

STATE OF THE SCIENCE

What's your experience?: A duoethnographic dialogue to advance disability inclusion in medical education

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Abstract

Background: Although disability inclusion in medical education is gaining interest internationally, scholarship and policy recommendations on this topic largely hail from the US, Canada, Australia and the UK. Existing scholarship, while calling for medical education to enact cultural and attitudinal change related to disability, has yet to exemplify how educators might critically examine their understandings.

Approach: As two medical educators and researchers, one based in New Zealand and the other based in Saudi Arabia, we took a duoethnographic approach to explore tensions, possibilities and assumptions regarding disability and disability inclusion in medical education. Through a year-long synchronous and asynchronous dialogue, we examined our experiences in relation to literature from critical disability studies and disability inclusion in medical education.

Findings: We present recurrent themes from our dialogue. We consider what disability means, explore definitions and models of disability in our contexts, as well as our lived curriculum of disability. We grapple with the applicability of disability inclusion practices across borders. We explore the complexity of supporting access without a clear roadmap, while recognising educators' potential in this work. Finally, we recognise that, if disability is relational, we have the power and responsibility to address ableism in medical education. Throughout, we return to the importance of local consultation with disabled people (learners, physicians) to better understand how services ought to be oriented.

Conclusion: Duoethnographic dialogue is a fruitful approach to critically examine understandings of disability with others and represents a necessary start to work in education that seeks to advance justice. We share possible actions to take the work forward beyond dialogue and suggest that readers engage in such dialogues with others in their own contexts.

1 | INTRODUCTION

Disability inclusion in medical education has garnered international interest.^{1,2} Research demonstrates that disabled learners encounter significant barriers in the structure, culture and climate of medical

education.³⁻⁸ This work demands a shift in the dominant ableist culture that frames the physician's body and mind as hyper-able and renders disabled people outliers, afterthoughts, or incompatible with the physician role.⁹ Attitudinal and cultural change is needed,^{3,10} yet, little work exemplifies how individual educators can move towards this change.

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Existing discussions about disability inclusion in medical education largely hail from the US, Canada, Australia and the UK.^{3–11} While core intentions of practice derived from these contexts may align with as-yet-unexplored contexts (e.g. in shared disability rights aims^{12,13}) our experiences suggest that knowledge and practice are always situated in the cultural particularities of their country of origin. Practices reflect local ways of working influenced by sociocultural, historical, political, legal, financial and staffing factors. This particularity of place requires contextual consideration to identify ways forward in educational practice across borders. Furthermore, established practice standards do not necessarily achieve just outcomes for disabled people.¹⁴ Ingenuity is necessary to advance practice beyond established guidance and create new possibilities.

Prompted by our current professional pursuits (for Lulu, considering how to develop formalised disability inclusion practice at her medical school in The Kingdom of Saudi Arabia and for Neera, beginning a research programme in disability inclusion in Aotearoa/New Zealand) we wondered, what tensions and opportunities arise when advancing disability inclusion in medical education in national contexts that have not been the focus of many scholarly accounts? Without a substantive body of literature on this topic arising from our current contexts, we sought to learn from our own experiences in relation to international literature. At the heart of our exploration is power, “a relational co-constructed process [that] represents a potential to exert influence.”²¹⁵ We consider whose perspective has been privileged in our own experiences, institutions, classrooms and programmes, who has the power to change conditions, and whether and how it might be otherwise.

We contribute to an international conversation about disability inclusion in medical education in two ways. First, taking seriously calls to “level the northern tilt” in global medical education and disability scholarship,^{16,17} we exemplify a critical dialogue across borders that privileges local knowledge while learning from other contexts. Second, our dialogue demonstrates a process of critical self-examination that is essential for educators and administrators seeking to advance cultural safety and educational justice around disability.^{18–20} We offer tools to guide local dialogues about disability inclusion that account for national context and raise critical consciousness about disability and ableism.

We begin by discussing our approach to this dialogue and our positionalities, then we share aspects of our dialogue that centre on recurrent themes: what “disability” means, working inclusion practice across borders and the potential for educators to participate in this work. We close by considering ways forward for our practice, as teachers and researchers. We move between forms of disability language, reflecting differing linguistic preferences among disabled people, our own philosophical underpinnings, and terms used locally.²¹

2 | OUR APPROACH

Our approach exemplifies a critical dialogue inspired by duoethnography.^{22–24} We chose duoethnography because it is a dialogic method wherein researchers use themselves as sites of inquiry to critically examine sociocultural narratives and reconceptualise

understandings.^{22–24} Sawyer and Norris explain duoethnography “challenges us to ask, ‘how have we come to know the world, and after this conversation, what meanings do we wish to maintain, modify, or reject?’”^{11,24} The method offered us a scholarly approach to (re)examine our perspectives on disability inclusion through the lens of our respective socialisation. Furthermore, duoethnography invites readers (you) to act as a “co-participant and active witness”^{21,22}— to consider our conversation alongside your own experiences. Thus, the method catalyses critical examination of the topic beyond our dialogue and into your local context.

We activated duoethnography guiding principles of *currere* (life as curriculum), *polyvocal and dialogic* (making each author's voice and disparate opinions explicit), *disrupting metanarratives* (challenging a singular overarching story through multiple, situated narratives), *difference* (not seeking universal meaning), *dialogic change and regenerative transformation* (engaging in dialogic storytelling towards conscientisation), *trustworthiness found in self-reflexivity* (rigour is established through the depth of researcher involvement and associated praxis), *praxis* (writing that brings together theory and practice), *ethical stance* (ethics is central, constantly negotiated between the authors) and *trust* (dialogue relies on a deepening spiral of trust and disclosure).^{22,23}

We excavated our understanding of disability inclusion in medical education through our respective professional and personal experiences, in relation to literature from medical education and disability studies. Over the course of one year, we engaged in ongoing dialogue on this topic, synchronously (monthly Zoom meetings) and asynchronously (written discussion in a shared GoogleDoc and independent reflective memos). We began by setting questions to prompt discussion that iteratively developed as additional questions, experiences and realisations arose (Table 1). As we progressed, we sought, read and discussed literature that spoke to matters arising in our dialogue. Throughout, we carefully considered how our

TABLE 1 Overarching questions shaping our dialogue.

Who are you: where do you come from, how do you identify personally and professionally?
What is your relationship to disability?
How do you understand disability? Where did this understanding come from? How did it arise? How has it shifted over time?
How is disability understood in your local, colloquial and medical education contexts?
Why are you interested in discussing disability inclusion in medical education?
What are some of your experiences with disability in medical education that stand out? How did you understand them at the time? How might you understand them differently?
How does literature speak to the matters arising in this dialogue? How does literature resonate with our current contexts? What underlies this resonance/dissonance?
Who is missing in this conversation?
What is the problem? Who am I in relation to the problem?

understandings are situated temporally, socially, geographically and culturally to make meaning through them. We have deconstructed and reconstructed our understandings in the spirit of Friere's notion of conscientisation.²⁵ We collaboratively reconstructed fragments of our dialogue into a narrative that mines “prevalent themes” and “key, interesting, or unanticipated ideas”^{5,23} and makes meaning of them through our own insights in connection with literature.^{23,24} We agreed on themes that represented aspects of our dialogue that we sat longer with, returned to and that felt important to share with the field. We developed a narrative arc together and each author was charged with crafting her own narrative voice from the data, which we refined together.

Our approach operated with an ethics of mutual care. Each author had the final say on writing individually attributed to her, our dialogue was kept private, we carefully focused on our own experiences in our narratives, focused on changing ourselves rather than the other person and did not impose our own meaning on the other. We are named authors and adult academics without a formal power-laden relationship; therefore, we did not seek institutional ethics approval for this work.

3 | OUR POSITIONALITIES AND RELATIONSHIP TO DISABILITY

We begin by articulating aspects of our personal and professional backgrounds that shape our worldview and the position from which we speak, including our relationship to disability. We draw connections between our experiences to identify how our positionalities informed our dialogue.

Neera: *I am an educator, researcher and former disability resource professional (DRP) based in Aotearoa/New Zealand. I was born and raised in the US and migrated to Aotearoa in my mid-30s with my husband. My father was a professor who migrated from India to the US in the 1960s to pursue further education. My mother is white, Irish Catholic and grew up in a working-class family. While I am “read” as an American first in Aotearoa (and feel my Americanness, acutely, living here), I often felt like an outsider growing up in the U.S., rendered “other” by my Indianness and my mixed heritage.*

Lulu: *I received my early medical schooling in Riyadh, Saudi Arabia. Later I worked towards a master's and a PhD in Medical Education first in Scotland then in Canada. Studying abroad has made me more aware of similarities and differences between cultures and contexts. In time, this experience has made me wonder about the more subtle differences we have with others. As a faculty member of a medical school in Saudi Arabia, I'm a teacher, administrator and a researcher. I elected to explore disability in academic medicine to learn more about how I can be more supportive and inclusive in my professional roles.*

Neera: *My relationship to disability is in flux. Historically, I identified as non-disabled. I have close relationships with disabled people - my husband, friends and family members. I have worked alongside disabled people for over 20 years as a vocational counsellor, health professions education (HPE) DRP, disability rights educator, university lecturer and*

researcher. While I attempt to work in partnership with disabled people, I have always held power to grant access to services and systems. Recently, I have been reckoning with my lifelong experience of undiagnosed anxiety. I am not ready to claim disability, but the label “non-disabled” no longer fits. Critical disability scholarship shapes my emerging sense of self.

Lulu: *I'm a fully-abled person. I have never been disabled. I have experienced disability in my own family. As a medical professional myself, I have come across a variety of disabilities that result from diseases in young and adult populations, both moderate and severe, physical and mental. Despite my intimate encounters with disability across ages, disease types and stages, I'm aware that I have had a clinical gaze in such encounters, failing to fully comprehend the lived experiences of disabled patients beyond the disease. As a medical educator, I became aware of mental disability among my students through academic counselling. For the past four years, I have learned a lot about disability from my students. Despite these experiences with patients and students, I can never fully understand what it is to be disabled.*

Our personal and professional experiences shape how we view and move in the world.²⁶ As women who have lived, worked, learned and grown up between cultures, we are accustomed to noticing and questioning norms. We have sat through the discomfort of learning new ways of knowing and doing and practiced cultural fusion, mixing and shifting our values and practices between cultures.^{27,28} This dialogue drew upon these capacities in both of us, encouraging us to proceed with humility, to notice our taken-for-granted positions and where they come from and to question them. Our differing relationships to disability provided fodder for our dialogue. We speak about our experiences with disability, but not disabled people's experiences.

4 | WHAT DO WE MEAN BY DISABILITY?

Articulating a definition of disability was an ongoing tension in our dialogue. Lulu sought a clear definition to share, while Neera resisted providing any singular definition. We anticipated that we would be speaking across national cultures, but quickly realised we were also speaking across different relationships to disability culture.²⁹ To explore this tension further, we gathered definitions and models from our contexts (Table 2) to consider in relation to how and what we had learned about disability.

The definitions used in law and policy attempt to draw clear lines around what constitutes a disability, therefore, who may qualify for services or protection. Legal definitions tend to be framed by a clinical marker, the presence of an embodied difference and encompass heterogeneous experiences (physical, psychological, cognitive, chronic illness, sensory). In line with legal definitions, U.S. medical students seeking accommodations disclosed all disability types—the majority being less readily apparent.³⁷

Models of disability developed by disabled scholars and activists (social,³³ political/relational,³⁴ whānau hau³⁵) complicate the legal definitions, showing that locating disability within a person (medical

TABLE 2 Definitions and models of disability.

Source	Definition	Analysis
Legal or Policy Definitions		
Ministry of Health (Kingdom of Saudi Arabia)	A disability is a total or partial, temporary or permanent physical, sensory, mental, communicative, educational or psychological impairment that has a substantial and long-term adverse effect on the disabled person's ability to carry out normal day-to-day activities and making him/her dependent on others, or in need of special tool, special training and special rehabilitation to use of it. ³⁰	Medicalised, disability is within the person
Americans with Disabilities Act (Amendments Act)	A physical or mental impairment that substantially limits one or more major life activities. ¹²	Medicalised, disability within the person
United Nations Convention on the Rights of People with Disabilities	Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others. ¹³	Embodied and social-relational, disability happens in the relationships between bodies and barriers in the world.
New Zealand Human Rights Act	Disability, which means—(i) physical disability or impairment; (ii) physical illness; (iii) psychiatric illness; (iv) intellectual or psychological disability or impairment; (v) any other loss or abnormality of psychological, physiological, or anatomical structure or function; (vi) reliance on a disability assist dog, wheelchair or other remedial means; (vii) the presence in the body of organisms capable of causing illness ³¹	Medicalised, largely places disability within the person
Models of disability		
Medical Model	“Disability is a medical problem that resides in the individual—a defect in or failure of a bodily system that is inherently abnormal and pathological,” ^{7,32} and therefore requires medical intervention.	Disability is within the person, medicalised
Social Model	People have impairments (the embodied experience) but society disables them through discriminatory practices that create physical inaccessibility, social isolation, economic dependence and removal of choice and control. ³³	Disability is social, produced by society, sets the embodied experience apart from social construction. ^{34,36}
Political/Relational Model	Disability is created and experienced in relationships between bodies, people, spaces, practices and ideas. Disability is also political, enmeshed in power relations and constantly contested. ³⁴	Disability is social-relational, recognises embodied and collective experiences and the influence of power
Whānau hauā	“Disability is a collective endeavour of both the individual and the whānau ^a as a whole. Whānau hauā are driven by a collective effort and the cultural obligations and responsibilities that whānau members have to each other and the whānau as a whole, while they strive to achieve balance within an environment of change and institutional barriers.” ³⁵	Disability is experienced collectively and produced socially, access and inclusion is a collective responsibility

^a“The term whānau ... refers to the extended family network who may live within or outside of a home. Whānau... can be made up of either whakapapa whānau or kaupapa whānau (Metge, 1995). Whakapapa whānau comprises members who are genealogically connected by common ancestors. Whānau may also be made up by those with a common purpose or experience... referred to as kaupapa whānau, whose members provide caring, support and nurturing roles that traditional whānau provide.”³⁵

model) is just one way of knowing disability. Instead, they reframe disability as created by social barriers, as a collective experience and responsibility, and influenced by power relations. Disability is not a stable construct; it has been negotiated over time and place and reflects particular cultural values.³⁸ Definitions and models shape how we think about disability and our responsibility towards it,³⁹ while the expression of these theoretical constructs in our lives often teaches us about disability, unconsciously.

Neera: *My understanding of disability was first shaped by my family and early schooling. In school, disabled people were largely educated in separate classrooms, or pulled from class to receive separate instruction. I did not attend classes, meaningfully, with disabled people until*

university. In my family, disability was considered unfortunate and deserving of charity. I learned disability meant “other” and that my responsibility was to help disabled people but that there were limits to what they could do based on their differences. My understanding shifted through my work, relationships with disabled people, engagement with critical disability studies and my lived experience of anxiety, towards an orientation of justice and anti-ableism. These experiences taught me that collective human decisions (e.g. architectural design, the 40-hour work week, knowledge must be evaluated through a timed written test) arbitrarily exclude certain people. I now see disability created through collectively enacted societal norms about bodies and minds that, in turn, shape possibilities.

Lulu: *I do not think I've grown up with anyone who had an overt disability. I now realise that my experience, like Neera, was of active segregation from people with disabilities. Only during my professional career did I come to learn formally about disability. Perhaps it was the paediatrics rotation (fourth year of medical school) that explicitly addressed disability, defining it, listing types and explaining disabled needs and medical care. In many ways, this shaped my understanding of disability as an infantile state, something children experienced and despite ageing, they remained in need of extra care and attention, much like children. Currently, as a faculty member, my adult students who have mental disabilities challenge my taken-for-granted understanding. Often, mental disabilities manifest during adulthood, where life stressors such as the rigours of medical education exacerbate it. Here, I became a witness to the everyday lives of adults with disabilities.*

Our early understanding of disability was influenced by social segregation, which we were taught was necessary and benevolent. This orientation belies non-disabled people's discomfort, preservation of a certain kind of social order⁴⁰ and assumptions about normality. Being separated limits our understanding of disability. We took this for granted until we were exposed to other ways of knowing disability, had meaningful relationships with disabled people and engaged with disabled peoples' perspectives. The potential for a transformed understanding about another group through meaningful relationships invokes Allport's contact theory.^{41,42} Critical contemplation of these experiences helps to lift our gaze towards the systems and structures that shaped our initial understanding. We must continue to learn from the experiences of disabled physicians and learners in our contexts to orient our work. Elsewhere, lived experience research,^{3-6,9} first-person narratives⁴³⁻⁴⁸ and collectives⁴⁹⁻⁵⁵ have informed inclusive change, producing counter-narratives that point towards more just praxis in medical education. Developing relationships with existing communities, seeking stories through research and fostering space for local initiatives to grow are avenues to further transform our local understanding of disability. In Table 3, we identify ways forward to build relationships that centre lived experience.

5 | WORKING INCLUSION PRACTICES ACROSS BORDERS

Our dialogue often contemplated cultural norms and grappled with reductive understandings of "culture" and its role in practice. In this section, we show such a grappling through a discussion of stigma and inclusion practices.

Lulu: *I have seen mentally ill students (e.g. experiencing depression) struggle in medical school. They have good days and bad ones. They do not report the bad days, fearing discrimination by faculty or their peers. It seems they ultimately fear their competency as physicians will be questioned should they appear less than able. This is especially true in my context and I think it is different from Western contexts where it is more acceptable to speak openly about mental illness.*

Neera: *Considering stigma is so important. In my research and practice in the U. S, I also saw students forgo support fearing discrimination. I have argued that medicine's capability imperative,⁹ an understanding of physicians as all-knowing and all-doing, restrains how schools and disabled learners negotiate systems purportedly designed to facilitate disability inclusion.^{10,59,60} Despite this force, I have seen students share their disability experiences with others to gain access to and change ableist systems.^{60,61} Yet, stigma still has power in the West! Not long ago a U.S. medical student published anonymously about their experience of PTSD in medical school, noting the "implicit threat"⁶² raised by being known as a person with mental illness in medicine. How do you see it operating differently in Saudi?*

Lulu: *In addition to fear of their competency being compromised as health practitioners, students may also fear what disclosing their disability would mean for their families. Arab cultures are collectivist, where the welfare of the group is prioritised over the individual. As a result, people with disabilities may consider how their disability might affect their families.*

The stigmatisation of disability shapes inclusion practice in the US. Scholars recommend that disability disclosure structures do not require students to share specific disability information with evaluating faculty.^{3,63-65} A third party, a DRP with expertise in disability inclusion in medical education, is responsible for working with a student and their programme to facilitate access. Accommodation discussions that include faculty are limited to identifying educational solutions to address barriers rather than discussing disability.

Neera: *How do the solutions identified in the U.S. resonate with you, Lulu? I have seen their potential while working as a DRP. Yet, my research gives me pause—I wonder whether this approach does enough to shift the capability imperative. Given your point about collectivism, there may be other considerations. What do you need to explore to improve practice in your context?*

Lulu: *Robust support systems must be in place for those with disabilities. At first glance, I think the U.S. model might be appropriate for my context. However, who the designated DRP might be and to what extent the teacher or school are involved requires further study. While I find the U.S. approach to be positive overall, I do wonder if it has the potential of disabling individuals further by encouraging them, tacitly, to keep their disability a secret. In my experience, it really comes down to the student. Some share candidly, while others are more reserved. Finding a way of addressing students' preferences should be a priority. I believe we should spend time exploring the experiences of disabled trainees and health professionals to better understand people's needs and their preferences. For example, how do they transition from undergraduate to postgraduate education (it is during this transition that critical career-related decisions are made, e.g. choice of specialty). Does disability affect one's choice of specialty? Beyond this transitional period, how do junior practitioners navigate the work environment?*

We often reflected on whether we could identify clear cultural differences and whether this was even desirable. Lulu once stated, "culture is not something you can hold in your hand and examine." We see the influence of multiple layers of intersecting cultures.⁶⁶

TABLE 3 Actions to advance critical praxis for disability inclusion.

Domain 1: Centre lived experiences	
<p>Actions</p> <p>Seek out disabled people's perspectives in your context: informally, through research.</p> <ul style="list-style-type: none"> • What key concerns do they have? • What barriers do they identify? • What resources do they bring? • How are they currently navigating systems? • What areas for change would they prioritise? <p>Look for resources disabled people have already made public.</p> <ul style="list-style-type: none"> • Reports by disabled peoples' organisations (those run by and for disabled people) • Social media (follow hashtags like #DisabledDocs and #DocsWithDisabilities) • Disabled peoples' writing and stories online (e.g. blogs, social media), in traditional media, in scholarly sources 	<p>Considerations</p> <ul style="list-style-type: none"> • Avoid the token trap (one person's perspective driving an agenda), seek out multiple perspectives. • Consider the disability justice principle to be led by the "most impacted"⁵⁷ - seek out and centre experiences at the intersections of disability and other marginalised lived experiences. • Recognise that people may be wary of engaging with you due to disability tax⁵⁸ and engagement fatigue. • Acknowledge and reciprocate the gift of sharing lived expertise (e.g. compensation, in kind service, mutual aid, bringing participants in as co-researchers, citation practice).
Domain 2: Seek out co-conspirators to learn from and build together	
<p>Actions</p> <p>Connect with others already doing this work.</p> <ul style="list-style-type: none"> • Within your institution, nationally • Other teachers, scholars • Accreditation bodies • Student groups • Community groups <p>Identify potential allies. Who is also interested, supportive within your institution, in associated organisations, in your community, in your country?</p> <ul style="list-style-type: none"> • Others interested and working in equity • People with lived experience themselves or in their families <p>Look for others in your institution who have successfully built justice movements. What can you learn from their journey, approach?</p> <p>Undertake a power mapping exercise.⁵⁶</p> <ul style="list-style-type: none"> • Whose support do you need to advance this work? • Who are the key stakeholders? • What core assumptions might you need to shift? 	<p>Considerations</p> <ul style="list-style-type: none"> • Recognise your power and position in the hierarchy, seek to share power, demonstrate your desire to support and learn rather than take up space (offer to make cups of tea and clean up). • Respect spaces for people with lived experience that may not welcome outsiders.
Domain 3: Think locally, consider globally	
<p>Actions</p> <p>Identify local values, guiding principles, ways of knowing, being and doing might influence the way you approach work to advance disability inclusion (e.g. Indigenous frameworks).</p> <p>Map governing practices and systems in your context.</p> <ul style="list-style-type: none"> • Disability rights laws • Disabled people's preferred language • Funding structures for accommodations, assistive technology, access improvements • Training structures • Healthcare systems • Existing disability support systems • Institutional practice and resources <p>Analyse established practices from elsewhere. What can you learn? What might need to be modified? Why?</p> <ul style="list-style-type: none"> • How does international research and practice guidance discuss disability inclusion? • How is this work relevant to your context? How and why does it not resonate? 	<p>Considerations</p> <ul style="list-style-type: none"> • Critically examine current conditions, practices and ways of knowing. How these might uphold ableism? How might they be otherwise? • Avoid adopting practices from elsewhere without critically considering their fit in your context.

Culture can also manifest subtly, a feeling that is challenging to articulate. Critiques of cultural competency establish that culture is not homogeneous.^{18,20} Yet, we appreciate that there are strong local

values and ways of knowing, being and doing that ought to inform practice. In Table 3, we identify ways that we can work, critically, in this tension. We suggest first exploring local values and goals

alongside disabled peoples' lived experiences, then seek out international approaches to disability inclusion to consider their local alignment.

6 | ROLE OF EDUCATORS - TUSSLING WITH AMBIGUITY, RECOGNISING SKILL AND RESPONSIBILITY

Throughout our dialogue we reflected on our experiences as educators and administrators working in disability inclusion. We explore some of the tensions arising that might inform the development of disability inclusion efforts in medical education. We contemplate educators' existing strengths and suggest disability-inclusive teaching aligns with broader movements towards anti-oppressive education and diversity, equity, inclusion and justice (DEIJ) in the field.

Neera: *In our conversations, Lulu, I have noticed your desire for clear parameters for how to work with disabled students. I hear this often from educators, and in my previous work I have attempted to offer such a template.⁶⁵ Yet, although we can identify some principles to work from, a general process to follow, I think this work requires us to continually question our assumptions about disability, about the ways things are usually done, and remain open to individual differences among students.*

Lulu: *Medical educators like clear guidelines because such tools help protect educators, students and ultimately the patients. Whereas working with disabled students requires accepting ambiguity and learning to sit in that space without an exact map. I have committed to sitting in that uncomfortable space and through this duoethnography with you, Neera. However, I understand that not everyone can afford to do that and as a result, may resist dealing with disability. I think it is important to consider the role of the institution in supporting faculty development in this particular area and to make it a priority by giving faculty the support they need when they are engaging with students who have disabilities.*

Neera: *I have faced similar resistance and I think your suggestion is spot on—how can we support our colleagues to learn, try to address any fears or concerns, while simultaneously ensuring students get a strong and supportive educational experience?*

Lulu: *I actually think educators may be well-equipped to do this work with students. As we gain experience teaching, we become accustomed to dealing with differences between learners, identifying what a learner needs and shifting our approach accordingly. It might be helpful to think about learners as a spectrum and disabled students are part of that spectrum.*

Neera: *I agree! I once worked with nursing educators who said, “we are nurses, we are used to developing creative solutions - we can do this!” They saw themselves as equipped to innovate. Seeing disability as another form of (normal) difference, something we are always already responding to as educators, seems useful. My colleagues in inclusive education argue similarly, that disabled people do not require “special” education.⁶⁷ Rather, educational practice requires multiple flexible strategies to support all students' learning.*

In a resource and time-limited environment, educators and administrators may view students with disabilities as an obstacle to

overcome. Skidmore suggests educational environments must shift from a pedagogical discourse of *deviance*, wherein difficulties in learning reflect deficits in students' inherent ability, to a discourse of *inclusion*, wherein the source of difficulties in learning reflects insufficiently responsive presentation of teaching.⁶⁸ The latter would reflect an understanding that disabled students have met admissions criteria and have the potential to learn, and our teaching modalities and structures ought to expand in response. Viewing disability as an expected form of difference that educators are poised to work with, while enhancing educator skills in creativity, flexibility and personalisation, may support such a paradigm shift. This shift would join disability with other DEIJ and anti-oppressive education efforts in our field that suggest we reconsider how and what we teach alongside programme structures.^{20,69-73} Recognising that culture is constantly (re)created through our actions and systems, educators might adopt a stance as mindful culture creators. Going forward, we need to build connections with “co-conspirators,” people who have similar goals with whom we can combine efforts to take the work forward in line with a larger mission (Table 3).

7 | REORIENTING THE PROBLEM

Our discussions about the concept of disability and tensions in enacting inclusion prompted us to reconsider what is the “problem” in need of a “solution,” and where we stand in relation to this problem. We reflect on our power and responsibility to make change in light of these insights.

Lulu: *Disability is not an individual experience. It is an interpersonal experience. It is important to recognise that different people play a significant role in empowering or disempowering disabled individuals. I'm referring to the Albagami dissertation reporting disabled peoples' experiences of the healthcare provided to them in Saudi Arabia.⁷⁴ I was troubled that study participants were so disempowered, they did not speak about themselves as independent individuals. Moreover, important people in their lives (parents and healthcare providers) contributed to their disempowerment. Not recognising the relational nature of disability is a large part of the problem.*

Neera: *In medical education I see disability treated as the problem that lives within the student. Our systems are designed to respond to disability individually, rather than anticipate it. This assumes that individuals “have” disabilities and when they encounter barriers it is because of “their” disability. Instead, I see the problem living in restrictive educational and practice design that prescribes and assumes certain bodies and minds. So, to me, the problem is ableism—an assumed normal body and mind, continually recreated through the ways we do things.⁷⁵ In medicine, being superhuman is assumed normal.⁹ Lulu, I appreciate your acceptance that disability is relational rather than individual. When we locate disability in power relations, interactions and systems, we can shift our focus towards enacting a more expansive understanding of doctors and medical practice.*

Lulu: *I see myself now as someone who is disability-adjacent. In my interactions with students, I am noticing my biases, assumptions and*

curiosities—wondering about their experiences but remaining in my role as a teacher. The self-restraint one must exercise is immense. For example, just because a student has a mental health issue, does not mean they will be interested in mental health as a topic for an assignment. Who am I in relation to this problem? I'm a part of it. I could be someone who helps or maybe someone who is trying to help. I might be someone who makes things more complicated. I need to ask my students.

Neera: *This practice of noticing and reconsidering is hard and important. I am someone who exists within the system of ableism, trying to resist and dismantle it. I am a person with some power within a sphere of this system: I am an academic (albeit early career) who teaches health professionals to be better teachers, I am called upon to speak about disability, I serve on university committees that direct HPE practices, I conduct research. I am given power and resources to influence. Yet, the structures and systems we work in make resistance difficult because non-disabled is embedded as the “default.” The system guides us to be ableist. Plus, having been raised in ableism, I need to continually unlearn internalised ableism. Working against this powerful force is challenging and I must use my power to keep working at it.*

Lulu: *I'm someone with power. That is why I think spending time really understanding ableism is necessary for me.*

This theme represents a new understanding of “the problem” that developed through our dialogue. This shift was possible by meeting each other at our current understanding, offering alternative ways of thinking that destabilised our taken-for-granted positions²⁰ and sitting with topics and questions that created friction.

8 | WHERE TO FROM HERE?

With our power and responsibility in mind, we recognise the limitations of what we can know through our experiences so far. We look forward, beyond this dialogue, to consider ways to take this work forward.

Lulu: *I'm acutely aware of the responsibility that comes with writing about disability but not being disabled myself. This work requires an intimate understanding of diverse experiences with disability and maybe deeper engagement with the disability community. Other than my experiences with my students, the ones sent my way, I'm not really part of any disability community. Navigating this intricate space is both humbling and challenging. I feel compelled to write about my own experience as a teacher/administrator but I also feel I should make space for my students to speak for themselves, to understand their experiences. I desperately want to find out what stereotypes I harbour about disability before I jump in and advocate for inclusivity.*

Neera: *We have an obligation to explore this topic, as people with power in medical education. Anti-racism work calls upon white people (those in positions of power) to do the work of naming and dismantling architectures of privilege.⁷⁶ Similarly, while we should be led by disabled peoples' views and lived experiences, disabled people should not be tasked with the “heavy lifting” of anti-ableism work. Our dialogue is an initial step to explore our ideas and experiences, an important beginning. We need to know more about disabled peoples' experiences*

in our respective medical education contexts to better understand the shape of the problem.

As we reflected on the insights, questions and knowledge gaps arising from our dialogue, we identified possible actions to take this work forward into praxis (Table 3). Asking ourselves how we might explore these matters further, we settled on the domains of centering lived experiences, seeking out co-conspirators and thinking locally while considering globally. These actions are informed by critical disability scholarship, which calls us to centre disabled people, to work against systemic oppression and to decentre the global north.^{16,57,77} This stance prompts us to ground our work in local experiences and values (e.g. considering Māori values in Aotearoa alongside local legal and educational frameworks), before considering how others around the world have organised their practice. We also offer considerations for newcomers to embark on this journey, respectfully, in alignment with calls from oppressed communities to work in ways that do not add to their labour and are non-extractive.^{57,58,77}

9 | CONCLUSION? THE DIALOGUE CONTINUES

We close with a reflection on what we have learned through our dialogue and process of duoethnography.

Neera: *I engaged in this dialogue to support and learn from an educational leader committed to developing their understanding of disability inclusion. I have seen the power of educational leaders who become inclusive champions. Engaging in duoethnography required vulnerability and care. I worried about imposing my knowledge on you but realised that it was only through sharing that we could re-evaluate our perspectives. Our dialogue has prompted me to position myself as a newcomer in Aotearoa as I embark on research here. I may have a strong U.S. understanding of disability-in-medicine, but I am a novice in this culture. This realisation has re-focused my energy on developing relationships to ground my work in this place. I ask questions and listen even more. Thank you, Lulu!*

Lulu: *I engaged in this dialogue for and because of my students. A quality medical education is the right of every medical student, and that means different things for different people. Inclusion is dynamic, fluid and highly shaped by context. Therefore, understanding experiences in their situated cultural context is necessary. However, meaningful boundary-expanding learning occurs across cultures. Engaging in this duoethnography with Neera, a disability expert in medical education, was boundary-expanding. Duoethnography was new to me, but I was willing to take part in the hope it would deepen my understanding. Through this research method, I realised that relationship building and trust are essential. In this process, I've come to realise more fully that our learning is shaped by our emotions and by others.*

The duoethnography process required building trust through actions such as honouring boundaries and acting gently to push our conversation forward. While we anticipated producing a “cross-cultural dialogue” we realised this was often subtle and multi-layered as culture is not a monolith. We dialogued from our individual, inter-sectional positions and hybrid cultural experiences. We have

highlighted where culture was most evident to us while resisting generalisations. Perhaps if we spent time immersed in each other's contexts (rather than discussing online), we might see cultural differences more clearly. Our dialogue was also temporally limited. With more time a deeper relationship would have enabled further insights.

We leave this leg of our journey knowing that the work remains unfinished. We take away from our dialogue that disability is relational, that medical educators have the power and responsibility to address ableism, and that locally grounded practices must be developed. Our discussions shared in this paper exemplify critical consciousness-raising by reflecting on our own positioning, assumptions and commitments. We have shared themes that threaded through our dialogue. In the spirit of duoethnography, we hope witnessing aspects of our dialogue has prompted you to reflect on your own experiences and to begin your own local dialogues (e.g. using prompts from Table 1).²² Readers who engage in a similar dialogue will find their own prevalent themes and we hope they share their learning with others in turn. May this exercise spark further critical dialogues about disability and ableism in medical education.

AUTHOR CONTRIBUTIONS

Neera R. Jain: Conceptualization; methodology; data curation; formal analysis; writing—original draft; writing—review and editing. **Lulu Alwazzan:** Conceptualization; data curation; writing—review and editing; methodology; formal analysis.

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Research data are not shared.

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