CASE REPORT

Accommodations for a Student With a Physical Disability in a Professional Physical Therapist Education Program

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Background and Purpose. Since 1973, the passage of federal laws and regulations has allowed increased access to education and employment for individuals with disabilities. Although the number of graduate and professional students with disabilities has not been reported, faculty in professional education programs must be prepared to address the needs of students with disabilities. The purpose of this case report is to describe the process used to determine reasonable accommodations and the modifications made in a professional physical therapist education program to enable participation by a student with a physical disability.

Case Description. At the age of 17, the student in this case report sustained a Grade V spondylolisthesis. She subsequently underwent 4 surgeries to stabilize her spine. The student's most significant impairment was weakness in right ankle dorsiflexion, for which she wore an ankle foot orthosis. Because of the spine stabilization surgeries, at the time of admission to a physical therapist program, the student presented with functional limitations in standing, sitting, lifting, and bending. Accommodations were developed that enabled her to participate in classroom and clinical education activities.

Outcomes. The student successfully completed all required academic and clinical coursework. She is now employed in the outpatient physical therapy department of an academic medical center where she works with patients with a wide variety of medical diagnoses.

Discussion. The faculty faced many challenges while determining and implementing reasonable accommodations that allowed the student to participate in and complete the physical therapist education program. Many of the challenges arose because of physical therapists' concerns that an individual with impairments and functional limitations could not become a physical therapist and practice safely. This report challenges physical therapists to reconsider the requirements to become a capable practitioner.

Key Words: Essential functions, Technical standards, Student with disabilities, Physical therapy education, Physical disabilities.

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BACKGROUND AND PURPOSE

Since 1973, the passage of federal laws and regulations has increased access to higher education and employment for individuals with disabilities. In 2000,[1] over 66,000 college freshmen reported having learning, sensory, or physical disabilities, and in the following year, 57% of undergraduates indicated that they were attending college to prepare for graduate or professional school. Although the number of graduate and professional students with disabilities has not been reported, faculty can expect students with disabilities to apply for professional education programs. Often, applicants to professional physical therapist education programs have been introduced to the profession through experiencing a personal injury. Therefore, such programs must be prepared to address the needs of students with physical disabilities. The purpose of this case report is to describe the process used to determine reasonable accommodations and the modifications made in a professional physical therapist education program to allow participation by a student with a physical disability. We also describe the challenges encountered and make recommendations for academic and clinical faculty facing similar situations.

Literature Review

The Rehabilitation Act of 1973[2] (Rehab Act) and the Americans With Disabilities Act[3] of 1990 (ADA) have increased opportunities for students with disabilities. According to Section 504 of the Rehab Act, students cannot be denied access to education at any entity that receives federal funding because of a disability. The protections of the Rehab Act extend to programs offered jointly with entities outside the academic institution, such as clinical education sites. Education programs have the authority to establish technical standards, based on faculty expectations and program philosophy, that students must be able to complete during their professional education.[2,4] A program's technical standards can be used to determine whether a student with a disability possesses the abilities necessary to participate, and is therefore a qualified student with a disability.

The ADA allows qualified applicants with disabilities to apply for admission to education programs.[3] To determine whether an individual is qualified to enter a professional education program, an admission committee can compare the applicant's abilities with the program's admission standards, which can be academic or technical in nature. A student who does not meet admission criteria can be denied entry. Once a student is admitted, the ADA requires that "reasonable accommodation should be made to allow a qualified disabled per-

son to achieve the essential functions of the job."[5] Essential functions define the abilities required to participate in and complete a program in a manner that does not compromise others' safety;[4] the nature of the job must change if the essential functions are removed.[5] Essential functions for a professional education program can be defined based on faculty expectations, program philosophy, and educational setting. Technical standards or essential functions may be described in physical therapist education program mission statements, student handbooks, admission materials, or in course syllabi. If an admitted student cannot meet the essential functions or components of a program with or without reasonable accommodations, a program may determine that student to be unqualified for participation.

Academic institutions can determine the manner in which reasonable accommodations are provided to qualified students with disabilities. Acceptable program modifications might include changes in the courses required for a degree or adaptation in the requirements for completion of a specific course.[6] Programs are not expected to make modifications that would compromise the health or safety of others[4] or to revise requirements essential to obtaining the degree or related to licensing requirements.[6]

Ingram[7] explored the opinions of physical therapist education program academic administrators regarding the essential functions for physical therapist students. Most program administrators who responded to a survey that was sent to all accredited physical therapist education programs in 1997 agreed that physical therapist students needed to practice safely and ethically and communicate effectively. Examination procedures were considered more essential for physical therapist students to perform than treatment procedures, since physical therapist assistants can complete treatment procedures.[7] Physicians have examined the essential functions required for medical students. Similar to the work of Ingram, they emphasized cognitive and interpersonal skills more than technical abilities. In 1996, Reichgott[8] proposed that there are 3 essential functions required for medical school: intelligence, in order to synthesize and apply the knowledge of medicine; a professional attitude, or "a degree of selflessness and commitment to the service of others"[8(p728)]; and the ability to "communicate and interact effectively."[8(p728)] Stiens,[9] recognizing that individuals with disabilities such as blindness have successfully completed medical school and become well-respected physicians, concludes that the most important aspects of work in medicine are the ability to make decisions based on clinical judgment and the ability to judge one's limitations.

Academic program faculty can define specific essential functions related to the program's philosophy. The objective of the program in this case report was to "produce physical therapists who can respond to complex patient/client needs quickly, scientifically and independently."[10 (p 2)] Admitted students needed to demonstrate, with or without reasonable accommodation, the ability to practice in a manner that ensured the safety of the patient/client, self, and others.[10] Because program graduates were expected to meet the needs of clients in all areas of physical therapy, students were required to complete full-time clinical education experiences in diverse clinical settings and to work with patients/clients with a variety of medical problems. While the concept of preparing graduates to enter any area of practice has not been debated in the physical therapist education literature, it has been discussed in the literature on medical education. A 1979 report[8] to the Association of American Medical Colleges from a Special Advisory Panel on Technical Standards for Medical School Admission stated that medical schools should prepare "undifferentiated graduates"[(p725)] who are prepared to enter any field of medical practice. In 2004, Van Matre et al[11] investigated beliefs about the undifferentiated medical school graduate in a survey of attending physicians, residents, and students from various specialties at an academic medical center and affiliated sites. Respondents indicated that communication and observation skills were more important than various technical skills, and overwhelmingly disagreed that students should be "undifferentiated graduates," having "all of the technical skills required to enter any specialty."[11(p4)] The authors recommend that rather than focusing on technical skills, the goal of medical education should be exposure to all areas of medicine so graduates can focus on any area of practice.[11]

During our literature search, we found no articles on the topic of physical therapist students with physical disabilities, though we did discover literature discussing nursing, occupational therapist, and medical students with learning disabilities[12-15] and medical students with physical disabilities.[8, 11] Though helpful, this literature does not address issues unique to physical therapist students with physical disabilities. This case report may serve as a resource for physical therapist education program administrators and faculty as they encounter questions related to accommodating students with physical disabilities in classroom and clinical settings. Approval for this case report was received from the Institutional Review Board at Northwestern University and the student gave informed consent for this report to be written. Throughout the report, the student is referred to by the pseudonym, Mary.

CASE DESCRIPTION

Student and Physical Therapist Program Description

At the age of 17, Mary sustained a Grade V spondylolisthesis. Approximately 3 years after the initial injury, pain and spinal instability led to 2 surgeries to complete a spinal fusion with rods and pedicle screws placement. After a period of rehabilitation, Mary required a manual wheelchair and bilateral forearm crutches for ambulation, due to lower extremity and trunk weakness. Because she was interested in becoming a physical therapist, she volunteered at a physical therapy clinic and began to research physical therapist education programs. One year-and-a-half after the first spinal surgeries, Mary was diagnosed with rod failure secondary to pseudarthrosis and underwent 2 more spinal surgeries. Following recovery from the surgeries, including further intensive rehabilitation, her most significant impairments were limited trunk flexibility and weakness in right ankle dorsiflexion, for which she wore an ankle foot orthosis (AFO).

Returning to college, Mary completed a Bachelor of Science degree in health sciences and a Master of Science degree in exercise physiology. She continued to be interested in physical therapy as a career. Because of her medical history and functional limitations, she explored careers in various health care professions and began working in medical research. She tried to contact the American Physical Therapy Association special-interest group for physical therapists with disabilities to seek their guidance about pursuing a career in physical therapy. However, the group had dissolved and she found little information about how a person with a disability might function as a physical therapist. When she called physical therapist education programs to inquire about physical and admission requirements for students with disabilities, she learned that there was a high degree of variability in programs' physical requirements. She ultimately chose a program whose technical standards did not emphasize physical abilities, applied for admission, and was accepted to enter.

When Mary began the program, the curriculum consisted of 7 trimesters over 26 months, included 4 full-time clinical expe-

riences (CE I–IV), and led to a Master of Physical Therapy degree. Shortly after she began, the program received approval for a new curriculum leading to a Doctor of Physical Therapy degree. Students who had begun the Master of Physical Therapy program were given the opportunity to complete additional coursework, including an additional 5 weeks of clinical education (CE V), and receive a transitional Doctor of Physical Therapy degree. Mary accepted the opportunity to complete the necessary coursework for the transitional Doctor of Physical Therapy degree.

Interventions—Academic Course Work

Determining reasonable accommodations to allow Mary to participate in physical therapist education began during the admissions process, when she informed the director of professional education (DPE) that she had a back condition. Once she enrolled in the program, her physician, with input from her physical therapist, provided written confirmation of Mary's disability, medical diagnosis, and functional limitations to the Office for Services for Students With Disabilities (SSD) and the DPE (Table 1).

The DPE, working with the SSD representative and the faculty, developed a written agreement to define appropriate accommodations for Mary (Table 2) and determined that the DPE would inform faculty of Mary's accommodations as appropriate. The agreement briefly described Mary's medical diagnosis and relevant medical history, her functional limitations and responsibilities, and the necessary accommodations. Mary was expected to use safe and effective body mechanics at all times; accurately assess her abilities to sit, stand, lift, and perform patient transfers; and use good judgment regarding the need for assistance. She was also expected to assess whether a patient's/client's status was sufficiently stable for her to work safely with that patient/client. Last, Mary was expected to inform classmates and faculty of the nature of her injury as appropriate, of specific procedures that should not be performed on her (eg, shortwave diathermy or vertebral mobilizations), and whether her symptoms increased during any class activity. After finalizing the accommodations agreement, the DPE notified the course coordinators that Mary had a back condition requiring accommodation during some classroom activities.

Although the DPE notified course coordinators about Mary's situation, the faculty discovered later that not all of them were fully aware of her need for accommodations, leading to problems in the spring trimester of Year 1 in the course Physical Therapy Care. Course content included bed positioning, bed mobility, wheelchair mobility, wheelchair prescription, transfers, adaptive equipment, and gait training. According to the accommodations agreement, Mary was expected to assess her ability to perform the required psychomotor skills independently or with assistance of an "aide," role-played by classmates and faculty. When she chose to use an aide, Mary was expected to explain the rationale for her choice of the selected activity and appropriately instruct the aide to safely, effectively, and efficiently accomplish the task. During the first practical examination in the course, the evaluating faculty member was not aware that Mary was able to request an aide's assistance. An aide was not available in the room and Mary did not request one. To protect herself from injury, she demonstrated poor body mechanics and ineffective skills, which led to failure of the examination. Immediately following the exam, Mary talked to her faculty advisor about her concern that the established accommodations had not been followed. Subsequently, another meeting was held with Mary, her faculty advisor, a director of clinical education (DCE), and the course coordinator, during which her accommodations were reviewed and clarified. For the remainder of the course, an aide was available during practical examinations and Mary determined whether she could perform the selected activities safely, with or without an aide. With these modifications to her performance expectations, Mary successfully completed the course.

Throughout subsequent clinical course work, Mary was expected to determine whether she could function safely as physical therapist or simulated patient, and request assistance if needed. When practicing some physical agents and manual therapy techniques in clinical courses, she was not able to serve as a simulated patient. She gradually learned her physical capabilities through active experimentation, and the faculty learned the necessity of teaching her how to perform tasks using the specified accommodations. Mary ultimately completed all academic course work safely and successfully.

Table 1. Functional Limitations

Position	Limitation
Standing	1. Standing in place — 1 hour maximum 2. Walking/standing — unlimited
Sitting	1. Supported — 2 hours maximum 2. Unsupported — 2 hours maximum
Lifting	1. Load — 20 pounds
	2. Load to be lifted infrequently, not to be a repetitive pattern
Bending	1. Proper body mechanics are to be used at all times • No bending at the trunk due to spinal fusion • Bending to be performed at the hips and knees
Spinal support	1. Soft lumbar corset to be worn when deemed necessary by student
	2. Hard lumbosacral orthosis to be worn when deemed necessary by student

Table 2. Accommodations for Mary

- If a patient is not sufficiently stable or requires greater than minimal assistance, Mary will arrange to have an aide available for assistance. In class or during practical examinations, the aide may be another student or faculty member.
- Mary may "perform verbally" when appropriate. In situations that she cannot reasonably be expected to manage alone, she can instruct an untrained aide sufficiently to manage the patient safely. For example, rather than perform a 2-person transfer, Mary would instruct two untrained aides in the skill. The aides must be able to transfer the patient safely and effectively based on her instructions. Each course in which clinical skills are taught will generate a list of which skills may be done using "verbal performance" and which must be fully demonstrated.
- A plinth will be provided at the rear of the classroom for Mary to recline during lectures, if needed.
- The directors of clinical education (DCEs) will work with Mary and the clinical sites during the clinical education selection process. The sites will be contacted to determine whether they can provide the accommodations that Mary requires. Written confirmation will be secured and copied for Mary.

Table 3. Schedule of Clinical Experiences

	Fall Trimester	Winter Trimester	Spring Trimester
Year 1			Clinical Experience I (4 weeks)
Year 2		Clinical Experience II (4 weeks)	Clinical Experience III (8 weeks)
Year 3	Clinical Experience IV (9 weeks) Clinical Experience V (5 weeks)		

Table 4. Clinical Experience Requirements During CE II–IV

- A minimum of 3 weeks of full-time experience working with inpatients who have problems that change abruptly; usually met in an acute care setting.
- A minimum of 3 weeks of full-time experience in an outpatient setting.
- Worked with patients with neurological conditions and patients with musculoskeletal conditions, in any setting.
- No more than 12 weeks managing patients of similar ages, with similar problems and levels of acuity.

Interventions—Clinical Education

The curriculum included 5 full-time clinical education experiences, integrated across the 7-trimester program (Table 3). For most students, CE IV and V occurred at the same facility. Prior to the clinical education selection process, one of the DCEs posted an e-mail message on the physical therapy education listserve requesting advice from other DCEs who had previous experience with students who have physical disabilities and who are ready to begin full-time clinical education experiences. The message yielded 2 responses, neither of which changed our plan for assisting Mary with her clinical education schedule.

Students selected their clinical placements from a list of available facilities. In the lottery method used for selecting placements, students were expected to collaborate with their classmates to create schedules that allowed all students to meet program requirements. The DCEs oversaw the selection process and were available for advice and counsel as needed. Because the curriculum prepared graduates to meet the needs of patients/clients in all areas of physical therapy, students were expected to complete CE II–IV in a variety of clinical settings (Table 4). Interventions to assist Mary to successfully complete all clinical education experiences began during the selection process.

Students chose their sites for CE I during fall trimester of the first year; minimal DCE intervention was required to assist Mary during this process. She met with the DCEs to discuss the best choices for her, and she selected an outpatient facility where patients primarily had musculoskeletal problems. A DCE phoned the center coordinator of clinical education (CCCE) at the facility and determined that she was able to accept a student requiring accommodations. Mary provided information about her relevant medical history and current physical status in her letter of introduction to the CCCE. She met the course objectives and passed her first full-time clinical experience.

The selection process for CE II–V was more challenging. Students selected all of these experiences during a 2-week period in fall trimester of the second year. During the selection process, Mary spoke frequently with the DCEs, who in turn contacted CCCEs at facilities that she was considering to determine whether they could provide accommodations. For experiences in acute care and pediatric or adult rehabilitation, the university offered to provide a physical therapy aide to assist Mary with patients requiring moderate or maximal assistance. The DCEs contacted CCCEs at 6 acute care hospitals, 2 pediatric hospitals, 1 rehabilitation hospital, and 1 outpatient private practice. No concerns were expressed by the CCCE at the outpatient private practice; the majority of patients at this facility had musculoskeletal problems, and the clinical instructor (CI) could be readily available, since the staff worked in close proximity to each other.

The CCCEs at acute care and pediatric hospitals expressed several concerns about accepting a student with a disability and providing accommodations. Their concerns and comments focused on 3 areas: 1) the student's ability to meet the facility's defined essential functions because no reasonable accommodations were available; 2) the facility's liability, should the student or a patient be injured during a treatment session; and 3) the lengthy process to train and assure competence of the physical therapy aide provided by the university. Of the 9 hospital CCCEs contacted, 5 reported immediately or after discussions with their supervisors that individuals with Mary's limitations did not meet the site's essential functions for a physical therapist, with or without accommodations. CCCEs at 3 acute care hospitals and 1 rehabilitation hospital were willing to create learning experiences for Mary. She selected an inpatient acute care placement in an academic medical center and an adult inpatient acute rehabilitation experience in a freestanding rehabilitation hospital, during which she would split her time between administration/education activities and patient care, focusing on aquatics. The DCEs later learned that Mary's choice of an acute care placement had required assistance from classmates, who chose not to select a facility that had agreed to accept Mary and provide accommodations.

Prior to each experience, the DCEs contacted the CCCE to request a meeting to plan the experience and answer any questions that the CCCE and CI might have. Mary, the university SSD coordinator, one or both DCEs, the CI, and the CCCE were present at all meetings. Expectations for Mary, the CI, and CCCE were defined using the university's objectives for each clinical experience, specific information about the facility provided by the CI and CCCE, and the student's accommodations agreement. Memos outlining the expectations were written by the SSD coordinator and were distributed to all parties. Each clinical education planning meeting was completed in approximately 1 hour. Due to facility liability concerns, the administrators for each clinical facility declined the opportunity for a physical therapy aide to be provided by the university. Aside from the increased time to arrange and conduct these meetings, no additional financial resources were expended in granting the student's accommodations.

The meetings with the CIs and CCCEs prior to CE III and CE IV–V went smoothly. Mary was scheduled to complete CE III at an outpatient private practice, working mainly with patients with musculoskeletal problems. Because the clinic was small, the CI was always readily available, so the aide offered by the university was not needed. CE IV and V were to occur in a large, inpatient rehabilitation hospital. Because the aquatic physical therapist and at least 1 staff person were immediately available when patients were in the pool, the CCCE determined that an additional physical therapy aide was not needed for that portion of the experience.

In addition to working in aquatic physical therapy, the CCCE and CI expected that Mary would have the opportunity to work with some patients outside of the pool with the CI providing supervision and serving as an aide as needed. The DCEs agreed that the objectives of CE IV and V could be met during the planned experience.

The meeting held prior to the acute care experience (CE II) in the academic medical center was more difficult. The physical therapy inpatient supervisor and the manager of inpatient rehabilitation services were included in the meeting at their request. They expressed concerns about Mary's ability to complete the experience successfully given the physical demands of the inpatient acute setting. They also reported that it would be difficult to devote a facility-trained physical therapy aide to Mary and were concerned that an aide provided by the university might not meet the facility's competencies. Eventually, all parties agreed that the experience could continue as planned, as long as Mary and her CI always worked together, with the CI serving as an aide when Mary needed assistance.

Mary finished all clinical experiences without any incidents, met the objectives, and successfully completed CE II–V. During CE II, Mary worked with her CI on general medical, surgical, trauma, cardiac, and intensive care units of the hospital. A meeting was held at the facility early in the experience to discuss her progress and any unanticipated problems that may have arisen. The CI reported that Mary was able to appropriately determine when she needed assistance and correctly direct the CI how to assist her. An onsite meeting was also held during CE III. Mary and the CI reported that she was progressing toward entry-level performance as expected.

Mary's final clinical experience occurred in a rehabilitation hospital. During the experience, the CCCE and DCEs had frequent discussions via telephone. Mary provided direct therapy services in the therapeutic pool for a variety of patients, with the CI present at all times. Mary also worked with another CI on an inpatient unit with adult and pediatric patients with a variety of diagnoses. During the administrative portion of the experience, Mary created and provided educational experiences for facility employees, physical therapist students, and staff physical therapists. These diverse learning activities allowed her to meet the objectives of the clinical experience.

OUTCOMES

Mary successfully completed all required coursework in the usual time frame required by the curriculum and was awarded the degrees of Master of Physical Therapy and transitional Doctor of Physical Therapy. In addition, she passed the licensure examination on the first attempt. Because she met the physical requirements needed for a physical therapist in an outpatient setting, she accepted a position in the outpatient physical therapy department of an academic medical center where she works with patients with a wide variety of medical diagnoses. She utilizes the assistance of PTAs and physical therapy aides with tasks that are outside of her physical abilities infrequently, approximately 2% of the time, and has become certified as a lymphedema therapist.

DISCUSSION

The faculty faced many obstacles while developing and implementing the reasonable accommodations that allowed Mary to participate in and complete the physical therapist education program successfully. Many of the obstacles arose because of physical therapists' concerns that an individual with her functional limitations could not become a physical therapist and practice safely. In seeking to become a physical therapist, Mary challenged some of physical therapists' deeply held professional values. Physical therapists view themselves as "fit and able" and different than their patients, who are individuals needing assistance.[16] Mary was required to acknowledge her physical limitations in order to request accommodations that allowed her to practice safely, which challenged physical therapists' perceptions of themselves as strong and healthy individuals. We believe that some academic and clinical faculty could not see Mary becoming a physical therapist because they focused on the physical aspects of the profession, with which she needed assistance.

While examining the experiences of physical therapists who had work-related musculoskeletal injuries, Cromie et al[16] reported that physical therapists valued their unique knowledge base, the importance of caring for patients, and working hard. Physical therapists believed that they knew how to prevent work-related musculoskeletal injuries and how to treat work-related injuries if they did occur. They put their patients' needs before their own, and emphasized the need to care for patients above the need to care for themselves, even if a patient's care placed the physical therapist at risk for personal injury. "Participants…described feeling pressure from colleagues and patients to be caring and hardworking, even when it could be detrimental to their own health."[16 (p 464)] Allowing Mary to enter a physical therapist education program required a change in these values. Mary had sustained a severe injury; the subsequent impairments and functional limitations required her to balance her own physical needs and limitations with decisions about how to provide safe and effective care for patients. Physical therapists who were unable or unwilling to examine their deeply held beliefs were unable to see how she might function safely in the clinical setting and become a physical therapist.

Physical therapy educators must consider the unique perspective that students with disabilities may bring to their education. Velde et al[17] reported that occupational therapy students with disabilities had a strong motivation to master required skills despite their disability and believed that having a disability would enhance their practice because they understood disability at a personal level. Similarly, Losh and Church[5] reported that medical residents with disabilities bring a unique perspective and special attributes that enhance patient care. Students with disabilities may experience additional stress if faculty members are unwilling to work with them to create solutions for potential problems. Students may then see their disabilities as barriers between faculty and themselves.[17] Rather than seeing only barriers, faculty are encouraged to partner with the student to achieve academic success.

The faculty learned many practical lessons by working with Mary. First, it is important to have and follow a process for managing the education of students with physical disabilities. Once students disclose the presence of a disability, we recommend that they be referred to the university office providing services for students with disabilities. Personnel from that office will obtain documentation of the disability from relevant health care providers and information about the requirements for participation in the education program from the academic department. If the SSD representative determines that a student's limitations may interfere with requirements for participation, SSD, the student, and the academic program can collaborate to delineate the student's limitations and propose reasonable accommodations. Since clinical educators are vital to the completion of physical therapist education, it is important to consider the needs and expectations of clinical sites when developing reasonable accommodations. We also recommend that accommodations that modify student expectations or those provided jointly with an outside entity be reviewed and approved by the university's legal counsel.

Students can play an important role by disclosing their disabilities early and re-

questing the accommodations they need.[18] Disclosure allows for provision of the agreed-upon accommodations and protection from discrimination.[19] Once the student has consented to disclose a disability, academic and clinical faculty who will be involved in providing accommodations must be notified. Academic faculty may need reminders at the beginning of each term about the student's accommodations. Finally, students may choose not to disclose their disability to anyone. They should not be expected to notify classmates about a disability, but can decide if and when disclosure to classmates is necessary. Students who have chosen to disclose to academic faculty may choose not to disclose to clinical faculty because of a fear of stigma. Students who do not disclose a disability to clinical faculty are not eligible to receive accommodations in the clinical setting.

We also recommend that students with disabilities work closely with the DCE when designing their clinical education schedule. A DCE might determine that making changes in the clinical selection process and requirements are reasonable accommodations. Frequent communication about a student's clinical choices allows the DCE to discuss required accommodations with CCCEs during the clinical selection process. Discussing the required accommodations with CCCEs allows them to choose to accept students with disabilities, leading to a more welcoming environment at the clinical facility.

The DCEs were surprised by the variability in responses from clinical sites when seeking clinical education experience options for this student, and by the discovery that the academic program's technical standards and the accompanying accommodations for the student did not always match facilities' essential functions. Believing that a CCCE willing to pursue the possibility of accommodations was a key component of an effective learning experience, the DCEs chose not to question CCCEs' reports that they were unable to provide accommodations and worked only with CCCEs who were willing to consider accommodations.

Working with Mary caused us to carefully reconsider what is needed to become a capable practitioner. As Mary discovered when exploring education programs, there is great variety among education programs' technical standards and essential functions. We challenge the profession to consider what it means to be a physical therapist, and develop technical standards that can be accepted by all education programs. We agree with DeLisa and Thomas[20] that incorporating and accommodating people with disabilities into health professions is a matter of social justice and equality, and we encourage educators to consider how programs can be more accepting of students with disabilities. As health professionals, physical therapists are expected to promote acceptance of people with disabilities. Viewing disability through the social model requires educators to adapt tasks and environments to facilitate the success of qualified students with disabilities. Through partnerships with students, educators can promote positive attitudes among educational constituents.[17] By exploring creative options for providing reasonable accommodations, both the facilities' essential functions and the students' learning needs may be met.

Recommendations for Future Study

DeLisa and Thomas[20] recently provided several recommendations for an agenda to incorporate qualified individuals with disabilities into the physician workforce. Most of their recommendations also can be applied to physical therapist education. Therefore, we recommend that the profession reexamine what it means to be a physical therapist in order to develop technical standards that can be used by all physical therapist education programs. Are physical therapists in a doctoring profession simply practitioners with physical skills or clinicians who critically analyze human movement in order to direct and supervise patient care? There is a need for more research that examines the number of qualified individuals with disabilities applying to physical therapy school, and their rates of admission, graduation, and resultant professional experiences. Additional research is also needed to identify the primary barriers to physical therapist education programs that people with disabilities encounter.

CONCLUSION

This case report is the first in the physical therapy literature to discuss the professional education of a student with a physical disability. We have described the accommodations that allowed a student with a disability to successfully complete a physical therapist education program and the process used to determine and provide those accommodations. Finally, we have offered recommendations for academic and clinical faculty to consider when a student with a physical disability participates in a physical therapist education program.

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