**Disability Rights in Higher Education Programs: The case of medical schools and other health-related disciplines**

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**Recognising and respecting the human rights of persons with disabilities constitutes an integral element of a democratic society. This caveat has been long articulated in health professionals’ rhetoric on the importance of embedding a human rights discourse in the protection and promotion of individual and global health. Having signed and ratified the International Convention on the Rights of Persons with Disabilities (UNCRPD), state parties are expected to educate doctors and other health professionals to understand the human rights dimension of disability. This article is concerned with exploring the extent to which the programmes and curriculum outlines in** medical schools and other health-related academic disciplines are informed by concerns about promoting disability rights education. Further, it discusses some future directions for monitoring the implementation of a disability rights discourse and suggests some ways in which a rights-based approach to disability can be incorporated in higher education programmes and curricula for health-related disciplines.

**Key words: Higher Education, Medicine, Health, Curricula, Disability, Human Rights**

****Introduction****

**A large percentage of people, currently estimated around** 1 billion people or 15% of the global population (WHO 2011)**, have been identified with a number of congenital or acquired disabilities. Thus, placing a pronounced emphasis on the promotion of disability rights across all academic disciplines is an ethical, as well as a legal imperative. This is especially true in disciplinary fields of study in which graduates are expected to be in direct contact with people with disabilities; this is a prospect for the vast majority of, if not all, professionals who are in daily contact with an increasing number of individuals with disabilities (**United Nations 2008**).**

**Disability should no longer be seen through a ‘deficit-oriented’ lens and as conferring a subordinated ontological status but should be re-conceptualised as an endemic and valuable aspect of the human experience and diversification (Corker and Shakespeare, 2002).** Disability has been re-conceptualised as a multifaceted form of social oppression on par with racism, sexism and other sources of social disadvantage that call for socio-politically informed interventions (Oliver 1990; Barnes et al 1999).

**This ideological paradigm shift is necessary, not only because of the legal recognition of disabled individuals’ human rights and entitlements, but also because of the omnipresent nature of the disability experience, which can potentially become a ‘lived’ reality for everyone (Goodley 2011; WHO 2011). Notably, it is anticipated that in the future, there will be a greater percentage of people with disabilities due to the prolonged life expectancy of the general population, as well as of people with chronic conditions. This is especially true if we bear in mind that 97% of impairments are acquired** (**Symons et al 2009)**.

A very important international legislative development is the United Nation’s Convention on the Rights of People with Disabilities (**UNCRPD), which defines disability as an ‘evolving concept’** (United Nations (UN) 2008:1) **that is largely contingent on social conditions and exigencies, thereby subscribing to a social relational, or what has been termed a ‘bio-psychosocial approach’, toward disability (Norwich 2010; Thomas 1999, 2004). Given the social dimension of the disability experience and the contextually mediated conditions through which disability is conceptualised and ‘lived’, the Convention highlights the necessity of promoting a disability rights discourse in the education of doctors and other health professionals.**

**The UNCRPD is considered the first international treaty to embrace a human rights model of disability that goes a step further from the social model of disability. This is because it recognizes disabled people as rights-bearing subjects without pre-empting the absence of impairment. Acknowledgement of the latter as a potential ontological denominator, presupposes that individuals with disabilities need more than the civic and political rights envisaged by the social model of disability. As rights-bearing subjects they also require social, economic and cultural rights in order to experience dignified living on par with their non-disabled peers (Degener 2016). This perspective recognizes ‘impairment’ as an integral aspect of human experience across a continuum of ontological variations and experiential embodiments of ‘impairment effects’ such as pain, fatigue, compromised quality of life and early death (Degener 2016).**

**In light of the UNCRPD and its human rights and social justice orientations the state parties should:**

Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care **(UNCRPD:Article 25d).**

**Along similar lines, the** **‘**European Disability Strategy 2010-2020: A Renewed Commitment to a Barrier-Free Europe’ is explicit on the necessity to ‘promote awareness of disabilities in medical schools and in curricula for healthcare professionals’ (p.9).

**Cotter et al (2009) pointed to another highly relevant dimension of the human rights discourse by focusing on the ways in which the neglect or violation of human rights may adversely affect health and subsequently cause disabilities. For instance, even though people with disabilities, in particular, learning difficulties in the UK, have been under the auspices of the NHS (National Health Service) for over 60 years, they are, paradoxically, by far more likely to have health problems in comparison with other segments of the population. For instance, research evidence from the** Medical Expenditure Panel Survey documented that disabled people were more likely, in comparison with their non-disabled peers, to hold the view that their doctors ‘had not listened to them, treated them with respect, taken enough time, involved them in treatment decisions or explained treatments properly’ (Shakespeare and Klein 2013:21). **These phenomena can be largely attributed to the inaccessibility of health services due to ignorance, prejudice and negative attitudes related to longstanding misconceptions held by health professionals, who might perceive disability as a form of ‘illness’ and individual pathology (Cotter et al 2009; Goble 2008;** Minihan et al 2011; Shakespeare and Kleine 2013; **Symons et al 2009; WHO 2011).**

**Historically, health care professionals have been positioned in negative terms because they have routinely treated people with disabilities in paternalistic and oppressive ways (Goble 2008; Sullivan 2009). The ‘discourse of professionalism’ (Fulcher 1999) manifested in health, educational, social work and other domains**, **has played a dominant role in contributing to institutional forms of oppression experienced by people with disabilities owing** to longstanding ‘institutionali­zation or other involuntary treatment, abuse, neglect and persistent devaluation’ (WHO 2011:77).

**Sadly, notwithstanding ostensible progress in introducing legal mandates to safeguard disability rights, a number of recent scandals in the UK have brought to the surface the ways in which people with disabilities have been abysmally neglected and abused while being under the care of the NHS and social care (**Parliamentary and Health Service Ombudsman and Parliamentary and Health Service Ombudsman 2016). Similarly, the Pancyprian Alliance for Disability (2016:77) – a disability advocacy consortium that consists of twenty organizations representing persons with disabilities and their families in Cyprus- categorically document that the health system has failed to ‘take into consideration the disability dimension under the CRPD or that otherwise secures respect of the dignity and difference of persons with disabilities’. As a result, a plethora of structural and ideological barriers to accessing quality healthcare have been reported with a notable example ‘the rejection that persons with disabilities are confronted with by other patients, the personnel of the public clinics and partly of the medical staff and their focus on the “deficiencies” of severely disabled persons’ (Pancyprian Alliance for Disability 2016:80)

Parallel to the ascendancy of international legal mandates that advance a human rights approach to disability, a human rights and medical ethics discourse has been at the epicentre of the rhetoric of the World Medical Association. As early as 1999, it declared that medical ethics and human rights are an ‘integral part of the work and culture of the medical profession’, and therefore, the ‘teaching of Medical Ethics and Human Rights [should] be included as an obligatory course in their curricula’ (cited in Crotter et al 2009:2).A number of other medical bodies, such as the Surgeon General, the Institute of Medicine and the Association of American Medical Colleges, have also alluded to the necessity of educating physicians in more effective and comprehensive ways so as to better address the needs of persons with disabilities (Shapiro 2011).

Even though it is not the primary focus of this article to discuss the ways in which **Disability Rights can inform Higher Education Programs, an important dimension of this endeavor should focus on enabling healthcare professionals to reflect upon their own role in creating and perpetuating disabling barriers.** Considerable research evidence suggests that accessibility to health care services is still significantly undermined by negative attitudes towards disability (Minihan 2011; Shakespeare and Kleine 2013; Symons et al 2009; **WHO 2011**), as well as a deficit-oriented perspective that positions people with disabilities as ‘abnormal’ and ‘deficient’ (e.g **Cotter et al 2009)**. This perspective is linked to the individual model disability that is associated with the medicalization and pathologization of disability experience and considers disability ‘to be logically separate from and inferior to “normalcy”’ (Corker and Shakespeare, 2002: 2).

The discussion in the previous paragraph provides evidence that higher education programmes and curricula should primarily concentrate on changing negative and discriminatory attitudes by enabling health professionals to problematise their own assumptions and misconceptions about disability. **This can be achieved by acquiring an informed understanding of** the human rights model of disability and the ways in which this is enshrined in international legal mandates (Degener 2016; WHO 2011) and informs/should inform their professional roles (British Medical Association 2007). The human rights model of disability valorizes impairment as an indispensable aspect of human experience that does not undermine human dignity or corrodes disabled people’s rights-bearing identities (Degener 2016). The ‘abled-bodied order’ (Campbell 2008) needs to be challenged by adopting a critical, reflective and reflexive understanding of the precarious ontological status of the ‘abled bodied’ ideal. (Goodley 2011)

**This article is concerned with exploring the extent to which the programmes and curriculum outlines in** medical schools and other health-related academic disciplines in Cyprus are informed by a disability rights discourse in view of the legal obligations of the country to implement the UNCRPD. The establishment of medical schools and health-related academic schools is a recent phenomenon in Cypriot universities. Therefore, it is important to identify the extent to which a disability rights discourse has been incorporated into the content and coverage of medical and other heatlh-related courses in light of international and national legal imperatives that stipulate the necessity of reconceptualising disability as a human rights and social justice issue. **This is especially true if we bear in mind** that **doctors and other medical professionals are also called upon to use the** International Classification of Functioning, Disability and Health issued by the World Health Organization in order **to make informed decisions on ‘**treating people with disabilities with respect and dignity, serving the public services with professionalism and upgrading the knowledge for all types of disability…’ **(**European Social Fund of the European Union and the Republic of Cyprus 2014:1).

The first section of this paper provides the theoretical framework against which the data analysis was undertaken. The following section draws on a documentary analysis of what medical and other health-related schools say about the content and coverage of their courses in order to explore the extent to which they are informed by a disability rights discourse. The final section discusses some future directions for monitoring the implementation of a disability rights discourse and suggests some ways in which different dimensions of a rights-based approach to disability can be incorporated into higher education programmes and curricula for health-related disciplines.

**Educating health professionals about disability rights**

**It is well documented that doctors and other health-care workers often lack the necessary knowledge and skills to meet the health care needs of people with disabilities (WHO 2011). As was pointed out in the first World Report on Disability:**

Health-care workers often lack adequate knowledge and skills on primary and second­ary and co-morbid conditions associated with disability and how to effectively manage the health care needs of people with disabilities. (WHO 2011:78).

This phenomenon can be attributed to the fact that undergraduate training programmes for health-care workers and doctors frequently fail to address the health needs of people with disabilities. Despite laudable rhetoric on the imperative to embed a human rights discourse in health-related practices, a formal human rights education is largely absent from schools of medicine and other health-related academic disciplines (Crotter et al 2009; Shakespeare and Klein 2013; Shapiro 2011). Hence, it is imperative that education and training for health care workers should enhance their understanding of the health care needs of people with disabilities, along with the ways in which they can address the host of disabling conditions experienced by this group of people (Symons et al 2009; Shakespeare and Kleine 2013; WHO 2011).

**Concerns about educating health professionals about disability rights have a twofold aim: First, to enable health professionals to meet the health-related needs of people with disabilities, and second, to acquire an explicit understanding of the ways in which disability is a human rights and social justice issue, so as to challenge their implicit misconceptions and discriminatory attitudes towards disability (Curry et al 2010; Shakespeare and Kleine 2013; WHO 2011)**.**.** This involves a thorough (re)consideration of medical curricula, with a view to providing disability-related training that is informed by the human rights discourse. **Embedding a human rights discourse in medical and other health-related academic disciplines is a sine qua non element of empowering doctors and other medical professionals to play a positive, rather than an oppressive, role in the lives of people with disabilities.**

In terms of the ethical dimensions of a human rights disability perspective, the emphasis is placed on cultivating and instilling positive attitudes towards people with disabilities and providing quality health care services for them. As we have already discussed, this access is significantly undermined by health professionals’ negative and stigmatising attitudes towards disability.

In view of the above considerations, disability research should place a more pronounced emphasis on exploring the ways in which the different dimensions of a rights-based approach to disability can be incorporated into higher education curricula for health-related and other academic disciplines, while providing evidence-based instructional strategies to deliver these curricula.

As part of Bologna’s process of encouraging collaborative institutional and communicative practices in higher education, emphasis should be placed on the necessity of fostering a global approach to promoting socially just forms of curricula (Nyborg 2004). Such curricula ‘should be rolled out and implemented cross-nationally so as to raise disability rights awareness at a number of levels’ (Liasidou 2014:128). During this process, people with disabilities should have a stake in articulating their views on the ‘scope and aims of these curricula’ (ibid:128).

**Research methodology**

The data were derived from a documentary analysis of medical and other health-related higher education programmes and curriculum outlines available on the universities’ websites. This corpus of data (textual data) was approximately 70000 words (for content and discourse analysis).Documents, according to Creswell (2014:223) constitute a ‘good source for text (word) data for a qualitative study’ It should be noted, however, that the use of documentary analysis as a sole method of inquiry is widely questioned, as it is believed to have certain drawbacks associated with the validity of the research agenda. By implication, its usefulness is usually acknowledged only in conjunction with other research methods. The shortcomings attributed to documentary-based research relate to the widely held assumption that the interpretation of a text should embrace the discursive institutional and political processes within which the text is embedded. Text, in other words, is considered insignificant without its discursive context, and therefore, other methods of inquiry should be concurrently used to analyse and expose the dynamic and reciprocal interrelations between text and context.

In order to enhance the research further we could have also observed lectures and other learning and teaching sessions to gain a more informed understanding of the 'messages' being conveyed to healthcare professionals about disability during their training. Nevertheless, without eschewing the fact that documents are part of the interactional order, Atkinson and Coffey (2011:80) contend that documentary materials should be regarded as ‘data in their own right’ in the sense that they can enshrine ‘a distinctively documentary version of social reality’, that needs to be given ‘due weight and appropriate analytic attention’.

Moreover, another issue worth mentioning is that due to the recent establishment of medical schools access to classes was not possible at this stage, as accreditation and evaluation processes by the state are still in process. Consequently, due to these constraints along with the discursive analytic focus of the study the suggestion is to conduct this type of multi-method data collection and analysis at a later stage as a follow-up study when these programmes will be accredited and well established.

Our targeted theoretical sample constituted, according to the typology introduced by Scott (1990), ‘open published documents’ and as a result, data collection did not involve examination and analysis of module handbooks and their implementation in class (eg during instruction) but examined the titles, descriptions, aims and learning outcomes of each course as they are publicly available on institutional websites. Even though our sample could have been more extended, the documents compiled provided rich data and useful insights into the extent to which these curriculum outlines are informed by a human rights model of disability, along with the ways in which universities portray and market disability through their websites in their medical degrees as this has implications for perpetuating and consolidating pathologized perspectives on disability. Of crucial importance, therefore, was not to provide generalizations, but to critically examine powerful and pervasive recurring linguistic themes, thereby exposing the ‘discursively constructed’ nature of the curriculum outlines under study (Cameron 2001:16).

Curricula constitute the consensual product of ideological contestations over learning expectations and outcomes. As such, Dahl et al (2013:32) suggest that, ‘discourses in a curriculum text can communicate powerful meanings about learning outcomes’. Thus, even though a curriculum cannot comprehensively depict the ways in which classroom pedagogy is enacted and influenced by the hidden curriculum, it is, nevertheless, a consensual document that is ideologically driven and can have significant ideological effects (Koch et al 2016)

**A total of 32 undergraduate and postgraduate degree programmes of 5 public and private universities (those which offer these programmes) were examined, including Medicine, Pharmacy, Nursing, Physiotherapy, Radiotherapy, Speech and Language Therapy, Health Management, Community Health Care, Biomedical Sciences. The data analysed included the titles of courses, course aims and course descriptions in each programme, along with the content and coverage of these courses, as they are provided online by each university’s official website***.*

**Critical Discourse Analysis and Disability Rights**

**In view of the stipulations of the UNCRPD and the imperative to enable health professionals to become acquainted with** ‘the human rights, dignity, autonomy and needs of persons with disabilities’ (Article 25), the aim of the analysis is to **gauge the extent to which the content and coverage of medical and other health-related courses are informed by the theoretical and practice-based underpinnings of a human rights and social justice approach to disability and difference. To this end, the analysis is focused on critically examining how disability is perceived and presented in the courses of medical and other health-related subjects through the language and terminology used. In addition, the analytical edge concentrates on how disability is connected to the general concept of diversity and the associated attempts to valorise diversity on the grounds of disability.**

**The analysis is based on the assumption that the role of language is instrumental in exploring the ways in which disability is understood, constructed and portrayed (Fulcher 1999; Liasidou 2008) in health-related higher education programmes and course content and coverage. As Tremain (2009:13) suggested in a discussion of the discursive nature of disability politics: ‘[I]f one speaks, signs, or writes, one always speaks, signs, or writes from somewhere, some social position, and does so with some set of political, social, and ethical values and beliefs’. Language is materialised through discourses and the subsequent discursive practices (Fairclough 2001, Van Dijk 2009) in medical, juridical and administrative domains, which can have a pervasive effect on the experiential dimensions of disability politics (Fulcher 1999).**

**While critical discourse analysis (CDA) is an interdisciplinary and heterogeneous methodological and analytical tool – different strands of which can** be variously applied according to the scope and aims of the focus of inquiry **(**Fairclough, 2001; Van Dijk, 1995) – **the emphasis of this study is placed on exploring the dominant, as well as the absent or, as otherwise defined, ‘subjugated’ or ‘marginalized’ discourses (see Luke 2002; Taylor 2004) that surface in the content and coverage of the courses under study. These discourses can have a pervasive effect on the way in which disability is conceptualised and projected,** because the ‘“unsaid” and the “unwritten”, can be as significant as what is said’ (Luke, 2002:104). For instance, it is usually the case that in discussions about disability, human rights and social justice discourses are frequently marginalised due to the overarching influence of an individual pathology perspective on the disability experience (**Tremain 2009).**

**Analysis and Discussion of Findings**

**Multiple readings** **of the text were executed, focusing in particular on the construction and portrayal of disability through the language and terminology used for disability-related issues and approaches adopted in the courses. Thematic and content analyses were employed, for the purposes of which ten primary codes (including secondary codes for a more specific categorisation) were generated, which are relevant to: (a) disability terminology (eg disability/impairment, special, diversity, disability categories, vulnerable), (b) medical and/or educational approaches to disability (eg assessment, treatment, care, rehabilitation, therapy, learning) and (c) social perspectives (eg rights, access, participation, protection).**

**Moving beyond conventional methods of documentary analysis, Critical Discourse Analysis (CDA) was used as a means to delve more into certain linguistic details, thus giving more credence and substantiation to the claims made.** CDA utilizes documents as ‘final products’ that reflect the prevalent discourses upon which the curriculum outlines under study are predicated. The analysis was not only textual; the linguistic features of the text were interpreted and analysed against their discursively constituted social context (Fairclough 1999, 2001a). In addition to critically analysing the ways in which ‘a text holds together to produce its own local network’, the aim was to identify ‘incompletions, gaps, paradoxes and contradictions in the text’ (Fairclough (2001a: 239), and to interpret how they are linked to the wider interactive network of social processes (Fairclough 1999, 2001a,b), thereby achieving an interdiscursive analysis of the text that involves interpretation and explanation (Fairclough 2001b)

**The findings from the analysis are reported in two main axes: (a) how disability is constructed through the language and terminology used in the titles, aims and content descriptions and coverage of the courses in each programme, and (b) the kinds of approaches to disability that are adopted in the programmes under study and the constructions of disability they represent. The results are supported by extracts from the documents under consideration. The extracts are presented in the following format: The programme title is in brackets [eg Nursing], followed by the course title (*Course* in italics), and finally, the course outline and/or description text, if applicable. As all of the original text is in Greek, the extracts presented in this paper are the authors’ translations.**

**In terms of discursive absences, it is interesting to note that none of the courses in the medical school refer to disability and its associated concepts – either in their terminology or in their descriptions.** One cannot really expect to decipher a disability rights discourse in university programmes that make no reference to disability. **Drawing on Foucauldian (1980:81) analyses of the power/knowledge couplet, these courses have relegated disability to the realm of ‘subjugated knowledges’that are , ‘located low down on the hierarchy, beneath the required level of cognition and scientificity’ (cited in Allen 2008:101).**

A similar analytical lens can be applied to understanding the failure to address disability in courses in the medical school as an example of how the human rights and worth of people with disabilities are not recognized by the medical establishment. The discourse of the ‘able-bodied order’ (Campbell 2008:155) legitimises the hierarchical supremacy of certain individuals who represent the embodiments of corporeal integrity, while those individuals who allegedly deviate from this ontological ideal are subordinated and considered less than ‘docile bodies’ (Foucault 1977). Their alleged inferior ontological status justifies their unequal and discriminatory treatment, which is considered an inevitable outcome of their allegedly ‘defective’ make-up.

In an attempt to understand the interdiscursive context (Fairclough 2001b) against which these courses have been developed and implemented, a recent Independent Review of the Commissioner for Administration and Human Rights (Ombudsman) of the Republic of Cyprus virulently criticised the failure to consult disabled people and their organisations in the drafting of the regulations of the University of Cyprus with regard to the admission criteria of the Medical School. This failure **a priori** precluded disabled students from studying medicine on the grounds of the unsubstantiated assumption that ‘prospective students with disabilities can potentially endanger patients’ lives while executing their medical duties’ (Ombudsman 2014:28). Although these anachronistic and discriminatory regulations were rescinded after the intervention of the Commissioner, this example is indicative of the longstanding prejudice and discrimination of medical professionals against disabled individuals.

**The terms *disability (anapiria), persons with disabilities* and *disabled people* are mentioned six (6) times overall in the course titles and/or descriptions, all in nursing courses. As discussed below, the term *disability* is mentioned in the context of care, rehabilitation and therapy, but also in the context of social issues and awareness, without, however, forging any explicit link to the issues of diversity, human rights and equity. The notion of disability and its associated concepts are framed against a deficit-oriented approach that calls for remedial and therapeutic approaches. Although these approaches are an indispensable component of a ‘bio-psychosocial’ approach to disability and difference, they were the only approaches adopted. This kind of mono-dimensional approach** can be attributed to the pervasive influence of modern biomedicine in monopolising the notion of disability and reducing it to a form of ‘illness’ and ‘individual pathology’ (Barton and Oliver 1992; Erevelles, 2000).

**Examples of the use of this terminology in courses titles, descriptions and content includes the following:**

**[Nursing] *Course Title:* Home Nursing *Course Content Outline*: 11. Nursing interventions and supportive therapies for people with chronic health problems, behavioural problems and disabilities. Nursing procedures that take place at home. Preparation of material and environment (bold highlight by the authors).**

**Although the word *disability* is used in some courses, more general terms such as *special* and/or *vulnerable groups* are used more often, and they seem to embrace disabled people, together with other groups of people. In that way, the binary perspectives between the ‘normal’ and the ‘special’ emerge and consolidate ‘the dualistic logic that legitimates the invalidation of people on the grounds of bodily difference from a medically fabricated norm’** **(Hughes, 2005: 82)**

**[Nursing] *Course Title:* Care of Special Groups of Population/Situations. *Course Content Description*: This class aims at the investigation and implementation of nursing in special groups of the population/situations (such as persons with mental/psychological or/and physical disability, people that have been abused, prisoners) within the community, aiming at the provision and improvement of the quality of life and care (bold highlight by the authors).**

**The term *special needs* is mentioned twice in the descriptions of the speech and language courses of a single university. The use of this terminology raises concerns over the validity of the language of special educational needs in the discussion about human rights and inclusion. Advocates of a human rights approach to disability discuss** **the ways in which the language of ‘special needs’ continues to locate the ‘problem’ within the individual** (**Runswick- Cole and Hodge 2009: 198) and is used ‘as a euphemism for failure’ (Barton, 1996: 5), to justify organizational ineptness to accommodate the needs and abilities of persons with disabilities.**

**Along with the general terminology used to describe disabled people, terminology of and references to specific disability categories are made in the course descriptions. These include the whole spectrum of disabilities and special educational needs, including the following terms: learning disorders, disorder of mobility abilities, communication disorders, pervasive developmental disorders, attention deficit disorder, eating disorders, muscle disorders, anxiety and separation disorders, etc.**

**[Nursing]: *Course Title*: Community Nursing, Primary Health Care and Public Health. *Course Content Description*: Children and adolescents that present Learning Disorders, Disorders of Mobility, etc.**

**In general, in such references, the word *disorder*, and its deficit-based connotations*,* is used to describe any kind of difficulty and disability, in spite of the fact that in the current disability literature, disability is considered as a ‘*state of life’ or as more specifically described in the UNCRPD, as ‘an evolving concept’*** (United Nations (UN) 2008:1)that results from the interaction of a person’s impairment with institutional and environmental barriers.

**In addition, there are cases in which the person with disabilities is labelled as the patient, under a more general category of individuals that may need particular medical approaches. This was more prevalent in the descriptions of the speech and language courses.**

**The terminology used, as well as the context in which disability is presented in the curricula analysed, seem to be relevant to the approach adopted based on the field of study and the scientific discipline, as they are influenced by the respective models and perspectives on disability. The majority of disability-related references lie under the individual model of disability. This observation is particularly true for courses referring to care, therapy and rehabilitation.**

**For example, almost all references to disability and/or vulnerable groups in nursing courses are connected strictly to care, as shown in the extracts in the previous section on terminology. In addition, in physiotherapy courses, as well as in some courses in nursing, the approach is from a therapy, treatment and rehabilitation perspective, and it is represented in the classes’ titles, descriptions and course aims:**

**[Physiotherapy] *Course Title:* Physiotherapy of Special Population Groups. *Course Aims Description*: [students will…] evaluate and treat *(therapevoun)* specific special population groups. (bold highlight by the authors).**

**[Nursing] *Course Title:* Disability and Rehabilitation. *Course Aims Description:* The aim of the class is the development of the role of nursing professionals in the rehabilitation of the chronically suffering (bold highlight by the authors).**

**What is also notable here is the perception of disability as a chronic disease and not as an ‘evolving concept’. Moreover, the term ‘suffering’ is often used in various nursing courses for people with disabilities and other chronic illnesses, which again seems to derive from the individual model of disability and is connected with ‘pity’ and subsequently with the charity model (Fulcher 1999)..**

**The notion of rehabilitation is also present in speech and language therapy classes:, and is sometimes exclusively linked to functionality:**

**[Speech and Language Therapy] *Course Title:* Rehabilitation of Cognitive Functions: *Course Content Description*: Understanding of theory and implementation of methods for responding to cognitive dysfunction.**

**Interestingly, in some other classes in the speech and language therapy programmes, a connection to education is made through the thematic units of educational psychology. This represents a superficial effort to link the course aims with the social and educational aspect of learners with disabilities, without, however, forging an explicit link with the imperative to adopt inclusive pedagogies as a means of enhancing students’ learning and participation (eg Florian and Spratt 2014). Due to the fact that language is multidimensional, and hence, the cycle of language impairments is rather compounded, assessment and intervention approaches should be based on an interdisciplinary approach that emanates from a compilation of the underpinning theoretical models. Language is a complex interactive system, and as a result, there is not always a single intervention approach matched to a given category. Hence, there should always be an ‘optimum’ combination of various intervention approaches in order to achieve the best possible outcome (Martin 2000; Ripley et al 2001).**

**In view of these considerations, an emphasis on an educational and pedagogical approach is largely absent. Educational approaches are important, as they take relevant information from other approaches in order to inform successful practices. Predominately in the educational context, emphasis is placed on communication as a social process and how the various contexts make similar and different demands on the communication of a child.**

**Notwithstanding the prevalence of the individual model approach and the assumption that people with disabilities suffer and need care, rehabilitation and medical attention, there are also scarce references to social issues and human rights in the description of some of the courses. However, these references, in stark contrast to the abovementioned disability-related references, are not specific to disability, although it can be implied that they encompass a more social approach to diversity.**

**For example, with regard to the social context and the relevant issues outside the impairment *per se,* some nursing classes emphasise the importance of family and environment in the critical view and assessment of diverse population groups, without, however, making any explicit reference to disabled individuals:**

**Similarly, the nursing course, Care of Special Population Groups/Situations, refers to nursing in the community aimed at the provision and improvement of quality of life and care. Nevertheless, although the role of the community is acknowledged, it is not regarded as a setting that needs to be re-structured as inclusive, but as a context in which the person should be further supported to fit.**

**The same approach is prevalent in the speech and language therapy class on Ethics and Counselling, which includes ‘ways of informing, guiding and facilitating persons with special needs in order to promote educational, professional and social adjustment’ (bold highlight by the authors). In addition, although there are some references to issues of human rights and equality, they are specified to multiculturalism and gender, but not to disability.** This omission can be attributed to reductionist understandings of difference on the grounds of disability, which have been historically analysed through the deficit-oriented lens of medicine and psychology, and excluded from sociological debates concerned with issues of social justice and equality of opportunity (Baynton 2001). **For example, the nursing courses in most of the universities include a class on *Intercultural Nursing*,which, among other things (eg culture, sensitivity and awareness, mental health, etc.), specifically incorporates thematic areas on human rights, diversity and the protection of the right to health.** Although there are references to ethnicity/cultural and gender issues, the issue of disability is blatantly ignored. This is not surprising, given that disability has been routinely excluded from theoretical and political analyses of human rights and social justice (eg Baynton 2001, Erevelles 2000). **Specifically, the course descriptions are as follows:**

**[Nursing] *Course Title:* Intercultural Nursing. *Course Content Description:* Cultural, structural, health, and historical [….] factors that influence the provision of care in different cultures at the national and international level, human rights and the protection of the right to health (bold highlight by the authors).**

**The aforementioned course is the only one that also includes the basic concepts of diversity and issues of prejudice. However, the social perspective of diversity is only acknowledged in relation to culture and not disability. For example, see the following extract:**

**[Nursing] *Course Title:* Intercultural Nursing. *Course Aims Description:* [….] The course focuses on issues of the self-evaluation of cultural prejudice, differentiation of terminology, issues of ethnicity, cultural diversity, minorities, race and special intercultural concepts relevant to nursing practice.**

**The failure to conceptualise disability as an issue of ‘cultural politics’** (**Slee 2001:386) echoes Curry and Montgomery’s (2010:284) suggestion that a ‘liberal medical education model’ should be embedded in related programmes and curricula to enable medical professionals to view their patients as ‘whole persons’ within a particular social, cultural and economic milieu. This is related to an increasing trend to emphasise ‘“cultural competence” in accreditation standards and curricular objectives’ (284).**

**Human rights are also included in the thematic areas *Medical Ethics and Human Rights* in the courses entitled Public Health and Promotion of Health for the Degree for Administration of Health Units. They contain no reference, however, to specific groups of people or issues relevant to disability**, thereby **ignoring** the idiomorphic nature of the disability experience **(**Shakespeare and Watson 2001). By no means should disability be subsumed within the bandwagon of ‘human diversity’ on the wrong assumption that the latter constitutes a paradigm shift from a reductionist individual pathology epistemology (Thomas 1999)**.** Addressing disability-related differences necessitates an informed understanding of the personalised and culturally grounded nature of the disability experience an issue that is at the core of the human rights discourse enshrined in the UNCRPD.

**Finally, raising the awareness of and cultivating attitudes towards disability are mentioned only once in a single nursing course, which states the following:**

**[Nursing] *Course Title:* Health Psychology. *Course Aims Description:* [The class] also aims at raising the awareness of students with respect to their own reactions towards illness, disability, pain, life and death (bold highlight by the authors).**

Far from raising awareness of the ways in which disability is a human rights issue, the notion of disability is placed alongside medical and ontological concepts such as ‘illness’ and ‘death’.

**Conclusions**

Notwithstanding some progress in promoting disability rights regarding the accessibility of heath, there are many issues that need to be addressed if Cyprus is to meet its legal obligations as a signatory member of the UNCRPD. Greater transparency regarding the data on disability necessitates the establishment of independent bodies in order to collect relevant data and to monitor the formulation and implementation of disability action plans to give effect to the national obligations under the UNCRPD. Although the Republic of Cyprus ratified the UNCRPD in 2011 (Law of 2011, N.8 (III)/2011), the progress has been questionable, despite instances of laudable rhetoric articulated in the First Report of Cyprus on the Implementation of the Rights of People with Disabilities (Department for Social Inclusion of Persons with Disabilities/Ministry of Labour and Social Insurance 2013). Although the professed intention of this Report was to document the progress achieved so far in terms of the implementation of the UNCRPD, it has been criticised in relation to its promotion and safeguarding of disability rights (see Liasidou 2016).

Currently, there is no training for medical students and staff with respect to disability, despite the fact that the provision of information and training for doctors and health and rehabilitation professionals employed in health environments regarding the needs and rights of persons with disabilities was one of the professed aims articulated in the First Disability National Action Plan (2013-2015). This training involves the ‘[c]ultivation of [the] proper perception, understanding and attitude of health personnel to the rights of persons with disabilities’ (§ 31).

According to the Cyprus Medical Association, disability assessment and training presently focuses on the evaluation/diagnosis of the impairment per se and is not based on the International Classification of Functioning, Disability and Health (ICF) issued by the World Health Organization. Nevertheless, the awareness and training of doctors and other health professionals about ICF is part of the new System for the Assessment of Disability and Functioning of Persons with Disabilities developed by the Department for Social Inclusion of Persons with Disabilities (DSIPD).

The design and implementation of the **New system of assessing disability and functioning**[[1]](#footnote-1) can potentially provide new perspectives on training, employment and inclusion (Hollenweger 2014). Such a prospect presupposes that the medical staff involved in the assessment procedures will become acquainted with the human rights model of disability to enable them to transcend the overwhelming influence of individual pathology and medical discourse, which have traditionally held sway over disability assessment procedures.

The System, with respect to medical staff training, has allegedly already been put into practice. However, the nature of this training is questionable, taking into consideration the criticisms about the deficit-oriented and paternalistic approaches currently adopted in the implementation of the new System for the Assessment of Disability and Functioning of Persons with Disabilities (Dimosthenous 2013; Symeonidou, 2014). According to Symeonidou’s (2014) analysis of the DSIPD study of the New System, ‘the rationale for the implementation of the ICF in Cyprus is characterised by principles that undervalue disabled people’ (11), while ‘[t]his process and its outcomes are based on the medical model that reinforces the professionals (doctors – assessors) and the state (which defines the policy of welfare payments according to these ‘categories’), rather than the disabled person’ (ibid:9). The way the ICF is implemented in the system and training of professionals is one-sided, as it embraces the priorities and vested interests of medical professionals, but disregards the key principles of social inclusion.

In addition, the findings of this study provide evidence of inconsistency, not only in the terminology/language used (even in the same programmes of studies), but also in the approaches to disability, both in the content, coverage and the aims of the medical and other health related courses.. This reflects an inadequacy in the theoretical and philosophical background of the disability-related issues covered or not covered in these higher education degrees, as well as the prevalence of traditional views of disability, which disregard the social and human rights perspective. Such inconsistencies and oppressive conceptualisations of disability, which are associated with the charity and individual models of disability, are also very common in various other political and educational documents in Cyprus, such as the new national curriculum of primary and secondary education and the country’s report on the UNCRPD and Disability Strategy.

Given the above considerations, the EU should provide more detailed guidelines and harmonisation criteria, and should establish international and independent local monitoring bodies in order to enhance national accountability regimes to safeguard disability rights in accordance with the stipulations of the UNCRPD. Beyond rhetorical proclamations, professed national targets and envisaged disability action plans, it is important for countries to provide systematic and reliable evidence-based information on the ways in which their professed disability-rights initiatives are facilitated and implemented. The provision and constant updating of national data on disability is an imperative that needs to be pursued in more rigorous and consistent ways at the European and national levels. Independent monitoring and reviewing of international and national bodies (eg academic institutions) should be established to oversee planning and implementation strategies pursuant to the UNCRPD. At present, the competent monitoring body is the Department of Social Inclusion for People with Disabilities, which is involved in all activities relevant to disability (eg European Structural Funds (ESF) Monitoring and Evaluation). As a result, no external (and probably unbiased) feedback is provided regarding issues of disability.

Simultaneously, there should be a more pronounced emphasis on reviewing and monitoring the ways in which EU structural funds are utilised in order to mobilise and enact reforms in light of the principles of the UNCRPD. For instance, Symeonidou (2014:2) pointed to the paradoxical fact that although ‘the implementation of the ICF is not among the priorities of the European Union as these are stated in the European Disability Strategy 2010–2020 (European Commission 2010), the project is co-funded by the Cypriot government and the European Social Fund….’

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