Analytical Decision-making Model for Addressing the Needs of Allied Health Students with Disabilities

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COMMENTARY

Analytical Decision-making Model for Addressing the Needs of Allied Health Students with Disabilities

Nancy Sharby, PT, MS, DPT
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The purposes of this article are to (1) review the literature on students with disabilities (SWD) in higher education with a particular focus on allied health and related professions, and (2) propose an analytical decision-making model for assessing students’ needs and providing reasonable accommodations in allied health education. Increasing numbers of SWD are entering higher education, but the rate of success for these students is lower than the rate for their nondisabled peers. A multitude of factors impact SWD, including the direct effects of the disabilities on learning and performing essential functions, academic and clinical faculty knowledge of the impact of disability in educational settings and their experience implementing accommodations, and the impact of legislation and institutional policies on service delivery. While all of these are important, the most critical issues appear to be academic and clinical faculty knowledge about how to address disability-related challenges in the educational environment and the support of SWD by those faculty. The proposed analytical decision-making model will assist allied health faculty in assessing students’ needs and providing reasonable accommodations. This, in turn, will enable allied health faculty to support SWD to meet essential components while upholding academic integrity and meeting the requirements of the law. J Allied Health 2009; 38:54–62.

An increasing number of students with disabilities (SWD) are participating in postsecondary education. In 1978, only 3% of college students reported a disability, with that number rising to 10% in 1998. More recent data from 2003–2004 by the National Center for Educational Statistics show that 11.3% of all students who pursue postsecondary education have a disability. That number is expected to rise by 14% in the coming years. There is also evidence of increasing numbers of SWD in allied health education, at least in physical therapy. The Federation of State Boards of Physical Therapy saw an increase from 1% to 4% of new graduates requesting disability-related accommodations on the licensure examination from 2000 to 2005. Unfortunately, college SWD fail or drop out at rates greater than that of their nondisabled peers. There is variation in these data, however, because attendance and graduation rates vary by programmatic level (i.e., graduate school, 4-yr undergraduate programs, 2-yr programs, and vocational programs), and graduation rates are higher at state as opposed to private institutions. There is evidence, however, that those who successfully graduate have similar employment profiles as nondisabled graduates. At the postsecondary level, across all areas of study, SWD face additional obstacles and barriers compared with their nondisabled peers. One of the most significant factors associated with success for SWD is the pedagogical knowledge and skill that enable faculty to support these students.

Compared with the significant body of literature on all postsecondary students with disabilities, the literature focusing on education for SWD in the health professions is unfortunately extremely limited. A growing number of articles from nursing and medical literature, however, provide a rich background to inform developing allied health education. SWD can be presumed to exist in allied health fields; however, published research could only be found for SWD in physical therapy, occupational therapy, and social work. For example, in 2001, the majority of physical therapy schools surveyed had one or more students with physical, sensory, or learning impairments. Glen-Maye and Bolin reported that 91.5% of social work programs surveyed in 2005 had students with psychiatric disorders and 88% of the schools reported providing accommodations for them. Data suggest that the most common disabilities seen across all college students are psychiatric disorders, learning disabilities (LDs), and attention-deficit/hyperactivity disorder (ADHD). This will be elaborated on in later sections.

The first purpose of this report is to review the literature on SWD in higher education with a particular focus on allied health, medical, and nursing professions. Topics to be covered include characteristics of college SWD, the legal foundation and logistics of delivering support services to these students, and successful accommodations. This literature, however, provides little specific guidance for assessing
the impact of impairments in the classroom or clinic and no
guidance in identifying reasonable accommodations that
support meeting the essential components of a course while
simultaneously upholding academic integrity and meeting
the requirements of the law. The second purpose of this
report, therefore, is to propose a decision-making model for
assessing the needs of SWD and providing them with rea-
sonable accommodations in allied health education.

Characteristics of Students with Disabilities
Who Attend College

While physical disabilities are the most obvious, LDs and
psychiatric disorders are the most prevalent on college cam-
puses.21,22 Studies report that 40%21,23 to 50%24 of college
SWD have an LD. In another study,22 38% of all college
students indicated they were so depressed it was difficult to
function at times, while 10% reported they had been diag-
nosed with depression. Considering data on allied health
students, in a 2001 study of physical therapy students with
disabilities,13 73% reported an LD, while 31% reported back
injuries. The next most common impairments were in the
areas of hearing and vision. Psychiatric disorders were not
included in this latter study.

The degree of disability present will be contingent on
many factors, including the presentation of the impair-
ment, availability of compensatory strategies, and demands
of the environment. Thus, a thorough analysis of impair-
ments, essential functions, and reasonable accommodations
is critical. While not every student with a disability can be
successful in every environment, with creativity, adaptive
equipment, and support by aides or others, many SWD can
be academically successful.10 Indeed, there are many anec-
dotal reports of medical and allied health professionals who
have successful careers while using accommodations for
various disabilities.9,25–31 The discussion that follows will
briefly describe characteristics of the major disability cate-
gories seen in college SWD and how each may impact stu-
dents’ learning. Students with Asperger’s syndrome are not
included in this review. Asperger’s syndrome is a condition
on the autism spectrum, and students with this condition
have only recently begun to appear in appreciable numbers
on college campuses. The data on college students with this
complex disorder are just beginning to appear,12,32 and cov-
erage of such is beyond the scope of this report.

Physical and Sensory Disabilities

Allied health professionals must possess a high degree of
physical and technical skill that may be compromised with
a disability. A salient issue when accommodating physical
and sensory disabilities is whether SWD need to perform all
of these physical and technical skills if they are capable of
performing the most essential or vital skills. This may be
possible if skills that cannot be performed can be delegated
to others.30 Altering the physical environment, purchasing
special equipment, adjusting schedules, and changing job
responsibilities are also possible accommodations for physi-
cal and sensory impairments.

Learning and Attention Disabilities

As previously stated, LDs are the most common impair-
ments reported by college students.21 Due to improved edu-
cational supports in primary and secondary education, these
numbers have been steadily increasing.1,6,9,34 The increase
in prevalence, however, has not necessarily translated into
greater understanding of these conditions. One factor that
may contribute to this lack of understanding is that they are
“hidden” conditions that do not present with readily
observable signs. Further, like physical disabilities, LDs
come in many forms with widely differing symptoms so that
each student presents with his or her own constellation of
challenges.21 LDs are defined as “a heterogeneous group of
disorders manifested by significant difficulties in the acqui-
sition and use of listening, speaking, reading, writing, rea-
sioning or mathematical skills.”35 They typically cause a dis-
crepancy between what the student is capable of learning
and their performance in some academic settings and may
appear as functional deficits in note taking and presenting
information orally as well as remembering and organizing
information.36,37 Additional behaviors associated with LDs
in classroom or clinical environments are presented in
Table 1.

Unfortunately, LDs may be perceived to be under the
student’s control or fabricated to access special privi-
leges.9,34,38 The discrepancy between intelligence and per-
formance may be misleading to faculty who might wrongly
assume a student is lazy or has poor work habits.36 Contra-
to some thinking, LDs do not disappear if the student
“works harder.” Indeed, a qualitative study reported that
faculty at a large research university expressed “deep mis-
trust” concerning the identification and accommodation of
students with LDs and often did not differentiate between
students with LDs and students who were unprepared.36
They were also deeply concerned that accommodating spe-
cific learning needs would diminish academic integrity.9,36
Concern has also been raised by nursing faculty that accom-
modating LDs would compromise patient safety.37 Regard-
less of the reason, faculty have been shown to be more will-
ing to provide accommodations for students with physical
or sensory problems than those with LDs.9

Some students with LDs are not identified until they
reach college.1 Many LDs are language based, and the
demands to process language increase as students reach
higher academic levels. Effective note taking, another
important learning tool, may be inadequate in students
with LDs to support the more demanding language func-
tions of college material.5,36 These concerns may be even
more acute for allied health students because of the tradi-
tionally rigorous nature of these programs, including the
need to learn the new language of medical terminology.
ADHD is another disability that has received a great deal of lay notice, usually associated with the concomitant use of stimulant drugs such as methylphenidate (Ritalin). ADHD is associated with the inability to screen out irrelevant stimuli and selectively attend; it can occur with or without symptoms of hyperactivity. Unlike LDs, which may not become apparent until learning at later stages in a student’s academic career, ADHD symptoms must occur before the age of 7 yrs. Lack of attention often creates difficulty with memory because of the need to pay attention to remember. Organizational skills are often impaired as well. The student with ADHD often finds it is difficult to attend to the multiple details that are essential to writing a paper or report, taking notes, keeping track of assignments, keeping the work area neat, and completing tasks on time. These are skills that have great significance in health care settings.

### Psychiatric Disorders

Mental illnesses are a broad range of conditions affecting an individual’s cognition, emotions, mood, judgment, behavior, and physiology. Contrary to popular perceptions, mental illness is common. At any given time, 26% of the U.S. population or 57.5 million people older than 18 yrs have a diagnosable mental illness. Less than 10%, however, have a serious mental illness such as major depression, bipolar disorder, or schizophrenia.40

Colleges and universities are seeing unprecedented numbers of students with psychiatric disorders,41,42 many of whom are reluctant to come forward to reveal their illness or ask for accommodations due to shame or fear.43 This is a particular problem in colleges because the late teens and early 20s are when many of these mental illnesses first emerge.22,42,44 Indeed, an estimated 20% of college freshmen fit the definition of needing psychiatric care.44 These conditions include depression, anxiety, eating disorders, substance abuse disorders, and various other self-destructive behaviors.42 Possible explanations for this increase in mental health conditions among college students include more students who are vulnerable to the stresses presented by life on a college campus and more students arriving with a preexisting mental health condition.42

Classroom, clinic, or social settings may present a level of stimulation that is overwhelming for the student with mental illness, making it difficult to function effectively. Faculty may see a student who is having difficulty concentrating, focusing, remembering, or handling frustrations or challenges. Students with depression may appear sad and listless, have low energy, and appear to be “unmotivated.” A student with anxiety may worry excessively, seek high levels of reassurance, or be a perfectionist with unrealistically high expectations for themselves. Additional symptoms of psychiatric disorders that may be demonstrated in a classroom or clinical setting are listed in Table 2. While these are all significant behaviors that can adversely affect patient care or work skills, with good treatment, mental illnesses can be well managed with reduction or amelioration of symptoms.45

In addition to having an appreciation of the impact impairments can have on college students, it is important for educators to understand the legal foundation of how disabilities are accommodated on college campuses.

### Key Legislation and Disability Support Services

In 1973, the first federal law that directly assisted SWD was passed. The Rehabilitation Act of 1973, including key provisions in Section 504, protects individuals with disabilities who are “otherwise qualified” from discrimination by federally supported entities including a “college, university or other post-secondary institution, or a public system of higher education.”46 This act was followed in 1990 by the Americans with Disabilities Act (ADA), which strengthened the provisions of Section 504 and extended the sanctions against discrimination to all entities, not just those that received federal dollars.47 Two components of Section 504 of the Rehabilitation Act and the ADA have particular importance to educators: essential functions and reasonable accommodations. Essential functions, also known as technical standards, are key to determining who is qualified to gain admission to a program of higher education, graduate from an academic program, or
perform a job. They do not dictate how a skill needs to be accomplished, but rather describe the outcomes that are "essential" to performing the task. In an academic program, essential functions provide a mechanism to assess a student's ability based on evidence. The challenge for educational programs is to determine what are truly essential functions and whether every student needs to perform every task associated with a particular profession or whether some tasks can be deemed nonessential.

Although many medical schools believe that all graduates must have the skills to practice in all medical settings, others have chosen to admit students who would be able to work in some, but not all, specialty areas. They believe that all medical school graduates should not be expected to perform all technical skills, although some essential functions are universal to all settings and must be achieved by all graduates. The Association of American Medical Colleges has identified five technical standards that a physician must meet to graduate from medical school: observation, communication, examination and procedures, conceptual skills, and behavioral/social skills. Some nursing faculty also believe that "delegation is an acceptable accommodation." In the studies previously cited, there is general agreement that critical thinking and problem solving, compassionate and professional behavior, and effective communication and patient relationships are essential to all professions surveyed.

In allied health education, this conversation has just begun. In physical therapy, some have argued that only students who can perform all the essential functions in every specialty area of practice should be admitted or should graduate. Research in the profession, however, found that educators believe that only practicing safely, ethically, and being able to communicate effectively were essential functions. This research also showed support for the delegation of tasks—that assessment skills were more highly valued than treatment skills.

**DISABILITY SUPPORT SERVICES**

Through Section 504, colleges and universities are required to provide support services for SWD "within reason" and the institution is responsible for the cost. The ADA adds that postsecondary institutions must "provide any reasonable accommodations" to support SWD for all education opportunities and services that are available to their nondisabled peers. In most higher education settings, an office of disability support coordinates these services. This office usually assumes the responsibility to verify disabilities according to established criteria and to work with faculty to provide reasonable accommodations. To receive a reasonable accommodation in postsecondary education settings or in associated clinic affiliations, the student must present evidence of a disability, inform the school or clinical site in advance that they have a disability and will require accommodations, and formally request accommodations. In college, unlike high school, accommodations are not automatically provided to all students who qualify, and students must register with the disability support office and make a request. Many students choose to attempt college without the supports they received in high school and do not inform the appropriate office. Clearly, the accommodation process is not informal or capricious.

### Collaborative Decision-making Model

Several models for implementing the ADA are offered in the literature. Hendrickson et al. offer a three-step model: (1) develop essential functions of the curriculum, (2) discuss with the student his or her limitations and potential accommodations, and (3) determine which accommodations are acceptable to the student and the institution. Francis et al. suggest a service model that depends heavily on collaboration among the campus disability services office, faculty, and a clinician. They also suggest bringing in legal counsel. Given the numbers of college SWD, the cost of engaging university council in discussions for every student, however, could be prohibitive. Additionally, legal involvement may inadvertently facilitate an unnecessarily adversarial environment. The third model is based on concepts developed by Essex-Sorlie and offers more detail, but it is limited to students with LDs.

These proposed models do not provide a pragmatic framework for developing and implementing the accommodations. Based on the reviewed literature and the authors' experiences with SWD, we propose using a more comprehensive paradigm. Using the proposed analytical decision-making model as a framework for problem solving in the

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**Table 2. Classroom and Clinic Behaviors Potentially Associated with Psychiatric Disabilities**

<table>
<thead>
<tr>
<th>Behavior</th>
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<tbody>
<tr>
<td>Stress intolerance or emotional lability</td>
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<tr>
<td>Impaired interpersonal function</td>
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<tr>
<td>Impaired work or school performance, especially if episodic</td>
</tr>
<tr>
<td>High-risk behaviors (drinking, drug use, unsafe sex)</td>
</tr>
<tr>
<td>Screening our environmental stimuli</td>
</tr>
<tr>
<td>Sustaining attention, focus, or attention</td>
</tr>
<tr>
<td>Maintaining stamina</td>
</tr>
<tr>
<td>Handling time pressures and multitasking</td>
</tr>
<tr>
<td>Interacting with others</td>
</tr>
<tr>
<td>Responding to change</td>
</tr>
<tr>
<td>Receiving and responding to negative feedback</td>
</tr>
<tr>
<td>Physical complaints and pain that have no apparent cause</td>
</tr>
<tr>
<td>Moodiness and/or irritability</td>
</tr>
<tr>
<td>Agitation or restlessness</td>
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</tbody>
</table>

accommodation-making process moves beyond the letter of
the law. It also incorporates the belief that ADA accom-
modations cannot be effective unless all stakeholders hold
positive attitudes that will enable them to view SWD with
high regard and believe in a flexible approach to achieving
mastery of essential functions. The model is conceptualized
in Figure 1 and maximizes the potential that decision
making related to SWD is evidence based and that accom-
modations offer appropriate supports but do not compro-
mise the standards of practice or the essential nature of the
educational program. While developed from the perspec-
tive of allied health education, it is generalizable to all post-
secondary students. A description of each component of
the model follows.

Positive Climate

The process of supporting SWD begins long before a stu-
dent submits to a faculty member an office of disability serv-
ices–endorsed accommodation request letter. The law and
institution-specific policies and procedures provide the
background from which all accommodations are made; fac-
ulty knowledge of these can increase efficiency, assure equi-
table treatment among students, and facilitate communica-
tion.10 The most significant factors identified with
academic success, however, are the attitude and support of
faculty who interact with students who are dis-
abled.1,8,9,11,24,28,51–53 Negative faculty attitudes have been
reported as contributing to preventing students from apply-
ing to nursing programs52 as well as students failing to ask
for accommodations8,25 and succeed on clinical place-
ments.8,52 Given these circumstances, it is important for
faculty to be informed about students’ needs and to be able
to offer accommodations nonjudgmentally.11,53,54

In the classroom or clinic, the first step to making appro-
priate accommodations is to provide a positive climate.
This will encourage SWD to feel comfortable openly dis-
cussing their learning needs and to feel safe asking for
help.55 Fortunately, attending workshops targeting percep-
tions, knowledge, and concerns can have a positive impact
on faculty members.55–57 Another step is including a state-
ment on course syllabi encouraging students to request
accommodations from disability services.6 A final sugges-
tion is to announce at the beginning of each semester the
intention to support all students to learn to their full capac-
ity and offer to discuss concerns.37,54

Identify Essential Functions or
Technical Standards

Similar to the law and institutional policies and procedures,
esential functions are not modifiable for a given student.
They are the outcomes of an educational program that
cannot be compromised, even if a disability is present. Out-
comes that are essential components are indispensable
skills that will need to be performed by competent practi-
tioners and “can be defined based on faculty expectations,
program philosophy, and educational setting.”9,25 Essential
functions should be documented and made available to stu-
dents in both general information and application materi-
The following questions may help to identify essential functions: What tasks may reasonably be delegated to an assistant in clinical settings? What assessment techniques can be modified to measure learning without compromising the nature of the course? What is the evidence that the traditional way of teaching or assessing these skills is the most effective?

Consider the following example from an occupational therapy clinical skills course. Before graduation, the student must be able to evaluate a patient with neurologic dysfunction and plan an appropriate intervention in a timely manner. Would it be acceptable for the student to bring brief, written notes into the lab sessions or examination situations? This raises the question as to whether the essential function is the ability to remember all of the special tests or to understand the indications for each test, how to perform it, and how to interpret the results. Is it appropriate for the SWD to perform all the tasks listed above and then direct a classmate acting as an assistant to perform the intervention? Performing tasks in a limited time frame may also be challenging for many SWD. The decision to allow the student more time to accomplish tasks in school should consider the future demands of the clinic. If the clinic will expect interventions to occur in a restricted time frame, then extended time is not ultimately a reasonable accommodation because it alters the essential nature of the course expectations, but allowing more time early in a student's learning may be appropriate.

**IDENTIFY STUDENTS’ CHALLENGES AND STRENGTHS**

This third step begins the collaborative component of the decision-making model. Faculty should meet with each student who discloses a disability and ask him or her to identify anticipated challenges. The performance expectations of the course should be explained and students encouraged to reflect on what specific activities will be challenging and what accommodations will help them succeed. This conversation is one that requires a nuanced understanding of disability law. Students are not required, or necessarily encouraged, to disclose their disability diagnosis to a faculty member, and the formal accommodation request will not include this information. Instead, only the requested accommodations can be discussed. It does not matter why a student takes longer to read and process information; the key is identifying the challenge and accommodating it in the classroom as appropriate. Consider the example of a student who is very bright and able to successfully integrate course information and develop creative interventions. This student, however, needs extended time to process information, which can compromise his or her ability to demonstrate problem-solving skills in a practical examination.

SWD, of course, have individual strengths, and many have developed effective academic compensatory strategies. For example, students may use assistive technology or have developed better auditory than visual memory. One student with dyslexia found that he could remember concepts most easily if he converted them into “pictures” in his head. He was able to recall information perfectly if he was granted extra time to translate the “pictures” back into words. He was talented at communicating with patients in language they could understand and in developing treatment plans but may not feel comfortable communicating with faculty. Other students who disclose their disability diagnosis to faculty, of course, may not have a full understanding of how the diagnosis specifically impacts their learning.

**ANALYZE LEARNING ACTIVITIES**

Learning activities are the bridge between students and their ability to achieve essential functions. Lecture, readings, discussion, lab demonstrations and practice, written assignments, reflection exercises, projects, and written, oral, and practical examinations are examples of learning activities. It is likely that only some of these learning activities will need to be reasonably accommodated for any individual student. It is likely that there are many effective ways to teach or assess course material. Consider, for example, a clinical course that utilizes cases and the difficulty it will present for a student with an LD. The student does not participate in the group problem-solving case discussions with peers, which may appear as disinterest or lack of attention. Because of earlier discussions, the faculty member may know that the student needs more time to process and decides to give all the students the cases the day before the lab to prepare in advance. This should not present a barrier to maintaining the academic integrity of the course and may in fact help everyone in the class.

**DETERMINE REASONABLE ACCOMMODATIONS**

There is ample evidence that providing accommodations to SWD can promote student success. While faculty have significant flexibility in developing reasonable accommodations, they may not refuse a request for accommodations provided the student has provided the appropriate documentation. Further, for students who are required to do field placement or clinical work, reasonable accommodations will be applied in these settings as well. Making accommodations in a clinical setting may be more complicated because each student’s abilities will need to be matched to the essential functions of each potential site. Because there is considerable variability among the essential functions at different sites, however, there are many possibilities to find a placement whose requirements match the student’s abilities.

Accommodating a disability is an individualized process. This is such a fundamental aspect of accommodating a disability that the law specifically calls for “case-by-case” consideration. The process must take into account the needs of the student, practical considerations of the specific learn-
Table 3. Suggestions for Reasonable Accommodations that May Be Warranted Depending on a Particular Student's Needs and Disability

<table>
<thead>
<tr>
<th>Suggestions for Reasonable Accommodations</th>
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<tbody>
<tr>
<td>Change of location for examinations/private test setting</td>
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<tr>
<td>Priority parking</td>
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<tr>
<td>Elevator key to access campus facilities</td>
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<tr>
<td>Access to a quiet area for composure and stress reduction</td>
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<tr>
<td>Note taker or tape recorder</td>
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<tr>
<td>Modified seating arrangement</td>
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<tr>
<td>Beverages allowed in class (e.g., for thirst resulting from medication)</td>
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<tr>
<td>Textbooks on tape</td>
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<tr>
<td>Test accommodations</td>
</tr>
<tr>
<td>Alternative formats for students to demonstrate course mastery</td>
</tr>
<tr>
<td>Use of computer software programs or other technical assistance</td>
</tr>
<tr>
<td>Flexibility in determining full-time status</td>
</tr>
<tr>
<td>Assignment assistance during hospitalization</td>
</tr>
<tr>
<td>Detailed course outline clearly conveying course expectations</td>
</tr>
<tr>
<td>(e.g., objectives, material to be covered, requirements/expectations, grading procedures, examination dates, and due dates for written assignments).</td>
</tr>
<tr>
<td>Develop a positive student-faculty relationship by showing interest; a good relationship facilitates achievement; be encouraging and supportive</td>
</tr>
<tr>
<td>Meet with the student to arrange how authorized accommodations will be implemented, clarify concepts, and discuss class progress</td>
</tr>
<tr>
<td>Highlight major concepts and terminology orally or visually</td>
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<tr>
<td>Offer study questions that indicate the relative importance of content as well as the format of possible test questions</td>
</tr>
<tr>
<td>Critique early drafts of papers in advance</td>
</tr>
<tr>
<td>Extend time for class work when appropriate</td>
</tr>
<tr>
<td>Modifications of examinations such as additional time, isolation, oral vs. written, or essay vs. objective</td>
</tr>
<tr>
<td>Use a variety of visual and auditory methods to present information; this will help all students, not just those with a disability</td>
</tr>
<tr>
<td>Provide continuous feedback with weekly assignments or quizzes, meetings, or e-mails</td>
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As previously stated, requests for accommodations will most likely come from the campus disability support office. Several reasonable accommodation strategies are typically used by disability support offices, and these are listed in Table 3. Faculty are key partners with disability services in developing and providing accommodations and should appreciate that these formal requests initiate the conversation about accommodations but do not conclude it. Accommodations adjust how someone performs an essential task and are often good teaching strategies that assist all students. For example, SWD have reported that courses that provide structure, direct instruction, and clear and consistent expectations support their learning. Also, allowing adequate time to learn, practice, and take examinations is also extremely helpful. Whatever the accommodation, they do not lower academic expectations, alter the essential nature of the educational activity or academic program, present a health or safety risk to themselves or others, or cause undue hardship to the program.

It is most efficacious if accommodations are developed via consultation with the student, the institution's disability resources office, and other faculty, which can also help expand the repertoire of accommodations beyond the standard few such as allowing more time for tests. An excellent source for work site accommodations that can be useful for clinical affiliations is the Job Accommodations Network. Also, a comprehensive treatment of reasonable accommodations in clinical education is available.

While most accommodations are not costly, they may require additional time from the faculty or clinical instructor, which can create indirect costs and, in physical therapy at least, the potential perception of the students as a burden. These findings echo concerns raised by faculty throughout higher education, with concerns about accommodations compromising academic integrity also salient. Faculty must respond to accommodation requests in a manner that is both legal and fair. At the same time, with the increasing numbers of SWD in higher education, it is inefficient to attempt to treat each situation as totally unique. A systematic, structured approach to this challenge will produce results that are consistently more efficient, effective, and successful.

Implement and Assess

All members of the teaching team, including teaching assistants and lab instructors, should implement reasonable accommodations in a consistent manner. As the semester progresses, the impact of each accommodation on the student's progress should be monitored. Indeed, assessment and modification as needed are overarching principles in providing accommodations. It is important to remember that reasonable accommodations are not static tools but should be monitored and adjusted as needed. As a course progresses, there may be unanticipated challenges. Conversely, the student may need less help than originally anticipated. An instructor is always allowed the freedom to creatively address the student's learning needs and develop new solutions. It is important to make adjustments as the course progresses to maximize the effectiveness for accommodations to facilitate student success.

Conclusions and Recommendations

Historically, SWD have been underrepresented in higher education, including in allied health education. Limited
faculty knowledge on the impact of disabilities in the education environment, inexperience with developing and delivering accommodations, and the lack of decision-making models are contributors to this problem. While disability support services on campuses may be helpful in supporting students’ needs, faculty must be creative in developing effective individual accommodation strategies to meet the learning objectives of allied health curricula. A six-step model for analyzing each student’s situation and needs in the context of legal standards and university policies has been proposed. We advocate its implementation to assist educators to meet the needs of each learner and improve our ability to add well-qualified and diverse graduates to our professions.

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