Seven tips for universities to strengthen disability competencies in health professions education

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Abstract

This paper presents an Indian university–led model for building faculty capacity to teach disability competencies in health professions education. Developed and delivered by a collaborative team of educators, health professionals, and individuals with lived experience of disability, the program draws on health humanities–based pedagogies to foster experiential and reflective learning. Implemented as a pilot by the Maharashtra University of Health Sciences, it builds on earlier work on Disability Inclusive Compassionate Care (DICC), through which disability competencies were conceptualized and later integrated into national curricula by the National Medical Commission of India.

We present our findings as reflective lessons distilled into a set of practical, transferable strategies for universities. These emphasize a shift to a human rights–based understanding of disability; the use of health humanities and lived experience to deepen learning; longitudinal and interprofessional integration across curricula; and institutional mechanisms such as dedicated centers and quality improvement approaches to sustain change. Together, these insights offer a scalable framework for embedding disability competencies in health professions education, advancing a transition from a predominantly biomedical model to a more inclusive, rights-based paradigm.

Keywords: Disability competencies, health humanities, human rights, intersectionality, interprofessional education, quality improvement

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Background

People with disabilities face persistent health disparities and ableism in health professions education.[1-4] These inequities arise from unjust conditions, stigma, discrimination and other social determinants and inadequate disability-related education.[5] Global momentum to address this is reflected in the World Health Organization's *Global Report on Health Equity for Persons with Disabilities* and its *Disability Inclusion Guide for Action*, which outlines disability training among its 40 measures to advance health equity.[5,6] A key priority is embedding disability competencies in the training of all health and care workers.

India's Rights of Persons with Disabilities Act 2016 (RPDA) mandates integration of disability rights across curricula.[7] In response, the DICC project launched in 2018 by educators and activists, led to disability competencies for Indian medical graduates.[8] Following sustained physician advocacy, the National Medical Commission (NMC) incorporated selected competencies as mandatory in the 2019 competency-based curriculum.[9] However, disability competencies remain largely absent from nursing and allied health curricula.[10] Encouragingly, the Supreme Court of India has continually challenged entrenched medicalization of disability within medical education,[11] underscoring an urgent call to action for universities across India.

What was done

To bridge this gap, we initiated DICC 2.0 as a university-based pilot at the Maharashtra University of Health Sciences (MUHS), India. Selected educators were trained to impart disability competencies using health humanities tools having proven effectiveness in fostering disability and trans-affirmative competencies within the Indian context,[9,12] and endorsed by the NMC.[13] This project was supported by a Provost's Global Faculty Awards grant from the University of Chicago Center in New Delhi. A blended-learning program was developed by doctors and educators (some living with disabilities) from the University College of Medical Sciences (Delhi); Kasturba Medical College (Manipal), Hamdard Institute of Medical Sciences and Research (Delhi), Initiative for Health Equity, Advocacy and Research (iHEAR), Sangath (Bhopal), University of Chicago, (USA) and MUHS where implementation was led by PKB under the leadership of then Vice-Chancellor (MK). Thirty-nine educators from MUHS-affiliated institutions participated (July 2023 and June 2024). Thirteen postgraduate students also attended the Theatre of the Oppressed (TO) workshop. Participants represented preclinical, paraclinical, clinical, physiotherapy, and Ayurveda disciplines. Most were senior faculty (n=30; 76.9%). Four health humanities workshops on poetry, disability ethics, graphic medicine, and TO were conducted for their pedagogical history in addressing ableism, equity, inclusion, and diversity.[8,9,12] Six participants (15.4%) piloted one or more of these methods at their own institutions with support from organizers, and submitted reflections. An online Focus Group Discussion, designed to capture feedback on the workshop tools, processes, and barriers and facilitating factors during the piloting experience, was conducted ensuring representation from all four workshop formats for richer experiential insights.

Our Learning

We present our findings as reflective lessons learned, distilled into seven practical tips.

Tip 1: Understand and teach disability from a human rights perspective

This year marks the 20th anniversary of the Convention on the Rights of Persons with Disabilities (CRPD), now one of the most widely ratified human rights treaties globally, with 193 signatories.[14] The CRPD reframes disability through a human rights lens rather than a purely medical model. It places a legal obligation on ratifying states to align their policies, curricula, and pedagogy with its principles.

In India, the RPDA 2016 reinforces this mandate. Section 39(2)(f) requires universities to include the rights of persons with disabilities in curricula, while Section 47(1)(b) mandates their inclusion in teacher training across health professions.[7] Despite this, implementation remains uneven. While the NMC has introduced disability competencies in medical education, other regulatory bodies (nursing, dentistry and allied health professionals) and Institutions of National Importance lag behind,[10]

raising concerns about social accountability. Universities, given their autonomy, have an immediate responsibility to lead this transformation. As per Section 39(2)(d), they must actively sensitize learners and faculty to the human condition of disability and the rights of persons with disabilities—making this not just a legal duty, but an educational imperative.[7]

Tip 2: Use health humanities as a pedagogical tool

We moved beyond lectures and brought disability learning to life through the health humanities. In our workshops, poetry written by people with visible and invisible disabilities opened conversations on discrimination, internalized ableism, and dignity. Participants didn't just passively read—they wrote, reflected, and reimagined how to teach these experiences. Through disability ethics case discussions, they grappled with real dilemmas spanning law, policy, and social justice in India. Graphic medicine and comics helped translate invisible struggles into powerful visual narratives. Most transformative was our immersive use of Theatre of the Oppressed—where learners became "spect-actors," stepping into stories of disability to challenge structural barriers and reshape outcomes. These methods engaged the affective domain in ways conventional teaching never could.[9]

Our experience shows that health humanities are not an optional "add-on" but are in fact essential to teaching disability competencies meaningfully. Universities should integrate approaches like poetry, ethics narratives, graphic medicine, and participatory theatre to move learners beyond checklists and diagnoses. Such pedagogies foster empathy, critical reflection, and a deeper respect for persons with disabilities as rights-bearing citizens—aligning education with dignity, autonomy, and inclusion in practice. [15-17]

Tip 3: Utilize lived experience and intersectionality of faculty disability champions

We saw a clear shift the moment faculty with lived experience of disability entered the classroom—not as subjects of discussion, but as educators and leaders. Participants themselves articulated this gap: many felt hesitant to teach disability without someone who could "speak from experience." When disability champions shared their own journeys—or when learners engaged with real patient narratives from clinical settings—the teaching moved from abstract principles to embodied realities.[18] Concepts like ableism, communication barriers, informed consent, and dignity were no longer theoretical;[19] they were anchored in stories of navigating inaccessible systems, negotiating identity, and asserting autonomy. Intersectional experiences—of being a doctor, aging, caregiving, or living with chronic conditions—deepened this understanding further.

This underscores why faculty champions with disabilities are also not optional, but essential.[20] They bring credibility, authenticity, and critical insight that traditional teaching cannot replicate. Their presence challenges stereotypes, disrupts hierarchical norms, and models inclusive professionalism. Universities must actively recruit, support, and center such educators—not just as "token" voices, but as important co-creators of curriculum and pedagogy. Only then can learners truly grasp the complexity of disability—not as a deficit, but as a lived, rights-based experience shaped by social, structural, and human factors.

Tip 4: Move beyond Foundation Course

Restricting disability competencies to the first year reflects a narrow, counterproductive approach. Disability health equity must be addressed longitudinally—across undergraduate training, postgraduate education, and faculty development. Encouragingly, participants in our project demonstrated that integration beyond the Foundation Course is both feasible and effective. They embedded disability perspectives into final-year teaching and postgraduate curricula, creating learning opportunities even in the absence of dedicated slots.

These integrations spanned diverse areas such as caregiving, HIV care, mental health, gender, amputation counselling, and breaking bad news. This pedagogical spread highlights that core domains—ableism, clinical accommodation, universal design, dignity, and accessibility—are not niche topics but essential competencies. Long overlooked within the traditional medical model,

they can and should be meaningfully taught within both clinical and non-clinical contexts.[11,21,22]

Tip 5: Involve interprofessional health professionals

We embedded interprofessional education at the heart of our approach, bringing together learners and faculty from medicine, physiotherapy, Ayurveda, (as participants) and nursing, and psychiatry (during piloting at own institutions) to collaborate with each other. Rather than limiting discussions to condition-specific care, our workshops expanded disability competencies into a broader, principle-driven domain—covering social, ethical, human rights, clinical accommodation, and universal design perspectives. Anchored in the WHO's vision of interprofessional collaborative practice, this approach reflected real-world care, where persons with disabilities navigate multiple professionals across the continuum.[23] The presence of disability faculty champions alongside diverse health professionals created a powerful learning environment that broke silos and deepened understanding.

Our experience shows that interprofessional engagement is not just beneficial—it is integral to meaningful disability education. Universities should intentionally design learning spaces that bring together multiple disciplines, aligning with global competency frameworks that prioritize teamwork, collaboration, and leadership. Such integration enables a shift from fragmented, biomedical teaching to coordinated, holistic care grounded in rights and inclusion.[19] By institutionalizing interprofessional education's foundational principle of learning *with, from,* and *about* each other, medical education can better prepare future health professionals to deliver equitable, person-centered care for people with disabilities.[24]

Tip 6: Establish Centres for Disability Studies

Universities are generators of knowledge, and Section 47(2) of the RPDA mandates them to promote teaching and research in disability studies, including establishing dedicated centres.[7] Yet, Centers for Disability Studies (CDS) remain largely absent across universities. Such centers are critical for bridging the social and human rights models of disability, moving beyond a purely biomedical lens. While both the University Grants Commission and the Supreme Court of India has mandated Enabling Units to provide accommodations for students with disabilities,[11] CDS can go further—offering humanities-based perspectives, supporting faculty development in NMC designated regional and nodal centers, and reshaping how medicine understands bodies and difference.

Recent momentum adds urgency. The 2025 resolution at the 78th WHO South-East Asia Regional Committee in Colombo, calling for the integration of health humanities into health professional education, offers a timely opportunity.[25] Universities must now invest in time, resources, and interdisciplinary structures to embed humanities within curricula. Establishing CDS can institutionalize this shift—legitimizing disability as an academic and intellectual domain, not a matter of charity, and ensuring sustained, systemic change.

Tip 7: Make transformation everyone's responsibility—through quality improvement

Our pilot identified familiar barriers: curricular overload, limited Foundation Course time, lack of trained faculty, institutional inertia, and the persistent view of disability as a "special topic" rather than a core competency. These are both structural and attitudinal challenges. Yet, our prior work on medical ethics,[26] disability competencies,[9] and trans-affirmative education[12] shows that first-year students engage deeply with themes of human rights and social justice. Practical integration is feasible through early clinical exposure, electives, and AETCOM modules. Administrative resistance can be addressed by aligning with disability legislation and reframing inclusion not as an add-on, but as a quality improvement mandate**.** Drawing on Deming's principles, universities can lead by embedding disability inclusion into policies, incentives, and accountability systems.[27]

Our experience underscores that disability competencies sit at the intersection of clinical care, ethics, public health, and social justice—making them a powerful platform for interdisciplinary learning and interprofessional collaboration. Universities shape not just knowledge, but professional morals and values, clinical judgment,

and social attitudes.[9,11,28,29] In health professions education, educators are gatekeepers to future healthcare systems.

Conclusion: Universities and educators must institutionalize disability competencies training as a core component of health professions education, ensuring that future health professionals are equipped with a rights-based and socially grounded understanding of disability. When complemented by health humanities pedagogies, this training can transform health professions education from a system that often mirrors societal ableism into one that actively identifies and mitigates it. Such an approach can facilitate a meaningful shift in future health professionals from understanding and adopting a predominantly medical model of disability, to a more compassionate social and rights-based model.

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