

**ADDRESSING AND ENHANCING DIVERSITY IN ACADEMIC
PROGRAMS: FACULTY, STUDENTS AND CLIENTS WITH DISABILITIES**

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This presentation assumes that two perspectives on disability exist, the perspective of the consumer and the perspective of the professional. Both perspectives are important, but they may be radically different. These perspectives have implications for attitudes, research, training and practice. The case study of a hard of hearing Master's level student of audiology illustrates new challenges in incorporating diverse populations into the profession.

The field of Rehabilitation Sciences—and within it audiology and speech pathology—is based on knowledge derived from scientific research and professional practice. It lacks knowledge that is subjective (i.e. social, knowledge that explains the experience of the disabled person, whether deaf, hard of hearing or with a speech disability). Programs in Disability Studies have developed in Western countries to study, teach, and learn about the experience of people with disabilities. Disability Studies draws more from experientially-based knowledge than from scientifically-based knowledge which is the basis for medical and functional interventions. On the one hand, health professionals, with training in audiology and other fields of the Rehabilitation Sciences, can develop a view of disability that is at substantial variance from its reality for many disabled people. On the other, disabled people can develop a view of health care that is at substantial variance to its value for them. Nonetheless, health professionals make decisions important to people with disabilities, including decisions about life and death and decisions about long term care interventions such as assistive technology, including hearing aids, assistive listening devices, and augmentative communications devices.

The role of the patient/client is associated with subjectivity, emotion, and personal experience and is related to Disability Studies. This experientially-based

knowledge is often under-valued. Ian Basnett, MD has written about this in the *Handbook of Disability Studies* (Basnett, 2001) Dr. Basnett laid out three stages of his experience. The first stage involved his feelings as an able-bodied physician examining an individual with severe spinal cord injury. As he examined this patient Dr. Basnett felt a sense of horror come over him. He said to his patient: “You can’t feel anything here on your shoulder? You can’t move your legs.” The second stage involved the period soon after Dr. Basnett severed his spinal cord. As a quadriplegic he was slightly more impaired than his former patient. The third stage involved the period when he had become at home with the concept of “being me” with quadriplegia. He recognized that his training and subsequent assessment of the potential quality of life of severely disabled people was clearly flawed.

Studies of quality of life of disabled people reflect the disparity in attitudes between professionals and people with disabilities in the value placed on disability as a determinant of quality life (Rothwell et al., 1997). In one study, 92 per cent of people with quadriplegia reported being glad to be alive while only 18 per cent of emergency service personnel believed they would be glad to be alive (Gerhart, et al.).

Professionals and people with disabilities may have different perspectives on the social consequences of illness and disability. Disability does not have the same social consequences as illness. For example, people with illness are usually cured. People with disabilities frequently live with disabilities for life. People who are ill are patients who try to get well. People with long-term disability are often not ill. People who are ill may be temporarily relieved of their family and work roles. People with disabilities cannot be permanent patients who forfeit their family and work roles.

These perspectives inform attitudes, research, education and training, and practice. If the perspective is more holistic, then Disability Studies may be an important tool to enrich professional activities. Both Rehabilitation Sciences and Disability Studies can be incorporated into curricula. Disabled people may be involved in training and practice as peers. Training then can involve practitioners, students, and people with

disabilities. Education and training can occur at various levels, including the individual faculty member, the health care system and public policy. Public policy and Disability Studies are closely related because of the need for increased accessibility in real life environments. The need for assistive listening devices in the cinema is but one example. Research problems may be chosen in communication with end-users. The World Health Organization's newly adopted International Classification of Functioning, Disability and Health is an example of a more holistic, integrative model (World Health Organization 2001).

The success of applications of scientific findings in professional practice has resulted in interesting new situations. More and more people with disabilities are studying, working and living in the community. Some hard of hearing students are even pursuing degrees in audiology. Let us consider a case study. A student with bilateral moderate to severe hearing loss has very successfully completed her undergraduate degree using an FM system. She is now in an audiology Masters program. However, she is challenged by new communications situations involving group projects and presentations. She must participate in clinical practicum that require monitoring the sounds generated by an audiometer, troubleshooting hearing aids via a listening stethoscope, recording speech responses of young children during language testing, and other situations. Questions arise for the faculty. Must the student "self identify" herself as a disabled individual to the clinical sites to which she is assigned? Which "hat" does a faculty member wear when the student experiences a communications failure in class? In clinical practicum? Should the faculty serve in the role of instructor? Audiologist? Advocate? If an FM system breaks down in class, is it the instructor's (audiologist) role to fix it? In clinic, if the instructor notices that the student is unable to accurately hear children's responses to test stimuli, does she/he recommend or prescribe an accommodation? Who is responsible for the provision of accommodations at outplacement clinical practicum sites? For example, a student may need to have the audiometer monitoring output patched in directly to her hearing aids in order to score audiometric tests accurately. What constitutes "reasonable accommodations" so that a student may satisfy accreditation for clinical contact hours and face to face contact?

Can the profession provide alternative career paths for students who, with reasonable accommodations, cannot hear a hearing aid signal or score audiometric tests? For example, a nonclinical track might be developed such as hearing aid marketing or accessibility policy analyst.

References

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