Policy Document

Medical Students with Disabilities (2026)

Executive Summary

The Australian Public Service Commission defines disability as a “limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities”. Disabilities can present in many ways, with each individual having their own unique experience. Disabilities can be physical, neurological, and mental, which all vary in severity. Not all disabilities can be seen, therefore we must never assume and always treat students with fairness, empathy and understanding. A disability does not necessarily mean a medical student will be unable to perform and uphold their duties as a future practitioner. Rather, they may require additional support and accommodations to complete their studies equitably, compared with a medical student without a disability.

Only 2% of medical students in Australia report a disability. This is in stark contrast to the 20% of Australians in the general community who have a disability. This underscores a striking inequity in disability representation in medical schools and subsequently, the medical workforce. Disability representation in healthcare is essential in promoting inclusivity and improving overall patient quality of care. Practitioners with lived experiences of disability can deliver more patient-centred care through greater empathy and understanding. Patients with disabilities report receiving better quality care from practitioners with similar lived experiences.

Furthermore, increased representation will help reduce stigma and challenge ableism within healthcare systems, which is ever so prevalent. Despite these substantial benefits of a diverse healthcare workforce, medical students with disabilities face significant barriers to entry, which persist throughout their medical education and clinical training. These barriers contribute to an underrepresentation of people with disabilities within the Australian medical workforce.

Medical students with disabilities are often required to repeatedly disclose their disability and provide updated documentation to access necessary support. This creates significant financial and emotional burdens, contributing to “disclosure fatigue”, discouraging students from seeking adjustments due to concerns about potential repercussions. These barriers hinder participation and place additional pressure on students, taking time from their learning.

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Australian medical schools and clinical training environments should embed a standardised approach to accessible learning, such as Universal Design for Learning (UDL), alongside consistent support plans to reduce reliance on reactive accommodation processes. Strengthening disability support structures, including specialised disability liaison officers with clinical literacy, will improve continuity of support for medical students during both pre-clinical and clinical training. In addition, universities should embed flexible training pathways in their courses, with clinical placements reinforcing these measures. However, limited research evaluates the effectiveness of accessibility initiatives such as UDL, standardised clinical placement adjustments, and clinically informed disability support services. With funding from the Australian government, universities should conduct further research to strengthen the evidence base for inclusive medical education strategies and inform flexible training pathways.

Currently, there is a national gap of available evidence evaluating medical students' experiences. AMSA calls upon Australian medical universities, healthcare institutions, and relevant governing bodies to fund and support research into the perspectives of medical students with disabilities. Researchers must collect more data on the prevalence and characteristics of medical students with disabilities in Australia. This research will ensure a better understanding of the challenges impacting student wellbeing and their learning, ensuring improved support and services.

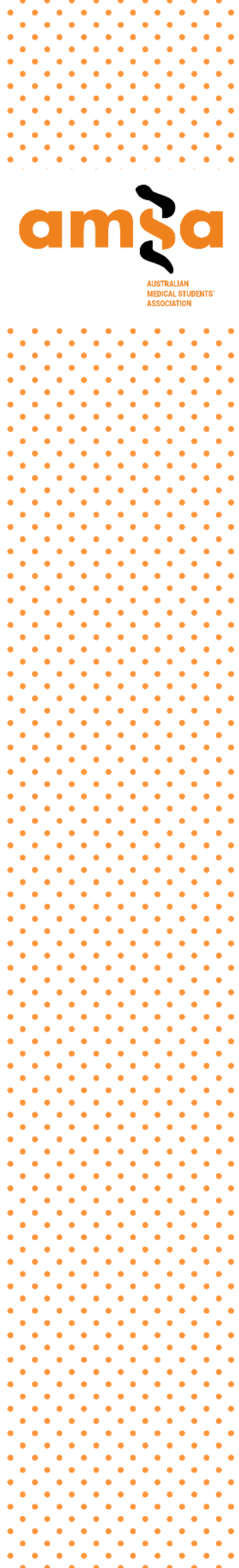
Together, these measures aim to create a proactive and inclusive medical education system, supporting students and reducing structural barriers. Medical education in Australia should be fair and representative of the community, while maintaining non-negotiable clinical competency standards and supporting all students to achieve safe patient care outcomes. This policy supports prospective and current medical students with disabilities, promoting equitable participation in medical education.

Policy Points

AMSA calls upon:

1. **Australian Universities & Medical Schools**
    a. Embed Universal Design for Learning (UDL) across curricula
        i. Ensure there is a shift from reactive, disclosure-based models to proactive accessibility design
        ii. Conduct their own UDL implementation and disability support research to enable comparison and standardisation
    b. Standardise reasonable, accessible adjustment processes across programs. Examples of adjustments may include:
        i. **AI, technology, and equipment,** such as note-taking devices or AI transcription tools (speech to text), magnification software or screen-reading technology, ergonomic supports, an adapted keyboard, joysticks, head/foot control, and Braille displays
        ii. **Accessible learning material,** such as electronic formats uploaded in advance, screen-reader compatibility, and good colour contrast to ensure students with colour blindness can appropriately access histology/pathology exams
        iii. **Assessment adjustment**, like modified formats, deadlines, and exam adjustments
        iv. **Communication**, including sign language, captioning, and transcripts
    c. Develop individualised support plans for medical students with disabilities through collaborative planning with their support teams, ensuring timely and effective implementation.
        i. Ensure clear review and escalation processes, and access to alternative progression pathways when standard requirements are not met, rather than defaulting to repeated academic years
    d. Train educators and supervisors in disability inclusion and their legal obligations under the *Disability Standards for Education* and the *Disability Discrimination Act*
    e. Appoint specialised Disability Liaison Officers (DLOs) with expertise in clinical training to support students, guide adjustments, and ensure alignment with clinical competency requirements.
    f. Distinguish between an inability to meet core clinical competencies and the use of alternative methods or assistive technologies to achieve the required standard.
    g. Establish zero-tolerance policies that reasonably define discrimination, reinforced by clear and accessible reporting pathways.
    h. Implement a Disability Entry Pathway (DEP) in line with AMSA policy.
    i. Universities must publish annual reports detailing the allocation and utilisation of disability support funding to ensure accountability
    j. Provide flexible or part-time clinical training pathways for students with disabilities through coordinated access plans with clinical placement sites

2. **AHPRA (Australian Health Practitioner Regulation Agency)**
    a. Collaborate with medical schools to publish transparent mandatory reporting guidelines that clearly separate disability support from fitness-to-practise assessments, and provide the funding, training, and resources required to implement these frameworks effectively.
    b. Establish and oversee independent external reporting pathways outside the university system, and recognise the provision and uptake of



reasonable adjustments as an endorsed practice supporting equitable progression to registration.

3. **Hospitals & Placement Sites**
   a. Ensure stigma-free access to reasonable adjustments, supported by trained supervisors and coordinated implementation with medical schools.

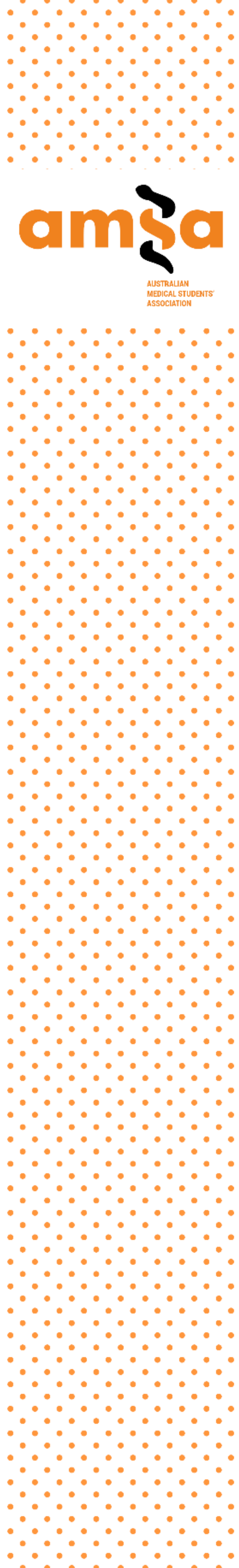
4. **Australian Medical Association (AMA)**
   a. Promote the inclusion of medical students and doctors with disabilities through
      i. accessible curricula
      ii. equitable accommodations
      iii. inclusive clinical placements
      iv. flexible training pathways
      v. improved disability awareness among faculty and supervisors
   b. Lead national initiatives to reduce stigma and discrimination toward doctors and medical students with disabilities.

5. **AMSA & Medical Student Societies**
   a. Monitor and report barriers faced by students with disabilities with anonymity and confidentiality
   b. Advocate for accessible policies at the university and national levels

6. **Australian Federal, State & Territory Governments**
   a. Fund and publish national data on disability inclusion in medical education, including experiences, support uptake, and outcomes.
   b. Explore targeted financial support pathways to assist students from underrepresented or lower socio-economic backgrounds in meeting the costs of specialist documentation required for ongoing disability support.

7. **Australian Medical Council (AMC)**
   a. Facilitate the development of a "Streamlined Adjustment Transfer" process to allow approved support plans to transition smoothly between clinical sites, reducing the administrative burden on students and clinical supervisors.
   b. Ensure national standards for clinical literacy among disability support staff to ensure adjustments are relevant to the clinical environment
   c. Strengthen accreditation standards to ensure that the requirement for a safe and supportive learning environment explicitly includes disability inclusion and accessibility within medical education. This could be achieved through:
      i. Embedding UDL principles within the medical curriculum
      ii. Structured accommodation systems that provide transparent and consistent processes for adjustment across all learning environments
      iii. Requiring training for educators and clinical supervisor in disability inclusion and their legal obligation under the Disability Standards for Education and the Disability Discrimination Act

8. **Medical Deans Australia and New Zealand (MDANZ)**
   a. Develop and coordinate a Disability Entry Pathway across undergraduate and graduate medical admissions.



9. **Admission testing (UCAT ANZ Consortium & GAMSAT - ACER)**
    a. Provide clear and accessible information regarding UCAT and GAMSAT accommodations, including eligibility criteria, documentation requirements, and timelines
    b. Implement equitable testing adjustments for candidates with disabilities
    c. Collect and publish de-identified national data on UCAT and GAMSAT accommodation requests and approvals

Background

INTRODUCTION

Disability is defined as a "limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities" [1]. This includes sensory, physical, intellectual, psychosocial, and neurological conditions arising from injury or chronic illness [1], some of which are not visible. Including medical students with disabilities is essential for an effective healthcare system [2], as their experiences enhance care through increased empathy and understanding of patient circumstances. Patient perspectives confirm the standard of care doctors with disabilities can provide, highlighting the value of disability representation in healthcare.

It has been reported that 2% of medical students in Australia have a disability [2], compared to over 20% of the general population [3]. This highlights a significant disparity in disability representation. Addressing this gap requires tackling barriers that limit entry into and retention within the medical field.

Current legislation mandates the removal of discriminatory barriers to ensure equitable opportunities for prospective and current medical students with disabilities [4]. Despite this, many still experience barriers to inclusive education [5]. Furthermore, limited data on disability prevalence and student experiences may be partly due to fears of professional repercussions [6]. This highlights the need for confidential data collection to inform national accessibility initiatives.

While legislation aims to mitigate discrimination [3], stakeholders must move towards practical, proactive solutions that make learning accessible from the outset, benefiting a diverse range of students while reducing the need for disclosure and reactive adjustments. Implementing such solutions will help guide institutions in supporting students and strengthening confidence in their future careers

ACCOMODATIONS

To ensure equitable access to medical education, institutions must implement support frameworks from the outset rather than responding when difficulties arise [7]. Currently, medical schools present many barriers before admission, providing unclear information on entry requirements and discouraging applicants with disabilities [5, 8]. Some students have stated that they have felt uncertainty about accommodation needs being met, affecting their decision to continue their studies [5].

Collaborative Planning and Universal Design

Students with disabilities have diverse needs. Medical schools should collaborate with students and their support teams to develop individualised support plans [9]. Medical schools should follow the UDL approach [7], to promote equity by providing flexible ways to access and demonstrate learning, reducing perceived barriers [7]. Unlike traditional models reliant on individual

accommodation requests, UDL shifts away from viewing disability as a deficit, leading to improved educational outcomes [7, 9].

Clinical Placements

Medical students with disabilities report significant variability in clinical placements, including teaching practices and provision of accommodations. This reflects limited staff awareness of appropriate adjustments and attitudes towards students with disabilities [5, 10]. Improving student experience requires a shift towards outcome-focused inherent requirements, mandatory clinical supervisor education, and flexible training pathways.

Placements should refine clinical technical standards to focus on learning outcomes rather than specific physical methods [11]. For instance, a requirement should state that a student must be able to "interpret clinical data" rather than "visually read a monitor," allowing for assistive technology or alternative sensory modes [11].

Mandatory training for staff and supervisors that focuses on inclusive clinical teaching and their legal obligations under the Disability Standards for Education should also be implemented [12]. This training should address any stigma held by supervisors, encouraging the use of different teaching techniques to promote better outcomes for students and patients.

The current lack of standardised flexible pathways in Australia forces students to suspend their studies, instead of working with a reduced clinical load [13]. Therefore, it is important to allow students the option of continuing their studies part-time or through a flexible study pathway.

PROGRAM FLEXIBILITY

Medical education policy has previously recognised the importance of structural flexibility within training programs. The 2022 AMSA policy (Medical Students with Disability) highlighted the need for formal part-time pathways, adaptable attendance requirements, and protected leave provisions for students with disabilities [14]. Yet, students with disabilities continue to face barriers, as rigid interpretations of professional standards restrict reasonable adjustments [12]. This indicates inconsistent implementation of previous policy points.

Medical School

The University of Edinburgh has introduced a structured part-time model within pre-clinical years to diversify the medical workforce [13,15]. The University revised its program structure to deliver the first three years completely online, followed by two years of in-person clinical training [13,15]. Through this model, the University of Edinburgh has emphasised that these initiatives bring a “breadth of talent” into medicine and foster “a more inclusive and effective medical workforce” [16].

Internship

Although part-time internship pathways formally exist, many medical interns report significant stigma associated with requesting them [13]. Existing data fails to capture the experience of medical interns with disabilities, limiting effective evaluation of structural barriers. Evidence demonstrates that flexible training reduces burnout and improves patient-centred care [13].

Transparency and Honesty

Flexible training pathways within Australian medical schools operate inconsistently across jurisdictions. Institutions collect limited data on whether part-time or other modifications maintain competency standards while improving access and well-being for students with disabilities [12].

This national evidence gap restricts the refinement of effective models and limits understanding of long-term outcomes. As a result, implementation varies between institutions, creating inequitable experiences for students depending on their training location. Stronger jurisdictional evaluation would provide greater assurance that flexible training pathways uphold professional competency standards, maintain accreditation requirements, and support long-term workforce sustainability [17,18].

ACCESSIBILITY OF PLACEMENTS

Clinical placement is an essential part of medical training, and is required to reach sufficient accreditation of a medical program [14]. Barriers to completing clinical placements restrict training and prevent students from becoming competent physicians. Current disability discrimination law fails to address the importance of providing auditable and practical solutions rather than solely relying on the abstraction of "rights" [19].

Role of clinical placement in medical training

Clinical placements are a core component of Australian medical training, exposing students to diverse clinical settings. According to the AMC, accredited programs require at least 2 years of placement, allowing students to demonstrate their skills across clinical medicine [14]. The AMC also believes that training in "diverse" and "in a broad range of primary and community settings" is an "essential component" [20]. As they guide future physicians toward their future career interests, while also exposing them to the practise of medicine [21]. This sets students up for success by allowing transition to an internship and becoming a qualified doctor [22].

Placement limitations for students with disabilities

Clinical placements remain a major barrier for medical students with disabilities. Limited outreach and support for placement accommodations can discourage disclosure, often due to fear that adjustments may affect participation [23]. Universities and placement sites may also lack the incentives, resources, or training required to implement accommodations effectively [5, 24]. These challenges are often larger in rural communities, where cost and capacity constraints limit support [25]. As a result, students may lose valuable clinical

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opportunities and spend less time actively participating. Contributing to inequities in assessment outcomes [24, 26].

What current law misses

Current law addresses the basic rights of people with disabilities in employment and education; however, a key limitation lies in its application [24, 26]. Under the *Disability Discrimination Act 1992 (Cth)*, "it is unlawful for an educational authority to discriminate against a student on the ground of the student's disability... [or] by subjecting the student to any other detriment" [19]. While federal law seeks to reduce disability based prejudice, it fails to acknowledge the implementation of accommodations. At the state level, the *Anti-Discrimination Act 1977 (NSW), Anti-Discrimination Act 1991 (Qld), Equal Opportunity Act 2010 (Vic), and the Equal Opportunity Act 1984 (SA)* attempt to address this gap by requiring accommodations unless they impose "unjustifiable hardship" to the placement site [27-30]. However, it is unclear what "unjustifiable hardship" is. This ambiguity allows institutes or placements to limit accommodations and make it difficult for students to challenge inadequate support.

ACCESSIBILITY OF COURSE CONTENT

Previous policy recognised the need to reduce barriers, yet medical students with disabilities continue to receive inconsistent support [31]. The COVID-19 pandemic exposed these structural weaknesses, revealing a reactive model that required students to disclose their barriers. By shifting the responsibility for access onto students, universities perpetuate stress and marginalisation [32].

UDL increases accessibility of course content by providing a proactive curriculum framework that improves academic achievement, engagement, and social belonging [7]. Educators can improve course accessibility by integrating adaptive technologies and artificial intelligence tools within UDL design [11, 32-34]. As reported in countries such as the United States, Colombia, and China, when implemented alongside individual accommodations, UDL strengthens support for diverse learners and promotes inclusive participation [33].

Medicine continues to evolve, and accessibility standards must evolve with it. As UDL remains a novel framework within education, medical schools must conduct research to ensure its effective implementation and faculty training, as inadequate training or research can hinder UDL success [32, 33, 35]. Governments should direct existing funding mechanisms, such as the Disability Support Fund [36], toward embedding UDL, using/developing adaptive technologies, and supporting medical students with disabilities.

STUDENT SUPPORT SERVICES

Legislative Compliance and the "Clinical Gap"

The Disability Discrimination Act 1992 and the Disability Standards for Education 2005 mandate "reasonable adjustments," but implementations remain inconsistent across medical education [12, 36]. Support models remain reactive, case-by-case adjustments that do not extend into clinical training [26]. A critical barrier is the lack of "clinical literacy" among university support staff, who may not understand the physical and cognitive demands of ward-based learning, including surgical theatre protocols and high-stakes clinical examinations [20]. Medical faculties must appoint specialised DLOs with expertise in clinical competencies and the distinction between an inability to perform a core task and using alternative methods (e.g., specialised stethoscopes or ergonomic modifications) to meet the required standard [9, 37].

Rural Equity and the "Disability Tax"

Medical students at Rural Clinical Schools (RCS) face intensified barriers due to limited access to diagnostic services and assistive technologies [26, 38]. This creates a "disability tax," where regional students incur travel and specialist costs to maintain medical evidence for support [10, 20]. The "funding vacuum" created when universities shift support costs onto students' NDIS plans disproportionately affects rural students with fewer alternative service providers [10]. Equity requires appointing Disability Inclusion Champions at RCS sites to manage local accessibility and providing targeted "Rural Disability Grants" to cover specialists and transport costs [38].

Standardisation and Professional Safeguards

Requiring students to repeatedly disclose and submit new medical evidence for each hospital rotation or academic year leads to "disclosure fatigue" and administrative exhaustion [10, 20]. A National Standardised Evidence Profile (a digital "passport" of adjustments) would allow pre-approved supports to follow students across university, hospital, and rural rotations [37, 38]. Students also forgo support for fear that disclosure will trigger AHPRA mandatory reporting and jeopardise future registration [20, 39]. "Demystifying Mandatory Reporting" guides led by AHPRA-registered DLOs could distinguish disability support from fitness-to-practice assessments and reduce stigma around seeking help [9, 40]. AHPRA must ensure students have confidence in undergoing registration, regardless of any disclosed disabilities.

BARRIERS TO SUPPORT SERVICES

Disclosure of a disability or health condition in medical education is complex, hindered by a culture of invulnerability and perceived professional risk [41]. Medical students are less likely to disclose than the general population due to fears of discrimination or questioning of fitness to practise [6]. Disclosure should not be mandatory except where required for patient safety or core competency requirements.

"Disability Tax" and Documentation Fatigue

Administrative and financial burden remain a key barrier [41]. Medical students require recurring documentation for university and clinical placements [39]. For those from lower socio-economic backgrounds, costs of specialist consultations and updated assessments create barriers [6]. These demands contribute to a "disability tax," shifting time toward bureaucracy and self-advocacy rather than study or recovery [41, 42], leading to "disclosure fatigue" and avoidance of necessary adjustments (i.e., reasonable modifications enabling students to meet competencies without lowering standards) [6,43]. This raises concerns that institutions may overreach in documentation requirements beyond what is necessary.

Performative Wellness

Medical culture equates competence with endurance and invulnerability [44], fostering performative wellness. Students feel pressure to mirror peer and clinician "resilience" to avoid being seen as a liability [42,45]. For those with invisible disabilities (e.g., ADHD, autism, POTS, autoimmune conditions), this can lead to "closeting" [42], with students masking symptoms or declining adjustments to avoid stigma [41, 46].

Clinical Instability and Adjustment Friction

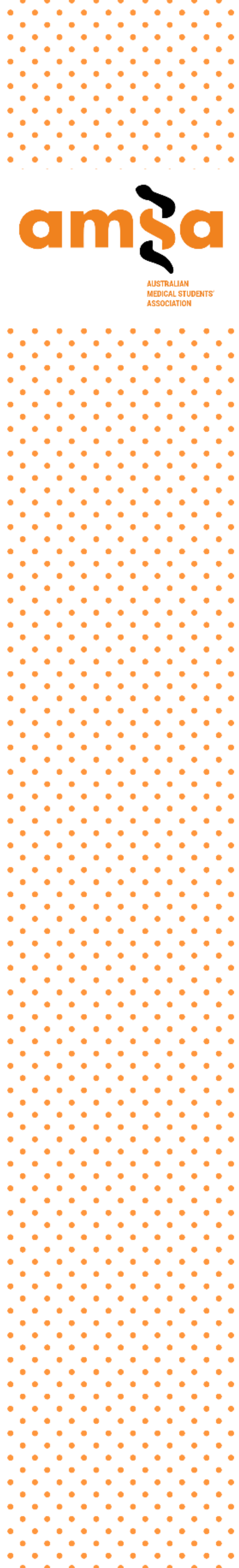
Barriers intensify during clinical rotations due to frequent changes, requiring repeated disclosure to supervisors with varying disability literacy [6, 39]. Practical barriers include lack of seating, rigid schedules limiting medication or glucose monitoring, and rejection of assistive technologies due to professionalism concerns [39, 43]. Students must justify adjustments, contributing to burnout and withdrawal from support [42, 47]. Reporting remains limited due to fear of repercussions, and informal behaviours (e.g., dismissive comments) are difficult to address.

PEER AND FACULTY DISCRIMINATION

Discrimination in Medical Schools

In a national study from the United States, 12.4% of medical students with disabilities reported discrimination from peers and faculty [48]. This included denial of opportunities, offensive remarks, and lower evaluations than peers without disabilities [48]. Discrimination most frequently came from faculty and residents [48], reinforcing an ableist culture in their careers [49]. Discrimination may also be unintentional, including compulsory examination repeats [49, 50], and inconsistent approval of reasonable adjustments [50, 51]. These challenges are compounded by anticipated stigma, further impacting well-being and medical school experience [49, 51].

Students lack access to accommodations and support services [51]. Without this support, learning and wellbeing are negatively affected, disadvantaging students throughout their careers [49, 51]. This also impacts the wider community, as clinicians with disabilities contribute to high-quality patient care [2]. Alarmingly, studies have found physicians in the United States holding discriminatory views towards patients with disabilities [52]. Furthermore, only 26.7% of physicians



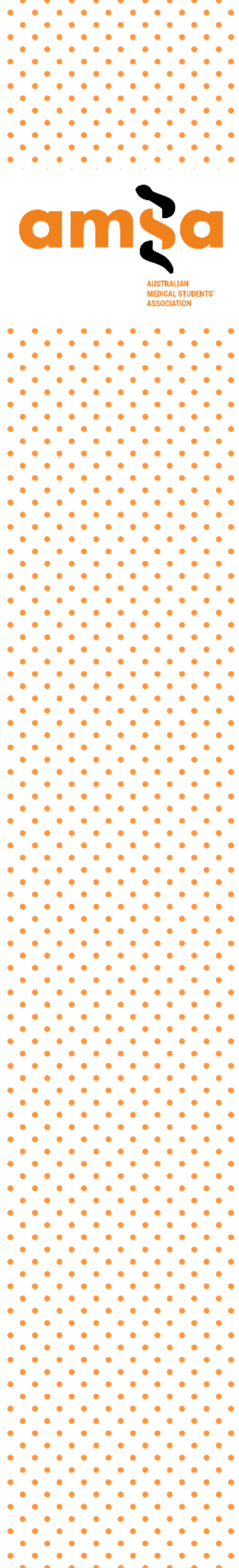
were very confident in providing equitable care to patients with disabilities [52], reinforcing the need for greater representation of clinicians with disabilities to better meet the needs of this patient population [48, 52].

Education and Awareness

Promoting a positive culture through education is key to creating an inclusive and safe space for students with disabilities [8,53]. Integrating a disability awareness program into medical school curriculum improves student attitudes, reducing instances of ableism [54]. Teaching patient-centred communication, the barriers people with disabilities face, and challenging misconceptions can all help reduce stigma [54]. Staff should also receive training on their roles and responsibilities according to the Disability Standards for Education [4].

It is important that both staff and students are aware of Disability Discrimination Act20 and relevant state and territory legislation. This will help universities develop a zero-tolerance policy against discrimination, creating a safer space for students with disabilities.

While existing literature illustrates the broader impacts of discrimination on medical students with disabilities globally, there is limited research for Australian students. Further research is essential to document the experiences of students directly, and better understand the challenges they face throughout medical school. This information is essential in establishing robust, tailored support systems for medical students with disabilities in Australia.



For More Information

Miller R, Sah S, Downey Twiss A. Policy Document Disability Entry Pathways. Australian Medical Students' Association. 2025. Accessed March 8, 2026. https://amsa.org.au/advocacy-and-policy/

- This policy proposes the introduction of a Disability Entry Pathway into medical school to improve equity and reduce barriers for applicants with disabilities. It highlights the need for accessible admissions processes to make medicine more inclusive.

CAST. UDL in Higher Ed. UDL On Campus. Accessed March 20, 2026. https://udloncampus.cast.org/page/udl_landing

- This webpage explains Universal Design for Learning (UDL) and provides examples of how institutions have begun implementing it to create more inclusive learning environments.

The following Acts prohibit discrimination and promote equity in Australia:

- Anti-Discrimination Act 1977 (NSW) pt 3 div 3.
- Anti-Discrimination Act 1991 (Qld) pt 4 div 8.
- Disability Discrimination Act 1992 (Cth) s 25.
- Equal Opportunity Act 1984 (WA) s 4(4).
- Equal Opportunity Act 2010 (Vic) pt 4 div 5.

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Policy Details:

Name: Medical Students with Disabilities 2026

Category: C - Supporting Students

History: Reviewed, Council 1, 2026

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