human rights paradigm itself, 4) accommodation policies, 5) an experimental focus group investigation of the proposed model, and 6) an explication of when accommodation might not be appropriate. The conclusion draws these various threads together into a lifeline for accommodation analysis and planning.
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# Table of Contents

Dedication .......................................................................................................................... ii
Abstract ............................................................................................................................... iii
Acknowledgements .............................................................................................................. v
List of Tables ........................................................................................................................ x
List of Figures ....................................................................................................................... xi
List of Abbreviations .......................................................................................................... xii
Glossary ................................................................................................................................. xiii
Note on Citation Style ........................................................................................................... xiv

## Chapter 1: Introduction ........................................................................................................ 1

- Conceptual Framework ...................................................................................................... 3
- Definitions .......................................................................................................................... 3
- Accommodation ............................................................................................................... 4
- Accessibility ..................................................................................................................... 4
- Essential requirements, or bona fide occupational requirements ....................................... 5
- Disability .......................................................................................................................... 6
- Use of the terms disability and disabled ........................................................................... 8

- Key Concepts ..................................................................................................................... 9
- Social Constructionism ...................................................................................................... 9
- The Duty to Accommodate ............................................................................................... 10
- The Researcher—An Occupational Therapy Perspective .................................................. 11

- Organization of thematic chapters .................................................................................... 13
- Conclusion ......................................................................................................................... 18

## Chapter 2: Literature Review ............................................................................................. 22

- Social Constructionism As A Useful Theory in Understanding Disability and Schooling .... 30

  - Social Constructionism Applied to the Concept of Disability ........................................ 33
  - Language as an Agent of Social Construction ................................................................ 37
  - Social Constructionism Applied to Education and Schooling: How Schooling Excludes Students With Impairments ................................................................. 41

- Development of the International Classification of Function, Disability and Health (ICF) – Where Medical and Social Models Join in a Context of Environmental Factors .... 45

  - Environmental Factors ............................................................................................... 46
  - Uses of the ICF to Construct an Accessible Post-secondary Experience ......................... 55
Conclusion ............................................................................................................ 56
References ............................................................................................................. 58
Chapter 3: A Lifeline for Accommodation Planning ........................................ 62
A lifeline for accommodation planning ............................................................... 63
Lifeline Strand One: Legislation ........................................................................ 63
Lifeline Strand Two: Theoretical models of disability ................................ .... 65
Lifeline Strand Three: Environmental Factors ................................................. 71
Lifeline Strand Four: Forming Joint Intentions to Facilitate Learning ............... 73
Composite Student .............................................................................................. 76
Discussion ........................................................................................................... 79
Conclusion ........................................................................................................... 80
References ............................................................................................................. 82
Chapter 4: The Human Rights Paradigm: Is It Effective? What’s the Alternative? ........ 84
The Concept of Discrimination .......................................................................... 85
Bona Fide Occupational Requirements (BFOR’s) ............................................. 92
Case Law and Tests of Discrimination .............................................................. 92
How Is This Paradigm Perpetuated? ................................................................. 102
Integrating and Synthesizing the Various Legal Tests of Discrimination ...... 104
Implications For Practice in Post-secondary Education ................................... 105
References ............................................................................................................. 113
Chapter 5: Council of Ontario Faculties of Medicine Policy for Medical School Applicants with Disabilities: A Policy Analysis .................................................. 115
Social and Medical Models of Disability ........................................................... 115
Medical Model of Disability ............................................................................ 116
Social Model of Disability ................................................................................. 116
The Social Model and the Evolution of Equity Legislation ............................. 119
Impetus for Medical School Policies ................................................................. 120
Hegemony of Medical School Policy Regarding Participation of Students with Impairments ............................................................. 122
Council of Ontario Faculties of Medicine Policy Initiative ......................... 124
Impact of COFM Policy on Other Medical Schools and Applicants ........... 126
Law Society of Upper Canada Policy ................................................................. 129
Critique of COFM Policy – Part I ................................................................. 130
Comparison Critique: The Law Society Policy .............................................. 133
List of Tables

Table 1: A Comparison of Medical and Social Models…………………………..68

Table 2: A Comparison of Thematic Strands……………………………………..75
List of Figures

Figure 1: A Lifeline for Accommodation Planning..............................79
List of Abbreviations

ADA – Americans with Disabilities Act
AODA – Accessibility for Ontarians with Disabilities Act
AFSD – Accessibility Fund for Students with Disabilities
BFOR – bona fide occupational requirement
COFM – Council of Ontario Faculties of Medicine
COU – Council of Ontario Universities
CSL – Canada Student Loan
ICF – International Classification of Function, Disability and Health
IDEA – Individuals with Disabilities Education Act
IEP – Individual Education Plan
IPRC – Individual Planning and Review Committee
LSUC – Law Society of Upper Canada
MET – Ministry of Education (Ontario)
MTCU – Ministry of Training, Colleges and Universities (Ontario)
OHRC – Ontario Human Rights Commission
QEDC – Queen’s Executive Decision Centre
UPIAS – Union of the Physically Impaired Against Segregation
WHO – World Health Organization
Glossary

Accommodation – reactive response, such as a change to a policy, procedure, task or activity in response to the needs of an individual with a disability to enable equal opportunity to participate;

Accessibility – proactive; systemic removal and prevention of environmental barriers to the equal participation of people with disabilities

Accessibility for Ontarians with Disabilities Act (AODA) – Ontario legislation requiring that specific standards for accessibility be met in buildings, information and communication, customer service provision, transportation and employment

Bona fide occupational requirement (BFOR) – a requirement for a task or activity to be performed in a particular fashion, which might be accomplished via an accommodation, but the alteration of which could compromise the essential nature of the task or activity.

See essential requirement.

Disability – the negative impact of the interaction between a person with a health condition and her/his environmental factors (WHO, 2001)

Essential requirement – a task or activity that is expected to be performed in a particular way, and might not be accommodated for a person with a disability without compromising the nature, purpose or function of the task
Note on Citation Style

Due to the interdisciplinary nature of my work – combining human rights legislation and court decisions with higher education – I am faced with a stylistic dilemma. While this paper follows American Psychological Association (APA) format wherever possible, APA provides no guidance on the formatting of Canadian legal materials. Citation of Canadian legal material is set out in *The Canadian Guide to Uniform Legal Citation*, popularly known as the McGill Guide. To resolve this conflict, I have chosen to follow the conventions of legal articles by italicizing the act or the most often-used name of the case in the body of the text. The full citation will be found in the reference lists, formatted according to the McGill Guide for such references. I have used McGill Guide style for all legal material, and APA for everything else.
Chapter 1: Introduction

What questions should be asked to determine if the requirements of academia are “bona fide occupational requirements” as human rights legislation suggests is necessary (British Columbia (Public Service Employee Relations Commission) v. B.C.G.E.U. (1999) [Meiorin]); Ontario Human Rights Code (Code) 1990), and which requirements are amenable to accommodation strategies, for the inclusion of people with disabilities in higher education? By what criteria do we assess whether an academic task must be accomplished or evaluated in a particular way?

This research investigates how educators think about what are created as academic requirements, and how to think about that more creatively and inclusively. It involves examining our assumptions about people with and without disabilities in academia as a microcosm of a constructed society. In particular, this inquiry examines assumptions about how professional clinical education is and might be delivered, and why requirements are defined as they are.

This manuscript-style dissertation is comprised of distinct chapters that investigate different elements contributing to the process needed to determine appropriate accommodation for students with disabilities in post-secondary education. The primary emphasis is on accommodation in clinical and fieldwork education. Various thematic strands, highlighted in the different chapters, offer specific insights on accommodation, and are viewed both individually and woven together, in the separate examinations that follow. The distinct examinations include: 1) theoretical foundations in the social
construction of disability and higher education, 2) social policy mandates for accommodation arising from human rights legislation and the human rights paradigm, 3) education policy initiatives aimed at managing the participation of students with impairments in professional education, and 4) application of legal test questions of discrimination to academic curricula. These examinations are aimed at contributing to a pro-active approach to higher education curriculum design that is inclusive of students with impairments, and informing the development of a theory for determining appropriate accommodations. To test the theory of determining accommodations, I use a combination of survey and focus group methods to investigate the application of human rights principles to academic requirements in health sciences.

Individual student experiences of disability in the academy point to foundational questions about how education is delivered, the assumptions on which performance standards are based, and why certain requirements pertain in particular ways. The legal mandate to accommodate students with impairments also challenges assumptions about how education is delivered, and about particular modes of delivery that may exclude marginalized groups of students.

Students with impairments are participating in the academy in ever-increasing numbers (Canadian Association of Disability Service Providers in Post-secondary Education (CADSPPE), 1999; Ministry of Training, Colleges and Universities (MTCU), 2008), at all levels of education and professional training. In this regard, professional education is of particular interest as the practice of a profession has very specific skills and knowledge expectations that can pose barriers to the inclusion of disabled students. In this work, I focus on clinical education in Health Sciences because it has practicum
components with requirements that appear to be bona fide and which present especially compelling rationales, at first glance. How we bridge accommodation and professional standards will result in the inclusion or exclusion of students with impairments, and may guide how we include other marginalized groups. A rationale for determining appropriate accommodation and a means of examining the delivery of education and practice skills is needed.

This introductory chapter first presents a conceptual framework, including some definitions and key concepts necessary to understand the discussion. I then describe the illustrative chapters to follow, which explore four themes informing the problem. The conclusion relates the research to applications beyond academia, in the employment sector.

**Conceptual Framework**

*Definitions*

It is important to clarify terms and concepts that have both common uses and are explicit terms of art in the field of disability accommodation, accessibility, and human rights law. These terms include accommodation, accessibility, essential requirements, and disability. How the term “disability” is used will also be discussed. Since the theory of social constructionism is used to understand the relationship among these ideas, it is also important to have an understanding of the concept of social construction. The legal concept of a duty to accommodate people with disabilities is also foundational to the overall discussion, and will be explained.

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1 “Terms of art” are words that have a particular meaning within a field; in this case, common words with specific meanings within the field of disability accommodation or human rights law.
Accommodation

In the context of disability, “accommodation” refers to the reactive adjustments or changes made to enable an individual with an impairment to participate in an activity. Accommodation is an individualized response to a person's experience of an environmental barrier to participation. Allowing a student with chronic pain to have additional time for frequent breaks during an examination, or waiving a requirement for full-time study due to mental illness in order to facilitate stress management, or providing class slides in hard copy with large print, are examples of accommodations.

Accessibility

Accessibility is a feature of the environment that facilitates disabled persons' participation. It includes various elements that make the environment usable in a flexible range of ways. For example, features such as lever handles and power openers on doors, roll-in showers with hand-held fixtures for adaptable positioning, built-in sound amplification systems, and policies that promote rather than restrict participation enable people with impairments to participate in daily life activities more easily. Principles of universal instructional design (UID) facilitate accessibility, such that accommodation becomes less necessary (Bryson, 2004; Burgstahler, Corrigan, & McCarter, 2004). Accessibility of curricula and learning environments includes providing access to materials in multiple formats, varied means of interacting with materials and information, and flexible teaching methods. When these and other strategies are used, students with impairments encounter fewer obstacles to be accommodated. Accessibility generally is achieved through pro-active initiatives.
It is important to note that the word accessibility in the context of higher education sometimes refers to financial affordability (Canadian Association of Student Financial Aid Administrators, 2006; McGill University, 2012). The emerging legislative initiatives and work by disability advocates is leading toward an appropriation of the term accessibility into the disability arena specifically. My work with colleagues in financial aid offices and fellow disability service providers suggests that this point frequently requires clarification. In my dissertation, accessibility will be used exclusively with respect to disability issues, not financial barriers.

**Essential requirements, or bona fide occupational requirements**

Essential requirements or bona fide occupational requirements (BFORs) refer not just to those aspects of curricula that are deemed important, but to those requirements or standards which cannot be accomplished in any fashion other than the conventional, without compromising the nature of the task. Essential requirements or BFOR’s are not just a matter of opinion, but are robust when examined from multiple perspectives—legal, curricular, and practical—and their methods are evidenced as necessary. A classic example is vision as a requirement for a taxi driver. The job cannot yet be done without vision, and lack of vision cannot be accommodated to the point that a taxi driver who is blind could safely do the job. Technology may change this someday, but it hasn’t yet. Another example is when administering CPR, the movements must occur in a particularly timed sequence, with sufficient force to pump the heart and lungs, or the manoeuvre will be ineffective. Someone without sufficient upper body strength and speed of coordination would have difficulty being accommodated to perform this task effectively with the requisite force and timing. In this case, the accommodation question
would not be “What is essential about the way the task is performed?” but “What is essential about including CPR in this program of study?”

Disability

Disability is also a term that bears some definition. Legal definitions of disability refer to a wide range of conditions and impairments. The definition currently relied upon in post-secondary institutions in Ontario is found in the Ontario Human Rights Code, 1990\(^2\) hereinafter referred to as the Code. According to the Code,

“disability” means,

(a) any degree of physical disability, infirmity, malformation or disfigurement that is caused by bodily injury, birth defect or illness and, without limiting the generality of the foregoing, includes diabetes mellitus, epilepsy, a brain injury, any degree of paralysis, amputation, lack of physical co-ordination, blindness or visual impediment, deafness or hearing impediment, muteness or speech impediment, or physical reliance on a guide dog or other animal or on a wheelchair or other remedial appliance or device,

(b) a condition of mental impairment or a developmental disability,

(c) a learning disability, or a dysfunction in one or more of the processes involved in understanding or using symbols or spoken language,

(d) a mental disorder, or

(e) an injury or disability for which benefits were claimed or received under the insurance plan established under the Workplace Safety and Insurance Act, 1997; (“handicap”) (Ontario Human Rights Code, 1990)

Similar definitions pertain in other jurisdictions (Alberta Human Rights and Citizenship Commission, 2007). Some of these definitions focus heavily on the impact of the condition on participation in “major life activities” (Americans with Disabilities Act, 1990), or on “normal day-to-day activities” (Disability Discrimination Act, 1995). Such activities

\(^2\) See Note on Citation Style, p.xiii
are affected not only by the impairment, but also by the design of the environment. Buildings, transportation systems, policies, available technologies, and other features of the larger environment, which are not addressed by the definition, also affect participation. The Union of the Physically Impaired Against Segregation (UPIAS) includes in their definition of disability the effects of such environmental features on participation in daily activities. In their Fundamental Principles of Disability document they state: “In our view, it is society which disables physically impaired people. Disability is something imposed on top of our impairments, by the way we are unnecessarily isolated and excluded from full participation in society. Disabled people are therefore an oppressed group in society. (UPIAS, 1976)” (cf Oliver, 1996, p.33).

Whether or not a given impairment is disabling in a specific context offers another range of definitions altogether. Based on the International Classification of Function, Disability and Health (ICF) (World Health Organization, 2001), Schneider, Hurst, Miller and Üstün (2003) describe disability as “the outcome of an interaction between a person’s health condition and the contextual factors in which the person finds herself or himself” (p. 592). Generally speaking, a disability is something that keeps one from doing some “major life activity” (Americans with Disabilities Act, 1990) for reasons that are largely beyond one’s control. Depending on the author, the reason may be due to impairment of the body structure or its function, or to an element of the environment that is disabling, as when stairs disable someone who uses a wheelchair, or print disables someone who is blind.

Most definitions of disability focus on the impairment identified in the body and its impact on daily life activities, to the exclusion of the effects of environmental features. In
contrast, the discussions in my dissertation will emphasize definitions that focus on the environment, because the teaching/learning environment with its policies, procedures, curriculum expectations and structures is where educators have control. They do not control the impairment. The responsibility of educators and disability service providers is not to address impairment directly, with treatment or diagnosis – that is the domain of medicine and rehabilitation. The responsibility for educators and service providers is to create an accessible learning environment.

Use of the terms disability and disabled

It has become proper in academic writing (American Psychological Association, APA 2005) and in government documents (Ontario Ministry of Citizenship, 2008) to use what is called “person-first language”, putting the person before the disability, both metaphorically and literally, as in “person with a disability” or “student with a disability”. However, Oliver (1990) points out how this grammatical structure puts the disability squarely in the person or student, missing the role of environmental constraints completely. Oliver points out that while people may have impairments, they are disabled by the structures around them. For this reason, Oliver uses the term disabled in the same way that the terms oppressed or marginalized are used—not as a characteristic of the person, but rather as an effect of external elements.

In this work, I use Oliver’s social model of disability and follow the reasoning that environmental structures are what disable people. Hence, I will follow Oliver’s convention in referring to “disabled people” or “disabled students” when referencing the effect of social structures on the participation of people with impairments. I will use “people with impairments” or “students with impairments” when referring to individuals
with what the World Health Organization (2001) defines as impairments in body structure or function.

This position will not be popular, but as Oliver quotes Foucault, “The job of an intellectual…is a matter of…shaking up habits, ways of acting and thinking, of dispelling commonplace beliefs… (Foucault, 1991, p. 11-12)” (cf Oliver 1996, p. 169-170). These language debates are the process of socially constructing disability, as we struggle with how language reflects, creates, and recreates the concept of disability as we assign various meanings to the word. This notion will be explored further in Chapter 2. I now turn to the elaboration of key concepts of social construction.

Key Concepts

Social Constructionism

The theory of social constructionism was elaborated by Berger and Luckmann in 1966. It is the idea that all manner of institutions, political structures, and social mechanisms result from human beings making choices and decisions about how society should be configured. All of our structures have derived meaning and form from the machinations of human thought. Indeed, the above definitions are a perfect example of social construction, particularly the variation noted in definitions of disability. Consequently, if educational delivery methods are viewed as a creation of human beings as the means to an educated population, based on assumptions of able-bodied participation, they could conceivably be re-created to be inclusive of people with impairments. Similarly, if disability has been ascribed a meaning that focuses on the impairment of body function, the very notion of disability could be re-constructed to focus on how the environment presents disabling barriers. As described above, this
dissertation will take the latter view – that disability is a function of the environment, of which educational systems are a part, and both of which are created by the decisions and choices of human beings. The premise here is that one could choose to re-construct disability as a function of the environment, and re-design our environments and systems to be inclusive of a variety of ways of participating.

*The Duty to Accommodate*

Another key concept is the duty to accommodate and the application of human rights in higher education. The *Ontario Human Rights Code* (1990) requires that people not be discriminated against in the provision of goods and services, of which education is deemed a service. Consequently, there is an imperative to ensure that the structures of educational systems do not discriminate against nor disable students with impairments, as disability is a designation protected by the *Code*. Academic requirements that cannot be accommodated and thereby exclude students with impairments must be examined rigorously before accommodation can be denied. It is this step that often confounds educators and disability service providers working with disabled students in the context of practicum and fieldwork education in particular.

The seven separate chapters that follow explore several accommodation issues in turn. A review of the relevant literature establishes the overall context. The next five chapters address in turn the notion of disability and its social construction, the legal duty to accommodate under human rights law, current educational policy reconciling accommodation issues with practicalities of professional practice, and the results of a focus group which applied four legal test questions from human rights case law to the determination of discriminatory practices in education, along with an explanation of
when students should not be accommodated, to maintain integrity of the task requirements. The concluding chapter presents a theory and rationale for determining what can and cannot be accommodated in professional education.

*The Researcher—An Occupational Therapy Perspective*

I am an occupational therapist with over 25 years of clinical experience with students with impairments, and nearly 20 years specializing in the post-secondary sector. When designing academic accommodations for students with impairments as a direct service provider, I am confronted with challenges to the delivery of higher education. Increasingly, students with impairments are participating in professional programs, many with significant practicum requirements. The challenge to design accommodations in these settings, without compromising professional standards, is formidable.

Occupational therapists analyze a required task to find alternative means of performing the task with an impairment. This is what disability service providers in education do as well. They consider the curricular requirements and the impairment in order to build a bridge, or accommodation, to provide equal opportunities for disabled students to learn and demonstrate knowledge.

How do we define which educational activities can be accommodated for people with impairments, and which accommodations will unduly compromise the fundamental nature of a skill? The *Canadian Charter of Rights and Freedoms (1982)* sets the stage for equal opportunity in Canadian society, and is underscored by provincial human rights and education legislation (Corbett, 2007; Hutchinson, 2001). The *Ontario Human Rights Code 1990* requires that people with disabilities be given an equal opportunity to participate in society, specifically in the provision of goods and services, which includes
education. If a person with an impairment cannot accomplish a task or access events, spaces or information in some way, the institution has a responsibility to explore and provide accommodation 1) to the point of undue hardship to the institution, 2) while preserving the health and safety of others, and 3) without compromising essential requirements of the task (OHRC, 2004). Gitlow (1999) also speaks clearly to the legal duty to accommodate, and somewhat to the interpretation of the duty, but without formulating a means to determine appropriate accommodations.

Educators and disability service providers struggle with the intersection of human rights legislation as public policy and the requirements of higher education (Helms and Helms, 1994; Hutchinson, 2001; Reeser, 1992; Roberts, 2009). The duty to accommodate students with impairments under the Code is very broad, with a high standard of undue hardship to be met before accommodation can be denied (OHRC, 2004). Implementing this legal mandate in higher education, particularly in fieldwork settings, poses a significant challenge to our creativity in retaining academic integrity while meeting the needs of students with impairments (Pardo, 1999). Too often, the focus remains firmly on defining the student’s disability or condition--quantifying, qualifying, re-evaluating and describing it--to be sure the student is eligible for accommodations. By contrast, Michael Oliver (1990) conceives of disability itself as a socially constructed notion, in which people with impairments become marginalized not by their own various conditions, but by the way institutions, policies, and practices including education are configured on assumptions of able-bodied participation, which in turn disable people.
This shift to locating disability in the environment instead of in the person reflects a paradigm shift from viewing people with disabilities as charity cases or medical problems toward questioning how we structure our social institutions such that they systematically exclude people with disabilities. This paradigm shift moves us from defining the impairment to defining what needs to be learned and demonstrated in higher education. This is the imperative of human rights legislation under the duty to accommodate disabled students (OHRC, 2004).

Currently, there is no consistent way of determining which academic requirements are bona fide (OHRC, 2004), and hence cannot be altered for students with impairments, and those which can be accomplished using a different method. It would be helpful to have a theoretical framework, and a set of analytical tools that could be used to determine whether response to disability ought to be focused more on the academic activity and/or task to be accomplished than on quantifying and qualifying the student’s condition. Combining an occupational therapy perspective on task analysis (Ashworth, 1995) with the means of identifying discrimination laid out in the human rights case law could provide the required framework and tools of analysis.

*Organization of thematic chapters*

In the following chapters, I examine the intersection of legislated mandates and academic integrity and explain how to apply human rights legislation to higher education, by analysing the specifically identified academic tasks. The resulting theory or model, and analytical tools, is equally applicable to accommodation of disability in primary and secondary education, as well as in the employment sector, and will
contribute to standards of practice in academic accommodation planning, a need identified by Reed, Lund-Lucas, and O'Rourke (2003).

In “Chapter 2: Conceptual Framework and Literature Review”, an in-depth review of the relevant literature in disability studies, human rights case law and legal commentary is presented. The conceptual framework of social constructionism (Berger and Luckmann, 1966) will be elaborated, and applied to the creation of both disability and educational practices, articulating assumptions that underlie the determination of academic requirements.

The first analytical chapter is “Chapter 3: A Lifeline for Accommodation Planning”, which presents a discussion of the social construction of disability and professional education, focusing on the debate about social versus medical models of disability, and how they are reconciled with the biopsychosocial model in accommodation planning. This reconciliation of models is set in the current legal context of the Code. Chapter 3 describes the interplay between law, disability models, and program requirements. A framework with which to conceptualize these issues is developed. Following an elaboration of the theory of social constructionism, I use this theoretical framework to discuss the Environmental Factors\(^3\) developed by the World Health Organization (WHO) in the International Classification of Function, Disability and Health (ICF) (WHO, 2001) as they apply to notions of accommodation within post-secondary education.

Examining schooling and disability as socially constructed, and using the WHO’s Environmental Factors to analyze those constructions, opens a path to the development

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\(^3\) When referring to the WHO Environmental Factors, I will use capital letters to denote these specific categories and ICF chapters, reflecting the WHO definition and use of these as terms of art, specific to the ICF.
of inclusive educational experiences for students with impairments. Application of the Environmental Factors can help educators and disability service providers understand the experience of students with impairments, and clarify the role and function of disability service offices in providing accommodation. Similarly, a pro-active process of accessibility planning can be clarified within the domain of Environmental Factors. A diagrammatic model of the relationship between theory, law, and curriculum is developed to illustrate these relationships.

In "Chapter 4: The Human Rights Paradigm: Is It Effective? What’s the Alternative?" I present a critique of the anti-discrimination human rights paradigm and recent, innovative accessibility legislation, which is changing the context in which accommodation occurs, moving toward a requirement for proactive planning for inclusion. This section addresses the legislation, setting out the dilemma of reactive legislation and the need for a pro-active approach, and introducing four questions from human rights case law to be used in determining discriminatory requirements. The four questions presented are: 1) is the requirement established in good faith? (Ontario (Human Rights Commission) v. Etobicoke (Borough) (1982) [Etobicoke]); 2) is there a rational connection between the requirement and the job/task to be done? (Etobicoke, 1982; Meiorin, 1999); 3) is there evidence of the necessity for the requirement? (Meiorin, 1999); and 4) is the requirement socially constructed in a way that excludes members of a designated group for reasons that are irrelevant to the task? (Granovsky v. Canada (Minister of Employment and Immigration) (2000) [Granovsky]) These are the questions that should be addressed in determining discriminatory curricular requirements.
Education policy is examined in “Chapter 5: Council of Ontario Faculties of Medicine Policy For Medical School Applicants with Disabilities: A Policy Analysis”. This chapter is an investigation and critique of current policy on the provision of accommodation in professional education, specifically in medical schools across Canada. It has been suggested by Oliver (1990) that social and academic policies function as mechanisms of control, designed to structure participation, guide decision-making, and justify action. These policies are position statements that promote a commitment to a direction. Medical school policies regarding disabled students are part of the discourse on disability, arising from and contributing to it, positively or negatively, depending on one’s view and how they are written. These policies control not only access to medical knowledge and power, but also how that knowledge is applied, who is allowed to use it, and how disability in medical students is to be viewed.

American and Canadian anti-discrimination and equity legislation has forced medical schools to consider more explicitly their policies to address the participation of students with impairments (Helms & Helms, 1994). In this policy analysis, the social and legislative contexts for these policies are described, and the policy guiding Ontario medical schools in particular is critiqued, partly because of its influence on other medical school policies in Canada. A comparison is made with the parallel policy of the Law Society of Upper Canada as an example of a proactive, inclusive policy statement. Recommendations are made for a different approach to such policies, using an occupational therapy task analysis instead of an analysis of impairment, which would encourage students with impairments to engage in a dialogue about accommodation,
and which would define the task requirements of medical school more than the characteristics of students.

A qualitative inquiry is presented in “Chapter 6: An Empirical Application of Legal Test Questions to Determine Discriminatory or Bona Fide Academic Requirements”. Courts and human rights tribunals have identified several test questions to be answered in order to determine whether discrimination is present; these test questions are set out above, and in Chapter 4. To investigate the idea that four of these test questions will be useful in preventing discriminatory academic requirements, I conducted a focus group of faculty from a professional education program with heavy practicum components (Rehabilitation) to apply the test questions to academic requirements. The focus group incorporated both survey and discussion techniques to explore whether or not use of the four test questions contributes to determining appropriate accommodations for disabled students in practicum components of professional programs, and why.

The focus group provided an opportunity to hear how faculty members felt about using the four questions required by the courts in determining discriminatory requirements to help determine appropriate accommodation for students with impairments in their programs. The process revealed additional considerations to contribute to the determination of appropriate accommodations. Chapter 6 addresses implementation of the four legal test questions, and points to the next level of investigation required.

The importance of looking beyond the impairment itself to the legitimate requirements of tasks is explored in “Chapter 7: Beyond Psychometric Evaluation of the Student—Task Determinants of Accommodation: Why Students With Learning
Disabilities May Not Need to Be Accommodated”. This previously published chapter situates learning disability accommodations in the WHO domain of Environmental Factors, and points out how elements of the educational environment pose bona fide occupational requirements which might not be feasible to accommodate, and makes the point that these need to inform accommodation planning as much as the diagnostic assessment of the student.

The dissertation concludes with “Chapter 8: A Theory--Tying It All Together”. This chapter presents a synthesis of issues and recommended directions for accommodation and program planning in professional education, with suggestions for future research. This final chapter ties together the legal mandate for accommodation and a pro-active approach to accessibility, with a biopsychosocial model of disability, specific program and practicum requirements, along with the results of focus groups applying these ideas to academic requirements. This final chapter presents a decision-making model for determining accommodation of disability using these combined analyses.

Conclusion

A fundamental understanding of how disability theory and legal imperatives inform decision-making in accommodation planning will be applicable beyond the classroom and fieldwork in general employment settings, where accommodation of employees is equally difficult to determine. The following chapters both explicate and integrate the various imperatives, identifying a path forward for educators and employers alike to determine appropriate and effective accommodations of impairment while protecting the bona fide requirements of academic or work-related activities.
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Chapter 2: Literature Review

“We are not setting forth a new orthodoxy; instead, we aim to make it a little more difficult to hold onto the old.” (Lincoln & Guba, 1985, p.16)

Students present a wide range of learning styles and needs. Students with hearing, vision and learning impairments face disabling challenges in the traditional methods of delivering education through the heavy reliance on spoken lectures and print material in particular. Students with physical impairments are disabled by the location of classes in inaccessible buildings and facilities. Assumptions of able-bodied participation are reflected in classroom teaching modalities such as the use of oral language, printed text, and video that relies on vision. Schools with large flights of stairs, no ramps or elevators and inaccessible washroom facilities preclude the equal and dignified participation of students with mobility impairments. Online learning presents a host of complicating access issues as well. Some aspects of online delivery can enhance access, such as materials compatible with screen-reading software to make print audible, or online instruction can present a barrier to participation with too many graphics and navigational hazards for people who cannot see well or read quickly enough to keep up with changes in pacing and presentation of content windows.

 Nonetheless, education legislation that promotes integrated educational experiences for students with impairments\(^4\) has helped move children in the primary and secondary levels of schooling into mainstream classrooms. Ontario’s *Education Act Regulation*

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\(^4\) In this work, I use Oliver’s social model of disability and follow the reasoning that environmental structures are what disable people. Hence, I will follow Oliver’s convention in referring to “disabled people” or “disabled students” when referencing the effect of social structures on the participation of people with impairments. I will use “people with impairments” or “students with impairments” when referring to individuals with what the World Health Organization (2001) defines as impairments in body structure or function.
gave parents access to the Individual Planning and Review Committee (IPRC) process, to have their child’s particular needs considered individually, resulting in an Individual Educational Plan (IEP) which required the school to provide supports to enable equal participation and learning opportunities for students with a range of impairments. Students progressing through this system have had greater opportunities to succeed academically, and then to move into the post-secondary level of schooling.

In Ontario, the provincial government recognized the disabling obstacles faced by students with impairments trying to access college and university education, and in 1987 responded with the Accessibility Fund for Students with Disabilities (AFSD), a designated funding envelope for colleges. The same initiative was established for Ontario universities in 1988. The purpose of the envelope funding was to enhance services to students with permanent disabilities, and to remove barriers to equal participation. While not all provinces offered such systemic funding, rising numbers of students with impairments in post-secondary education were noted across Canada in a report by the Canadian Association of Disability Service Providers in Post-secondary Education (CADSPPE) (1999) on best practices in service provision to this group. Later, the Ontario Ministry of Training, Colleges and Universities (MTCU) presented data on 15 years of the AFSD envelope funding which showed exponential growth in the number of students with impairments attending Ontario universities (MTCU, 2008).

As the number of students with impairments moving through the educational system increased, a wide range of accommodation issues emerged. Individual accommodation plans were developed and implemented in colleges and universities across the country. The same trend was seen in the United States, in response to the "Americans with
Disabilities Act and the Individuals with Disabilities Education Act 2004 (IDEA). These efforts elicited scrutiny from both disability service providers and faculty members, as various strategies and requests for accommodation challenged traditional classroom methods.

Accommodation issues have become particularly complex and thorny in graduate and professional education, as students prepare to meet professional standards, and to conduct research in the complex world of graduate and post-graduate education, where multiple sources of research funding and complex ownership of the responsibility for accommodation collide with bona fide requirements for work done in particular time frames with prescribed methods. Several authors speak to the dilemmas and needs in accommodation of graduate and professional students. In 1998, the Ontario Ministry of Education and Training (MET, now Ministry of Training, Colleges and Universities, MTCU) established a working group to examine the issues of graduate and professional students with disabilities. The group, called Access to Graduate and Professional Education, or AGAPE, produced a report entitled “Removing the Barriers to Graduate and Professional Education and Careers”. This report was shared with the service providers in universities, and became known as the AGAPE report. Responsibilities of institutions and professional regulatory bodies were outlined, and 34 recommendations were made for enabling participation of graduate students with disabilities (MET, 1998).

At about the same time, in Alberta, Patricia Pardo and Debra Tomlinson of the University of Calgary wrote a comprehensive paper entitled “Implementing Academic Accommodations in Field/Practicum Settings” (Pardo & Tomlinson, 1999). Pardo and Tomlinson outlined the issues pertaining to models and definitions of disability, the
impact of various human rights cases involving accommodation in post-secondary education, and surveyed disability service providers across Canada. Their research resulted in 28 recommendations, and emphasized the need to determine essential competencies, or bona fide occupational requirements, mindful of the participation of students with impairments, in fieldwork settings in particular.

In 2010, Marilyn Rose developed a working paper for the Council of Ontario Universities (COU), entitled “The Academic Accommodation of Graduate Students with Disabilities” (Rose, 2010). Rose outlined the context and issues affecting graduate students with impairments, elaborated on the legal duty to accommodate, and the need to define essential requirements that had also been noted earlier by Pardo (Pardo and Tomlinson, 1999). Rose concludes her working paper with the following exhortation to institutions: “the responsibility of individual graduate programs is to think deeply about and articulate clearly the essential requirements for degree completion” (Rose, 2010; p. 14). Rose also listed 4 recommendations for improving the successful participation of graduate students with disabilities specifically, and resurrected the 34 recommendations of the AGAPE Report as still relevant.

Accommodation of graduate and professional students continues to present unique challenges to faculty and disability service providers. The very notion of accommodation and accessibility in graduate education and research brings into question earlier assumptions about expected forms of participation. The investigative reports noted above call upon faculty to give careful consideration to the determination of academic requirements.
The designated funding envelope initiative in Ontario (AFSD) followed, and was congruent with, the requirements of the Ontario human rights legislation, first enacted in 1962, amended to include “handicap” in 1982, and “disability” in the Ontario Human Rights Code 1990. The Code sets out the duty to accommodate persons with disabilities in the provision of goods and services, which includes the public service of higher education. Accommodation must be provided to the point of undue hardship, which is defined by three considerations: cost, outside sources of funding, and health and safety risks. There are parameters pertaining to each of these, including detailed explanation of actual costs, evidence of efforts to obtain outside funding support, and a four-point risk analysis of health/safety concerns. As well, accommodation must be provided up to the point where the nature of the task, job or enterprise would be seriously compromised. This is where the analysis of essential or bona fide requirements enters the picture.

Through implementation of the Code, and similar requirements in all other provinces, academic requirements collide with accommodation needs and accessibility considerations. To address the dilemma of how to implement the duty to accommodate in post-secondary education, it is necessary to think critically about how students are expected to engage in schooling. To guide this thinking and subsequent decisions about what requirements might be discriminatory in nature or effect, there needs to be a framework for analysing academic requirements. Human rights legislation and resulting legal decisions offer a range of test questions that may be useful in conducting an analysis of essential requirements, or bona fide occupational requirements (BFOR’s), requirements that cannot be altered without compromising the nature of the task (British
The test questions have been developed and applied mostly in employment settings to date, from which we are left to extrapolate an application to academic settings. Nonetheless, the determinants of discrimination, the test questions set out in the court decisions, do offer a means of inquiry which might be effective in furthering the deep thinking Rose (2010) requires of graduate-level educators. The test questions have been applied by disability service providers in analyses of service provision where efforts have failed to provide appropriate accommodations in post-secondary settings. It is only a logical next step to explore the application to academic program requirements themselves.

Both the Ontario Human Rights Code, 1990 and the Accessibility for Ontarians with Disabilities Act, 2005 (AODA) as well as human rights legislation in other provinces, require that schooling be delivered with equitable access to learning opportunities. This mandate challenges delivery methods and how to best accommodate students with impairments. In my experience working with faculty to define course requirements and appropriate accommodations, curriculum expectations often seem to be grounded in assumptions and decisions about content and delivery of curricula, without consideration for how students with impairments participate in the course activities. For example, when a film was chosen to be part of a course, the need for closed captioning
for students who are hard of hearing was not considered in advance. As H.M. Kliebard (1992) states, “…the effects of the inclusion or exclusion of elements of the culture in the curriculum may vary according to the social, political, and institutional contexts in which those selections are made” (p. 181). Depending on where disability is situated in relation to other priorities, the cultural context, and the profile and visibility it has, disability may or may not be incorporated into curriculum decisions, either in content or practice.

As a licensed health care professional, experienced service provider and consultant, I am often asked by educators and fellow service providers to review medical documentation of disability, because educators and service providers focus on documenting and quantifying the severity of the impairment to justify accommodation. Focusing on quantifying the student’s impairment neglects issues in the environment over which educators have legitimate influence, in determining curriculum, tasks, and how assessment will be addressed. The issues of impairment, medical or psychological treatment of the impairment, and quantification of severity lie in the domain of medicine and rehabilitation, not the design and delivery of schooling. Educators and service providers design and revise elements of the curriculum and environment in which students function, and that realm is the appropriate venue for their intervention. Understanding how that venue is constructed is critical to identifying what aspects might be reconstructed to be more inclusive, and what tools can help organize that process.

Following an elaboration of the theory of social constructionism, I will use this theoretical framework to discuss the learning environment as situated within the
Environmental Factors\textsuperscript{5} developed by the World Health Organization (WHO) in the International Classification of Function, Disability and Health (ICF) (WHO, 2001) as they apply to notions of accommodation within post-secondary education.

Examining schooling, in particular higher education, and disability as socially constructed, and using the WHO’s Environmental Factors to analyze those constructions opens a path to the development of inclusive educational experiences for students with impairments. Application of the Environmental Factors can help understand the experience of students with impairments, and clarify the role and function of disability service offices in providing accommodation. Similarly, the more pro-active process of accessibility planning, also a process of social construction, can be clarified within the domain of Environmental Factors.

In Chapter 1, I identified what I consider to be key terms specific to the discourse on accommodation and accessibility. In the next section of this chapter, I will elaborate on the theoretical perspective of social constructionism, through the social construction of disability, schooling, and the ICF’s Environmental Factors (WHO, 2001). To clarify, I am addressing the practices, systems, standards, and procedures that are institutionalized in higher education--schooling at the highest level, not education in general, nor schooling in the primary or secondary sectors. The WHO Environmental Factors will be used to deconstruct the environment of higher education. The Environmental Factors framework will then be used to inform the potential re-construction of that environment to be more inclusive of students with impairments. Throughout the chapter, I will draw on more than twenty years of experience as an occupational therapist, instructor, and

\textsuperscript{5} When referring to the WHO Environmental Factors, I will use capital letters to denote these categories as reflecting the WHO definition and use of these as terms of art, specific to the ICF.
disability service provider in post-secondary education to illustrate social
constructionism in higher education. I will use examples from my experience to show
how the application of Environmental Factors supports the participation of students with
impairments in higher education through appropriate individual accommodation as well
as pro-active accessibility planning.

**Social Constructionism As A Useful Theory in Understanding Disability and Schooling**

In this discussion, I rely heavily on Berger and Luckmann’s (1966) formulation of
social constructionism as one of the earliest explications of this theoretical perspective. I
also rely substantially on Michael Oliver’s (1990) work on the social construction of
disability, which is a compelling illustration of both the theory and its application.

Social constructionism is an epistemology that attributes various concepts,
institutions, traditions, and culture itself to a creation of the human mind. As Ward
Goodenough says: “culture [is located] in the minds and hearts of men.” (cf Geertz,
1973, p. 11). This idea is important to the understanding of how disabled people
become marginalized, and how the organization of schooling contributes to that
marginalization. For example, “If the culture values vision, then relies on print materials
for the delivery of curriculum, all those with low vision or who are blind are thus
marginalized by definition and design, not by any inherent quality of their being.” (C.
Salavantis, personal communication, April 28, 2009)

Social constructionism holds that human meaning-making activity creates the social
reality within which we live, based on values, interests, and perceptions that are not
grounded in naturally occurring observable phenomena, like gravity or photosynthesis,
but in the way we choose to interpret and create the world of culture, values, and
traditions. (Berger & Luckmann, 1966; Simpson, 2002; Stone, 1993). According to Berger and Luckmann (1966), “Humanness is socio-culturally variable. In other words, there is no human nature in the sense of a biologically fixed substratum determining the variability of socio-cultural formations” (p. 49). People seeking to organize and ascribe meaning to their world create socio-cultural formations such as family structures, concepts such as money and academic credit, institutions like schools, banks, and government. A researcher from another universe could discover gravity and photosynthesis, independent of the behaviour and explanations of humans. But the concept of familial organization, money in a bank, credit on a transcript, or the roles of political office would require some explaining as to how those have been collectively established and agreed upon as forms and functions in our cultures.

Berger and Luckmann (1966) go on to emphasize the social context in which humans create their reality:

Man’s [sic] self-production is always, and of necessity, a social enterprise. Men [and women] together produce a human environment, with the totality of its socio-cultural and psychological formations. None of the formations may be understood as products of man’s [sic] biological constitution…. Social order is not part of the ‘nature of things,’ and it cannot be derived from the ‘laws of nature.’ Social order exists only as a product of human activity (p. 51-52).

Berger and Luckmann, writing in 1966, were not compelled to use gender-neutral language, as authors are today (American Psychological Association, 2001). This is an example of how socially constructed practices change over time. In the 1960’s it was perfectly acceptable to make sweeping generalizations about “man”, without including women; not any longer. Now it is understood how such practice marginalizes women. Similar shifts are taking place in the language of
disability, as I will explore in the section on the social construction of disability. The construction of social structures, forms of governance, social supports, institutions, language, and cultural practices are not developed in solitude or a void; they require the participation of humans in concert.

Berger and Luckmann (1966) refer to the theatre as an illustration of this concept of creating reality. People attending a play agree to participate in the reality that is created on the stage, for the duration of the play. The reality presented in the play may bear little relation to the everyday experience of the audience members.

The transition between realities is marked by the rising and falling of the curtain. As the curtain rises, the spectator is “transported to another world,” with its own meanings and an order that may or may not have much to do with the order of everyday life. As the curtain falls, the spectator “returns to reality,” that is, to the paramount reality of everyday life (p. 25)

The theatre illustration serves as an analogy for how everyday realities of social institutions, norms and mores of behaviour are selected and enacted by members of a society. According to social constructionism, social realities change diachronically, over time, and synchronically across cultures. Nothing is inherently biologically determined, or “God-given.” The movement toward gender-neutral language illustrates changes in values and practices, for example. Whereas referring only to “man” used to be acceptable, we are now encouraged to use more inclusive language, as we better understand how language reflects values that inform practices.

Viewed through the lens of social constructionism, various structures and concepts can be seen as potentially malleable, or subject to revision; if something is created by human beings in the first place, presumably it can be recreated in the face of new information or critique, which triggers struggles over meaning and structures of power. I
will explore the theory of social constructionism further by viewing disability and schooling through a constructionist lens, showing how social constructionism helps explain the experience of students with disabilities. I will turn the lens of social constructionism to disability next.

Social Constructionism Applied to the Concept of Disability

The fact that the definition of such concepts as banking, academic credit, and kinship systems vary between cultures and across time attests to their socially dependent nature (Anderson, 1996; Charlton, 1998; Davis, 2002). Similarly, the meaning of disability may be quite different between societies, and in different contexts, depending on how it is defined and assigned meaning (Oliver, 1990). The social participation of people with different impairments may depend on whether one is in an agrarian or industrial society, the various features of the physical environment, and social expectations of behaviour and productivity. Different cultures view various types of disability as a sign of divine favour, or as a sign of evil possession; as a strictly medical condition, or of no particular consequence (Charlton, 1998). For example, Nora Ellen Groce (1985) writes about the island community on Martha’s Vineyard where many residents were born deaf over several generations, and so everyone was bilingual, using both sign language and spoken English as a matter of course. Deaf people were a normal part of almost every family, and the modes of communication between people naturally evolved to reflect this diversity. In this context, deafness was hardly remarkable.

A telling example of exactly how disability is a constructed concept is described by Alden Chadwick, citing a question from the British Department of Social Security about
how to define disability: “In the White Paper *Measures to Tackle Discrimination Against Disabled People* the Government asked for guidance on ‘…what types or degree of disability (their) definition should cover and what conditions might be excluded or included’” (Chadwick, 1996, p.28). This example illustrates the social construction of disability in action as policy-makers actively set out to select components of the definition of disability. Lennard Davis (2008) describes a similar process in the creation of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), used by psychiatrists and psychologists to define and diagnose psychiatric conditions. Every few years, Davis says, a group of experts “gather around a table” and consider updates that have become necessary, essentially redefining what behaviours or symptoms are to be included in the conceptualization and definition of disabling psychiatric illnesses. The result is a book of definitions detailing the most recent constructions of illness and how these will thenceforth be referred to (Davis, 2008).

The role of disability theory is important in understanding the context in which disability service providers practice, and the perspective that students with impairments bring to the accommodation planning process. Two models of disability have prevailed to date in the analysis of disability in society – the so-called medical model, and the social model. The medical model isn’t really a model so much as an ingrained view of disability as resident in the person, a problem to be fixed, with normalizing interventions by expert practitioners. This view evolved with the evolution of medicine as a profession, the cultural valuing of objective observation and judgment over subjective experience, and the notion that medical knowledge is restricted to and controlled by those who have been acculturated to the profession. The roots of this perspective lie in
the evolution of medicine as a positivist science and a profession with a perceived role to control and care for sick and disabled people, who are viewed as victims of personal tragedy (Chadwick, 1996; Davis, 2008; Foucault, 1973; Oliver, 1990). Chadwick points to current understandings of disability as a result of the medical management of disability: “In short, it would not have been possible to understand disability--to know it – until there were attempts to control it or manage it” (1996, p. 30). The fields of medicine and rehabilitation assume responsibility for this control and management, often with the complicity of disabled people themselves who have limited options, and who do require treatment of conditions from time to time or for directly medical needs (Oliver, 1996). In this context, disability became something undesirable, and was appropriated by medicine as within that domain, to be controlled and eradicated. (Foucault, 1973; Oliver, 1996) The medical model locates the concept of disability in the individual, as a defect of body function or structure in need of medical remediation and control. In the medical model, disability is perceived as negative and in need of fixing; the medical professional is the expert and agent of change; the person is considered to be a ‘patient’, a passive recipient of treatment.

While there is clearly a significant role for medical treatment of impairment, the medical model has been criticized for ignoring the environment in which disabled people actually function and carry out their lives (Oliver, 1996; McColl & Bickenbach, 1998). This dichotomy of approaches has spawned much debate, and is important to understand before considering how the ICF and its Environmental Factors seek to resolve this schism by incorporating both medical and social models. I will elaborate on a combined model in the later section of this chapter, on the development of the ICF.
The medical model stands in stark contrast to the social model (Jaeger and Bowman, 2005; Llewellyn and Hogan, 2000; Pfeiffer, 1993). The social model of disability relies on the theoretical foundation of social constructionism, and has gained significant traction in the field of disability studies and accommodation planning (Oliver, 1990; Thomas, 2004; Tregaskis, 2002). The social model was developed by British sociologists in the 1980’s and 1990’s, who were disabled themselves. These theorists took the view that it is social structures that disable people, and the problem is not how to fix the person, but how to construct a more accessible social fabric. The social model is not truly a model either, as it does not so much pose a relational structure of causation, but presents a paradigm shift by locating disability in the environment rather than in the person. This way of viewing disability was taken up with enthusiasm by the disability rights movement, and has been both loudly touted as the correct approach to understanding and addressing disability, and roundly criticized as limited and unrealistic. (Humphrey, 2000; Priestly, 1998)

The social model conceptualizes disability as entirely a function of structures in the environment, and not as a characteristic that is resident in an individual. Features of environments as they have been created are said to exclude the participation of people with impairments (Oliver, 1990). For example, stairs keep people who use wheelchairs out of buildings, and the reliance of higher education on print materials affects the participation of people with vision impairments and learning disabilities. In the social model of disability, the concept of impairment is neutral; it is just one aspect of the multifaceted person. The person with an impairment is considered to be an expert on
their condition and an active agent of change. It is the environment that needs to be fixed, according to the social model.

Chadwick speaks clearly to the need to focus on the environmental organization and structures as the problem, to focus on the task, not the student. “The social model must be operationalised in such a way as to facilitate the refocusing of policy and action onto cultural assumptions, disabling barriers, work practices and organisational structures rather than individuals and their impairments” (Chadwick, 1996 p. 38-39). Beyond asking students about the nature of their impairment, we need to ask what barriers they experience in the assumptions, practices and structures of higher education, what policies impede their participation, and what attitudes they find hinder them.

The debate has seen some reconciliation in the emerging interactionist theorists, such as Thomas Shakespeare (1993), and in the World Health Organization’s (WHO) biopsychosocial model (WHO, 2001). The latter incorporates the physiological elements of impairment, along with the environmental factors of attitude, policies, technology, buildings, and relationships and the impact on activities and participation. In the WHO model, the work of disability service offices can be situated squarely in the environment, while acknowledging the medical realities of impairment and function in an education context. This perspective allows for both accommodation, as an individual response, and the promotion of accessibility, through a systemic approach to disabling elements of the environment.

*Language as an Agent of Social Construction*

The dichotomy of approaches between social and medical models is manifested in the language struggles over what constitutes politically correct wordings about
disability, a reflection of the struggle with the evolving concept and meaning of disability. Because this language debate is germane to the discussion of the social construction of disability and how that construction manifests in language, it is worth addressing here in some detail.

In 25 years as an occupational therapist, I have seen many shifts in language use about people who have various conditions in different settings. Being educated in this area in the early 1980’s meant learning within the medical model, in which the people we served were “patients,” expected to be patient recipients of treatment. In the early 1990’s, I moved into community-based rehabilitation, in which we served “clients”, in a client-centred practice where the person with an impairment was an equal player in setting goals and participating in treatment or service provision. My work in higher education started with “special needs students” or “disabled students,” who became “students with disabilities” because it was felt that “special needs” was not only confusing, it was patronizing. The term “disabled students” was thought to suggest a lack of capability, in otherwise competent people. “Students with disabilities” placed the value and priority on the identity as a student first, and the disability was less important, albeit resident in the student. Now, 20 years later, it seems an achievement that this phrase and the priority it purportedly reflects has not only become integrated in disability service provision, but the Ontario government and the Publication Manual of the American Psychological Association (APA) require the use of language that places the person first, or what is sometimes referred to as “person first language,” placing the person ahead of the disability in a sentence. This form is defined as appropriate
language use by both of these influential bodies (APA, 2001, p. 69; Ontario Ministry of Citizenship, 2008).

It is felt by some people in the disability activist community that this wording, “person with a disability”, prioritizes the person over the disability. However, Oliver (1990) makes a significant point about language when explaining his preference for the term “disabled people” over “people with disabilities” (p. xiii). His premise is that disability is the oppression that results from environmental features that limit the participation of people with impairments. To refer to “people with disabilities” attributes the disability to the person. Oliver prefers the term “disabled people”, as analogous to “oppressed people”. He uses “people with impairments” instead of “people with disabilities” because the former term refers to a characteristic of the individual body or function, leaving the disability as a result of the environment. If disability is socially constructed by the structures in which people with impairments participate, why would it be preferable to say “people with disabilities”, which points to the disability as within the person? As Oliver points out, the person may have an impairment of their body structure or function, but it is the design of transportation systems, buildings, attitudes and systems that disable people from participating equally.

The language debate is illustrative of the larger question about the nature and locus of disability – a characteristic of the person, or a function of the environment? In the context of Oliver’s (1990) explanation, “person with a disability” confuses the notion of disability with impairment. According to Oliver (1996), the notion of disability is something socially constructed and imposed “on top of our impairment”, as the UPIAS definition states. Therefore it is appropriate that the term disability be used to describe
the situation in which people with impairments find themselves--disabled by social constructions, such as the built environment or education policies and systems. The phrase “student with a disability” places the disability squarely in the student; it is the student who possesses the disability. Consequently, Oliver refers to “disabled people” as the group that is marginalized by systems, and “people with impairments” to describe people who have an impairment of the body. He suggests this shift to recognize disability as a form of oppression imposed on top of impairment, and to recognize impairment for what it is, as a feature of body structure or function.

While I agree with Oliver in theory, the language preferred in the current disability legislation and by my constituents and other people in the disability movement is “person [or student] with a disability”. To reconcile this debate in my own writing, I have decided to use “disabled people” when speaking about systemic issues that limit the participation of people with impairments, to acknowledge the role of structures in disabling people. I use “person [or student] with [specific impairment]” when referring to individual situations, cognizant that a “student who is blind” is most importantly a student, and the impairment that needs barriers removed is blindness, but it is our reliance on print that imposes a disability. This will not be a popular position, but as Oliver quotes Foucault, “The job of an intellectual…is a matter of…shaking up habits, ways of acting and thinking, of dispelling commonplace beliefs (Foucault, 1991, p. 11-12)” (cf Oliver 1996, p. 169-170). These language debates are the process of socially constructing disability, as we struggle with how language both reflects and recreates the concept of disability as we assign various meanings to the word.
Social Constructionism Applied to Education and Schooling: How Schooling Excludes Students With Impairments

Educational systems, schools and the practices of schooling are also socially constructed. “The institution is created to serve a mandate, and it is assessed in terms of its success in meeting the mandated purposes and goals” (Olson, 2003, p.54). Education systems may be federally mandated or left to state or provincial jurisdictions, with various organizational components. Schools are clearly developed in a variety of styles, sizes and functions, from home schooling, charter schools, and public schools to private vocational institutes, universities, and professional schools. Schooling itself is designed and administered with locally or regionally-specific curriculum requirements, schedules, procedures and class sizes, with different levels of discipline and forms of control. It is clear that “school” is not a naturally occurring phenomenon; it has been developed over time into a sophisticated system of disciplinary areas, developmental stages and academic standards. Particularly in post-secondary education, the use of entrance and exit criteria, evaluation milestones, and standards of achievement for entering professional practice thereafter, are aimed at fulfilling expectations that are carefully and deliberately crafted toward certain objectives. The goal is stated and the means of achievement set out. From my discussions with faculty, it seems that much of this is based on assumptions about what “normal” students do, how their bodies and minds function, what participation looks like, etc. The expectations and criteria are challenged when someone with academic ability and a different bodily form or function comes along. We must ask what sort of construction allows otherwise qualified students to be excluded for reasons unrelated to academic ability, such as hearing impairment.
Why is schooling constructed in such a way, and could there be different paths to the goals of schooling?

Perhaps there are several paths to methods of schooling, if we reconsider how, and more importantly why, schooling is built as it is. There are several analogies that help to explore different paths. One useful analogy lies in the feminist work of Sandra Harding (1991). Harding describes the participation of women in the evolution of science. There is an interesting parallel to the participation and contribution of disabled people to the evolution of schooling. Harding points out how if women posed more of the questions of scientific inquiry, the methods of investigation and results might look very different. She explains how women’s different perspective is obscured, the absence of which exerts a fundamental influence on what is determined to be scientific or valid knowledge. Speaking from the standpoint of feminist theory, Harding says, “If hierarchical models of causation and control are associated with desirable masculine personality traits, the less hierarchical aspects of nature will be harder to detect, because they are not given reality, made visible, by the preferred hierarchical model” (p. 45). Herein lies the parallel to disabled people’s participation in the construction of schooling. By substituting ableist/disabled for hierarchical/male in Harding’s description, the influence of the absence of disabled people in constructing schooling becomes apparent: “If [ableist] models of causation and control are associated with desirable traits, the [disabling] aspects [of schooling] will be harder to detect, because they are not given reality, made visible, by the preferred [ableist] model.” To the extent that disabled people are excluded from the creation of structures of higher education, those structures cannot
reflect or include the perspective of people with impairments, nor facilitate their participation.

Oliver (1996), and Carnoy and Levin (1985) address the hegemony of school systems, and how they reproduce the social structures in which they are embedded. Carnoy and Levin’s work provides another illustrative analogy about how the structures of schooling reproduce exclusion of students with impairments. Their study shows that expectations differ for students of higher or lower socio-economic status, and so those students grow, and recreate similar expectations as adults in their own community schools. Similarly, applying this hegemonic dynamic to students with impairments, if expectations are lower, or the structure does not include them by design, they do not benefit equally from the learning opportunities. The impact of expectations may affect the students’ ability to compete academically and vocationally later in life. Students with impairments may be underrepresented in higher education and employment, further influencing the basis for lower expectations.

Another analogy that refocuses our thinking about students with impairments is based on J. Bourne’s comment regarding racism, that “it’s not black people who should be examined, but white society.” Oliver followed this idea with, “It is not disabled people who should be examined, but ableist society” (1996, p. 142). Taking the parallel one step further, I would suggest that it is not students with impairments who need to be examined, but ableist schooling.

As class size and pace of work increases, an effect similar to that described by Oliver in the industrial revolution can be observed in schooling. Oliver (1990) describes the marginalization of disabled people in the industrial age, when factory work, mass
production, and requirements for uniformity of function increased, to the exclusion of disabled people. In the early factories, long work days and heavy, dangerous machinery required physical strength, prolonged positioning, and repetitive movements with limited breaks and no alternative means of executing tasks. The strict performance expectations excluded people with impairments from the factory workforce. People who perhaps required seating and breaks, or who lacked physical strength, did not fit in. Now, a similar dynamic of mass participation for able-bodied students is emerging in higher education. Where we once saw small lecture and seminar settings, I now have colleagues with over 700 students in class at once, with limited opportunity for dialogue or clarification for an individual. I see the pace expected for producing assignments and writing large-scale examinations is increasing as students work through 5-6 courses in a 12-week period, with added lab and tutorial sessions. Lectures are sometimes delivered by television or online, where the instructor never actually sees the students at all. For students with impairments in these new venues, the scope for participation both shrinks and expands. Opportunities to participate shrink if the format and technology make the information less accessible, and expand if the technology helps them learn from home, or amplify the lecturer, or utilize closed captioning (Burgstahler et al., 2004). These changes are evidence of a reconceptualising of the organization and delivery of education, and present an opportunity to reconstruct content and delivery to include students with impairments, simultaneously constructing and deconstructing the notion of disability.
Development of the International Classification of Function, Disability and Health (ICF) – Where Medical and Social Models Join in a Context of Environmental Factors

A social constructionist perspective informed the development of the social model of disability, which in turn informed the World Health Organization’s ICF (2001)—a deliberate construction of a holistic conception of disability that includes several domains: medical elements of body function and structure, activities and participation, and socio-environmental contextual factors. The ICF was developed as a tool to facilitate common understandings and descriptions of impairments of body structure and function along with the impact of various contextual factors on the lives and participation of people across different cultures, languages, and health care systems. Because different cultures and systems define health and disability in different ways, it is difficult to classify and code health and disability issues in a way that makes them comparable across countries, cultures, and languages. This in turn makes it difficult to understand socio-economic and political issues, identify patterns, or design and implement broadly applicable solutions to problems. For example, if the problem of amputation due to landmine explosions is described in terms of the loss of a limb in one instance, and the incidence of infection in another, and the impact of landmines on farming families in another, it is difficult to capture the whole problem and develop an approach. Or in the post-secondary context, if the problem of depression in university students is described in terms of the loss of motivation in one instance, and laziness or absenteeism in another, and the incidence of suicide in another, the issue of depression is masked and difficult to conceptualize. A system that incorporates all aspects of health and functioning was needed, a way of describing the impact of injuries or depression that worked across language and cultural boundaries. A new framework and common
language needed to be constructed, which is what the World Health Organization did in creating the ICF.

The ICF is intended for use in defining statistical parameters, research, health and social policy development, and in clinical practice. It presents a coding system for describing the health status and participation of people across health conditions, at the levels of the body, the person, and the environment. The system incorporates health and impairment, participation and restrictions, and factors of the environment that facilitate or impede participation, as well as personal factors (Üstün, Chatterji, Bickenbach, Kostanjsek, & Schneider, 2003). This comprehensive system offers an opportunity to incorporate the physical aspects of impairment with an appropriate role for medical intervention in one domain (Body Structures and Function), while offering a place and role for the environmental context in another domain (Environmental Factors). Accommodation planning and accessibility are part of the Environmental Factors domain. In the ICF, the use of medical and social models in combination is referred to as the biopsychosocial model. This combined model captures the current need of institutions and disability service offices for medical documentation of a non-evident condition, while they influence change only in the environment--a social model approach.

*Environmental Factors*

The ICF Environmental Factors domain identifies five factors: 1) Attitudes and Beliefs; 2) Services, Systems, and Policies; 3) Products and Technology; 4) Natural and Human-made Environments; and 5) Relationships and Supports (Schneidert, Hurst, Miller, & Üstün, 2003; WHO, 2001). These five factors will be used here to analyse the
construction of post-secondary schooling, and as guides for the creation of more accessible learning environments.

Environmental Factors is the most appropriate domain upon which to focus for educators and education policy-makers, because it is the only domain in which they have legitimate control or influence. Educators and education policy-makers have no clinical role in addressing impairment in the domain of Body Structure or Function, and higher education settings are not treatment settings; these are legitimately in the purview of medicine and rehabilitation. Once the person engages in pursuing higher education, the learning environment can either enable or restrict participation of people with impairments, so it is fitting that examination of the social construction of schooling be directed to the teaching/learning environment, using the five factors defined by the ICF.

The Environmental Factors all have two elements of particular use in deconstructing the teaching/learning environment. These two elements are 1) barriers, which obstruct participation, and 2) facilitators, which enable participation. An example of a barrier in Policies, Services, and Systems would be the requirement for full-time enrolment, while a facilitator would be an option for part-time study for students who need to pace their studies to maintain their health. How do the barriers and facilitators specific to each Environmental Factor contribute to the construction of schooling? In the following sections, I examine each of these factors in turn, in order to illustrate how the barriers and facilitators specific to each Environmental Factor contribute to the construction of post-secondary schooling.
1. Attitudes and Beliefs

Beginning with Attitudes and Beliefs as the cornerstone of all other factors, the familiar adage comes to mind: “Where there’s a will, there’s a way.” Where there is a willingness to design for inclusion, it will be easier to find a way. Attitudes toward the inclusion and participation of disabled people in post-secondary schooling contribute to the social construction of disability, as they reflect the values placed on inclusion and express views about impairment. Alternately, attitudes are critical to implementing accommodation and building for accessibility. In 20 years of working with students with impairments in higher education, I have often heard the question: “If they have learning disabilities, what are they doing in university?” This question reflects the assumption that someone with a disability in an area of learning must not be capable of any learning, and does not belong in higher education. Since learning disabilities are defined as occurring in the presence of average or above-average intelligence (Learning Disabilities Association of Ontario, 2001), the erroneous assumption that students with learning disabilities do not belong in higher education is a significant attitudinal barrier. This attitude contributes to the conceptual construction of disability in the context of schooling. Similarly, comments made to me by faculty in professional programs that students with impairments do or do not “look like” an occupational therapist, or a teacher, or a nurse – in other words, do not seem to fit the image or stereotype--reflect an attitude that people who are patients or clients could not also be practitioners. This type of comment poses an attitudinal barrier for students with impairments in the professions similar to that faced by students with learning disabilities who participate in schooling.
Often instructors consulting me about accommodation of students with disabilities raise the question of fairness. Why is it fair to treat students with impairments differently? The countering question is if they are different to start with, why is it fair to treat them as if they are the same as non-disabled students? For the student with a repetitive strain injury, who cannot write by hand and uses dictation software to produce essays, what is fair about requiring a hand-written exam in a standard time frame because that’s how non-disabled students write it? Or if carrying a full-time course load exacerbates a student’s mental illness, what is fair about requiring a pre-specified amount of work within a given time frame? Attitudes about fairness, equity, social costs, and academic integrity all affect the policies and practices in higher education, collectively constructing the notion of disability by defining who can participate and who cannot.

Facilitators of participation in the Attitudes factor include valuation of inclusion, appreciation of the experience and perspective that disabled students bring to the classroom or profession, and respect for how inclusive design of curricula and environments makes it easier for people to contribute. A welcoming, pro-active attitude opens opportunities for creative thinking and problem solving, benefitting not only students with impairments, but also the entire community (Bryson, 2004; Burgstahler et.al). When Attitudes and Beliefs are deliberately examined, the opportunity to change them and deconstruct the notion of disability is present.
2. Natural and Human-made Environment

The Natural and Human-made Environment factor poses many obvious barriers and facilitators in higher education. For example, the buildings on post-secondary campuses are often old. I performed an accessibility audit on a library that was built in 1924. Prior to its renovation in 1997, the library had a large flight of stairs to the main entrance, and limited or no elevator access, which made it difficult, awkward and sometimes impossible for students with mobility impairments to use the library.

Consulting on laboratory renovations has shown me how benches are not designed with lower access points for wheelchair users. Lighting and acoustics can be poor, and signage inconsistent, making it hard for students with low vision or hearing impairments to access information. The frequent need to adapt these settings for students over the last 20 years has shown me that until recently, campus and residence buildings have often been constructed without keeping in mind people who navigate with wheels or low vision or hearing impairments. To the extent that these needs are neglected in planning and design phases, elements of the environment contribute to the disablement of people with impairments.

Facilitators in this category include universal design principles of equity and flexibility in use, low physical effort requirements, simplicity, and tolerance for error (Universal Design Education, 2004), and features such as lever handles, level access, power-assisted doors, effective lighting, and noise reduction (Management Board Secretariat, 2004). Attitude informs this category as well, as these design features become desirable stylistic elements and are valued by people with and without any impairment of body structure or function. As new campus environments are designed
and constructed, these features are increasingly included. I was pleased to see, when reviewing blueprints for a new residence building in 2002, that level entrances, near-by elevators, doorways and washrooms had been designed for accessibility; this was more pro-active than anything I had seen in several years of reviewing building plans. As well, the AODA requires that disabled people be part of the planning and design of public buildings, to ensure that a variety of ways of interacting with the environment is incorporated. This is the very physical realm in which post-secondary education is socially constructed, and is slowly being reconstructed through the participation and decision-making of disabled people, architects, and planners together.

3. Policies, Services, and Systems

Elements in the ICF factor Policies, Services, and Systems are constantly being created, reviewed, and revised in higher education, in response to changes in governance, regulations, or evolving program delivery needs. At Queen’s University, an Internal Academic Review is conducted in every department, every seven years, so several departments are reviewing their programs and procedures at any given time. The Senate requires policy reviews periodically, and I have participated in numerous committees drafting and revising policies or services and their accompanying systems. I have handled complaints about access to admission and financial aid services, requirements for pre-requisite courses, registration systems, and student support services that are more or less accessible to students with impairments, depending on how they are designed and delivered. Examples include web-based resources that are not compatible with screen-reading software, limited resources for individual appointments to help access information, and policies precluding make-up examinations
that all pose barriers to equal participation in learning and demonstrating knowledge for students with impairments. All of these barriers, while not deliberately created to exclude students with impairments, nonetheless disable them from equal participation in the educational environment.

Facilitators that could be constructed include accessibility requirements for institutional websites, options to meet with staff when registering or completing paperwork in inaccessible formats, and built-in alternative dates for exams to be used when disability issues interfere. Planning for inclusion, with flexibility, equity, and simplicity in mind at the outset would construct a more inclusive set of policies, services, and systems, requiring fewer exceptions as accommodations of impairment.

One particularly significant issue in the Environmental Factor of Policies, Services, and Systems is consideration of what constitutes essential requirements, or bona fide occupational requirements (BFORs). In order to determine what is a bona fide requirement in an academic discipline, several questions can be applied to the requirement that help refine the rationale for its inclusion. I have found some of the most useful questions to be: 1) What is being tested? 2) What is the nature of the task? 3) Does it have to be done in only one way? 4) If so, why? This last question is the most important. The reason something is done in a particular way, and whether the method can or cannot be modified for reasons relating only to the task, must be clarified in order to determine whether or not it can be accommodated. If the objective of the task can be achieved with the use of an accommodation, the method of execution is probably not a BFOR.
Cases that have gone to various levels of human rights tribunals and courts in Canada look at several questions to determine if a requirement or standard is discriminatory (Etobicoke, 1985; Granovsky, 2000; Grismer, 1994; Meiorin, 1999). For this application, the various questions used in case law decisions on discrimination can be synthesized into four basic considerations: 1) Is the requirement established in good faith? (Etobicoke, 1985) 2) Is the requirement rationally connected to the job or purpose for which it is intended? (Etobicoke, 1985; Meiorin, 1999) 3) Is there evidence that the requirement is demonstrably relevant or necessary? (Meiorin, 1999) 4) Is the requirement socially constructed such that it excludes specific groups, for a reason that is irrelevant, based on assumptions about function or the group? (Granovsky, 2000) It is noteworthy that this last case raises the role of social construction of disability in the analysis, formulating the discrimination question to include that perspective.

Considering curriculum requirements in light of these questions may result in priorities and objectives that are defensible and helpful in identifying what tasks can and cannot be adapted for students with disabilities. The process of applying these questions to an analysis of curricula affords an opportunity to think differently about the definition of learning objectives and the required methods of demonstrating knowledge and competencies. In this way, the construction of disabling barriers can be avoided.

4. Products and Technology

Post-secondary education relies on a plethora of items in the Environmental Factor of Products and Technology, from low-tech handwriting implements to white boards that record notes in classrooms, laboratory equipment, and online libraries, to mention a few. Reliance on such tools contributes to the construction of disability in
these environments by expecting that all students will access these technologies with, for instance, normal vision and hearing. Students with vision or hearing impairments report to me how these expectations obstruct their participation. Lack of amplification, reliance on course packs of poor-quality copies, and certain web-based materials make it difficult for students with particular types of impairments to access information. A variety of accessible formats act as facilitators, allowing students a range of ways to interact with and access the material, focusing on their learning rather than how to obtain information. Some products can be either facilitators or barriers, depending on the disability and how the product is used. For example, I have had students in my class tell me that Power Point slides can pose a barrier with too much text, too little contrast, small-sized print copies, or when posted online without a text version. They can also be a facilitator, if used to make material clearly visible, with accessible fonts and contrast. Slides can also be converted into a text document for use with a screen-reader when posted on a course website. 

What drives the choices we make with respect to tools and materials? Vendor sales strategies, emerging classroom technologies, and access to resources--none of which arise from the needs of learners--inform choices of tools and materials. What are legitimate reasons for the choices made, and what are matters of convenience or economy? What different choices could be made that would lead to a more inclusive experience for learners with impairments? I leave these questions to the curriculum designers and education developers with the power and expertise to reconstruct teaching environments to enhance participation of students with impairments.
5. Relationships and Supports

The ICF identifies an environmental factor of Relationships and Supports, to capture the kinds of informal arrangements and relationships with family, friends, and acquaintances that help disabled people with activities and participation, as well as the formal relationships with professionals and caregivers. Family members, neighbours, and friends who share the driving of an accessible vehicle, contribute personal care or meal preparation, or accompany a disabled person, act as facilitators of participation (WHO, 2001). Friends who provide notes informally, retrieve books from the library, or walk and clean up after a guide dog would be considered facilitators of the student’s participation in the post-secondary environment, as would helpful faculty members and teaching assistants. Professionals and caregivers can function as either barriers or facilitators, depending on how they affect participation. Barriers in this category would include the absence of such supportive people and mechanisms, for example, in isolated rural settings, or when students live independently away from home and have a limited social support network. The elements included in the Relationships and Supports factor evolve partly as a function of the values and cultural traditions of the student’s social context, and contribute to the construction of disability, or the facilitation of participation.

Uses of the ICF to Construct an Accessible Post-secondary Experience

Grounding accessibility work in social constructionist theory enhances the understanding of how post-secondary schooling environments are our own creations, and so amenable to change. Application of the ICF to those environments provides a lens through which to examine the construction of schooling, and allows us to identify
opportunities for inclusion by design, reconstructing higher education for inclusion of students with impairments. I have suggested that the ICF Environmental Factors provide a structure for designing individual accommodations, by identifying the barriers and facilitators in particular situations and framing a domain of intervention for disability service offices.

Institutions in Ontario are required by the AODA to have annually updated accessibility plans in which pre-existing barriers are addressed and new barriers are prevented through a vetting and review process. Some institutions have used the WHO Environmental Factors to organize their accessibility plans, addressing the five areas across all departments (Roberts, 2003). This is another instance in which the ICF is used as a tool to reconstruct the environment of higher education, on a systemic level.

Conclusion

Following a description of the theory of social constructionism, I have elaborated on the theory through an examination of the social construction of disability, including a discussion of language use and its contribution to the construction of disability. Similarly, I explored social constructionism through an analysis of structures of schooling, such as curriculum and policy decisions. When curriculum, policy, and building decisions are made without anticipation of how students with impairments will participate, students are disabled from participation in those structures. The WHO ICF Environmental Factors were applied to educational settings to provide a framework for analysing the social construction of the post-secondary environment, and to identify a domain for intervention—removing environmental barriers and building facilitators. The identification of these factors speaks to the way in which the environment of teaching
and learning is constructed in a variety of ways, beyond the construction of the physical environment. Identifying attitudes, policies, services, and systems as part of the environment illustrates social constructionism at work by showing how expectations, objectives, methods, cultural norms, and reward systems exclude students with impairments. The social constructionist framework enables the taking apart of socially constructed assumptions and the rebuilding of the teaching/learning environment. Accommodation and accessibility planning are exactly that, the step-by-step reconstruction of the teaching/learning environment to remove existing barriers and facilitate the equitable participation of students with impairments.
References


*Ontario Education Act Regulation 181/98*

*Ontario Human Rights Code, R.S.O. 1990, c. H-19*


Ontario Ministry of Training Colleges and Universities Postsecondary Education Division (2008) Disabilities statistics at Ontario universities for discussion at IDIA. Presented at fall meeting of the Inter-university Disability Issues Association Nov. 7, 2008 Toronto


Chapter 3: A Lifeline for Accommodation Planning

As a practitioner in the field of accommodation planning for post-secondary students, I have struggled with the many elements affecting academic accommodations. While human rights and disability legislation require the accommodation of students with disabilities and there are published guidelines for implementation (Ontario Human Rights Commission [OHRC], 2004), there is little incorporation of disability theory and the political contexts in the guidelines. Informed by the social constructionist perspective, this chapter explores the application of the medical and social models of disability (Oliver, 1990) together with the World Health Organization’s (WHO) biopsychosocial model and Environmental Factors (WHO, 2001) to accommodation planning with students with disabilities. David Olson’s (2003) notion of joint intentions between instructors and students provides a unifying concept for the process of determining accommodations for students at the post-secondary level. Combining these perspectives, a useful framework for informed accommodation planning evolves.

The use of Olson’s idea of shared responsibility for learning parallels the requirements for inclusion of students in developing academic accommodation plans, along with the mutual respect mandated in implementation of the human rights legislation. Olson’s idea of “joint intentions” describes the mutual nature of accommodation planning. The contribution of the social model of disability (Oliver, 1990) to describing the political context in which accommodation is both mandated and provided, and the usefulness of the WHO model of barrier identification are included in analyzing the determination and provision of accommodation. An example of the process is outlined with a case study from the post-secondary sector.
A lifeline for accommodation planning

When planning academic accommodations with disabled students, there are many factors to consider, and a cohesive framework is needed that combines legislation with a theory of disability and the environment within education. These factors can be thought of as four strands in a lifeline: 1) the legislated mandate; 2) the theoretical models of disability, including threads of the medical model governing documentation of disability, the social model focusing on student participation, and the biopsychosocial model which combines medical and social models; 3) the environmental factors; and 4) the unifying strand of Olson’s idea of joint intentions in curricula. Woven together, these multi-threaded strands create a lifeline through the challenging sea of accommodation requests, assessments, recommendations, and academic considerations. These important strands in the lifeline, which will be explored in detail, are woven together here to provide that cohesive framework, a solid lifeline through accommodation planning.

Lifeline Strand One: Legislation

The first strand is the legislation that mandates accommodation of disability (Ontario Human Rights Code (Code), 1990)\(^6\). Human rights codes and anti-discrimination legislation mandate accommodation of disability in the provision of goods and services, of which education is considered to be a public service. This includes private schools, which also fall under human rights codes and have a duty to accommodate (Brown v. Trebas Institute Ontario Inc. (2008) O.H.R.T.D. No. 8 2008; Ontario Human Rights Commission, 2004). To assist instructors with implementation of the Code in the education setting, the Ontario Human Rights Commission published

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\(^6\) See Note on Citation Style, p.xiii
their Guidelines on Accessible Education in 2004 (OHRC, 2004). The expectations and boundaries described in the Guidelines assist with accommodation planning and meeting the duty to accommodate, within the interpretation of the Code. Sections pertaining to both post-secondary and primary/secondary sectors are included. The legislation requiring accommodation puts emphasis on environmental adaptations that enable students to succeed, and on the removal of sources of discrimination. The emphasis is not on treatment of the condition or structural impairment (Ontario Human Rights Commission, 2004). Nowhere in the Guidelines are instructors mandated to treat the student’s disability or medical condition; accommodation focuses on altering the task and environment to meet the needs of the learner. This reflects a trend in social policy that is consistent with the social model of disability (Oliver, 1990).

The Ontario Human Rights Code (1990) and Guidelines on Accessible Education (OHRC, 2004) and similar documents in other jurisdictions are not exactly clear on the extent of accommodation required, except that the onus is on the educational institution to prove that it faces “undue hardship” before denying accommodation. Proof of undue hardship includes rigorous evidence of financial hardship, or health and safety concerns. The compromise of essential requirements that would substantially alter the nature of the endeavor is also a limit on accommodation. These are powerful and compelling legal imperatives, helpful in understanding what is meant by “reasonable” accommodation, and a critical strand of the lifeline through accommodation planning. Theoretical models of disability also contribute to accommodation planning, and two of these are threads woven into the next strand.
Lifeline Strand Two: Theoretical models of disability

The second strand in the lifeline weaves in threads of political perspective that create the context for accommodation planning. It is important to consider political contexts and various interpretations of disability, in order to be grounded in current thinking about disability and empowerment that the student may bring to the process. This strand consists of two threads, the medical model of disability based on a positivist approach and the social model of disability from a constructionist foundation (Oliver, 1990). These two threads are combined into the second strand, the biopsychosocial model by the WHO (2001).

Medical model thread.

The positivist tradition informs the medical model of disability, in which disability is viewed as a structural anomaly, conceived as negative and abnormal, requiring some combination of repair, treatment, surgery, and rehabilitation, to normalize function. Both the expert and the agent of change are the medical professionals; the patient is the passive, compliant recipient of services. The physical environment, attitudes, policies, and technology are largely overlooked as contributors to disablement (Ünstun, T.B., Chatterji, S., Bickenbach, J., Kostanjsek, N., Schneider, M., 2003; McColl & Bickenbach, 1998; WHO, 2001).

Requirements for documentation of disability for accommodation planning are grounded in the medical model—the reliance on an expert third party for objective diagnosis or assessment of body structure and function. The presence of an impairment of body structure or function is the domain of the medical model, and its role in
accommodation planning may be limited to verifying that impairment or a medical condition requiring accommodation exists.

**Social model thread.**

The social model of disability (Oliver, 1990) arises from a constructionist perspective (Anderson, 1996), and has gained significant favor in the last decade as it identifies the locus of disability in the environment more than in the person (Bickenbach, Chatterji, Badley, & Üstün, 1999; Chadwick, 1996). In this approach, the focus is on the political, social, and environmental factors that disable people from full participation more than the physical, emotional, or sensory impairment of body structure or function, so emphasized by the medical model. Various civil rights movements contributed to development of the social model--rights for African-Americans, Vietnam veterans, and women formed the basis of a rights-based equity movement among people with disabilities (Davis, 2002; Oliver, 1990; Pfeiffer, 1993). In the social model, disability is conceived as a difference, value-neutral, not necessarily defining of the person. Treatment and normalizing function may or may not be the objective. The person with a disability is viewed as having significant expertise in her or his own condition and needs, and is important as an agent of change. The person with a disability is an active participant in setting goals, based on her or his interests and situation. The environment, and its policies, attitudes, and supports are the “problems” in need of repair. (Bickenbach et al., 1999; McColl & Bickenbach, 1998)

The social model is a particularly useful perspective for education, since education does not treat or repair the student’s physical, emotional, or sensory impairment. Education aims to maximize learning potential. The environment, in all its
socio-political complexity, is what instructors can actually influence, so accommodations are focused there to be most appropriate and effective.

Complex social and environmental threads are combined in the social model of disability. It values the role, experience, and expertise of the person with a disability, and supports including the person with the disability in the determination of goals. Social constructionist theory (Anderson, 1996; Davis, 2002; Jaeger & Bowman, 2005) informs this perspective, in that it views the institution of education itself, the legislation, and all the inherent policies, procedures, and systems as social constructions, and so the barriers to participation are of our own creation, not the “fault” of the person with a disability--in this case, the student. Instead of attempting to treat the student’s disability, social constructionist theory suggests addressing the environmental barriers that preclude participation in society, or in this instance, school. Increasingly, this is the political and cultural view of disability that is brought to the table by students when creating accommodation plans in post-secondary education. See Table 1 below for a comparison of medical and social models, as adapted from Gill (1987) by Blacklock (personal communication, March 11, 2009).
Table 1: A comparison of medical and social models of disability

<table>
<thead>
<tr>
<th>Medical model (positivist)</th>
<th>Social model (constructionist)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem is the body structure of the person</td>
<td>Problem is the environment</td>
</tr>
<tr>
<td>Expert is the medical professional</td>
<td>Expert is the person/the student; professionals are resource people</td>
</tr>
<tr>
<td>Solution – fix the person/ the student</td>
<td>Solution – fix the environment</td>
</tr>
<tr>
<td>Agent of change – professional</td>
<td>Agent of change – anyone who fixes the environment</td>
</tr>
<tr>
<td>Role of the patient – passive recipient</td>
<td>Role of the student – active participant</td>
</tr>
</tbody>
</table>

(adapted from Gill, C. (1987), and Blacklock, B. personal communication March 11, 2009)

Because of this profound valuing of the person with a disability, the social model has much in common with human rights legislation, which also requires individualized, mutually determined accommodation. This parallel makes the social model a useful perspective to inform the accommodation planning process. Taking this view, elements of the environment, over which instructors have more control, are viewed as disabling. The curriculum, the physical arrangements and procedures in the classroom, teaching strategies, time frame and pacing expectations, resource materials, formats and more are subject to the instructor's discretion. All these elements either facilitate or restrict the participation of students with impairments. Accommodation plans for students with impairments must consider the student as knowledgeable and participatory in goal setting, and address aspects of the environment that contribute to the disablement of the student. These elements likely can account for most restrictions of participation in
cases of learning disability, emotional disability, sensory impairment, or various physical disabilities. How the task is performed—orally, or relying on print, or in a particular time frame—can empower or disable a student when combined with an underlying structural impairment that might not affect participation in other settings. For example, a student who is blind or has a reading disability is enabled to read with the use of electronic format; for them, print is disabling. Students who are hard of hearing are enabled to participate through the use of assistive listening systems (FM), and disabled by exclusive reliance on speech to convey information. The student is integral to the determination of accommodation, and the tone with which this process takes place would be well served by a deep appreciation of the social model of disability.

“As all theories... so far have been found to be false ...so surely will any theories that we expound today.” (Lincoln and Guba, 1985 p.16) Likewise, both the medical and social models have proven insufficient to effectively inform accommodation planning.

The next evolutionary step in developing a theory for accommodation planning is a combined approach, as is proposed by the World Health Organization. The biopsychosocial model forms the next thread in the disability theory strand in the lifeline.

Biopsychosocial model thread.

The World Health Organization’s International Classification of Function, Disability and Health (ICF) presents a third thread in this strand – the combination of medical and social models into the “biopsychosocial” model (Ünstun, Chatterji, Bickenbach, Kostanjsek, & Schneider, 2003; World Health Organization, 2001). While the medical model largely ignores the environment, the social model does not give enough attention to the roles of body structure/function. Neither is sufficient unto itself to
conceptualize disability, so the ICF combines them into the biopsychosocial model to address both the body’s structural and functional capabilities and inabilities, from a medical point of view, as well as the activities and participation of people in their environments and communities (World Health Organization, 2001). Examples of this combination are readily apparent in accommodation. In the case of learning disabilities, diagnosis based on standardized testing by licensed professionals is critically important (reflecting the medical model’s reliance on expert validation), and the solution may be in assistive technology (reflecting the social model’s emphasis on environmental factors). Similarly with a physical disability like rheumatoid arthritis, the medication to control inflammation is important (medical model intervenes to “fix” the person), but safe railings and careful scheduling of activities are necessary to enable the person to participate (social model adapts the environment). In the case of a mental illness like depression, the medication and therapy provided within a medical model may facilitate concentration, but community and family attitudes, supports like flex-time and pacing, and modifications of routines (social/environmental aspects) enable participation. We can see from these examples that there is a role for professional assessment and/or treatment of structural impairments, but instructors have the most control and impact in the environment of learning.

The teaching/learning environment is created primarily by the institution, the instructor, or others in the educational community. It is not a naturally occurring environment; it is constructed and configured from historical traditions based on assumptions about function and participation. These constructions can be re-configured from “barriers” to “facilitators of participation” (World Health Organization, 2001). The
next strand explores how barriers and facilitators as categorized by the World Health Organization contribute to understanding accommodations.

*Lifeline Strand Three: Environmental Factors*

A third strand that guides accommodation is the World Health Organization’s classification of Environmental Factors (World Health Organization, 2001). Much of what requires attention to meet the needs of learners with impairments is the reconstruction of environmental factors, in the largest sense of environment--the attitudes and beliefs, expectations, policies, and physical environments that we have configured, based on assumptions about how people without impairments interact with their world, pursue and achieve goals, and define competency or success. This view is captured in the WHO conceptualization of Environmental Factors, which will be described here in detail.

*Five threads within Environmental Factors strand.*

Within the domain identified by the ICF as Environmental Factors, this strand incorporates five threads, each of which contains both “barriers” and “facilitators” of participation. These five threads can be particularly useful in identifying areas of intervention or attention in an accommodation plan. The five threads are: a) Attitudes and Beliefs; b) Natural and Built Environment; c) Policies, Services and Systems; d) Products and Technology; and e) Relationships and Supports (WHO, 2001).

The Attitudes and Beliefs thread includes those ideas and values held by people in the environment that inform their decisions, priorities, and actions of people outside the individual with an impairment. The Natural and Built Environment thread refers to the out-of-doors, the climate and terrain, and the buildings, structures, and spaces both
naturally and deliberately created, in which students engage in their education. The Policies, Services, and Systems category comprises a large portion of the educational environment, including the curriculum itself, policy and procedural requirements, tuition structures, daily schedules, and routine expectations, among a vast array of other policies and services that affect the daily lives of students. The Products and Technology factor also contributes enormously to the environment of the school – computers, Smartboards, texts, data projectors, lab materials, electronic library and classroom resources, and automated systems all contribute to the technological environment that can either facilitate or obstruct students' participation. The Relationships and Supports factor consists of the myriad informal relationships and arrangements that are made in individual lives, such as family help, carpooling, friends and volunteers, all of which help the student succeed in daily life.

Using these five threads within the Environmental Factors strand, we are able to identify where various interventions take place, clarify roles, and ensure that whatever can be changed by the institution to facilitate the student's participation is thoroughly addressed. In this application, the ICF is used to identify the barriers to participation in education faced by students with impairments, and to frame the development of facilitators of that participation. An accommodation plan is basically a list of environmental facilitators, developed in the context of a social model of disability, to address functional limitations in activities and participation in education. What weaves together the legislated mandate and theoretical perspectives of the accommodation process is Olson's notion of a joint intention between instructor and student.
Lifeline Strand Four: Forming Joint Intentions to Facilitate Learning

This strand weaves in David Olson’s work on forming joint intentions for learning. Olson espouses the formation of “joint intentions” between instructors and students to share the responsibility for learning, expanding on John Dewey’s emphasis on shared activity to facilitate understanding (Dewey, 1980, cf Olson, 2003). Olson describes a process in which learning activities and assessment are negotiated with the student, preferably explicitly but more often implicitly, based on both the instructor’s intentions in curriculum design, and the student’s intentions to participate in learning. Olson emphasizes the need to find common ground for this process. From my perspective, joint intentions between an instructor and a student with an impairment must be particularly deliberate and explicit, to result in the required accommodation plan.

Olson argues that although the institution of education itself attempts to make students responsible for their education, instructors also have responsibility, by providing not only the curriculum but also the context for learning, specifically the educational environment. Olson brings the debate over responsibility partially to rest in the notion of joint intentions: “The essential feature of pedagogy, it may be argued, is combining the intentions of the teacher and learner in a joint intention.” (Olson, 2003 p. 243) This can be anticipated to pose some challenges, as it is not always easy to agree on goals and directions at the best of times, not to mention with the age, role and power differentials between instructors and students. Nonetheless, it is incumbent upon instructors to develop instructional methods congruent with the knowledge and skills of students, to effectively engage them in the learning process. Finding what makes the
student connect with the material is part of the instructor’s responsibility (Olson, 2003), and this includes methods to facilitate participation of students with an impairment.

Similarly, the student, in order to learn, has to be willing to explore the material, and agree to participate in the process toward a particular learning objective. Olson notes that one can no more force a student to learn than one can will the weather to comply; there has to be some willing engagement on the part of the student as well. The evidence of this joint intention, and indeed whether it has succeeded, is the agreement on criteria for performance. The instructor usually sets out these criteria, and while the student is not usually directly involved in initially setting the criteria, by participating in the educational process the student agrees to work toward the established objective. This default process is not particularly mutual, “joint,” or intentional, but no doubt is more the daily reality of teaching and learning. The question of how a student with an impairment might progress toward the learning objectives is the point at which a joint intention is explicitly created.

In the case of a student with an impairment, the formation of joint intentions starts when the curriculum poses a series of tasks, or attempts to define and convey the “officially sanctioned” knowledge to be addressed in the classroom (Olson, 2003). Content areas and performance standards are established, to be elaborated, detailed and implemented by the instructor. Providing the context, content, and an environment conducive to learning is the instructor’s (and institution’s) responsibility. Then, presumably the instructor and student agree, implicitly or explicitly, on what will be learned and how, what will be evaluated, and how evaluation will be conducted. Hopefully, students find goals, directions, and interests that dovetail with those of the
teacher, and they embark on this mission together (Hutchinson, 2002; Test, 2004); they have an implied joint intention. Olson says, “joint intentions…provide a bridge between the official … knowledge of the society and the beliefs and intentions of [students] that allows the learner to take responsibility for learning” (Olson, 2003 p. 250) Herein lies the heart of accommodation planning.

A common thread in all the strands of accommodation planning is the need to collaborate with students to develop accommodation plans in a mutually agreeable process. The legislation requires participation of the student (Ontario Human Rights Commission, 2004), as does the social model of disability, and Olson (2003) describes the negotiation of what will be learned and how assessment will occur in his discussion of joint intentions. All of our strands incorporate an expectation of mutual process. See Table 2 for a comparative summary of thematic strands.

Table 2: Comparison of thematic strands

<table>
<thead>
<tr>
<th>Threads within each strand</th>
<th>Legislation Strand</th>
<th>Theoretical Strand</th>
<th>Environmental Strand</th>
<th>Joint Intention Strand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual participates as resource/expert</td>
<td>Human Rights Code thread</td>
<td>Medical Model thread</td>
<td>Social model thread</td>
<td>WHO Model thread</td>
</tr>
<tr>
<td>Environment is the focus of accommodation</td>
<td>Yes – accommodation must address structures</td>
<td>No</td>
<td>Yes</td>
<td>Yes – focus is on the person</td>
</tr>
<tr>
<td>Process is mutual and joint</td>
<td>Yes, process requires students to be specifically included</td>
<td>No</td>
<td>Yes</td>
<td>Yes, via social model origins</td>
</tr>
</tbody>
</table>
The result of weaving all these strands together is a lifeline for effective accommodation planning, developed with the student, to facilitate participation in the learning environment. Following is an illustration of the use of the lifeline with a case study of a composite student. Dylan, the student in this example, is a completely fictional character, based on 20 years of work with disabled students at all levels of schooling.

**Composite Student**

The following illustration, while fictional in its entirety, is comprised of actual situations observed in my practice over 20 years and across thousands of students.

At the post-secondary level, Dylan is taking three courses--English, history, and philosophy. He has quadriplegia affecting the strength and coordination of both arms and legs, and uses a power wheelchair for mobility. Classes meet in three different rooms, in different buildings on campus, one of which is completely inaccessible. Snow and ice accumulations interfere with efficient travel across campus, and the chair cannot navigate over the short-cuts other students might use to cut down travel time between classes. One room has fixed seating, so Dylan cannot get his chair close enough to the front of the class to be comfortable asking questions or seeing the board. Assignments are required weekly in each course, some requiring use of library resources that are difficult to manipulate with his hands. The accessible transportation system often runs late, requiring him to be hours early or risk being late for class. This contributes to his stress and fatigue. Due to limited endurance and the need to pace and carefully schedule his work, short deadlines are sometimes impossible to meet, and Dylan loses marks for lateness, depending on his health. The English and history professors use
detailed Power Point slides and provide annotated notes on their websites, but the philosophy professor speaks mostly from overheads that are not otherwise available. Notes are harder to obtain in this course. The midterm assessment requires attendance at an inaccessible location and handwriting long essay questions in a limited amount of time. Personal care activities require attention more often than the examination time frame allowed, so Dylan has even less time available within the set hours to complete the assessment activity. Dylan approached the Office for Students with Disabilities (OSD) on campus to develop an accommodation plan that would remove the barriers he faces and help him pursue his goals in higher education.

Consistent with the medical model, documentation of Dylan’s functional impairments and necessary considerations was provided by his physician. Consistent with the social model principle of empowering the student with a disability, Dylan functioned as the expert on the impact of his impairment on his participation in his education, explained the barriers he faced, and the OSD counselor engaged with him in developing joint intentions between the college and the student, to be refined by the student with each of his professors. They addressed each thread of the Environmental Factors strand in turn. With respect to the Natural and Built Environment, Dylan identified classroom location and snow removal as issues. The OSD arranged for the class to be relocated to an accessible room, and spoke with the maintenance crew to identify routes that required priority snow removal as an accommodation. One seat from the fixed seating arrangement was removed, allowing space for Dylan’s chair to move in closer to the front of the class. The location for assessment was changed to provide an accessible computer lab and with accessible washroom facilities near by.
In Products and Technology, barriers to producing written assignments and accessing library resources were addressed with assistive technology, including dictation software and scanning technology to get readings into electronic format for easier manipulation, highlighting, and note taking. Assessment was conducted using an electronic copy of the examination questions read aloud by the computer, and dictation software.

The Policies, Services, and Systems factor posed barriers in the practice of assigning late marks and deductions from class participation for lateness. An unfair disadvantage was created by the time frame for exams, when Dylan had to take time out for personal care. Exemptions to these policies were implemented, and Dylan arranged a transportation schedule with the transit company well in advance to reduce the likelihood of being late. A parking permit was issued for his van as well, for use when a driver was available. In the area of Relationships and Supports, a volunteer note taker was provided, to type notes and send them to Dylan in electronic format to reduce the need to manipulate paper materials.

All of these needs and accommodations were identified with Dylan’s input, respecting his physical impairment as the status quo, while addressing the environmental barriers to his participation in higher education. Policies and procedures that were constructions of the faculty or institution but not actually integral or essential to learning or assessment of knowledge were altered, without changing the curriculum requirements, level, or required standard of performance. Recognizing that his medical condition affected his participation in post-secondary education, and that legislation mandated accommodation, the social model informed the tone of the accommodation
planning, the ICF provided a structure to organize the plan, and the process was conducted through mutual participation, forming a joint intention for accommodation and learning. See Fig. 1 for an illustration of the inter-weaving of factors in accommodation planning.

Figure 1: A lifeline for accommodation planning

Discussion

Joint intentions for accommodation plans with students with disabilities can be difficult to develop. Within the legislated mandates under which joint intentions or accommodations are formed, accommodation plans need to address curriculum requirements and environmental factors, identifying both barriers and facilitators of
learning. Curriculum requirements define the task to be done while five categories of environmental barriers to be addressed are defined by the ICF, and the education and human rights legislation provide both a legal imperative and contribute to the political context. Political contexts are critical in setting the tone for developing and implementing accommodation plans, since participants bring their views and experiences of disability to the table along with varied expertise and mandates. The social model of disability helps with understanding this political context. A synergy of these models, weaving the strands together, enhances development of joint intentions to provide accommodation to students with disabilities as mandated by anti-discrimination legislation – human rights codes.

These interdisciplinary perspectives locate the process of accommodation planning in a larger social, philosophical, and legislative context, while emphasizing the joint or mutual nature of the process. It is demonstrably a complex process, involving many important threads. Table 2 (above) summarizes the common threads within each strand of the lifeline for accommodation planning.

Conclusion

Instructors, administrators, and students would benefit from having a comprehensive and systematic way of thinking of about how such complex accommodation plans can be formed, such as a lifeline woven of the medical and social models together in the biopsychosocial model of disability, the legislation, the ICF concept of barriers/facilitators of participation, and the concept of mutual, joint negotiation.
This chapter described a lifeline for understanding and developing accommodation plans, woven with four thematic strands: 1) human rights legislation requiring that accommodation be provided, with the participation of students with disabilities; 2) theoretical models of disability, in particular the biopsychosocial model, that sets out the political context for accommodation planning; 3) environmental factors from the WHO ICF (WHO, 2001) to identify the barriers and facilitators of participation addressed in accommodation plans; and 4) the notion of joint intentions for learning. An important thread common to all the strands is the need for inclusion of the student in a mutually agreeable process. The lifeline described is intended to help guide service providers, students, and instructors, along with administrators and specialists in coming together in a mutual process that is respectful, dignified, and specific, to create effective accommodation plans at the post-secondary level where the process is driven by these models and anti-discrimination legislation.
References


Chapter 4: The Human Rights Paradigm: Is It Effective? What’s the Alternative?

Judith Mosoff states, “…profound social and legal changes are necessary to effect meaningful inclusion of people with disabilities.” (2000, p. 225) Why? Hasn’t human rights legislation increased inclusion of people with disabilities?

The Court states in its analysis of *Meiorin*, “Accommodation…does not challenge deep-seated beliefs about the intrinsic superiority of such characteristics as mobility and sightedness. In short, accommodation is assimilationist. Its goal is to try to make "different" people fit into existing systems.” (*British Columbia (Public Service Employee Relations Commission) v. B.C.G.E.U.* (1999) [Meiorin] at para. 41)7 Although post-secondary institutions are mandated by law not to discriminate against, exclude or restrict access for people with impairments8, barriers to full participation remain. By focusing on fitting people with impairments into established structures via accommodation, instead of questioning those structures, the human rights paradigm is proving to be inadequate for really improving the participation of disabled people. (Bickenbach, 2003; Mosoff, 2000) While it has served as a strong impetus for change in the lives of people with impairments, it is a system driven by complaints, and by efforts to determine if and when exceptions are justified. The negative impetus, to avoid complaints, is inherently conflict-ridden, adversarial, and stressful. A model driven by

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7 See Note on Citation Style, p.xiii

8 In this work, I use Oliver’s social model of disability and follow the reasoning that environmental structures are what disable people. Hence, I will follow Oliver’s convention in referring to “disabled people” or “disabled students” when referencing the effect of social structures on the participation of people with impairments. I will use “people with impairments” or “students with impairments” when referring to individuals with what the World Health Organization (2001) defines as impairments in body structure or function. When referring to legislation that uses the term disabled or disability, I will keep the language consistent with the legislation for clarity.
complaints is like a donkey that only experiences the stick behind him, without any carrot ahead of him. An approach that focuses on the carrot of an inclusive community is needed.

To show how the evolution from defining the stick to defining the carrot, I will explore key cases that have contributed to the development of how discrimination is determined, and the considerations that must be taken into account in that determination. While the cases outlined arise in the employment sector and are not all based on disability, they nonetheless supply the foundation for dealing with disability discrimination issues. The cases present a number of test questions to be answered in determining discriminatory job requirements. I will describe how these key cases have driven the development of accommodation strategies in post-secondary education specifically. A consolidation of the test questions into the four most useful in post-secondary education will be used to illustrate the shift away from designating characteristics of people or grounds of discrimination toward analyzing requirements, policies and practices, which leads in turn toward defining requirements to be inclusive. Finally, I will show why a pro-active approach is likely to be more effective for including people with disabilities in post-secondary education.

The Concept of Discrimination

The concept of discrimination emerges from the notion that people have certain rights that must be respected equally for all, regardless of various characteristics like race or religion. Human rights are basic entitlements that we confer upon one another as human beings. These rights cannot be conferred differentially because of characteristics that differ between us, which are not relevant to the exercise of these
rights. Discrimination is disallowing the equal exercise of rights we have collectively
defined and enshrined in social policy.

Not all activities that distinguish between people are discriminatory in an equity
sense. Sometimes it is appropriate and important to “discriminate” between people, in
the sense of discerning between groups that qualify for benefits or need special
attention of some sort. For example, identifying minors as vulnerable, needing support
and protection, restricted from assuming certain responsibilities, and having
expectations for health care and education for them is not considered discriminatory on
the basis of age – it attempts to discern a difference in maturity between children and
adults for the purpose of ensuring their safety and well-being. This type of
discrimination, or discernment, is not the behaviour prohibited in human rights
legislation.

Human rights law in Canada has evolved through the exploration of domestic
questions of discriminatory behaviour and practices to determine what constitutes
discrimination, on what grounds, in what situations. Following World War II, growing
awareness of racist and anti-Semitic practices and rising momentum in the fledgling civil
rights movement resulted in efforts to sort out questions of discrimination (e.g. Racial
Discrimination Act (1944); Re Drummond Wren (1945); Saskatchewan Bill of Rights,
1947). The Universal Declaration of Human Rights (UDHR, 1948), to which Canada is a
signatory, enshrined the right to non-discrimination. Following the UDHR statement on
human rights, further domestic legislation began to appear in the Fair Employment
Practices Act (1951), and the Female Employees Fair Remuneration Act (1951). These
initiatives and their attendant issues stimulated the provinces to develop human rights codes.

The *Canadian Bill of Rights* was passed in 1960, and Ontario established the Ontario Human Rights Commission (OHRC) in 1961 to administer the subsequent *Ontario Human Rights Code* (hereinafter the *Code*) (1962), which was the first of its kind in Canada, with other provinces following suit in due course. The provincial human rights codes recognize the right to non-discrimination set out in the UDHR, and develop a mechanism of redress for acts of discrimination. In 1982, the Charter of Rights and Freedoms came into effect, and in 1985 Section 15 of the Charter firmly established principles of human equality in the fabric of Canadian society. The concept of discrimination had been approached by the Court prior to these important pieces of legislation, but without a legal link to terms, conditions, and potential remedies, many solutions were inadequate, missed the mark, or simply were not pursued.

Since the passage of human rights legislation, the concept of discrimination has received much more thoughtful and constructive attention, with the advent and resolution of many key cases contributing to what we deem discriminatory, as well as a plethora of remedies. Nonetheless, because of the changing nature and demographic of Canadian society, these concepts of equal rights, designated grounds, and remedies are ever-moving targets, shifting with the re-examination of social assumptions, political dynamics, and economic trends that define who is oppressed and requires equalization of opportunity.

Race and religion formed the basis of early anti-discrimination law, and six characteristics were consistently designated in the emerging human rights codes as
grounds on which one must not discriminate. These included race, creed, national origin, colour, religion, and sex; mostly binary distinctions between people. A person was thought to be of a certain race, creed, national origin, colour, religion, or sex, or not of that group. The assumption that these are mostly binary distinctions becomes problematic as considerations of mixed-race, multi-national, and transsexual individuals arise. However, in the chronology of the evolution of human rights law, disability was the first designation that was dramatically heterogeneous, relative to the initial designated groups. Disability was not included as a designated group until after a framework addressing these first six groups was established.

Disability as a ground of discrimination was not conceptualized in the original drafting of the Human Rights Code. Disability became a designated ground much later, in 1982, with the introduction of Section 15 of the Charter, through the evolution of grounds of discrimination, and the unequal implementation of employment benefit policies.

Additional grounds emerged with new questions brought before the Commission. In 1982, age was addressed as a ground of discrimination in Ontario (Human Rights Commission) v. Etobicoke (Borough), [1982] 1 S.C.R. 202 [Etobicoke]. Two firefighters filed a complaint, based on mandatory retirement at age sixty, which was eventually upheld as discriminatory because physical ability can vary widely at age sixty. Also, it was noted that there was no bona fide occupational requirement identified which would require retirement at that age. While this is one of the early notes regarding the need for bona fide occupational requirements to be defined, no means of defining such requirements was articulated until later.
The notion of adverse effect was articulated in *Ontario (Human Rights Commission)* and *O’Malley v. Simpsons Sears Ltd.* [1985] 2 S.C.R. 536 [O’Malley]. This case explored whether it is discriminatory to require people to work on days of religious observance, and how the rules for scheduling work created an adverse effect on those who observe the Sabbath on Saturday. It was determined that policies that penalize workers who are Saturday observers are discriminatory on the basis of religion. This case showed that even policies that bore no intent to discriminate could be discriminatory in their effect, and presented a valid claim of discrimination. Thus intent was not required to constitute discrimination; an adverse effect was sufficient. This principle is important when considering the design and delivery of educational programs in which there may not be intent to discriminate or exclude students with disabilities, but barriers to equal participation are nonetheless created.

An initial step toward building an inclusive workplace environment, instead of defining rules that exclude or require exceptions, was the examination of employment benefits policies that were constructed on the assumption that workers are generally male. Such policies created unequal access to benefits based on sex. As employment policies began to address absence from work due to things like health-related conditions, accident or illness, and physical disability, the differential administration of these policies for men and women began to be examined. Policies that excluded access to workplace benefits for either sex were found to be discriminatory and needed to be based on a different assumption, e.g. that workers are parents, whether male or female, and family-related benefits should be administered equally. The notion of broadening
the categories addressed by benefit plans contemplates the idea of inclusion by design, or a pro-active model instead of a model reactive to more discreet categories of people.

The differential application of benefits to women who were pregnant versus women who missed work for other reasons was raised in Brooks v. Canada Safeway [1989] 10 C.H.R.R. D/6183 (S.C.C.). This case illustrated that policies that create a differential burden on only some women (pregnant women) are still discriminatory on the basis of sex, because only women can become pregnant. With this interpretation, a within-groups comparison became useable to determine discrimination. This rationale laid the groundwork for the subsequent case of Battlefords and District Cooperative v. Gibbs [1996] 3 S.C.R. 566, in which physical disability carried a benefit that was different from mental disability, and was therefore found to discriminate against people with mental illness.

From the examination of the differential treatment of men and women in the workplace, assumptions about sexual orientation, marital and family status evolved as well. If the sexes need to be considered equally in employment relations and benefit plans, there are implications for benefits in same-sex relationships. With recognition of those relationships in the workplace, implications for civil and common-law relationships emerged, to give men and women equal rights and access in terms of property and child support (Egan v. Canada, [1995] 2 S.C.R. 513, 124 D.L.R. (4th) 609 [Egan]; Vriend v. Alberta, [1998] 1 S.C.R. 493, 156 D.L.R. (4th) 385 [Vriend]).

Policies that create exclusion due to apparently binary distinctions like male/female, or within groups of people like women/pregnant women and disabled/physical or mental, pose a barrier to full participation as equal citizens. By contrast, policies that
reduce differential effects on people open the door to broadening the thinking about policy development as a tool for inclusion. A carrot begins to emerge.

The extension of the concept of discrimination into the area of disability took time, but now disability is the most common category of human rights complaint in Ontario (OHRC, 2007). Although initial conceptualizations of discrimination were focused on binary distinctions such as race and religion, in which one was considered to be of a particular origin or not, disability is not so delimited. Disability can fluctuate over time, vary in severity and impact from one person to the next with the same condition, and one can be both disabled and not disabled in one’s lifetime. Because disability is harder to define, the anti-discrimination model may not be as effective in building equal opportunity for people with disabilities. Membership in a group of people with impairments may or may not denote social oppression for any given individual. The environmental factors such as Natural and Built Environment, and Products and Technology, play a far more significant role in determining equal participation than is the case for people with diverse racial, ethnic, national, or religious origins. If one considers the context of the requirement or activity where discrimination is alleged, it may be easier to determine discrimination than by defining various characteristics of people. Even race, religion, and national and ethnic origin are no longer clear binary distinctions – witness the blended characteristics of people like Barack Obama, Tiger Woods, and the countless inter-racial couples with blended faith backgrounds, and gay and lesbian couples creating their own family structures. With less clearly binary categories of people, it becomes increasingly difficult to designate grounds of discrimination, to prove
membership in a discrete group, and demonstrate a resulting marginalized, vulnerable status.

_Bona Fide Occupational Requirements (BFOR’s)_

The evolution in thinking about what is and is not discriminatory, and on what basis, has led to some key questions that must be asked to determine if job or task requirements are discriminatory in their effect. Not only must a designated ground be evident, but also specific analysis of the requirement, policy, or task is necessary to determine discrimination. This is another step toward focusing on factors contributing to exclusion rather than characteristics of the person. Instead of asking whether a person with certain characteristics should be allowed to participate, the question becomes what makes a requirement or policy necessary? With the focus on this second question, an analysis of the environmental constructs can be undertaken, and those environmental constructs may be more problematic than characteristics of the person. Requirements that impose a burden on a designated group for reasons that are not truly significant or defensible need careful examination. If an accommodation could be made that would enable the participation of members of the group, the accommodation needs to be considered. The cases described below will highlight the questions raised to determine discrimination. The questions are presented as the key indices of what constitutes a bona fide occupational requirement or qualification.

_Case Law and Tests of Discrimination_

As mentioned above, in _Etobicoke_, the question of whether mandatory retirement was discriminatory on the basis of age was raised. The Supreme Court identified two
questions, or tests, to determine whether the requirement of mandatory retirement was bona fide--one subjective, the other objective:

1) Subjective--Was the requirement determined in good faith, with the honest belief that the requirement is necessary for the performance of the job?

2) Objective – Is the requirement reasonably necessary, is it rationally connected to the performance of the job, and is there evidence to that effect?

(Etobicoke, 1982)

This was one of the first attempts to define what constitutes discriminatory policies, practices or standards. If the answers to both the subjective and objective tests were in the affirmative--the requirement had been created in good faith, and was rationally connected to performance of the task with evidence to support that connection--then no accommodation was required. The requirement, policy, or standard was considered to be a “bona fide occupational requirement”, or BFOR.

Tests of BFORs evolved further with Meiorin. Ms. Meiorin was an effective forest firefighter for three years. Then, an aerobic fitness test was instituted to determine fitness for safe performance as a firefighter, resulting in a standard that became a purported BFOR. The standards established by the test were based only on physical capacities of male firefighters. Despite having performed the same duties for several years alongside her male colleagues, when Ms. Meiorin was unable to pass the fitness test to meet the standard, she was relieved of her employment. She filed a complaint of discrimination on the basis of sex. The three questions considered were: 1) is there a general connection between the requirement and the task; 2) was the requirement or standard established in good faith; and 3) was there evidence of a rational connection
between the requirement or standard and the task? The Court found that while there was a general connection between fitness and the safe execution of firefighters’ duties, and the standard was adopted in good faith, there really was no evidence of a rational connection between the particular standards based exclusively on male subjects and what was actually necessary to do the job. In other words, that particular level of aerobic fitness was not a BFOR. The standard screened out people who clearly had demonstrated the ability to do the job, and since women would be less likely to be able to meet the standard established by only male firefighters, it was deemed discriminatory toward female firefighters. The standard was one that only a designated group of people would be unable to meet, and thus imposed a burden on that group. The result of this consideration is that standards have to be shown to be necessary to execute the task. They cannot be arbitrary, nor can they have an adverse effect that excludes a particular category of people, in this case women. Thus consideration of the construction of a standard was incorporated into the determination of discriminatory practices, and Meiorin became known for defining the “three step test”. The three step test can also be useful when considering how academic policies and requirements are constructed. (This idea is explored in depth in Chapter 6: The Duty to Accommodate and Academic Requirements: Report on the Results of a Focus Group Aimed at Testing Four Determinants of Discrimination.)

Two critical shifts in thinking occur with Meiorin. This case did away with the distinction between direct and adverse effect discrimination. The traditional distinction between direct discrimination that has clear intent, and adverse effect discrimination, in which requirements that appear neutral inadvertently affect groups differently, is
eliminated with one conceptualization of discrimination as discrimination regardless of intent. Taken from the analysis in *Meiorin*, “The parties to this appeal have accordingly invited this Court to adopt a new model of analysis that avoids the threshold distinction between direct discrimination and adverse effect discrimination and integrates the concept of accommodation within the BFOR defence.” (*Meiorin*, para. 24)

Prior to *Meiorin*, if a requirement was shown to be directly discriminatory, it could be justified if it was shown to have been established in good faith and rationally connected to the performance of the job. This type of rationale would be a common conclusion to questions of discriminatory academic requirements. Instructors don’t typically establish academic requirements in bad faith, or to confuse or trick students, and no one has time to require things that are not connected to the curriculum. In the unlikely event that requirements were established in bad faith, and/or unrelated to the curriculum, the requirement could be struck down as discriminatory. Such an outcome can be difficult to obtain in academic situations. If the requirement was shown to have an adverse effect on particular groups and thus be discriminatory, it could still be shown to be rationally connected to the job and not feasible to accommodate, so it remained intact. Neither of these paths required examination of the requirement itself. The direct/adverse effect distinction, referred to as the bifurcated analysis, kept the requirement in question from being analyzed, and so sustained the status quo. No real fundamental change in the requirement would result. The analysis of *Meiorin* captures this eloquently.

Accommodation seems to mean that we do not change procedures or services, we simply "accommodate" those who do not quite fit. We make some concessions to those who are "different," rather than abandoning the idea of "normal" and working for genuine inclusiveness. (*Meiorin*, at para. 41)
Absence of intent had been eliminated as a defense in *O’Malley v. Simpson-Sears*, because the impact of employment schedules on people whose religions required observance on Saturday was still detrimental despite not having been intentionally created to discriminate on that basis. Intent became a moot point. Therefore, if intent is not required to show discrimination, the distinction between direct (intentional) and indirect, or adverse effect (unintentional), becomes moot as well.

Nonetheless, Buckley (2006) notes that

“…even though discrimination is discrimination, conceptualizing an equal rights infringement as direct, adverse effects, or systemic discrimination may be helpful in litigating and analyzing the case to the extent that it helps to illuminate the dynamics by which discrimination is imposed.” (p. 180)

The distinction remains academically useful in deconstructing earlier defences if applied to academic requirements, and in illustrating the futility of relying on the distinction between intentional and unintentional discrimination, emphasizing the idea that discrimination is discrimination regardless of intent. Having clarified that intent is a red herring in the analysis, the focus shifts to examination of the requirement or standard itself. The elimination of a bifurcated analysis opens the way for more careful consideration of how requirements and standards are established in the first place. In the context of creating academic policies, requirements, and curriculum that do not exclude students with disabilities, the reflective educator is called upon to make such a careful consideration.

*Meiorin* demonstrates the importance of examining the construction of a requirement, similar to the question in *O’Malley*. *Meiorin* defines consideration of how requirements are established, whether they might be discriminatory from their inception,
and demands that they be created to be inclusive from the start. Possible accommodations must be thought of before the requirement can be established. If the requirement can be met with accommodations, those must be utilized and included in the standard or expectation. McLachlin, J. states in *Meiorin*:

> … the possibility that there may be different ways to perform the job while still accomplishing the employer’s legitimate work-related purpose should be considered in appropriate cases. The skills, capabilities and potential contributions of the individual claimant and others like him or her must be respected as much as possible. Employers, courts and tribunals should be innovative yet practical when considering how this may best be done in particular circumstances. (para. 64)

The principles described above can be applied to an academic setting if “job” is replaced with “academic requirement”, “employer” is replaced by “educator”, and “work-related purpose” is replaced with “academic-related purpose”:

> … the possibility that there may be different ways to perform the academic requirement while still accomplishing the educator’s legitimate academic-related purpose should be considered in appropriate cases. The skills, capabilities and potential contributions of the individual claimant and others like him or her must be respected as much as possible. Educators, courts and tribunals should be innovative yet practical when considering how this may best be done in particular circumstances. (adapted from *Meiorin*, para. 64)

*Meiorin* sets out 6 specific questions to consider in analyzing and justifying a workplace standard. These questions frame the conceptual context in which standards need to be developed. The same substitution of terms has been applied:

(a) Has the [educator] investigated alternative approaches that do not have a discriminatory effect, such as individual testing against a more individually sensitive standard?

(b) If alternative standards were investigated and found to be capable of fulfilling the [educator’s] purpose, why were they not implemented?

(c) Is it necessary to have all [students] meet the single standard for the [educator] to accomplish its legitimate purpose or could standards reflective of group or individual differences and capabilities be established?
(d) Is there a way to do the [academic requirement] that is less discriminatory while still accomplishing the [educator's] legitimate purpose?

(e) Is the standard properly designed to ensure that the desired qualification is met without placing an undue burden on those to whom the standard applies?

(f) Have other parties who are obliged to assist in the search for possible accommodation fulfilled their roles? (Meiorin, para. 65)

Buckley (2006) describes the above questions as providing not only an illustration of the depth of analysis required, but also basically an instructional guide for the development of standards, including considerations of accommodation. (p. 189-190)

The case of British Columbia (Superintendent of Motor Vehicles) v. British Columbia (Council of Human Rights) (1999) [Grismer] plays a significant ongoing role in the determination of discriminatory practices and accommodation of disability. In this case, a truck driver with limited peripheral vision was denied a driver’s license upon failing the standard test of peripheral vision, a presumed BFOR for a truck-driving license. However, his vision could be corrected with the use of special lenses, but no testing was conducted using the lenses. The court decided that individual testing was required, using the lenses, because under those conditions, Mr. Grismer might be able to meet the BFOR for peripheral vision. Accommodation could have enabled him to meet the requirement, so the BFOR could have been achieved, and a driver’s license could not be denied on the basis of that vision impairment. Also of note, individual testing was not considered to constitute an undue hardship, because provisions for individual testing in other situations already existed within the Ministry. Grismer required the Transportation Ministry to test individually, with accommodation, before denying the benefit of a driver’s license. The BFOR was not denied, but it could be accommodated, and therefore had to
be accommodated, so while it may be a bona fide requirement, it could be met with accommodation, and was not a valid obstruction to accommodated performance, qualifying the complainant for the benefit (a driver’s license). Buckley (2006) describes how *Grismer* took this one step further by showing that these principles did not apply only to employment or job-related standards, but to all cases of discrimination, including governments. According to Buckley,

In order to prove that its standard is “reasonably necessary,” the defendant always bears the burden of demonstrating that the standard incorporates every possible accommodation to the point of undue hardship, whether that hardship takes the form of impossibility, serious risk, or excessive cost (2006, p. 191).

While Buckley does not make explicit the link from governments to educational institutions, it is a short step to include the Ministry of Training, Colleges and Universities, and by extension, institutions themselves in the duty to demonstrate that standards “incorporate every possible accommodation to the point of undue hardship”. It is important to note how the emphasis has moved from the person to the environmental elements of policies, requirements and standards as potentially discriminatory, versus the notion of categorizing the individual.

*Granovsky v. Canada (Minister of Employment and Immigration), [2000] S.C.J. No. 29* [*Granovsky*] incorporates the concept that the disability is not just a characteristic of a person, but also a function of the way society is constructed. Mr. Granovsky challenged the provisions of the Canada Pension Plan that allowed “drop-out” periods for payments for people who were permanently disabled from working. His disability resulted in intermittently declining function, while being partially able to work, so he was not permanently, totally disabled but partially disabled, which later evolved into a
permanent disability. Since he had not contributed sufficiently to the Plan due to employment that was intermittent for disability-related reasons, he was denied benefits. He claimed that the provisions for reducing the amount the employee is expected to pay should be applied to his situation as well, and the construction of the system’s criteria excluded him because of the evolving, degenerative nature of his disability.

While the Court found that Mr. Granovsky did in fact have a disability and functional impairment affecting his work history, and that the Plan did deprive him of benefits that other people with disabilities received, the Court also noted that the Plan distinguished between disabled and non-disabled employees, not between members of the disabled group, such that Mr. Granovsky was treated differently within the correct comparator group. The Plan was not designed or administered to meet the needs of people with temporary or partial disability, so Mr. Granovsky was outside the target group of the “drop-out” provision. His lack of benefit was not in contradiction to the purpose of the CPP policy, which was to distinguish between people with permanent disability and those without permanent disability. Nor had Mr. Granovsky’s dignity been infringed in the design or administration of the program.

One might argue that a system that cannot deal with the complexity and changing nature of disabling conditions is an affront to the dignity of people with fluctuating or deteriorating conditions; such a system will not serve the population effectively, and should be revised. Unfortunately, this argument is of no help to Mr. Granovsky when the Court views its role as determining discriminatory practices in the delivery of existing services, not in determining which services should be delivered with what criteria in the first place. This case speaks to the social construction of disability by the establishment
of definitions of disability, and to the fallibility of a system constructed to define and then
critique itself, rather than to build an inclusive society. Academia might well take a cue
from this hegemonic model of self-determination and self-critique, and aim for a less
preposterous and more accountable approach.

Granovsky also speaks to the difficulty of a system that has responded to more
dichotomous, homogeneous kinds of issues, like race and religion. Mr. Granovsky’s
disability was both fluctuating in its impact on function and work, and progressively
deteriorating, which characteristics are not well addressed by “either/or” policies or
analyses. Despite the need to consider discrimination and accommodation questions on
an individual basis, the policy in question in this case does not allow for conditions that
are not all-or-nothing. Herein lies the complexity of addressing disability through an anti-
discrimination model like the human rights paradigm. To date, the human rights
paradigm requires pigeon-holing of individuals based on designated characteristics.
People are not so tidy. On the other hand, defining the task requirements, whether they
are bona fide, and whether they can be accomplished with accommodation, forces
consideration of how the task or environment is constructed rather than depending on
criteria characteristic of the person. Defining tasks in this critical way will eventually help
us shift from quantifying personal characteristics to building an inclusive society, based
on what is learned from analyzing BFOR’s. Eventually, a BFOR decision rubric could be
developed and implemented to prevent the need for accommodation in the first place.
How Is This Paradigm Perpetuated?

Our tests of discrimination and our practices reflect this anti-discrimination paradigm, but our thinking has evolved toward the promotion of inclusion by design, not just through the construct of anti-discrimination. This shift is illuminated initially in the increased awareness that treating people the same is not necessarily treating them equally. As The Honourable Claire L’Heureux-Dube states, “Section 15 [of the Charter] has enabled courts to move from requiring that laws treat similarly situated individuals identically to requiring that laws treat individuals as substantive equals, recognizing and accommodating their underlying differences” (L’Heureux-Dube, 2006, p. 4). Subsequently, the Meiorin and Grismer analyses of discrimination show the importance of considering how standards are established by requiring that standards be examined and developed to include considerations of accommodation from the start.

Meiorin, Grismer, and Granovsky all point to the movement away from questions of only discrimination/non-discrimination, toward the extent to which BFORs must be considered with and without accommodation, before ruling out participation. Before a benefit or participation is denied because of an inability to meet an unaccommodated BFOR, that BFOR has to be 1) evidenced as being necessary, and demonstrably, defensibly linked to the benefit/job, and 2) individually evaluated, in the context of accommodation. These two requirements show a shift toward thinking of how to include people, not just prohibiting or correcting exclusion. These two factors combine to point our thinking toward anticipating what impact policies, procedures, and requirements will have on people with disabilities, so that these can be designed more thoughtfully, with
evidence of the relevance to the task, to be inclusive and accessible from the beginning. This thinking begins to construct the carrot of a pro-active approach.

The analysis in *Granovsky* goes on to reinforce this inclusive approach by incorporating the World Health Organization’s Environmental Factors as a framework for locating the “problem” of disability in the social (i.e. deliberate, collective) construction of the environment, or the workplace requirements and standards created. With *Granovsky* comes the advent of explicit consideration of the social or collective, deliberate construction of policies, standards, and expectations which may in and of themselves create systemically discriminatory situations. This explicit consideration recognizes that the “problem” is not just in the person and their fit with the status quo; the problem is a function of the way social programs, spaces, policies, and standards are created in the first place. This key shift is reflected in case law, from a medical model interpretation of disability where the problem is in the person who is not to be excluded/discriminated against because of her/his disability, toward a social-political model – a pivotal moment in the pursuit of equity for people with disabilities. *Granovsky* provides an excellent analysis using the distinctions made in the World Health Organization’s International Classification of Impairment, Disability and Handicap (ICF) (WHO, 1980), and utilizes them to highlight the role of social constructions (e.g. the Canada Pension Plan) in handicapping individuals:

> It is therefore useful to keep distinct the component of disability that may be said to be located in an individual, namely the aspects of physical or mental impairment, and functional limitation, and on the other hand the other component, namely, the socially constructed handicap that is not located in the individual at all but in the society in which the individual is obliged to go about his or her everyday tasks. (*Granovsky*, para. 34)
The case goes on to say,

…while the notions of impairment and functional limitation (real or perceived) are important considerations in the disability analysis, the primary focus is on the inappropriate legislative or administrative response (or lack thereof) of the state. Section 15(1) is ultimately concerned with human rights and discriminatory treatment, not with biomedical conditions. (Granovsky, para. 39)

This shift in thinking toward a social mandate for inclusionary thinking, beyond merely determining grounds for discrimination, points toward inclusion by design. The remedy may be something that involves changing a policy, redesigning a standard or reconstructing a physical space. Buckley (2006) describes it well:

The comprehensive accommodation analysis provides a principled framework for a consideration of whether or not an employer has carried out its positive duty to create [emphasis added] equality in the workplace. It delineates a deliberative and participatory process that encourages the parties involved to scrutinize underlying and systemic manifestations of discrimination. Further, it builds in consideration of equality norms into the reconstruction of workplace policies and practices. It articulates a “transformative ideal for equality law” (48) that is fully consistent with the norm of substantive equality. (p. 190)

This description is exactly the kind of activity required of educators designing curricula, to “…build in equality norms into the reconstruction of [education] policies and practices.”

**Integrating and Synthesizing the Various Legal Tests of Discrimination**

The tests of discrimination described in the questions posed in *Etobicoke, Meiorin, Grismer,* and *Granovsky* above can be synthesized to some degree into two areas for consideration of discriminatory treatment. First, there are what I will term “fair play” questions, querying the relevance of the contested requirement to the job or to the purpose of a policy. Second, there is consideration of whether a requirement, standard, or policy is a social construction based on assumptions about people which are not
relevant or appropriate, such that the requirement, standard or policy should be changed, or re-constructed to be more inclusive. Combining the analytical questions utilized in the above cases, suggests the following synthesis:

1. Fair play considerations:
   a. Is the requirement, standard or policy established in good faith? (Etobicoke, Meiorin)

   b. Is the requirement, standard or policy rationally connected to the job or purpose it is intended for? (Etobicoke, Meiorin)

   c. Is there evidence that it is demonstrably relevant/necessary? (Is it a bona fide occupational requirement/qualification?) (Meiorin)

2. Social construction consideration:

   a. Is the requirement, standard or policy socially constructed such that it excludes specific groups, for a reason that is irrelevant, based on assumptions about function or the group? (Granovsky)

   **Implications For Practice in Post-secondary Education**

   The movement away from defining discrimination toward defining requirements and standards needs to inform the practice of accommodation planning for disabled students in post-secondary education. Until we have built a truly inclusive institution and educational practices, we will need to continue to implement the principles of the human rights legislation and accommodation. At the same time, we also need to avoid an approach that relies exclusively on qualifying individuals as marginalized members of society to improve access and participation. A more proactive emphasis is needed in the development of legislation, policies, and practices.

   In post-secondary education, the practice of accommodation planning strongly reflects the anti-discrimination paradigm, as accommodations are put in place to prevent complaints of discrimination from the failure to make the learning experience accessible
to students with impairments. Anti-discrimination questions at the post-secondary level are answered in terms of enforcing or making exceptions to existing assumptions, rules, policies or practices, such as determining whether refusing extra time on examinations would be discriminatory (*Justice Institute of British Columbia v. British Columbia (A.G.)* (1999), 17 Admin. L.R. (3d) 267), or whether denying the use of a computer constitutes unequal access to learning and assessment opportunities (*Callaghan v. University of Victoria*, 2006 BCSC 1503, [2007]). Sometimes the question is whether the disability to be accommodated exists (*Hannaford v. Douglas College*, 2000 BCHRT 25, 37 C.H.R.R. D/336) or is relevant to the academic program requirements (*Franco v. Vancouver Community College*, 2004 BCHRT6, [2004]). Other cases explore whether refusal of services such as building access constitutes unjustified discrimination (*Berg v. University of British Columbia*, [1993] 2 S.C.R. 353), or how much money is too much for an accommodation (*Howard v. University of British Columbia* (No. 1) (1993), 18 C.H.R.R. D/353) or whether the failure to accommodate caused an undue burden on the student (*Brown v. Trebas Institute Ontario Inc.*, 2008 HRTO 10). All these questions and cases take an anti-discrimination approach, defining whether the “stick” of legislation should be applied. None of them focus on formulating the “carrot”, designing a more fully inclusive learning environment, nor do they arise from any affirmative mandate or social justice perspective to do so. With the implementation of new standards under the *Accessibility for Ontarians with Disabilities Act, 2005* (AODA) that mandate to be pro-active was launched in a direct way.

The subjective and objective tests put forth in *Etobicoke* might be used in post-secondary accommodation planning, but they do not go far enough. For post-secondary
practitioners, whether a requirement was made in good faith and with a rational connection to the task is often more a subjective or traditional connection than a critically determined necessity, and too frequently could form the foundation of arguments pertaining to academic integrity. Without looking more deeply at the issues involved, much-needed analysis and academic accommodation would stop here.

Meiorin demonstrated that a standard or test has to be relevant to the task required, with evidence of the relevance, before it can be used to exclude people. In post-secondary education, requirements for handwritten answers to tests, prolonged sitting in exams, and short deadlines are examples of standard requirements that may exclude students with impairments from equal opportunities to demonstrate their knowledge.

Grismer determined that individual testing, with accommodation, was necessary before a requirement could be determined to be a BFOR, and that individual testing where that capacity exists does not constitute undue hardship. This is highly relevant to the individualized assessment of students with disabilities in post-secondary settings. Individualized assessment of a student’s knowledge, utilizing accommodations to demonstrate that knowledge in the context of the impairment, must be afforded the student, to determine if the BFOR’s of the curriculum can be demonstrated. Similarly, individualized assessment cannot be considered to be undue hardship on the institution, especially when the capacity to make up exams in the event of illness or other exceptional circumstance already exists.

In designing our learning environments to meet the needs of diverse learners, we are designing for inclusion, presenting the carrot, not just the stick, moving toward it willingly and pro-actively.
Critique of Human Rights Legislation as a Paradigm For Change

Significant development of the ideas behind human rights legislation has taken place. However, the negative impetus paradigm remains problematic for the reasons shown above. The human rights system is driven by complaints. Filing a complaint requires that someone is first aggrieved, offended, or injured in some way, and that they then have sufficient means in terms of information, energy, resources, mobility, and cognitive skill to find their way to launch a complaint, and sufficient endurance to see it through, which can take many years of investigation, hearings, and appeals. The system as it has functioned in Ontario for the past several decades was cumbersome and tedious. It has favoured people with less severe disabilities, who have the above-noted wherewithal to get through the process. Mosoff notes, “Decision-makers are much more likely to order individualized remedies, rather than systemic ones which would ultimately have a more significant and meaningful impact on the lives of people with disabilities.” (p. 274)

As well, the fact that human rights legislation is both federal and provincial leaves room for varied interpretations across provinces, and this undermines the effectiveness of the system as a means to advance the participation of people with impairments. As Ian McKenna notes, “Uneven duties of accommodation in the human rights legislation of the Canadian jurisdictions are inconsistent with the demands of section 15 of the Charter and produce unfairness, uncertainty and legalism.” (McKenna, 1997, p. 209). Section 15 of the Charter of Rights and Freedoms guarantees that “Every individual is equal before and under the law and has the right to the equal protection and equal
benefit of the law” Provincial codes and definitions that result in differential treatment between provinces undermine this equal protection principle.

The threat of a complaint may function as a deterrent to some discriminatory practices, or as a motivator to review policies for discriminatory effects, but even such risks have been known to be ignored because the perceived cost of the preventive action/initiative is thought to be greater than the cost of settling a complaint (McIntyre, N. personal communication, June, 1997). There are many aspects of the human rights paradigm that do not actually work in the best interest of disabled people. The principles of non-discrimination have merit, certainly, and the corrective, remedial recourse may be useful in raising awareness of how not to conduct business or build buildings or develop policies and practices, but it doesn’t effectively promote inclusion by design, valuing the contribution and participation of people with disabilities in the creation of social structures and systems.

The evolution in thinking about what is and is not discriminatory, and on what basis, has led to the key questions explored above, and to the development of an impressive list of enumerated grounds on which discrimination is explicitly prohibited. While these enumerated grounds vary somewhat between provinces and are less specific at the federal level, the constitutional capacity to identify analogous grounds leaves the door open to explore bases of discrimination that may arise with shifts in the culture, demographics, or economic dynamics of a society. This has occurred with the addition of sexual orientation as a prohibited ground of discrimination. Considered as an analogous ground at the federal level, the provinces have added it into their amended human rights codes (e.g. Egan, 1995; Vriend, 1998). The capacity to identify areas
where discrimination occurs and address it without being limited to enumerated grounds exists at the federal level, laying the groundwork for change at the provincial level. This flexibility of interpretation also lends itself to consideration of various types and degrees of impairment as requiring accommodation, as would have been useful in *Granovsky*.

Despite this progress, human rights law remains an anti-discrimination paradigm focused on defining, discouraging, and repairing discriminatory behaviour. It is remedial, not typically preventative, until a case raises an issue that is of interest to the greater public good, when a Commission might pursue a point for that reason. Human rights legislation as written at the provincial level doesn’t set out a positive model to strive for, but a negative consequence to avoid. As the Court stated in *Meiorin*,

"Accommodation does not go to the heart of the equality question, to the goal of transformation, to an examination of the way institutions and relations must be changed in order to make them available, accessible, meaningful and rewarding for the many diverse groups of which our society is composed. Accommodation seems to mean that we do not change procedures or services, we simply "accommodate" those who do not quite fit. We make some concessions to those who are "different," rather than abandoning the idea of "normal" and working for genuine inclusiveness. (para. 41)"

Similar criticism has been leveled at the World Health Organization’s initial International Classification of Impairment, Disability and Handicap (WHO, 1980). That organization rewrote their document to reflect a more positive, inclusive, capacity-focused perspective in the International Classification of Function, Disability and Health (WHO, 2001). The difference in focus is evident even in the title. An approach that focuses as much or more on building inclusion as a value in our society is needed.

New legislation that mandates accessibility is consistent with a pro-active approach to inclusion. Currently in Ontario, legislation itself is becoming more proactive than
reactive, as seen in the *Accessibility for Ontarians with Disabilities Act, 2005*, or AODA (Ontario Ministry of Community and Social Services, 2005). The AODA sets out standards for accessibility in areas of customer service, employment, transportation, information and communication, and the built environment.

The advent of this type of legislation is a hopeful step toward building for inclusion instead of defining exclusion and “othering” one another to various degrees of exceptionality. The AODA states:

> Recognizing the history of discrimination against persons with disabilities in Ontario, the purpose of this Act is to benefit all Ontarians by,

(a) developing, implementing and enforcing accessibility standards in order to achieve accessibility for Ontarians with disabilities with respect to goods, services, facilities, accommodation, employment, buildings, structures and premises on or before January 1, 2025; and

(b) providing for the involvement of persons with disabilities, of the Government of Ontario and of representatives of industries and of various sectors of the economy in the development of the accessibility standards. 2005, c. 11, s. 1.

This pro-active imperative clearly carries a different tone and direction from purely anti-discrimination law, moving toward designing social structures and spaces for inclusion of people with disabilities in a positive way.

From human rights legislation and the analyses of cases that challenged the concept of discrimination has come an emphasis on how various standards, requirements, and policies are established that either exclude or include people with disabilities. *Meiorin, Grismer, and Granovsky* demonstrate how much forethought and anticipation of diverse people’s participation is required in determining standards and work requirements. These are extrapolated into an academic setting when students with disabilities participate in academia. Now, accessibility legislation will provide a new way of looking at inclusion, not as an exception to the status quo, but as a mandate to create
environments and policies so people with all types of abilities and impairments can participate fully in the institutions, spaces and activities of their communities. Applied at the design stage, in the development of curricula and academic policy, the four test questions of discrimination can similarly contribute to the pro-active inclusion of students with disabilities.
References

Accessibility for Ontarians with Disabilities Act, S.O. 2005, c. 11, as am. by S.O. 2006, c. 35, Sched. C, s. 2.


Canadian Bill of Rights, S.C. 1960 c. 44


Fair Employment Practices Act, 1951 S.O. 1951, c. 24

Female Employees Fair Remuneration Act, 1951, S.O. 1951, c. 26


Ontario (Human Rights Commission) and O’Malley v. Simpsons Sears Ltd. [1985] 2 S.C.R. 536 [O’Malley]


Racial Discrimination Act 1944 S.O. 1944, c. 51


Saskatchewan Bill of Rights Act, 1947, S.S. 1947, c.35


World Health Organization International Classification of Function, Disability and Health (Geneva, Switzerland, World Health Organization, 2001)

American and Canadian anti-discrimination and equity legislation has forced medical schools to consider policies to address the participation of disabled students more explicitly. In this chapter, the social and legislative contexts for these policies are described. In particular, the policy guiding Ontario medical schools is critiqued, partly because of its influence on other medical school policies in Canada, and partly as an example of a reactive policy designed to help applicants self-screen before applying. A comparison is made with the accommodation policy of the Law Society of Upper Canada as an example of a proactive, inclusive policy statement. Recommendations are made for a different approach to such policies, an occupational therapy task analysis, which would encourage students with disabilities to engage in a dialogue about accommodation, and which would identify the task requirements of medical school more than the characteristics of students.

Social and Medical Models of Disability

The medical model locates disability in the individual, whereas the social model of disability places the locus of disability in society (Gill, 2003; Oliver, 1990) While both models recognize a fundamental impairment of physiology, the emphasis for facilitation of participation is on the medical expert’s intervention in the medical model, and on the proactivity and responsiveness of social policy in the social model. There are several other fundamental distinctions between the two models, a brief examination of which will help to position the discussion of the evolution of medical school policies regarding students with disabilities.
Medical Model of Disability

The medical model derives from a long tradition of positivist thinking, implementation of “the medical gaze” (Foucault, 1973) and the separation of the person from the illness or symptoms (Anderson, 1996; Jaeger & Bowman, 2005; McColl & Bickenbach, 1998). This model empowers the medical professionals as experts, who act upon the patient recipient of care and advice, in an effort to repair what is broken and make the person “right” or “normal”, since the assumption is that to have impairment or to function differently from a norm is negative and in need of fixing. The patient is not viewed as an active participant or expert in their condition or its treatment, but mainly as the locus of the problem.

I have heard this approach, addressing the problem instead of the person, reflected in bedside or clinic communication – “the knee in room 12”, or “that fracture in bed 2” etc. Any patient who has had a clinician speak about them and their impairment to a near-by colleague as if the patient had vacated the premises for the moment has felt this de-personalization in the focus exclusively on the physical problem. Aspects of the environment, such as the person’s home life, or policies and practices in the work setting, or attitudes encountered are not viewed as part of the medical practitioner’s purview, and are often not addressed in treatment of “the knee in room 12”. The problem, the focus of intervention and treatment is “the knee”, not the person, nor the person’s larger environment.

Social Model of Disability

The social model of disability is an outgrowth of social constructionist theory (Donoghue, 2003; Oliver, 1990). According to Michael Oliver,
the disabled individual is an ideological construction related to the core ideology of individualism and the peripheral ideologies related to medicalisation and normality. And the individual experience of disability is structured by the discursive practices which stem from these ideologies (1990, p. 58).

The model presents disability as a social construction based on the ways in which policies, procedures, institutions and structures, built environments, roles, and competencies are defined, assuming a “normal” configuration of vision, hearing, mobility, and health. For people with disabilities who possess a wide range of competencies, these socially sanctioned and engrained assumptions pose endless, yet needless barriers to participation.

Bryan Turner describes professions as social constructions: “Professions are not fixed social entities, but structured forms of occupational strategy” (Turner, 1987). He goes on to describe the evolution of medicine as a social construct.

It is … important to see occupations within a historical perspective. Medicine as a professional activity was a specific product of late nineteenth-century social conditions… The growth of medical dominance in the first half of the twentieth century was associated with urbanization, the development of health insurance, improvements in medicine and the expansion of the hospital as the site of scientific medicine (Turner, 1987).

From the viewpoint that our institutions are socially constructed and disability is a social construction based on various assumptions of normalcy, it would seem that careful reconsideration and reconstruction of those assumptions could eradicate or at least redefine the constructs within which the barriers occur, thereby facilitating the participation of people with disabilities. If socially derived institutions such as education and medicine were developed to include people with a variety of competencies and means of achieving, there would be fewer inherent barriers, and people could both
benefit from and exercise greater creativity in how various objectives are achieved, and who contributes to that achievement.

In contrast to the medical model, the social model recognizes that a person’s knee may have some physiological impairment of function, but the problem lies as much with the requirement to utilize stairs in the home or workplace, or an expectation of prolonged sitting or walking as it does with the knee. After considerable thought and revision, the World Health Organization (WHO) captured environmental components in the International Classification of Function, Disability and Health (ICF) (WHO, 2001). This document recognizes the environment as a critical factor contributing to disability, and classifies environmental factors into five categories: Attitudes and Beliefs; Policies Services, and Systems; Relationships and Supports; Products and Technology, in addition to the Natural and Built Environment (WHO, 2001). The person with the disability is also considered an expert in their particular condition, and is included in the problem-solving, setting of treatment goals, and implementation of treatment. The category of Personal Factors includes such elements as ethnicity, religion, gender, personality, etc. These are viewed as neutral features the person brings to their whole situation, value-free characteristics that contribute to the individuality of that person. The presence of mobility impairment is not viewed as negative, but as value neutral. The approach to facilitating activities and participation may or may not include knee surgery or medication, but should most definitely include consideration of such requirements and modification of the environment or tasks to remove the barrier for someone with limited use of a knee, for example. This model considers disability to be a social construct, based on what we assume everyone can or should be able to do. How we
view differences creates the biggest barriers for people with disabilities, according to the social model (Oliver, 1990).

*The Social Model and the Evolution of Equity Legislation*

The social model of disability has gained popularity over the last 15 years, developing as the minority group model in the United States, with the civil rights movements of the 1960s (Davis, 2002; Jaeger & Bowman, 2005; Pfeiffer, 1993). African Americans, women, and then people with disabilities have diligently sought to claim a more just position in society, to enhance equal opportunities by questioning the assumptions made about their participation and roles. The prevailing view of minority groups was challenged on every front, opening doors to greater participation, and these movements began to be reflected in powerfully positioned legislation, such as the *American Civil Rights Act* of 1964, the proposed *Equal Rights Amendment* for women in the US (Howe & Johnson, 1999), and the *Human Rights Code 1990* in Ontario. Pfeiffer (1993) offers a good description of the evolution of the disability rights movement, and addresses how the *Americans with Disabilities Act 1990 (ADA)* grew out of the civil rights movement, from the *Civil Rights Act* and *Equal Rights Amendment*, as disabled people developed more proactive strategies. The *ADA* is a potent American anti-discrimination law that evolved while the social model of disability was emerging in Britain, and the minority group model was growing in the US. (Gill, 2003; Oliver, 1990). Such legislation and the subsequent efforts to interpret and apply these principles resulted in a shift toward considering how we define and limit participation of marginalized groups, including people with disabilities. One of the most compelling of these civil rights initiatives for disabled people in the US, and disabled students in
particular, was *Section 504 of the Rehabilitation Act of 1973*. This law mandated equal opportunity in mainstream education. Following this initiative was the *Americans with Disabilities Act 1990 (ADA)*, enhancing the duty to accommodate people with disabilities in any federally funded program or business (Association of American Medical Colleges, 1993; Essex-Sorlie, 1994a; Gitlow, 1999; Winner, 2000)

In Ontario, the *Ontario Human Rights Code 1990* (hereafter referred to as the *Code*) evolved from the post-World War II anti-discrimination laws pertaining to race and creed. These separate laws were consolidated into one Human Rights Code in 1962, which has been updated several times, most recently in 1990, and amended to include 16 grounds on which discrimination is prohibited (Howe & Johnson, 1999). These designated grounds formerly referred to handicap, but now use the less patronizing term disability. It is significant for post-secondary education that the *Code* specifically included learning disability in the definition of disability, as this has been the largest group of students with disabilities in universities (Faigel, 1998).

**Impetus for Medical School Policies**

Michael Oliver (1990) has suggested that social and academic policies function as mechanisms of control, designed to structure participation, guide decision-making, and justify action. These policies are position statements that promote a commitment or direction (Oliver, 1990). Medical school policies regarding students with disabilities are part of the discourse on disability, arising from it and contributing to it, positively or negatively, depending on one’s view and how they are written. They also are designed to govern participation, guide decision-making, and justify action. These policies not
only control access to medical knowledge and power, but how that knowledge is applied, who is allowed to use it, and how disability in medical students is to be viewed.

The equity legislation and the rising popularity of a social model of disability had the effect of creating a need in all areas of university education, and so in medical schools, to accommodate students with disabilities (Essex-Sorlie, 1994b). Such uncharted territory posed a number of new questions and challenges to traditional thinking about students and curriculum requirements (Association of American Medical Colleges, 1993; Gitlow, 1999; Helms & Helms, 1994; Little, 1999; Meier, 1993; Reichgott, 1996; VanMatre, Nampiaparampil, Curry, & Kirschner, 2004). Disability became the largest area of human rights complaints in Ontario (Ontario Human Rights Commission, 2006), and disability in education was frequently featured in complaints under the ADA in the US (Essex-Sorlie, 1994b; Gitlow, 1999)). In an effort to respond to this emerging challenge, medical schools felt compelled to develop policies to address the situation, and began with defining physical capabilities or technical standards for applicants and students with disabilities (Association of American Medical Colleges, 1993).

Standards and admissions policies of medical schools, as part of the governance of the medical profession, have an impact on people with disabilities to the extent that a medical model of disability prevails. “Governance” here is used in Foucault’s sense of government, “modes of action, more or less considered, which were designed to act upon the possibilities of action of other people. To govern, in this sense is to structure the possible field of action of others (Foucault, 1982, p. 221, cited in Hunt and Wickham, 1994, p. 24)” (Chadwick, 1996; Hunt & Wickham, 1994). This is what admission and
standards policies are all about. And, they pose an excellent opportunity to perpetuate an exclusive, or shape a more inclusive, medical training.

Chadwick (1996) describes the significance of such policies in “local government”, here interpreted as the medical school community, and speaks to the importance of examining them. He asserts, “the power/knowledge at work in actual instances of governance within the organizational structures of local government needs to be examined; the structures which provide the opportunity for subjects to act on others by governing their conduct need to be made conspicuous” (Chadwick, 1996). In an effort to explore the structure of medical school policies, I reviewed current policies in Canadian medical schools. In their structure and wording, they perpetuate an individual, medical or personal tragedy model of disability instead of a more empowering, dignified, and respectful view of people with disabilities as participating in learning, delivering, and receiving medical treatment, such as the social model of disability affords (Chadwick, 1996; Oliver, 1990).

Hegemony of Medical School Policy Regarding Participation of Students with Impairments

I would suggest that such policies need careful examination for hegemonic tendencies, such as conceptualizing students with disabilities as patients, to ensure that policies focus as Chadwick suggests, on the assumptions, practices, and structures that discourage students with disabilities from applying to medical school. Van Matre et al (2004) note that the expectation for every graduate to be “undifferentiated” and “pluripotential” is “more inhibitory to disabled applicants” (para. 3). This expectation of ability to practice equally well in any area of specialization upon graduation is discouraging to students who know they will need to focus heavily in certain areas to
accommodate a disability. This is entirely possible in specializing after graduation; it is a significant barrier prior to that stage. This tendency for policies that define the student to discourage applicants supports the view that policies would be more effective if they defined the task instead of the student. No doubt the institution and those with responsibility for removing barriers would also be better served by the clarity of this direction, rather than becoming mired in the murkiness of individual differences, quantifying individual characteristics of physiological capability. A focus on what tasks need to be completed and what parameters of completion are bona fide requirements opens the door to a range of means to the ends, fostering exploration of both creative and effective innovations in methodology that may well serve all parties better. Smith and Pearson (1999) and Losh and Church (1999) support this view quite clearly in their discussions of documenting and developing specific job descriptions of tasks to be performed in residency training. Smith and Pearson (1999) describe several steps to accommodation of medical residents with disabilities that focus on observation, setting goals and solving problems, instead of listing required characteristics. Losh and Church (1999) focus on the development of a specific job description, outlining a process for determining essential functions or tasks that must be done. Combined with the occupational therapy strategy of task analysis that will be discussed later, this would seem a viable direction for professional education to pursue.

The implementation of legislation mandating the accommodation of disabled people has had a trickle-down effect on applicants to medical school. As more students with disabilities apply to medical school and request accommodation under the Americans with Disabilities Act (ADA) or the Ontario Human Rights Code 1990, medical
schools are pressed to identify what tasks students must perform in particular ways and why, so as to know when to accommodate and when not to do so. In Ontario, the Council of Ontario Faculties of Medicine (COFM) developed as a policy statement a set of technical standards for “students with disabilities” in medical school, which was approved and launched in November of 2003 (Council of Ontario Faculties of Medicine, 2003). An implementation guide followed in May, 2004. The COFM policy, entitled Essential Skills and Abilities Required for the Study of Medicine was the first province-wide policy in Canada, applied by all medical schools in Ontario.

**Council of Ontario Faculties of Medicine Policy Initiative**

In 2002 the Council of Ontario Faculties of Medicine (COFM) began work on a policy statement that would clarify expectations for students with impairments applying to medical schools in the province of Ontario. It was felt that students with impairments deserved a clear statement of what physical and sensory capabilities would be required in medical school programs, so they could make a more informed decision prior to applying, thereby saving the student a great deal of money, time and frustration if the medical program was infeasible given their impairment, and saving admissions committees the awkward task of sorting out whether an applicant would be viable in spite of their impairment. It was hoped that a clear set of physical expectations at the application stage would prevent future difficulties for all parties involved. Consequently, a number of faculty members and administrators from Ontario medical schools gathered together with their disability officers and a representative of the Ontario Human Rights Commission (OHRC) to craft a set of technical standards for medical school applicants with disabilities.
I had the opportunity to participate in a day-long workshop which was conducted as part of this process, beginning with an orientation to the Ontario Human Rights Code and its application to higher education, followed by a series of exercises which I facilitated to determine what would be considered “essential requirements” under the Code, bona fide task expectations and how the bona fide nature of them could be determined. With this background information in mind, the group spent several weeks thereafter working on a policy, technical standards, and an implementation guide. Several other medical schools’ policies were reviewed, in particular that of Dartmouth Medical School in New Hampshire (Dartmouth Medical School, 2007), which was felt to have developed a useful template, reflective of the values and emphasis desired by COFM for its policy.

The policy entitled Essential Skills and Abilities Required for the Study of Medicine emerged, with a preamble and subsequent list called Technical Standards for Students in the MD Program (Council of Ontario Faculties of Medicine, 2003). The list includes a number of capabilities outlined under the five categories of 1) Observation, 2) Communication, 3) Motor, 4) Intellectual-conceptual, Integrative and Quantitative, 5) Behavioural and Social Attributes.

During the discussion of what should be considered essential, it was felt by the disability officers in the group, some of whom had disabilities themselves, that the standards perhaps addressed the wrong end of the issue – reflecting a modernist, reductionist approach of focusing on defining the ideal, normal medical student, instead of on the environmental factor of the curriculum task requirements. Concern was expressed that students would pose an endlessly variable group in terms of physical
and sensory capabilities, and with the evolution of various technological aids and changing methodologies, a firm description of physical capabilities would prove to be an endlessly moving target, rife with requests for exceptions.

As an alternative, the social model of disability would place the emphasis on defining the task requirements as environmental demands and expectations of medical students or physicians. It is conceivable that greater definition and control could be achieved by defining what must be accomplished than by rigidly and repeatedly attempting to define, by physical characteristics, who is allowed to attempt the accomplishment. Students with impairments may be able to achieve the objectives in ways that policy-makers cannot imagine, not being disabled people for the most part.

For example, the group was challenged at one point to entertain more creative and optimistic perspectives when one participant commented that the inability of the sighted participants to imagine how a student with low vision could take a clinical history did not mean it wasn’t possible; it meant the sighted participants could not imagine it. One might ask where that locates the problem.

**Impact of COFM Policy on Other Medical Schools and Applicants**

The COFM policy deserves careful scrutiny and review, as it likely has the single most pervasive influence on medical school applicants of any such policy in Canada; it is applied directly by 6 of the 17 medical schools in Canada, and is reflected in similar policies across Canada. A critique of the policy four years into its implementation reveals language that is hegemonic, and paradoxically not as inclusive as the policy needs to be in order to meet equity-promotion objectives. This shortcoming is reflected in the policies of other medical schools as well.
Other than Ontario, Quebec, and Alberta, most provinces have only one medical school, and only four of those--McGill, and the Universities of Saskatchewan, Calgary, and British Columbia--have any policy statement on applicants with disabilities that can be located by searching their websites. McGill University’s statement is almost identical to the COFM document, and the other three offer a few lines in a very similar direction, but implementation was not addressed except to refer students to the Disability Services Office of the institution. In visiting the website of each medical school, I noticed a striking similarity in the wording of their policies regarding the skills required of medical students. McGill University offered a more extensive and appropriate rationale for their essential skill requirements, but University of Saskatchewan, University of Calgary, and University of British Columbia had little or no preamble setting the tone of their policies, and the content of the requirements was similar or less explicit than that of the COFM policy. The statements of the Universities of Saskatchewan, Calgary, and British Columbia bore a notably cautionary tone, almost a warning of the expectations. For example, the University of Saskatchewan posts only this sentence:

While a disability should not preclude a student from consideration for admission, the disability must not prevent the student from communicating with patients and colleagues, from making observations and analyzing clinical data, and from making the medical judgments expected of a physician who has completed the educational program leading to the M.D. degree at this University. (University of Saskatchewan College of Medicine, 2007)

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9 As of June, 2007
Similarly, the University of Calgary posts the following two statements:

From the Applicant Manual:

Students with disabilities are encouraged to pursue their studies as long as their continued involvement does not pose a health or safety hazard to themselves or others, and as long as they are able to meet core requirements for a medical degree. (University of Calgary Faculty of Medicine, 2006)

From the medical school site:

Physical disabilities must not prevent the student, upon graduation, from communicating with patients, making observations, gathering and analyzing data necessary to arrive at medical judgments, and from performing the therapeutic interventions expected of a physician who has completed the educational program leading to an MD degree. (University of Calgary Faculty of Medicine, 2007)

By contrast, the more elaborate COFM policy states, in just the first two paragraphs (emphasis added):

A candidate for the MD degree must demonstrate the following abilities:
Observation
A student must be able to participate in learning situations that require skills in observation. In particular, a student must be able to accurately observe a patient and acquire visual, auditory and tactile information.
Communication
A student must be able to speak, to hear and to observe patients in order to effectively and efficiently elicit information, describe mood, activity and posture and perceive non-verbal communication. A student must be able to communicate effectively and sensitively with patients, families and any member of the health care team. A student must also be able to summarize coherently a patient's condition and management plan verbally and in writing. (Council of Ontario Faculties of Medicine, 2003)

Compare with the McGill University policy statement, updated on their website March 16, 2007 (emphasis added):

As a Medical Expert and Communicator, the student must have abilities in the areas of observation, communication, motor, intellectual/conceptual, integration and quantitation [sic].
Adequate skills in the area of observation require that the student be able to accurately observe a patient and acquire visual, auditory and tactile information. The student must be able to decode written documents, use a stethoscope with or without aids, and observe near and distant objects.

To communicate, the student must be able to speak, write, hear, and perceive non-verbal communication. A student must be able to communicate effectively and sensitively with patients, family, and any member of the health care team. A student must be able to summarize coherently a patient’s condition and management plan verbally and in writing. (McGill University Faculty of Medicine, 2007)

The COFM and McGill policies clearly bear a striking resemblance, suggesting the strength of this trend of identifying features and characteristics of the student over the particulars of the tasks to be accomplished, and the influence of one such policy on another, as McGill based its policy on the COFM document (Wolfforth, J. personal communication, June 6, 2007).

While accommodation is sometimes suggested as a possibility, or not even suggested, the process for students to obtain accommodation remains obscure, discouraging applicants with disabilities. Within Ontario, only the University of Ottawa offered a fully prominent description of how to request and obtain accommodation in addition to the COFM policy and implementation guide.

Law Society of Upper Canada Policy

Comparison with a similar policy from the Law Society of Upper Canada (Law Society of Upper Canada, 2007) illustrates ways in which the language of the COFM policy could be enhanced to encourage disclosure and mutual accommodation planning with students with disabilities. A more inviting tone and an approach that defines the task demands more than the student characteristics would better serve the purpose of aiding accommodation planning, and defining what, versus who, can and cannot be
accommodated in medical school curricula. The Law Society policy states quite clearly in its second paragraph, with respect to the licensing process: "The Law Society...encourages the participation of members of equality-seeking communities in its design, development and presentation" This is a more proactively inclusive approach than much of the tone in the COFM documents.

It is compelling that physicians themselves are challenging assumptions about how medical education is conducted (Helms & Helms, 1994; Little, 1999; Mercer, Dieppe, Chambers, & MacDonald, 2003; Reichgott, 1996; VanMatre et al., 2004) and the "ideal" of the "undifferentiated graduate" as put forth in the AAMC guidelines. As deliberately conceived and constructed entities, education and medicine could conceivably also be reconstructed, through thoughtful examination of why their methods, techniques and modes of practice are designed and implemented as they are. Creative exploration of alternate means of teaching and practicing medicine could expand the horizons and methods to reach more participants in both education and health care, as well as allow for the participation and contribution of groups currently excluded for lack of a more thoughtful construction of expectations in the fields.

**Critique of COFM Policy – Part I**

In order to position itself in the larger legal and ethical contexts, and to be effective in eliciting disability-related information and promoting the development of accommodation planning, a policy pertaining to students with disabilities needs to express its intent in language that invites and initiates dialogue about equity and accommodation with students with disabilities. The language of the COFM policy is notably devoid of references to equity, human rights and equal opportunity, legal or
moral obligations of inclusiveness, or invitations to participate in a collaborative process to determine accommodation needs. There is no positive identification with the Human Rights Code and the duty to accommodate, nor any intention or commitment to fulfill that particular duty. This omission excludes from apparent consideration the rights of students and the related responsibilities of the institution, leaving the impression that all the responsibility for accommodation resides with the student.

The first paragraph of the COFM policy lays out the institution’s responsibility to produce competent clinicians, but makes no mention of the institution’s responsibility to students to provide an equal opportunity to become a competent clinician. The statements in this first paragraph regarding competencies do not suggest any openness to considering how “comprehensive, compassionate care” might be provided; rather, generic skills presumed to be required are listed, with no invitation to discuss issues with respect to how these skills might be demonstrated by people with disabilities.

The entire second paragraph is a warning regarding the similar requirements of the licensing examination, as if the institutions need the rationale of the licensing exam for setting out their requirements, which has the overall effect of reinforcing the barriers to be overcome, instead of welcoming the opportunity to prepare for these subsequent exams in any meaningful way by determining appropriate accommodation of disability along the way. The concept of “teaching to the test” is raised as well – does the licensing exam set the curriculum, or should the opposite be true?

The third paragraph indicates that all students must meet these standards, and that this “…does not preclude students with disabilities”. While no doubt intended to encourage students with disabilities who might be having second thoughts about being
both able and welcome at this stage, the afterthought of inclusion reads as exactly that – an afterthought. The paragraph goes on to say, “Students who anticipate requiring disability-related accommodation are responsible for notifying the medical school.” Disability-related needs clearly are the student’s problem, and a ‘problem’ at that, of which the school requires ‘notification’, as opposed to inviting a solution-focused dialogue. The school apparently has no responsibility with regard to proactively inviting disclosure of that information, or offering to engage in mutual determination of strategies. An alternative might read, “Students who anticipate requiring disability-related accommodation are invited to contact the Disability Services Office or Dean of Student Affairs to discuss possible strategies.”

While it is clear that the student must notify the school of disability-related needs, a number of questions remain. When must the student notify the school? If the student does so prior to acceptance, the student might worry that accommodation needs could affect the admission decision. If the student notifies the school after acceptance, they risk incurring feelings of resentment, mistrust, or betrayal, especially if the situation is not simple and easy to accommodate. The statement also does not indicate why the student must notify the school. Is this so that the two parties can begin immediately to develop an appropriate accommodation plan and explore any curricular issues well in advance so as to best meet the student’s needs? Or is it to screen out applicants whose accommodations might be complex or challenging? This is not clear. The onus appears to be entirely on the student to “notify”, and no onus on the medical school is articulated to invite, participate, identify barriers, or mutually design and implement accommodation.
The final paragraph of the introduction to the policy indicates that students with disabilities may be granted an extension of the usual time frame expected for completion of the degree, and that this will be considered on a “case-by-case basis”. This language might be interpreted to be reflective of the medical model, as if students are cases to be managed, more than individual students with rights and unique needs deserving of a dialogue on how best to facilitate their participation in the program. Extensions of the time frame could be described as being considered on an “individual” basis, instead of “case-by-case”. This term also illustrates to some extent the blurring of boundaries and roles which can occur when clinicians are also academic instructors – many clinicians have expressed to me over the years the temptation to view the student from a clinical perspective, as a patient, which is not appropriate when designing academic accommodations for otherwise qualified students.

**Comparison Critique: The Law Society Policy**

By contrast, the Law Society of Upper Canada (LSUC) has developed a policy to address the diverse needs of law students who have a right to equal opportunity when participating in the Law Society’s licensing exams (Law Society of Upper Canada, 2007). The LSUC also presents a number of professional competencies that must be demonstrated by students-at-law, but they are separate from the accommodation policy pertaining to the licensing examination. While it is true that the LSUC policy pertains only to the licensing and credentialing of lawyers, not the academic training stage that the COFM policy addresses, and it is also true that the practice of medicine is demonstrably more physical than the practice of law, nonetheless the LSUC policy stands as a shining example of expressed inclusivity and intent to accommodate.
There is strong language at the very beginning of the section entitled “Rationale”, which identifies an awareness of and commitment to meeting the duty to accommodate. While it is true that the Law Society and the duty to accommodate under the Human Rights Code are both founded in the realm of the law, and LSUC might be anticipated to be more closely wedded to overtly addressing and implementing the Human Rights Code, the duty to accommodate applies equally in medicine, and should be made equally apparent. The very first sentence of the LSUC policy reads “the Law Society of Upper Canada (LSUC) has both a legal obligation under the Ontario Human Rights Code (hereinafter ‘the Code’) and a strong public interest in ensuring that all of its operations reflect principles of equity” (Law Society of Upper Canada, 2007). This Rationale section goes on to identify five ways in which the “Licensing Process” demonstrates a commitment to the participation of “members of equality-seeking communities”, presumably including students with a range of needs.

It is highly significant that specific references are made to the concept that treating people equally sometimes means treating them differently: “LSUC has acknowledged that treating people identically is not synonymous with treating them equally. Substantive equality requires the accommodation of differences that arise from the personal characteristics cited in the Human Rights Code.” It has been my experience that this is a particularly difficult concept to convince faculty to entertain, never mind accept, and it is quite impressive that an organization as traditionally conservative as LSUC has embraced this broadening paradigm so publicly. Recognition is also given to the inadequacy of continually ad hoc solutions and the need for formalizing a process of individualizing accommodation. The legitimacy of the rising
demand for accommodation is a cause for proactive response, not merely patrolling the boundaries. The statements in the LSUC policy are positive, strong articulations of the intent and direction of the procedures that follow this Rationale section.

Following the introductory preamble to the COFM policy reviewed above, COFM developed a set of technical standards, used in all Ontario medical schools and reflected in similar statements in other institutions across Canada. These are where the definition of the student’s characteristics and abilities are most specifically articulated, and where task requirements would be more useful. A separate critique of these follows.


The COFM policy goes on to define technical standards that must be met by candidates for the MD degree – presumably all candidates, including those with disabilities. The standards are explained in terms of physical or mental capabilities required to perform specific tasks. They are often phrased in such a way, however, as if to justify their requirement, instead of defining the task to be accomplished by whatever means might be feasible. For example, the standard for Communication states, “A student must be able to speak, to hear and to observe patients in order to effectively and efficiently elicit information, describe mood, activity and posture and perceive non-verbal communication.” (Council of Ontario Faculties of Medicine, 2003, para. 6). Could the standard not read, “A student must be able to effectively and efficiently elicit information, describe mood, activity and posture and perceive non-verbal communication.” Does this description not allow for a range of ways in which a student might obtain this information? The means by which tasks can be achieved might be
anticipated to vary with the evolution of technology, emerging clinical knowledge and changing methods, which might open doors for students with disabilities to complete required tasks in a variety of ways (DeLisa & Thomas, 2005; Reichgott, 1996).

The Council of Ontario Faculties of Medicine has a much more positive-sounding and inclusion-focused document to accompany the Essential Skills and Abilities, the Implementation Guide, but it is nearly impossible to find. The COFM technical standards document is on both the provincial applications website (Ontario Medical School Application Service, OMSAS) and on the individual faculties of medicine websites, but the Implementation Guide (Council of Ontario Faculties of Medicine, 2004) which outlines the accommodation process is only to be posted on the faculties of medicine sites. Consequently, it is initially much harder for an applicant to put together the requirements for physical capabilities with the recourse to accommodation. Of the six medical schools in Ontario, all of them have a link to the COFM policy Essential Skills and Abilities, but only the University of Ottawa had a link to the Implementation Guidelines, where students could see a commitment to accommodation, and how accommodation planning should be structured. That same institution was the only one to post how to actually seek accommodation at that institution. So for a student with an impairment applying to medical school, the tone of the Skills and Abilities document is likely quite discouraging, and there is little or no ready access to the much more positively framed Implementation Guide.

While the COFM Implementation Guide is somewhat more positive in tone, and does spell out responsibilities of the faculties of medicine, it would benefit from the
influence of the LSUC policy and procedure, which sets out an overtly positive, inclusive, and responsible approach to the provision of accommodation.

Conflict: Human Rights Mandate Versus Academic Freedom

There appears to be an inherent conflict posed by the duty to accommodate students with disabilities, as mandated by the *Americans with Disabilities Act* and the *Ontario Human Rights Code*, and the academic freedom of medical schools to determine applicant qualifications, curriculum, delivery methods, and graduation standards in the effort to be accountable for public safety in the eventuality that medical students practice medicine (Gitlow, 1999). Not all medical students necessarily practice – some may do research, work in the corporate sector, or do other things entirely. This conflict is evident in the policies that firmly entrench the emphasis on defining traditional standards, without sufficient attention to inclusivity. Policies pertaining to students with disabilities do not overtly embrace the intention of the Code, and firmly ground all activity within the purview of the medical model. Nonetheless, the duty to accommodate pertains and must be incorporated.

In my experience, there is sometimes surprise or resentment expressed among faculty that the Human Rights Code, usually associated with overtly heinous treatment of people or deprivation of basic life necessities, would be applied to higher education. Nonetheless, unequal or discriminatory treatment of marginalized groups on the basis of membership in that group is a human rights violation, and inclusive policies, procedures, and methods of curriculum delivery need to be generated to ensure equal opportunity to participate in the educational process. In fact, the Human Rights Code requirements challenge us to re-examine our standard assumptions, traditional ways of defining
curricula, and ideas often taken for granted about how medicine is taught and practiced, and explore new horizons of technology, methodology, and configurations of participation. The Code does not restrict academic freedom; it calls it to a higher plane of accountability, which should eventually enhance the credibility of the profession and its curricula, not undermine it. This challenge is posed by the ADA as well (Reichgott, 1996).

If we reflect back for a moment to the discussion of the medical versus social models of disability, they shed significant light on the conflict between the Code’s duty to accommodate people with disabilities and the academic freedom enshrined in medical education. The Code was developed in the same era as the emerging social model of disability, where the person with the disability is viewed as expert in her or his own disability and needs. The traditions of medical education evolved in the context of the medical model, where the professional is the expert and the patient the passive recipient of care. The influences here are obvious – the Code empowers the person with a disability to participate, while medical education is empowered by the medical model to elevate the professional and subjugate the student with a disability first to the role of patient, and to acculturate her or him to the purposes of the program, the practice, and the power of the medical establishment. There are times when both models are appropriate, and a model that combines these forces in concert would be helpful.

The World Health Organization (WHO) recognizes the value of these potentially mutually exclusive approaches, and implements a combination, referred to as the “biopsychosocial model” (WHO, 2001). This approach allows a place for the medical
model in the diagnosis and treatment phases of dealing with disability, but also includes the aspects of the social structures and environment that prove disabling for people with various combinations of physical or sensory capabilities and impairments. The two models can be viewed as joining from opposite ends of a spectrum, to offer ways of thinking about the range of influences on the participation of people with disabilities. At the same time, they must be viewed as overlapping, so that social structures, attitudes and the role of the patient can be considered as important factors from the very first presenting symptom, to modification of the environment, through accommodation. A biopsychosocial approach would allow for all these factors to play their rightful roles in shaping medical school policies and procedures for students with disabilities.

*Power of Medical Knowledge*

Medical knowledge carries great power, since it relates to the ability to save lives, relieve suffering, and cure illness (Turner, 1987). The expertise of a physician is respected, and there is a need to retain that respect, both because it is deserved, and it is necessary for the patient’s confidence in the care provider; anxiety about the competence of the physician or the care that is being implemented is not conducive to healing. People need to have confidence in their physician, to trust the physician enough to participate in the assessment and treatment of their condition. This confidence is entirely legitimate in terms of expertise developed that is critical to the successful treatment and eradication of symptoms that only the physician can effect. Gitlow (1999) points to the question that if “the handicapped” are patients, and sharing knowledge with them shares power, how does the medical profession retain power and status as those who can effect cures? (See also Chadwick, 1996; Tremain, 2001)
At the same time, this power is limiting by generating myopia toward patients as recipients of expertise instead of participants in decision-making and care. When students with disabilities are viewed as patients, this myopia is extended to them. As Turner puts it, “the client by definition is excluded from the esoteric knowledge of the professional association.” (Turner, 1987) The notion that *they* cannot be *us* becomes a self-fulfilling prophecy, perpetuating assumptions about how things must be done and who can participate as a contributor.

The medical model is hegemonic, recreating its control mechanisms and perspectives by virtue of its controlling power. (Donoghue, 2003; Jaye, Egan, & Parker, 2006; Jones, 2004) An illustration of this dynamic is the establishment of a policy that formalizes what is intuitively obvious to rationalize the naming of essential skills. VanMatre et al (2004) describes the discouraging effect of such policies in terms of the historical documents of the AAMC, referring to the “undifferentiated graduate”, and an earlier 1950 document of the American Surgical Association committee on undergraduate medical education which make use of the term “without handicap”:

Both the words ‘without handicap’ in the 1950 statement and the general concept of undifferentiation [sic] have been regarded by some as a mandate to medical educators to provide broad learning experiences and opportunities to all students (Reichgott, 1996). Others, however, have addressed this concept as placing the onus on every individual graduate to be ‘undifferentiated,’ and able to enter a specialty (Hartman, 1981). This latter interpretation – that the undifferentiated graduate is also to be ‘pluripotential’ – is more inhibitory to disabled applicants. (VanMatre et al., 2004) para. 3)

It is important to explore what tasks need to be done exactly as they are now prescribed, and which ones could in fact be done differently to accommodate a student with an impairment. Creativity is required in considering how things can be done, using
a different order of events, different positioning, assistive technologies, or other emerging methods (Manders, 2006). The rise of technological changes in medical equipment and assessment tools, methods of evaluation, types of corroborating evidence available, and ever-expanding diversification and specialization of health care professionals challenges us to keep up with and utilize different techniques all the time.

Also, the field of medicine itself, through medical advances, enables people to function increasingly well with a range of conditions/disabilities, including physicians who themselves may use invisible contact lenses, pace makers, prescription drugs, cochlear implants, prostheses, etc.

The generalist debate, questioning the concept of the “undifferentiated graduate”, raises the question of how practical and realistic it is to continue to insist on the production of “undifferentiated graduates” as a goal of medical education (Meier, 1993; VanMatre et al., 2004). If this concept is not actually what happens, if it is a mirage due to the inherent focus students put on their studies according to their own interests and goals throughout medical school, and the specialization that happens after medical school further differentiates students into areas of select expertise, why could medical education not begin this process in the undergraduate years, embracing the fact that students to some extent do specialize before graduation, and allow students with impairments to do so openly and constructively? Focusing education earlier need not be to the exclusion of knowledge in all areas of medicine, but perhaps the performance standard in some areas in which the student will never practice after graduation could be altered in recognition of this, and a medical degree “with emphasis in…” an area of specialty could be recognized? The body of knowledge in medicine is growing at an
exponential rate, and it may no longer be realistic to think we can continue to graduate truly competent generalists in all areas. Expanding specialties open doors for participation of people with impairments, as the diversity of practice reflects the needs for varied expertise, and mirrors a variety of interests and abilities. Between the tug and pull of expanding knowledge, needs for diverse practices, and increasingly diverse students, the field would seem ripe for reconsideration of assumptions about the “undifferentiated graduate” (VanMatre et al, 2004). While there will always be common foundational material that all graduates must know, it might be timely to consider the possibility of earlier specialization which might be inevitable later.

Another reason that it might be time to have a thoughtful look at how we restrict access to medical school is the growing demand for physicians, which currently exceeds the supply (Esmail, 2006). While defining how to restrict access to medical education, and excluding people with disabilities, the very diverse public that medicine sets out to protect is deprived of representative physicians. In medicine, this is referred to as iatrogenic treatment – the treatment causes another condition to emerge, in this case, a shortage of physicians, especially those who are representative of the populations served. It would make sense to utilize the potential of all those who can contribute, including persons with disabilities, to maximize capacity to protect and heal the public (Cohen, cf. (DeLisa & Thomas, 2005), and to provide physicians from some of the same populations served.

One Strategy to Define the Task Requirements – Occupational Therapy Task Analysis

One way to look at defining the task is to turn to occupational therapy’s traditional domain of task analysis. In occupational therapy (OT), tasks and activities are broken
down into component parts, to identify what specific skills are required for a person with a disability to carry out the task. Up to a point, the person may receive treatment with rehabilitation techniques and strategies to enhance function (improve strength, range of motion, dexterity, problem-solving, planning or execution of a wide range of daily activities, etc.), but once maximum function is achieved, the environment and the means of doing activities are modified to facilitate participation. The primary goal of OT has always been to facilitate independent living and engagement in meaningful activity, of the client’s choosing, which has laid the groundwork for embracing a more client-centred, collaborative ethic for helping people to move toward their goals. Occupational therapy has been one of the first and most pro-active of the allied health professions to break from a strictly medical model, to establish formal standards of care that identify a “client-centred practice” in which the person with a disability is a primary partner in setting goals, an important expert in their own condition, needs and abilities (Canadian Association of Occupational Therapists, 2007).

From primary interventions like preventing contractures of a burned hand to implementation of a modified keyboard or dictation software and lever-style door handles in the workplace, an OT analyses what the person needs to do in her or his environment, and works with both the person and the environment to facilitate participation. Occupational therapy enables people to do what they need to do, in spite of what gets in their way – whether the barrier is in the person or the environment. The psychosocial rehabilitation movement in OT arose from the empowerment of psychiatric survivors to being active, direction-setting achievers of their own goals in consumer-run businesses. In school-based occupational therapy, the task components that are
required to participate in classroom education, field trips, laboratory activities and other educational events are carefully broken down so that appropriate means can be developed to facilitate the participation of students with disabilities. In a subsequent setting and application, where medical school is the “school-based setting”, a careful analysis of the task components required in medical education could identify what can be modified or executed in a different way, what cannot be altered, and why, both in academic and especially clinical skills (Manders, 2006). Fixing the individual student is no longer the issue; environmental adaptation is key.

Conclusion

How to get from defining the student to defining the task? Medicine, in collaboration with students with disabilities and occupational therapy, has the expertise to determine the tasks that must be done in a particular fashion or time frame, and those that could be adapted or modified. Using the experience and template of accommodation in the employment sector, a job description could be developed that would outline sufficiently specific expectations to make accommodation planning easier. A paradigm shift is required from relying on familiarity or tradition to define competencies, to a paradigm invoking creative, courageous analysis to define competencies. To quote Chadwick,

“The achievement of change will thus require an individual and collective struggle to apply the knowledge of the social model (in all its configurations) so that it starts to become a powerful, but bearably light local government practice; and from here it can be drawn by other disabled people into the gaps between their experiences and the individual model. However, for this to happen… The social model must be operationalised in such a way as to facilitate the focusing of policy and action onto cultural assumptions, disabling barriers, work practices and organizational structures rather than individuals and their impairments” (Chadwick, 1996).
Policy development that is informed by and embraces a balanced combination of medical and social models in a comprehensive biopsychosocial approach that includes students with disabilities in the process will maximize the participation and contribution of medical students with disabilities.
References


Chapter 6: The Duty to Accommodate and Academic Requirements: Report on the Results of a Focus Group Aimed at Testing Four Determinants of Discrimination

“…it’s convenient… to highlight the people, but the focus of our rage and our action should be the structures.” (Shakespeare, 1993, cf Oliver, 1996, p.168)

This chapter describes a study to investigate whether and how four test questions of discrimination, as set out by court decisions, are useful in identifying and preventing discriminatory requirements in academic programs. I begin with a presentation of the background of the legal duty to accommodate students with impairments\(^\text{10}\), specifically in clinical education, and explore the application of four test questions of discrimination to clinical education as a means to determine bona fide requirements, and appropriate accommodation. This study used a focus group of clinical education faculty in occupational and physical therapy. Focus group participants applied the four test questions to their programs’ clinical education requirements. The focus group incorporated both survey and discussion techniques to explore whether or not the four test questions contribute to determining appropriate accommodations for disabled students in professional programs, and why. Participants determined that the four test questions of discrimination as set out in court decisions were indeed useful when applied to clinical education requirements. The questions were rated in terms of helpfulness in determining accommodations for students with impairments in clinical education.

\(^\text{10}\) In this work, I use Oliver’s social model of disability and follow the reasoning that environmental structures are what disable people. Hence, I will follow Oliver’s convention in referring to “disabled people” or “disabled students” when referencing the effect of social structures on the participation of people with impairments. I will use “people with impairments” or “students with impairments” when referring to individuals with what the World Health Organization (2001) defines as impairments in body structure or function.
education. Following are the background, method, results, discussion, and conclusion of the study.

Educators struggle with the application of human rights legislation to the specific requirements of curricula with respect to disabled students (Hutchinson, 2001; Ontario Human Rights Commission, 2004; Alberta Human Rights and Citizenship, 2007; Pardo, 1999; Wales, 1997). Rather than targeted and pro-active, the duty to accommodate students with impairments under provincial human rights codes (e.g. Ontario Human Rights Code, 1990) is broad and reactive. New accessibility legislation in Ontario, the Accessibility for Ontarians with Disabilities Act (AODA), 2005) requires that information, services, and systems be designed for inclusion of people with impairments, presenting a pro-active mandate for the analysis of services and systems, including the delivery of education. Implementing these legal mandates in professional fieldwork settings poses a significant challenge to conceptualizing notions of academic integrity, forcing an examination of the structures of higher education (Pardo, 1999).

Currently, there is no consistent way to determine if academic requirements are or are not “bona fide”, where the term “bona fide” refers to requirements which cannot be altered without changing the fundamental nature of the task, or where the accommodation required would substantially alter the nature of the task. Consequently, it can be difficult if not impossible to determine whether they can be altered or redesigned to include students with disabilities.

In 1995, Kay Ashworth of Sinclair College in Dayton, Ohio developed a protocol for determining whether course requirements in the Certified Occupational Therapist Assistant (COTA) program could be accommodated for students with impairments.
Ashworth proposed nine questions, to be asked with respect to each course objective, such as whether the objective had a physical or cognitive component that could or could not be performed in an alternate fashion, whether the student had to demonstrate the skill themselves and independently, what the consequences would be if the skill were not demonstrated, and so on (see Appendix A). Marguerite Wales (1997) and Barbara Blacklock and Jane Thierfeld Brown (2001) elaborated on this idea, bringing the notion of an analytical protocol to accommodation decisions. In 2004, the Inter-university Disability Issues Association (IDIA) developed these ideas further, in their document, The Role of Disability Service Providers in Determining Essential Requirements (IDIA, 2004). This document set forth an entire process for determining essential requirements in academic accommodations, but unfortunately the document was not published except within IDIA.

In Canada, human rights decisions on accommodation use several test questions to determine if discrimination is present (Ontario (Human Rights Commission) v. Etobicoke (Borough), [1982] 1 S.C.R. 202, 132 D.L.R. (3d) 14 [Etobicoke]; British Columbia (Public Service Employee Relations Commission) v. B.C.G.E.U., [1999] 3 S.C.R. 3[Meiorin]; Granovsky v. Canada (Minister of Employment and Immigration) (2000) 1 S.C.R. 703 [Granovsky]; Alberta Human Rights and Citizenship Commission, 2004)\(^\text{11}\). Four of the test questions which seemed to me to be potentially useful in analysing academic requirements and tasks are: 1) “Is the requirement established in good faith?” (Etobicoke, 1982); 2) “Is there a rational connection between the requirement and the job/task to be done?” (Etobicoke, 1982; Meiorin, 1999); 3) “Is there evidence of the

\(^{11}\) See Note on Citation Style, p.xiii
necessity for the requirement?" (Meiorin, 1999); and 4) Is the requirement socially constructed such that it excludes members of a designated group for reasons that are irrelevant to the task, or based on assumptions about function, or the group? (Granovsk, 2000)

The notion that requirements are created collectively by people, in the context of assumptions about both bodily function and capability, and how tasks are done, is founded in the theory of social constructionism. Briefly, social constructionism is the idea that all social structures are developed by dint of human thought and decision-making, not necessarily naturally-occurring or “God-given” determinants (Berger and Luckman, 1966). Disability itself is thought by some to be a social construction—a function of how social policy and physical structures are established based on assumptions of able-bodied participation (Oliver, 1996; Granovsk, 2000; World Health Organization, 2001).

The four legal test questions listed above present an interesting means of examining and determining potentially discriminatory curricular requirements. To date, they have not been combined in a useful application for educators to identify what requirements may constitute discriminatory barriers and which are bona fide academic requirements. Using the legal test questions builds on the ideas put forth by Ashworth (1995), Wales (1997), Pardo et al (1999), and Blacklock et al (2001) and provide a protocol to enable educators to examine the construction of curricular requirements, to help identify discriminatory requirements as appropriate or inappropriate for accommodation, and to design requirements that are inclusive of disabled students from the start.
Methodology

Rationale for focus group approach

The rationale for using a focus group approach to investigate the application of legal test questions of discrimination to determine discriminatory requirements in academic programs is set out by David Morgan, who says, “focus groups let you hear the participants’ perspectives on your goals. …[T]hey can provide useful suggestions about how to get where you want to go, and they can also point to potential pitfalls in your tentative plans.” (p. 14). In the present research, I established a focus group in order to explore the application of the case law questions as a litmus test for accommodation in the practicum component of university-based professional programs. Members of the focus group were clinical instructors from both occupational and physical therapy programs. Participants’ perspectives identified issues that they and, by extension, other faculty members may see as obstacles and benefits of applying the four test questions to practicum requirements.

The focus group approach to generating feedback is supported by Morgan (1998), according to whom, “During the implementation of a project, there is a need for qualitative information that provides depth and context” (p. 14). For the current research, the focus group provided an opportunity to: hear from the people who design and implement academic requirements in professional education; understand how applying the four questions to academic requirements works or doesn’t work and why; and investigate what would work better according to the focus-group participants.

The focus group incorporated a didactic presentation of background information on the Ontario Human Rights Code, the duty to accommodate students with disabilities,
and the four legal test questions of discrimination, followed by a short survey. These two components, a didactic presentation and survey, were conducted as a prelude to the focus group discussion. Using both survey and discussion methods provided quantitative as well as qualitative data. The survey provided quantitative feedback on use of the four test questions. Survey questions appear in Appendix A. Richly detailed information, or “thick description” (Geertz, p.6), was obtained from discussion of a follow-up question, “Do the legal test questions help discern what can and cannot be accommodated? If yes, tell me why the legal test questions help? If not, why not.” This question explored how faculty members felt about applying legal test questions to academic requirements. The quantitative and qualitative information from this study lays the groundwork for future research on the same questions with different groups, e.g. medicine, education, nursing, and college-level professional programs.

Participants

Faculty members from schools of medicine and rehabilitation therapy were recruited by direct email invitations to participate. A letter of introduction was sent to over 50 potential participants, with a Doodle calendar to indicate availability and to establish a common date and time. Five clinical educators from the rehabilitation therapy, two physiotherapists (PT’s) and three occupational therapists (OT’s), were available on the same date and participated in the focus group. Participation in the focus group constituted an accredited faculty development activity, so that those who participated received credit for 3 hours of faculty development from the Royal College of Physicians and Surgeons. Potential participants were informed of the nature, purpose, and scope of the study, the method, and the benefits to the department and themselves in meeting
their requirements for participation in research and faculty development activities where applicable. In the initial letter of introduction, participants were informed of their right to withdraw from the study at any time. This information was repeated in subsequent correspondence about participating, and at the start of the focus group session. There were no risks to participants, and no deception of any kind was involved.

Participation in the focus group discussion was open, live, observed, and recorded both manually and digitally by a research assistant. Identities were apparent in the group, known to myself, and the facilitator and the research assistant, both of whom signed a non-disclosure agreement. Confidentiality and anonymity were maintained.

Implementation of the focus group

Faculty members were asked to attend a 3-hour, workshop-style focus group. The group was conducted in the Queen’s Executive Decision Centre (QEDC), Queen’s University School of Business, with the aid of a professional co-facilitator and a research assistant. The QEDC is a large classroom with desks and laptops for each participant, set in a single semi-circle facing the front of the room. I stood at the front, while the professional co-facilitator sat in the centre of the semi-circle, running the computer technology used to coordinate material presented on and retrieved from the individual laptops, using a combination of proprietary group-support software, Groupsystems, running on laptops sharing a closed wireless network, designed by QEDC for group facilitation activities. Three participants seated themselves to the right of the co-facilitator, and two to his left.

Faculty member participants were asked to bring course/practicum requirements with them, from their areas of specialty. After a didactic orientation to the
accommodation mandate and the four legal test questions of discrimination as a method of identifying essential requirements, participants were asked to do a short activity.

First, to address the Human Rights Code requirements for accommodation, participants applied the four questions from the case law to their program requirements, to determine if the requirements are bona fide (i.e. cannot be accommodated) or not, and to identify issues arising from the application of these four test questions. Initially, the group members worked individually on their own, with pencil and paper, to apply the four questions to their course objectives, asking themselves whether the objectives were developed in good faith, rationally connected to the course requirements, evidenced as necessary, and whether it was constructed such that it excluded students with impairments. As they began to finish, small side conversations developed among the OT’s and PT’s as they explored the application of the questions informally among themselves.

Following the conclusion of this exercise, participants completed a short anonymous survey using the QEDC survey software (see Appendix B) and individual laptops to enter their responses and comments about the utility of the four questions in determining bona fide requirements in their course/practicum objectives. Survey responses were consolidated on the computer screens by the software that displayed results anonymously and instantaneously. The co-facilitator and I then used the consolidated data along with pre-determined questions to guide the subsequent discussion of issues, concerns, barriers, and facilitators of participation of disabled students. This discussion was recorded both digitally and with notes taken for analysis and summary of themes and issues generated for future consideration. The digital
recording was initially transcribed into text by NoNotes, an online transcription service. I edited the transcription for accuracy.

Results

Observations of participants showed consistent engagement with the material being presented. The participants asked spontaneous questions of one another and of myself as the researcher, they offered comments, and explored challenging situations as a group. I observed the participants sharing their thoughts, questions, and ideas with one another in informal discussions over particular survey questions during their analyses of their course objectives. While not recorded at this point, I nonetheless observed that in their effort to apply the principles and test questions, the participants' discussion was characterized by inquiring tones, frank statements, and real-life examples drawn from their own experiences. The level of engagement suggested that the subject matter was of immediate interest to the participants, and that exploring their reasoning for curriculum and program requirements was important to them.

The four questions investigated for their helpfulness in determining discriminatory requirements were, again:

1) Is the requirement established in good faith? (Etobicoke, 1982)

2) Is there a rational connection between the requirement and the job/task to be done? (Etobicoke, 1982; Meiorin, 1999)

3) Is there evidence of the necessity for the requirement? (Meiorin, 1999)

4) Is the requirement socially constructed in a way that excludes members of a designated group for reasons that are irrelevant to the task? (Granovsky, 2000)
Quantitative results

Quantitative results from the survey questions provide specific information on which questions were most helpful. The questions were rank ordered by participants from most helpful to least helpful, and each of the four questions was rated on a 5-point scale of helpfulness, with 1 being least helpful and 5 being most helpful.

The first question presented, regarding establishment of the requirement in good faith, was ranked third in helpfulness, and was rated 3 out of 5. Participants found it difficult to imagine requirements that were not established in good faith, as this was interpreted as deliberately setting out to exclude people, or establishing requirements that were designed to trick students. As one participant remarked, "I can’t imagine the situation in which I would say, ‘That was not done in good faith.’ I don’t even have a concept of how that would look." Another participant stated, "I would have a hard time proving ‘good faith’, so I would not find that helpful.” In contrast, one participant felt that the question of establishing requirements in good faith was useful: "Good faith is about self-reflection. ‘Am I doing this in good faith? Or am I doing this because of ego or some other reason?’"

Results indicated that the second question, regarding a rational connection between the requirement and the task or objective, was ranked second in helpfulness, and was rated 4.4 out of 5. One participant explained, "[The second question] makes you look at why the objective has been set and why it is being evaluated in the way that it is.” Or, as another participant stated, “especially in evaluation, is the way you are evaluating really connected to the way you are delivering, and what you want [students] to demonstrate--does it actually get that?”
Participants reported that they found the third question, about evidence for the necessity of requirements, was most helpful because it made them think about why a requirement was framed as it was, and whether there really was a good, solid reason for it. Comments indicated that the question of evidence for a requirement was also helpful in reviewing evaluation methods for arbitrary, potentially discriminatory elements. One participant responded in the survey comment box, “the question about evidence to support the relevance of a requirement is OUTSTANDING [sic]. I think it is where we need to go in this day and age of evidence-informed health care”. The question of evidence for the requirement was ranked as most helpful of all the questions, and was rated 4.8 on a helpfulness scale of 1-5. The second and third questions\(^{12}\) in fact were ranked as the most helpful overall in analyzing program requirements for discriminatory elements, although it had been anticipated that the fourth question\(^{13}\) would prove to be the most helpful. I will explore the results for the fourth question next.

Participants felt that the fourth question, regarding the social construction of requirements, was too hard to apply to clinical education. The notion that all requirements and elements of the delivery of education are selected and developed by people, who could conceivably change the requirements if alternate means to the same ends were identified, seemed not to fit an analysis of clinical requirements. As one participant stated, “I didn’t find the socially constructed question particularly meaningful in this context.” The question regarding the social construction of educational

\[\text{\footnotesize \(^{12}\)“Is the requirement rationally connected to job [or course objective]” (Etobicoke, 1982), and “Is there evidence of the necessity of the requirement?” (Meiorin, 1999)}\]

\[\text{\footnotesize \(^{13}\)“Is the requirement socially constructed such that it excludes members of designated groups, or students with disabilities?” (Granovsky, 2000)}\]
requirements and delivery methods was ranked fourth, as least helpful, and was rated the lowest, 2.8 on the 5-point scale of helpfulness. One participant explained that the question of socially constructed requirements fit systemic issues better than course objectives: “The social construction question certainly applies at the system level, but in terms of course objectives, it doesn’t.” It was felt that course objectives and requirements were based on such specific elements of clinical practice that they could not be analysed in terms of how they were constructed. It was felt that clinical skills were based on requirements of regulatory bodies, or naturally occurring delimiters of hands-on practice that could not be performed in any alternative fashion. It appeared to these participants that it would be difficult to examine clinical skills and deconstruct their origins, rationales, or methods. More systemic issues, like overall program requirements and policies, were felt to be more readily considered as to their origins in a socially constructed milieu.

**Qualitative results**

Along with the completion of the quantitative survey data, qualitative data from the group discussion revealed similar thematic trends. Comments and suggestions from the survey indicated that the legal test questions helped participants to determine what could be accommodated by considering the relevance of requirements and evaluation methods to clinical practice. It was noted by one participant that “although most of my course objectives are prefaced with words such as describe or develop [sic] (which can be done in a variety of ways), others are prefaced with demonstrate [sic], which requires more thought as to the importance of how this would be evaluated”. Another participant commented, “…it did allow us to think through some of the physical requirements for the
program.” This participant thought the questions were most useful in considering evaluation methods, more than individual course objectives.

The questions also helped participants determine what could not be accommodated. One participant described use of the four legal test questions as follows: “It helped me to make my reasoning explicit.” Such reflective analysis is exactly the kind of thinking that is needed to determine potentially discriminatory requirements, and to explain to students what can and cannot be accommodated, and why.

When asked for additional questions that would help determine bona fide requirements in the context of clinical education, participants made three excellent suggestions. First, a participant said “my main question has always been ‘what is the essential core skill or knowledge here, and what is just an artefact of the way we teach or test?’” This question raises the important distinction between the knowledge or skill to be demonstrated, and issues arising from constraints on evaluation, such as limited physical lab resources, high volumes of students whose work is to be evaluated, or convenience of testing set-up. Two other suggestions were to ask, “Can this objective be met in another way?” and “Are there specific physical or cognitive requirements associated with this requirement?” Ashworth also raised these two questions in her earlier protocol for evaluating occupational therapy curriculum requirements for elements that can and cannot be accommodated (Ashworth, 1995). It is important to note that these distinctions continue to arise, encouraging educators to reflect and re-examine teaching and evaluation methods.

When asked what issues or concerns were raised in the focus group exercises for participant faculty members, several important comments indicated the value of re-
examining curricula, teaching, and evaluation methods. With respect to using the four legal test questions as a means of analysis, participants offered comments such as: “It helped me to consider alternate methods”; “[Thinking through the four legal test questions of discrimination helped with] knowing when to stop trying to accommodate”; and “[It raised the question of] what are the requirements for entry into the profession versus practice in the profession, given... there are numerous roles one can fill...” In an excellent summary of the issues raised, one participant said, “We really need to think through how we are doing things ...we need to determine the barrier where it is no longer possible to accommodate.” All the issues discussed pointed to the need to thoughtfully examine why students are taught and evaluated as they are, articulating rationale, accommodation strategies, and boundaries, so as to build a more inclusive, flexible curriculum.

Discussion

This study was created to give faculty members, i.e. specifically clinical instructors, an opportunity to test the application of four legal test questions of discrimination to curricular requirements in order to see whether the questions help discern what requirements are bona fide and cannot be altered. By determining which requirements cannot be altered, or demonstrated in some alternate fashion, the task of determining accommodations for students with impairments can be made easier, and more accountable. The clinical instructors who participated in this study agreed that the legal test questions were helpful, and raised several issues worth elaborating here.

When asked what issues or concerns the exercises in the focus group raised, one person stated, “It helped me to consider alternate methods for the student to complete
the assignments related to the course.” Other participants talked about the difference between entering the profession through a generalist program, and actually practicing in a profession where one might specialize after graduation, and might choose a setting that more easily accommodates a particular type of disability. One participant described the issue in the following way: “What are the requirements for entry into the profession vs. practice in the profession, given that as a [physiotherapist] there are numerous roles one can fill, some of which do not require the physical/mobility/vision and hearing skills that others do.” This comment captures the dilemma of generalist programs, which require students to demonstrate all skills that might ever be required in any form of practice, but which some students with impairments could not complete, and in which they would never practice. Accommodation is often more feasible after graduation than within the scope of the academic program, but students with impairments may not have the opportunity to get that far if programs do not consider what is necessary and what might be done differently, or in a specialized practice.

Another issue raised by participants was the importance of knowing when to stop accommodating a student with a disability. Applying the legal test questions to their course objectives helped the participants with “Knowing [sic] when to stop trying to accommodate. When has the student been given enough resources, and they simply will not be able to acquire the competency.” This is a difficult point to determine, and having questions based in case decisions presented a helpful guide to making decisions on when accommodation would not enable the student to demonstrate the competency. One participant noted, “[W]e really need to think through how we are doing things, also we need to determine the barrier where it is no longer possible to accommodate, e.g.,
can someone else palpate [a muscle or organ] for you [as the therapist].” Of note, Dartmouth Medical School (2007) has identified the point at which an assistant makes a clinical judgment based on their direct contact with the patient, as in palpation, to be the point at which accommodation via an assistant stops being appropriate. In other words, an assistant might be an appropriate accommodation, unless that person’s judgment includes clinical determinations, e.g., that an organ is indeed enlarged upon palpation.

Participants posed some additional questions that could be asked to prevent barriers to students with disabilities that revealed some of the reasons for the analysis of requirements. One participant presented this question, “Why do we expect the student to perform in this manner[?] Is it for reasons of patient safety, or because we have come to expect it done in this way?” Another participant expressed the point precisely, “What are the limitations, could a [physiotherapist] practice only being able to perform part of the required job – what are the boundaries for this[?]”

It was anticipated that of the four questions used, the fourth question regarding social construction of requirements would be most useful. Because this question forces examination of methods used in teaching and evaluating students’ clinical performance, and the demands of clinical curricula itself, it was thought that this would be a useful question. However, clinical instructors who participated in the study did not find this question as helpful as they found the second and third questions to be, regarding good faith and a rational connection to the task and evidence of the necessity of the requirement, respectively.

Participants found it difficult to see how the performance of a clinical, hands-on skill could be conceived as socially constructed, created by the chosen values and decisions
of people, when these skills are exercised in the context of physical or biological parameters. Nonetheless, clinical procedures and the requisite skills change and evolve over time, with shifts in understanding, new insights and technologies, and changes in what are considered best practices. In those ways, clinical skills and practices derive from decisions of human beings about how best to treat medical conditions, thereby socially constructing the subsequent requirements of clinical education. For example, when rehabilitating people who had had a total hip replacement, patients used to be immobilized for long periods of time and then gradually introduced first to strengthening and eventually to weight-bearing activities. Now, patients are mobilized with weight-bearing activities very quickly following surgery, because of the increased knowledge of the role of mobilization in healing. Pursuit of that knowledge about the timing of mobilization was a choice made by human beings. The knowledge was pursued through research that was chosen and prioritized by human beings. The research was chosen to be funded by human organizations. The research resulted in choices about treatment models, which in turn changed the way therapists decide to treat patients with total hip replacements. Our understanding of illness and treatment is driven by choices that are made by people, and to that extent, treatment becomes socially constructed. Education of student therapists is therefore informed by socially constructed requirements. How that education is delivered depends not only on the best practices as defined by professionals in the field, but also the people-generated constraints of hospital resources, instructor time, and institutional demands, resulting in the social construction of clinical education. If clinical education is “built” by people, the requirements should be
analysed in terms of how inclusive or exclusive they are of people with impairments, for valid or invalid reasons.

Conclusion

The clinical educators who participated in the focus group workshop grappled with the relationship between the legal test questions used to determine discriminatory requirements, most commonly in an employment setting, and the application of those test questions to clinical curricular requirements. They concluded that indeed, the questions could be useful in the academic setting, to promote reflexive thinking, examination of requirements, and analysis of curricula. The questions were helpful in identifying tasks where alternate means to an end would be feasible, making it possible to accommodate a student with an impairment, or to clearly define why accommodation is not feasible. This kind of reflexive practice is expected of professionals in clinical fields, to promote critical thinking and growth. Using the test questions of discrimination as a tool for reflexive practice gives voice to the kind of analysis required to determine appropriate accommodation.

Beyond accommodation, incorporation of the four questions can also lead to the construction of more inclusive, accessible curricula, by preventing the creation of barriers and discriminatory elements in the development of programs, courses and requirements. If clinical educators developed courses and programs with these questions in mind as a proactive strategy, and ensured the answers were apparent from the outset of the course or program, there would be less need for accommodation later, as a retroactive strategy. So while these questions were proposed as a useful tool in
determining appropriate accommodation, they could perhaps be even more useful in preventing situations that require accommodation.
References

Accessibility for Ontarians with Disabilities Act, S.O. 2005, c. 11, as am. by S.O. 2006, c. 35, Sched. C, s. 2.


Chapter 7: Beyond Psychometric Evaluation of the Student—Task Determinants of Accommodation: Why Students With Learning Disabilities May Not Need to Be Accommodated

Abstract

Students with learning disabilities obtain a wide range of recommended accommodations in secondary school, which they anticipate will continue into postsecondary education. Although the student’s specific learning disability (SLD) contributes to the accommodation planning process, it is not the sole determinant of appropriate accommodation. Academic requirements have integrity of their own, bona fide elements that cannot be altered without changing the nature of what is being taught or assessed. It is important to remain cognizant of bona fide requirements, which may not be altered when recommending academic accommodations. This is especially true when the student is heading into postsecondary or professional education. This article uses the World Health Organization’s model of disability and the human rights context to highlight the role of bona fide requirements in accommodation planning.

Introduction

Canadian human rights and education legislation does not require any specific type of accommodation for any given condition in any particular setting. This leaves much room for interpretation in individual cases, taking into account the nature of the condition, the resulting impairment, and the environmental context. While it is important to understand the nature and extent of the student’s disability, it is also critical to under-
stand the nature of the task required of the student. The specific impairment a student may have is, therefore, only one half of the equation in determining appropriate accommodation at the postsecondary level. Bona fide task requirements are as important a consideration as the identification of impairment. Focusing on task requirements in a particular course or program of study helps to determine accommodations that equalize the opportunity to participate without compromising the integrity of the academic task. Only when we consider both sides of the issue—the student’s functional capability and the requirements of the academic task—can a balanced and appropriate accommodation plan be devised. Without an analysis of requirements, we risk two things: compromising standards or practices that are indeed necessary for external, real-life reasons, and on the other hand, we risk perpetuating assumptions that exclude students with disabilities from participating equally.

While academic task requirements, policies, procedures, and instructional methods are often developed with implicit assumptions about normal vision, hearing, information-processing, and print capabilities that merit reconsideration, postsecondary education requirements are also rife with bona fide professional practice constraints. The work of accommodation planning is about examining academic requirements for barriers that affect disabled students' equal participation, without compromising essential

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15 Throughout this article, Michael Oliver’s use of “disabled person” is employed rather than the current convention of “person with a disability,” to emphasize how the environment disables people, causing them to be marginalized, oppressed, and thereby “disabled” by structures designed without them in mind. Oliver notes that the phrase “person with a disability” locates the disability squarely within the person, instead of in the environmental Factors that keep the person excluded (Oliver, 1996). Since task requirements are a Factor of the environment, and we are considering how they exclude students with impairments, this review employs this language form to emphasize the role of requirements in disabling, or enabling, students’ participation.
requirements. It is important to go beyond the student and consider the bona fide task requirements, those that cannot be modified, along with those than can and should be achieved by alternative means, before deciding to accommodate.

The purpose of this article is to elaborate on the importance of an essential, or bona fide, requirement and explicate the role of that concept in determining academic accommodations at the postsecondary level.

**Literature Review**

The Ontario Human Rights Code 1990 sets a boundary for accommodation by stating explicitly that discrimination is not present (i.e., accommodation would not be required to rectify discrimination) when the person is unable to perform essential duties expressly because his or her disability prevents them from doing so. “A right of a person under this Act is not infringed for the reason only that the person is incapable of performing or fulfilling the essential duties or requirements attending the exercise of the right because of disability” (*Human Rights Code (Ontario)*, R.S.O. 1990a). This section of the code speaks to the notion that there are requirements that cannot be accomplished by people with certain disabilities. Examples would include a person who is blind driving a bus. It would not be discriminatory to prohibit people who are blind from driving a bus, because of the requirement to see the road, read traffic signs, and so on. Hence, the vision requirement for a driver’s license does not discriminate against people who are blind. Similarly, it would not be discriminatory to exclude people with

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16 In this context, “essential requirements” is used as a term of art, specific to human rights legislation, referring to performance requirements that cannot be altered without compromising the nature of the task. Otherwise known as “bona fide occupational requirements” (BFOR), these elements are developed in good faith, are rationally connected to the job or program, and are evidenced as necessary (*Meiorin*, 1999).
severe reading disabilities from tasks that require fast, accurate reading for the health and safety of others and where an effective accommodation could not be made. The notion of bona fide requirements is elaborated substantially in case law decisions (Granovsky v. Canada [Minister of Employment and Immigration], 2000; British Columbia [Superintendent of Motor Vehicles] v. British Columbia [Council of Human Rights], 1999; British Columbia (Public Service Employee Relations Commission) v. B.C.G.E.U. 1999; Ontario (Human Rights Commission) v. Etobicoke (Borough), 1982) where the focus is on determining whether a requirement is justifiable and not discriminatory.

Pardo and Tomlinson (1999) identify the need to define and defend academic requirements in fieldwork settings. Their work draws on Canadian and American court cases involving discrimination in postsecondary education, where the emphasis on differential treatment of students with impairments and the need for accommodation speaks to the necessity of articulating why various policies and procedures are required in programs and courses. Lindstrom (2007) also notes the importance of considering the larger context in which accommodation is implemented. “Professionals must consider the environmental, biological, cognitive, language, and behavioral signs influencing an individual’s ability to learn tasks in a specific context when making accommodation decisions” (p. 235).

A useful framework for including the task in the analysis of accommodation comes from the World Health Organization (WHO). The WHO identifies not only the impairment, but also the environmental factors, including policy structures and delivery methods, which contribute to disablement (WHO, 2001). In the WHO biopsychosocial
model, the word *impairment* refers to the body structure or function that is affected. For example, in the case of learning disabilities, this would include brain structures responsible for cognitive functions such as memory, attention, visual and auditory processing, and so on. An impairment of auditory processing due to brain chemistry or structure would affect listening, understanding, and recalling what was heard. Functional implications for participation in school would result in what are known as “participation restrictions” (WHO, 2001) in that the student might not keep up with taking notes in lectures or recalling spoken material. To the extent that the student is unable to access classroom material due to delivery methods that rely on audible, spoken language, that student is disabled by the environmental requirements for speech and sound-based instruction.

The Environmental Factors category (WHO, 2001) includes accommodation strategies because accommodations are most often changes to an element of the environment that contributes to, or detracts from, the participation of students with impairments. Environmental factors are divided into five subcategories: attitudes and beliefs; policies, services, and systems; products and technology; built and natural environment; and relationships and supports (WHO, 2001). Without going into each of these environmental factors in equal depth, this review will focus on three that relate to accommodation, task analysis, and the role of bona fide requirements.

1. Attitudes and beliefs: Attitudes and beliefs comprise an Environmental Factor in that they exist outside the person with an impairment\(^\text{17}\) and affect the person’s equal

\(^{17}\) Attitudes held by the person himself or herself are considered in the WHO category of Personal Factors—characteristics and traits that the person brings to the situation that are held to be value neutral in the biopsychosocial model, for example, race, personality, religion, and so on (WHO, 2001).
participation. This category of environmental factors includes the attitudes and beliefs of professionals who identify, diagnose, and accommodate students with impairments. Attitudes and beliefs about disability, equal opportunity, and accommodation itself inform both diagnostic and accommodation processes. Beliefs in different definitions and criteria for the diagnosis of a specific learning disability (SLD), for example, result in conflicting information for clients, affecting their self-image and sense of empowered, autonomous participation.

The belief that a diagnosis, or even identification, is sufficient to compel accommodation becomes problematic when there is no impact of the impairment on the task at hand or when there is no inequity of opportunity to participate. For example, a student with poor auditory memory would experience no functional impact in a flexibly paced, text-based correspondence course that requires no audible discussion or presentation and so would not require accommodation in that course. If no listening is required, there is no impact of auditory memory, and no inequity of opportunity to learn. Believing that the presence of a condition requires accommodation in and of itself ignores the importance of a nexus between the impairment and the bona fide requirements, or real-life constraints, as well as the feasibility of potential accommodation strategies in various settings.

2. Policies, services, and systems: The Environmental Factor of policies, services, and systems (WHO, 2001) encompasses academic requirements as a form of policy. Academic requirements are a function of instructional goals, chosen methodologies, policies, and systemic requirements. The following example illustrates the importance of policies in determining disability itself and accommodation strategies.
For postsecondary students with learning disabilities to legitimately access the programs and supports offered at the postsecondary level, institutional policies require them to provide acceptable documentation in the form of a psychoeducational assessment or neuropsychological assessment to validate that they do, in fact, have a diagnosed disability. Currently, there is no one definition of “learning disability” that is used consistently by clinicians and implemented universally by institutions (Sparks & Lovett, 2009). Legal definitions of disability refer to a wide range of conditions and impairments but most typically do not delineate a definition of who is disabled (Harrison & Holmes, 2012).

For instance, the Canada Student Loans Program (CSLP) defines permanent disability as follows:

A functional limitation caused by a physical or mental impairment that restricts the ability of a person to perform the daily activities necessary to participate in studies at a post-secondary school level or the labour force; and is expected to remain with the person for the person’s expected life. (Government of Canada, 2009)

This definition exemplifies the functional limitations approach to classifying disabilities, taking into account both the person’s experience of impairment and how it influences the person’s function in the postsecondary environment. In this definition, disability is identified not only in terms of an underlying medical condition but also by the functional limitations caused by impairments. The functional limitations definition adopted by CSLP, while firmly maintaining the role of impairment in defining disability, recognizes that disability may be influenced by external factors, such as how the student participates in activities and the environment. Hence, students must also demonstrate
that their specific impairments are causing a functional impact in the educational environment that is permanent in nature.

Herein lies the dilemma. The presence of a diagnosable condition does not necessarily require accommodation or produce a functional limitation in all situations. There is nothing to accommodate if the condition does not compromise the student’s equal opportunity to participate in education. For example, a person may have an underlying SLD in math, dyscalculia. So long as this condition has no impact on the person’s studies in philosophy or literature, there is no disadvantage to accommodate. However, if the dyscalculia interferes with calculation tasks in mapping in geography or surveying land in civil engineering, these functional limitations may require accommodation.

There are times when the requirement itself is entirely well supported and evidenced as necessary, and accommodation would not be appropriate. Students may not be accommodated if a requirement is bona fide and the method involved cannot be altered. In the example of a student with dyscalculia, accommodations may be possible in mapping software programs, but there may not be a feasible accommodation for calculating medication dosages adjusted for body weight during an emergency medical procedure.

The policies, services, systems, and Environmental Factor in the WHO framework captures the way in which social and academic policies influence the need for accommodation.

3. Products and technology: An equally critical eye must be applied to what products and technologies are relied upon as accommodation strategies. Sometimes, assistive
technology is a perfectly appropriate accommodation. In other situations, the reliance on a form of technology may not equal the physical performance of a task, such as reliance on reading or dictation software when the student is in a clinical placement that requires quick and accurate reading or writing of patient information. Hand-held scanners have been suggested as an accommodation, but the accuracy of scanning is affected by the quality of the print scanned. Clinicians’ handwriting, Medic-alert bracelets, stained copies, and damaged labels are just a few examples of print that could not be read reliably by a scanning device. Although such devices may be useful in some settings, they may not be appropriate in all situations. The vast array of products and technologies utilized as accommodations bears another entire chapter, or several. For now, it will suffice to say that sometimes products and technologies present a brilliant solution; other times they may be infeasible because of real-life constraints on the performance of a task.

**Human Rights and the Duty to Accommodate**

In Canada, antidiscrimination legislation strives to promote equality of opportunity to participate in society and, in this case, in educational institutions. It does not purport to maximize each individual’s success. Human rights legislation seeks only to ensure equal access to the opportunities and resources available at an institution without discrimination on the basis of disability (*Human Rights Code (Ontario)*, R.S.O. 1990a) or impairment, where the disability or impairment is not essential to the task (*Human Rights Code (Ontario)*, R.S.O. 1990b). This is why the legal analyses of bona fide requirements focus on what must be achieved, how, and why, more than on quantifying or verifying the individual’s specific condition.
Canadian human rights decisions on accommodation of disability focus on the nature of the required task. Investigations of discrimination in employment settings by various courts and tribunals tend to focus on the task requirements and whether they can be accommodated or not. The focus is not so much on quantifying the impairment but on an examination of the requirements and proposed accommodations (British Columbia (Superintendent of Motor Vehicles) v. British Columbia (Council of Human Rights) 1999, Granovsky, 2000; Meiorin, 1999). If one considers the context of the requirement or activity, it is easier to determine appropriate accommodation than by defining various characteristics of people without that context.

In Granovsky v. Canada (Minister of Employment and Immigration) 2000 the Supreme Court of Canada stated,

In summary, while the notions of impairment and functional limitation (real or perceived) are important considerations in the disability analysis, the primary focus is on the inappropriate legislative or administrative response (or lack thereof) of the state. Section 15(1) [of the Charter of Rights and Freedoms] is ultimately concerned with human rights and discriminatory treatment, not with biomedical conditions. (para. 39)

It must be understood that the Charter of Rights and Freedoms has a complex relationship with postsecondary institutions, which will not be fully addressed here. Nonetheless, the principles of equity and equal opportunity enshrined in the Charter do inform the development of provincial human rights legislation, which mandates accommodation by both public and private schools. Thus, we can nonetheless take some guidance from Supreme Court decisions citing the Charter because the analysis
is instructive in applying principles to the requirements of higher education. In the above quotation, the “administrative response . . . of the state” is analogous to the administrative and curricular structures and requirements of the institution. One might paraphrase this idea as the “administrative and academic response of the institution,” and in other words, academic requirements. Extrapolating from the court’s comment, antidiscrimination legislation is concerned with equal opportunity, not the quantification of biomedical, or in this case psychological, conditions. So in order to achieve a balance between understanding the condition and designing appropriate accommodation for specific tasks, both must be considered.

Accommodations should equalize the opportunity for the student to compete fairly, to gain and demonstrate knowledge unimpeded by limitations of an impairment that are irrelevant to the academic task at hand. Accommodations are not meant to enhance performance, like performance-enhancing drugs—if only the student had artificially induced advantages, she or he could achieve better marks. Another sports analogy often used in this field has become a cliché; to “level the playing field” is used to describe the objective of accommodations. Accommodations are meant to level the playing field between teams or individuals, not tilt it to the student’s advantage or act as insurance against failure. Given a fair chance, with appropriate accommodations, it is up to the student to succeed or fail. Many postsecondary programs derive their mandate from requirements of professional practice or are designed to develop independent scholarship. Both of these origins present strong rationales for the programs’ required activities. These cannot be ignored in implementing accommodations, and after sufficient scrutiny and due consideration, recommendations of clinicians may or may not
be incorporated, depending on the nature of the activity and the legitimate, essential requirements of participation. Extra time on tests where no time-related disability exists but where extra time “would benefit the student,” clarification of test questions that becomes too informative, and exemptions from written tests because the student performs better on projects are examples of recommendations that become unfairly advantageous when applied without consideration of the curriculum rationale.

Conclusion

No consistent definition of what constitutes a disability exists in Canadian jurisprudence, as definitions vary from province to province and definitions of SLDs particularly vary across jurisdictions and in the literature. Many definitions focus on functional limitations, and legal decisions emphasize equality of opportunity. Having considered the role of environmental factors in contributing to the participation or disablement of students with SLD, it is clear that not only the impairment must be carefully analyzed but also the task requirements that present bona fide requirements—naturally occurring, real-life delimiters that cannot be altered to accommodate an impairment. For conditions that are not readily apparent, it is important to quantify the student’s function in order to understand where the gap in equitable opportunity lies. It is also imperative that we “quantify” or analyze the task, in order to build an appropriate bridge to allow for equal participation.

The WHO provides a framework for the environmental analysis with its five Environmental Factors. Accommodation is most often an alteration of one of these environmental factors—a change in a policy, procedure, technology, built environment, or method, informed by a change in attitude. As well, human rights legislation as social
policy is itself an environmental factors, emphasizing how we construct the environment as contributing to participation or disablement. Human rights decisions have focused on the requirements of the task more than the biomedical or psychological condition to determine discriminatory requirements. Together, the WHO Environmental Factors and legal opinions focusing on the task point toward accommodation that balances both student impairment *and* bona fide task requirements in postsecondary education.

Accommodations are required in postsecondary institutions to allow for equal but not enhanced participation and to ensure equal opportunity but not unfair advantage in demonstrating knowledge and skills. They are not implemented solely to allow for improved performance and may not always be appropriate if specific task demands cannot be altered due to essential or bona fide requirements or where there is no interaction between impairment and task demands.
References


*Ontario Human Rights Code, R.S.O. (1990a).* R.S.O. 1990, c. H.19, s. 1; 1999, c. 6, s. 28 (1).


Chapter 8: A Theory – Tying It All Together

*Weavings*

Students with impairments present challenges to traditional delivery methods and academic requirements in schooling. With creative analysis of the reasons for such methods and requirements, new means to educational ends can be devised that enable participation of this under-represented group of students, particularly in professional and clinical fields.

This dissertation presented an exploration of the many threads inherent in accommodating students with impairments in traditional schooling, specifically in clinical education settings. Clinical education was chosen as the focus because it is one of the most challenging settings in which to determine appropriate accommodations, due to the hands-on, technical elements of clinical practice, as well as the health and safety impacts on clients of practicing professionals. The knotty accommodation planning process was unraveled to reveal several strands contributing to a lifeline for accommodation planning. These strands included medical, social, and biopsychosocial model perspectives on impairment and disability, the duty to accommodate as mandated in provincial human rights legislation, and the role of curricular requirements. The relationship of impairment, legislation, and curricula was examined, focusing on the interplay among disability models, law, and program requirements. This examination suggested a way to conceptualize the issues together to inform accommodation and accessibility planning.
This concluding chapter revisits the various strands in each chapter, and weaves together the main points into a lifeline or framework for determining what can and cannot be accommodated in professional clinical education, and for future accessibility planning, to facilitate participation of disabled students while preserving academic integrity.

Conceptual Strands in Review

The social constructionist framework enables the taking apart of socially constructed assumptions and the rebuilding of the teaching/learning environment. Accommodation and accessibility planning are exactly that--the step-by-step reconstruction of the teaching/learning environment to remove existing barriers and facilitate the equitable participation of students with impairments. I looked at how disability is created “on top of impairment” (UPIAS, 1976; cf Oliver, 1996) by social structures that are based on assumptions of able-bodied participation, such as educational institutions and delivery methods, policies, and practices. A comparison of medical and social models of disability, and the combined biopsychosocial model (WHO, 2001) were presented as informing accommodation decisions from initial documentation of impairment to eventual altering of the environmental factors contributing to disability and participation.

The legislated mandate to accommodate people with disabilities is another strand that was explored through a retrospective on human rights legislation and a focus on the more proactive accessibility legislation recently introduced in Ontario. Older human rights provisions were identified as reactive, individualized responses to barriers that require exceptions and lengthy complaint processes to implement. The more recent legislation of the Accessibility for Ontarians with Disabilities Act 2005 (AODA) was seen
as promoting pro-active, systemic inclusion and accessibility as an alternative. This positive initiative points toward a paradigm shift of including disabled people by design, specifically the pro-actively accessible design of schooling and academic practices which may better meet the needs of people with impairments.

The importance of identifying essential requirements that can or cannot be accommodated was set out using the Court-identified test questions of discrimination. The use of the Court’s test questions was evaluated in a focus group of clinical education faculty who concluded that these questions were indeed useful in identifying what can and cannot be accommodated in clinical education. If the questions help identify accommodations that can or cannot be made, presumably the same questions could also be used pro-actively when creating curriculum and policies so as to prevent barriers to participation. Determining when accommodations would compromise a bona fide requirement and therefore should not necessarily be provided was also explored, specifically in terms of learning disabilities and legitimate task requirements. Respecting the integrity and nature of a particular activity is critical in the appropriate application of accommodations, and provides a balancing perspective on when not to accommodate.

Two policies addressing the needs of students with impairments were compared in order to look at how different perspectives on disability contribute to the social construction of disability and impacts on participation. The Council of Ontario Faculties of Medicine (COFM) document, “Essential Skills and Abilities”, (COFM, 2004) which attempts to define necessary functional capacities for incoming medical students, was compared to the Law Society of Upper Canada’s (LSUC) (LSUC, 2007) accommodation policy, which invites students with impairments to disclose their needs so that
environmental elements can be altered to facilitate their participation. The prescriptive, cautionary tone of the former is contrasted with the more open, inviting tone of the latter, illustrating the importance of tone and language in the social construction of disability through more or less inclusive education policy.

**Integrating Strands**

When educators are presented with a disabled student who requires accommodation that seems unreasonable, infeasible, or inappropriate, the first questions often asked are to seek verification or quantification of the impairment – does it merit an exception to standard delivery methods, policies, procedures, or practices? How severe is it? Who says so? The focus is on how severe the impairment is, how it will impact future situations and requirements, whether it presents an insurmountable (or unimaginable?) challenge.

The medical model approach to disability would support this focus. This emphasis on defining the student and the requisite level of function is evident in the COFM policy document that sets out what a student’s functional abilities should be prior to entering medical school. By contrast, the more pro-active approach taken by LSUC invites students to seek accommodation and proposes environmental modifications to facilitate participation. The LSUC policy is an example of moving toward the social model of disability, addressing the environment and established practices more than relying on determinations of impairment.

Situating questions about accommodation and accessibility in the World Health Organization’s International Classification of Function, Disability and Health (WHO,
reconciles the apparently conflicting medical and social models into a combined model that incorporates both bodily impairment and environmental factors in considering how disabled students can participate. The WHO framework clarifies the roles and domains of various people involved in accommodation and accessibility planning, locating clinicians and skill-building staff in the domain of Body Structure and Function, while the disability services staff and others address the domain of Environmental Factors, including the subcategories of Attitude, Policies, Technology, Natural and Built Environments, and Relationships and Supports.

Once impairment is established as existing and affecting participation (Body Structure and Function) in educational activities and settings (Environmental Factors), using the WHO framework, educators can re-examine those educational activities and settings for barriers that prevent participation of people with that impairment. The subcategories of the WHO Environmental Factors outlined above help organize an examination of the structures people have created to see if, with some creativity, those structures--tasks or policies or practices--could be reconstructed to include students with impairments, and facilitate their participation.

In order to determine which Environmental Factors can be modified without compromising the integrity of the task, or the academic integrity of the requirement, I proposed use of the legal test questions of discrimination established by the courts in employment settings, known as the three-step test. These three questions are: 1) Is the requirement established in good faith? 2) Is there a rational connection to the job or purpose for the requirement? 3) What is the evidence of the necessity for the requirement? (Meiorin, 1999) Following on the analysis in Granovsky, which
emphasizes the social construction of disability, and policies and practices, the following question was also proposed for any consideration of discriminatory requirements: 4) Is the requirement socially constructed such that it excludes people with an impairment, for reasons that are irrelevant, based on assumptions about function or students with impairments? (Granovsky, 2000)

Clinical education situations involving hands-on, in vivo work with clinical subjects might reasonably be considered the most challenging setting in which to determine accommodation and access strategies. If the Court’s test questions of discrimination are effective in such situations, surely those questions can be used to guide analysis of other kinds of academic activities, in the effort to find creative means to the same ends. These four questions were shown by clinical educators to be useful in clinical academic settings, especially the third question regarding evidence of the need for the requirement to be executed in a particular fashion. Asking these questions with respect to academic requirements, policies and practices will present challenges to the conceptualization of what is considered important in schooling practices, and why delivery methods and policies have been constructed in particular ways. Hopefully, such creative challenges will enable educators and policy-makers to open opportunities for students who function in a variety of ways to participate fully in higher education, in classrooms, labs, fieldwork, and subsequently in the world of work.

Decision-making framework

In short, accommodation decisions and accessibility planning need to be situated in the Environmental Factors domain of the WHO ICF. The Environmental Factor that poses a barrier to disabled people’s participation, or could be constructed to facilitate
that participation, can be analyzed using the four test questions of discrimination posed in this research. When decisions are based on determination of bona fide or essential requirements, discrimination is less likely to occur.

A fundamental understanding of how disability theory and legal imperatives inform decision-making in accommodation planning will be applicable beyond the classroom and fieldwork in general employment settings, where accommodation of employees can be equally difficult to determine. The preceding chapters integrated these mandates, which arose in the employment sector and gave rise to the analytical process articulated here, and identified a path forward for educators and employers alike to determine appropriate and effective accommodations of disability while protecting the bona fide requirements of academic or work-related activities. Applying the four test questions of discrimination can also be useful in designing curriculum requirements and policies when used at the design or planning stage, to prevent barriers to participation by people with disabilities, shifting the focus from the impairment to the task, and from the individual to the system.

Having taken the three-step test questions of discrimination from the employment sector into academic applications, and having added the fourth question based on Granovsky and social constructionism, the resulting four-question model was shown to be useful in academia, and from there into employment of people with impairments.

**Epilogue**

The test questions of discrimination are intended for all groups designated under human rights legislation for protection from discrimination. As this work has progressed, it has become apparent to me that the analysis of the participation of people with
disabilities using the four test questions of discrimination points the way to analyzing the participation of members of all designated groups. Asking what is the necessity for doing something in a way that excludes members of religious, cultural, ethnic, familial, gendered or other groups provides a mechanism for design of a more inclusive community for all people. People with disabilities have led the way in asking these questions about inclusion; they are not the only people who will benefit from the answers, and the ongoing inquiry. Recall Chadwick (1996): “The social model [or currently, the biopsychosocial model] must be operationalized in such a way as to facilitate the focusing of policy and action onto cultural assumptions, disabling barriers, work practices, and organisational structures rather than individuals and their impairments.” (p.38-39).
References


Appendix A

Questions in Kay Ashworth’s Skills Analysis (1995)

Answer each question Yes or No, for each course objective:

1. Is this skill an integral part of the learning objectives of this course?
2. Is there only one way for this skill to be demonstrated?
3. Would elimination of this skill alter the learning objectives of this course?
4. Was this one of the skills this course was created to teach?
5. Does the student need to be physically able to perform this skill independently?
6. Does the student need to be cognitively able to perform this skill independently?
7. Would there be any significant consequences if this skill was not learned?
8. Would there be any significant consequences if this skill was performed at varying levels of competency?
9. Is it necessary for the student to be able to transfer this skill to another setting?

Determination

1. This is an essential skill.
2. This is an essential physical skill for which there is an accommodation.
3. This is an essential cognitive skill for which there is an accommodation.
4. This is an essential physical skill for which there is no accommodation.
5. This is an essential cognitive skill for which there is no accommodation.

For questions 7, 8, and 9, two out of the three must be answered “Yes” for the objective to be considered essential. Once a skill is determined to be essential, exploration of accommodations flows from examination of the next 5 questions.
Appendix B

Survey questions referred to a static presentation of the four test questions on a screen about the questions, and included:

1) Please identify your area of specialization.

2) Which question did you find most helpful? (Order of helpfulness--top to bottom)

3) Please rate question 1 above in terms of how helpful you found it (1-5 scale; 1=not at all helpful, 5= very helpful)

4) Please rate question 2 above in terms of how helpful you found it (1-5 scale; 1=not at all helpful, 5= very helpful)

5) Please rate question 3 above in terms of how helpful you found it (1-5 scale; 1=not at all helpful, 5= very helpful)

6) Please rate question 4 above in terms of how helpful you found it (1-5 scale; 1=not at all helpful, 5= very helpful)

7) Did you find the questions helpful in determining what can be accommodated in your program? Respond with a yes or no and please comment on your rationale.

8) Did you find the question helpful in determining what cannot be accommodated? Please respond with a yes or not and please comment on your rationale.

9) What other or additional questions would help you determine bona fides in this context?

10) What issues or concerns did this exercise raise for you?

11) What questions could be asked to prevent barriers to participation by disabled students in your program area?

12) What approaches could be used to encourage faculty members to employ the 4 test questions pro-actively?

13) Other comments or suggestions?