

That Sinking Feeling

People with Disabilities in Hospital Wards

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ABSTRACT

This study examined the experiences of people with disabilities in general hospitals. Specifically, we identified and analysed the barriers and difficulties that people with disabilities face while hospitalised. Using qualitative methods, our findings were based on a combination of in-depth interviews and a focus group with twenty inpatients in total. Three major barriers to proper care arose from the transcripts: inaccessibility, practitioners' lack of medical knowledge, and negative stereotypes. While some of the findings reinforce existing knowledge about barriers faced by people with disabilities, some address barriers that have not yet been investigated with qualitative instruments, such as lack of specific medical knowledge. In addition, the findings suggest the need to refer separately to physical and service accessibility, the latter including human service and communication. Practical recommendations include the need to upgrade healthcare accessibility regulations and ways to help people with disabilities receive equal health services during hospitalisation.

KEYWORDS

People with disabilities; hospital wards; accessibility; medical knowledge; stigma.

I. Introduction

Disability is currently understood as a complex and evolving concept, deriving from the interaction between the person, the impairment, and the disabling society. An interactional view of disability acknowledges that disability is not related solely to one's bodily functions or health condition (Bickenbach et al., 2015). Rather, as opposed to the individual/medical model, the social model views disability as socially produced, and focuses on the environmental barriers that prevent people with disabilities*1 from full and effective participation in society (Shakespeare, 2006). This view of disability is central to both the World Health Organization's International Classification of Functioning, Disability and Health (ICF; WHO, 2002), and the Convention on the Rights of Persons with Disabilities (CRPD, 2006, Article 1), which defines persons with disabilities as those with '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'.

In recent years, access to health care for various minority groups and the need to adapt health services to groups that suffer from exclusion and discrimination have been discussed, with increased frequency, in both research and practice (Burns, 2017). Various minorities face challenges that undermine their chances of receiving equal treatment, including language barriers (Schuster et al., 2017); healthcare practitioners' lack of knowledge; and health officials' unwillingness to help (Thomas et al., 2005). The number of people with disabilities is estimated at about one billion worldwide (WHO, 2018) and in Israel, the context for our research, there are 1.5 million disabled people (Israel Central Bureau of Statistics, 2019). This is, however, a unique minority group, combining many medical subcategories, making it difficult to plan and make accommodations for each person's needs, especially in health services. In addition, people with disabilities are 'the last civil rights movement' (Driedger, 1989) and, in Israel in particular, the concept of disability as a political identity is quite new.

Various surveys and analyses reveal that people with disabilities are more likely than non-disabled people to think that their doctor has not listened to them, has failed to treat them with respect, has not taken enough time, has not involved them in treatment decisions, or has not explained treatments properly (Lawthers et al., 2003; Toombs, 2004). For example, people with invisible disabilities are more prone to severe exclusion, especially when the disability is mental illness (Bril-Barniv et al., 2017), or to be treated with suspicion by doctors who attribute their physical complaints to emotional or psychological reasons, thus delaying an accurate medical diagnosis. Women, in particular, often find that their medical needs remain unmet, in general and in relation to women's medicine (Rothler et al., 2020; Schopp et al., 2002).

Israel's Municipal Accessibility Index (Dorfman et al., 2019) documented three significant differences between people with disabilities and non-disabled people regarding satisfaction with health services. First, people with disabilities reported that they felt uncomfortable speaking openly with health professionals. Second, they tended not to believe that doctors were doing their best to treat them. Third, people

with disabilities claimed that doctors did not believe them when they complained about pain (34% vs. 18% among non-disabled people).

Despite extensive medical research on many issues related to the lives of people with disabilities and specific medical rehabilitation procedures, significant data on health inequality in terms of the medical requirements, daily needs, and functioning of people with disabilities have yet to be collected (Shakespeare et al., 2018). Only a small number of studies have examined the accessibility of services provided by health systems for people with disabilities (Heslop et al., 2018; Krahn et al., 2015; Phillips, 2012). The current research examines encounters between people with disabilities and healthcare employees, specifically during hospitalisation in General Hospital wards in order to help professionals understand the hospital experience of people with disabilities better and improve the services provided to them.

1.1 Access to Health Services in Israel

The healthcare system in Israel is essentially public, funded via government budgets. Every Israeli citizen is entitled to join one of four health funds for basic medical coverage (Clarfield et al., 2017). Changes in the approach to disability in Israel have contributed to political support for the rights of persons with disabilities, including the passing of the 1998 Equal Rights for Persons with Disabilities Law and Israel's ratification of the CRPD, which mandates the right to health (Kanter, 2015). In a similar way to the American Disabilities Act (1990), the 1998 law requires equal access and full participation for individuals with disabilities, declaring their right to be equal members of society and to be treated with respect and support (Vilchinsky & Findler, 2004). However, as mentioned, Dorfman et al. (2019) found significant differences between people with and without disabilities in their satisfaction with Israeli health services.

The Israeli Equal Rights for Persons with Disabilities Law defines accessibility as 'the ability to reach, understand, or approach something or someone' (Israeli Ministry of Justice, 1998). Article 9 of the law offers a comprehensive explanation of access that includes the physical environment, transportation, information and communications, in addition to access to other facilities and services that are open or provided to the public. It also addresses the oft-neglected disparities between urban and rural areas, thereby introducing a geographical dimension that is particularly relevant to issues of access. This Article therefore broadens our notion of access beyond the physical environment. The Israeli law extends access not only to buildings but also to services and proceedings provided inside buildings occupied by government agencies (Mor, 2017). This new concept is referred to as 'service accessibility'. In 2013, service accessibility was implemented through the enactment of the Equal Rights for Persons with Disabilities Regulations (Ministry of Justice, 2013). This article reviews the service components that must be made accessible. Yet, although further, partial, healthcare accessibility regulations were signed into law in 2016, regulations regarding service accessibility within the healthcare system are still being discussed in the Israeli parliament.

1.2 Patient-Centered Care and People with Disabilities in Health Services

Patient-Centered Care (PCC) is defined by the US Institute of Medicine (2001:3) as ‘providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions’. PCC is considered central for ensuring that patients receive appropriate accommodation and personalised treatment – not only in terms of clinician–patient relationships but also in terms of designing a supportive and nurturing healthcare environment (Berwick, 2009). In particular, PCC emphasises partnerships between patients and healthcare professionals and acknowledges patients’ preferences, needs, and values. Applying PCC promotes flexibility in the provision of healthcare and seeks to move beyond the traditional paternalistic approach (Delaney, 2018), and is thus particularly appropriate for marginalised groups.

Liberati et al. (2015) suggested examining patients’ and healthcare providers’ voices by merging the dyadic and organisational approach to PCC. The PCC framework could serve as an effective basis for treatment for people with disabilities and for helping healthcare service providers understand more broadly the concept of ‘reasonable adjustment’ regarding access to health (Marsden, 2017). Schwartz Council et al. (2012) argued that PCC planning (PCCP) enhanced care for complex patients requiring long-term relationship-based treatment and changed their relationships with healthcare and comprehensive care providers. The use of PCCP was found to be especially relevant for patients experiencing long-term health conditions as a means of creating relationship-based care when the treatment involved different professionals.

In Israel, providing PCC was prioritised at the national level when the Ministry of Health took the first steps to include patient experience as a dimension of healthcare quality (Zimlichman et al., 2013). Yet the Israeli health system is still struggling to overcome barriers and the current status of PCC implementation is relatively poor (Topaz et al., 2020). Staff shortages and lack of resources and training are major barriers to PCC implementation in Israel (Zisman-Ilani et al., 2020).

The current research examined the social phenomenon of encounters between people with disabilities and the healthcare system, specifically during hospitalisation in general hospitals. Combining PCC with inclusive research strategies allowed us to reveal practical knowledge based on everyday care practices and their implications. Although our research included interviews with people with disabilities and healthcare providers from all sectors, the current article focuses on findings from the patients’ perspective.

2. Research Method and Design

This inclusive research incorporated people with disabilities as co-researchers and acknowledged their voice as experts by experience (Ollerton, 2012). In this study, we used the grounded theory approach (Glaser & Strauss, 2017). This qualitative methodology focuses on individuals’ experiences and their interpretations thereof,

in order to identify the core themes that represent the shared experiences of all interviewees regarding their hospitalisation experience and thereby develop and deepen the existing knowledge and make it applicable by healthcare professionals, policymakers and advocates.

The study was designed to reflect the complexity of the phenomenon from several perspectives. Due to the paucity of relevant research in Israel, the study used an array of instruments. We related to people with disabilities as Israeli law defined them, but also as a social rather than a medical category. The study included both a focus group and in-depth interviews. This combination was designed to shed light on a variety of issues that people with disabilities deal with and their perspectives on these issues. The information collected allowed us to map the major barriers to receiving appropriate medical care faced by hospital patients with disabilities.

2.1 Participants

The focus group included ten adults with disabilities (five women and five men) who were part of the Health and Disability Forum of Alumot (n.d.), an NGO supporting social startup ventures that help ‘those on the margins of Israeli society’. They met regularly every several months to discuss how the Israeli health system might be improved for people with disabilities. The forum consisted of 14 members, but only 10 were able to attend on the day the focus group was held. We asked them to discuss the experiences of people with disabilities in inpatient wards. The content that emerged from the focus group helped fine-tune the relevant questions for the in-depth interviews.

The interviews were conducted with ten other participants with firsthand knowledge of the inpatient experience of persons with disabilities. They included two women who were family members of a person with a disability and eight people (seven women, one man) with disabilities. All of them had been admitted into a general hospital within the past five years.

The participants ranged in age from 22–60 years (participants’ characteristics are reported in Table 1 and Table 2). The members of this group had different disabilities – types of disability including motor (wheelchair users), sensory (deafness), physical health (cystic fibrosis), mental health (PTSD) and neurodiversity (autism). Participants were admitted into different hospitals in various regions throughout Israel. This range allowed for a broad and diverse picture of the study’s topic to emerge.

2.2 Procedure

To recruit participants for this study, we adopted a purposeful sampling strategy, as is commonly used within qualitative research. We actively selected the most appropriate sample of people to respond to the research questions by using snowballing and voluntary sampling techniques (Marshall, 1996). Interviews were then scheduled with the participants meeting our criteria: adults with disabilities who had

Table 1 Participants with Disabilities' Characteristics

Name	Disability	Ward
Gloria	Muscular dystrophy; uses a wheelchair	Intensive Care Unit; Rehabilitation
Dalia	Cystic fibrosis	Maternity
Brenda	Deafness	ENT
Sophia	Cystic fibrosis	Maternity
Alex	Autistic spectrum and cystic fibrosis	Internal Medicine
Erica	Motor disability; uses a wheelchair	Internal Medicine
Anna	PTSD	Gynecological Ward
Mira	Using a wheelchair	Orthopedic Ward

Table 2 Participant Family Members' Characteristics

Name	Disability	Ward
Hope	Two autistic daughters; raises a granddaughter with cystic fibrosis	Orthopedic; Maternity
Nancy	Partner of a person with quadriplegia	Internal Medicine

been hospitalised in a general hospital or, when it was not possible to interview the disabled person themselves, their family members.

The individual interviews were conducted at a location selected by the participants during 2019. Each interview lasted 40–120 minutes, depending upon the interviewees' wishes. Eight interviews were audiotaped and later transcribed, whereas two interviews were documented in writing, at the participants' request. The interview opened with the question, 'Can you tell me about your experience of being admitted to the hospital?'. Subsequent questions followed the interview guide, which addressed the experience of being admitted into a hospital as a person with disabilities, positive and negative experiences related to the interaction with hospital staff, and response to accommodation needs.

2.3 Data Analysis

Data analysis was conducted via an iterative process of reading interview transcripts. While reading, we marked sentences and paragraphs from the interviewees' words that constituted meaningful units for the continuation of the analysis. Next, data segments were sorted and combined in a new and distinct way by comparing their different components for similarities and differences. In the next step, the first

author wrote open codes identifying major themes and then explored these themes in analytic memos. In the process, the condensed meaning units were abstracted and labeled with a code. These themes, along with the research questions, formed the basis of the coding scheme (Hennink, Hutter & Bailey, 2020).

In the next analytic stage, all researchers team re-examined and edited the categories, and new categories were then created to reflect issues that had not arisen during the initial stages. Out of all these categories, the primary ones were conceptualised and defined and henceforth became the basis for the entire study. These categories were selected because they contributed the most to defining and clarifying the experiences of people with disabilities when admitted to and during their stay at the hospital. Finally, according to grounded theory (Glaser, 2017), a theoretical conceptualisation of the descriptive image arose from earlier stages while using terms from relevant studies from which we could then clarify the data and construct the theory.

2.4 Ethics

We approached the interviewees only after receiving approval from the Ono Academic College Ethics Committee. Before each interview, the participants received written and oral information about the study's aim. Participants were reassured of confidentiality regarding their disclosures and our handling of their data. Anonymity was guaranteed by using pseudonyms. It was clarified that participation was voluntary. In addition, a great effort was made to meet all accommodations required for each participant, including the provision of a quiet environment, documenting interviews in writing, and conducting both face-to-face interviews in the open air, and online interviews via Skype or Zoom.

3. Findings

Three major interrelated themes arose from our data analysis: (1) inaccessibility (lack of either physical or service accessibility); (2) lack of specific medical knowledge; and (3) negative stereotypes. Each theme reflected a different aspect of the challenges people with disabilities faced when hospitalised, along with their personal points of view regarding these challenges.

3.1 'I Feel Like I'm Sinking': Inaccessibility

Although it is crucial that hospital wards be accessible, most interviewees described various aspects of *inaccessibility*. According to the interviews, people with disabilities met with two kinds of inappropriate accommodation when admitted to the hospital: physical inaccessibility, and a lack of what the Israeli Equal Rights for People with Disabilities (1998) defined as 'service accessibility'.

3.1.1 Lack of Physical Accessibility

Although accessibility regulations require that all public environments be accessible to people with disabilities, many elements in the hospital environment are not

adequately adapted to such patients' specific needs. People with disabilities face inaccessible environments daily. However, when hospitalised, their experience can become far more restrictive:

I can really go anywhere. My disability has never stopped me before. But when I get to the hospital, this lack [of physical accessibility] is crucial. It is so important to me to be independent, and this makes it almost impossible. (Erica, wheelchair-user).

Lack of equipment is a common issue people with different disabilities face when hospitalised. Even small things can drastically affect one's experience when specific needs are ignored. For example, Gloria, who has muscular dystrophy, refers to equipment that is uncomfortable for her:

I know that there are very soft mattresses and there are hard mattresses. I need a harder mattress because when I lie on a soft mattress, I feel like I'm sinking, and then it's harder for me to breathe. When I need to undergo physical therapy or something like that, it's even worse. I know it sounds like I'm just spoiled, but it's really not that.

3.1.2 Lack of Service Accessibility

The interpersonal communication aspect of accessibility is crucial. Often it seems that the medical staff are unwilling to make the extra effort to accommodate specific needs of people with disabilities. Obviously, an inaccessible environment often affects the patient's health for the worse.

Many participants described situations in which services were inaccessible to them. More often than not they faced problems that could be solved with relative ease. Often the patients felt that it was nearly impossible for them to obtain a more accessible service, although most of the situations in question could be easily solved if there were a clear medical protocol.

Anna, who has been diagnosed with PTSD, described how an anesthesiologist had to fill out a form before gynecological surgery that did not appear to indicate PTSD but only anxiety disorder:

Before surgery, there was a meeting with the anesthesiologist, so I told him I had PTSD. So he said to me: Very well, I'll mark it down as anxiety disorder. And I told him, I don't have an anxiety disorder but PTSD. These are two different things. So he indicated anxiety disorder anyway. And then he got really angry with me for insisting [...]. He took the pen and erased everything and told me: That's it! No anxiety disorder and no nothing. It was very humiliating.

This situation could have been completely different had the anesthesiologist chosen to comment on the form rather than argue with the patient. Other situations related to mental health will be discussed below, as this was found to be a major conflict area between patients and staff.

People with sensory disabilities need specific accommodations to be able to understand medical instructions and procedures fully. Due to her visual impairment, Yael, for example, could not read what was written on her release papers:

I leave the hospital with a stack of documents. The nurse explains all kinds of things to me, and at the end, when she finishes talking, I need someone to read the whole thing to me again. Also, in the admission process, when getting stickers, when things need to be signed. Do I know what I'm signing? No. Because I can't see it.

3.2 'Like a Turtle': Lack of Medical Knowledge and Practice

The most frequently addressed issue among the interviewees was that the medical staff lacked the knowledge needed for adapted treatment of a medical condition, in other words, of the impairment and its interactions with the current medical situation:

After my surgery, they made a mistake. While I'm on antidepressants, I was given some medication that when combined with antidepressants can cause an extremely dangerous reaction. The drugs must not be combined, and they didn't know that. (Anna)

In some cases, doctors admit to patients that they do not know how to treat them because of unfamiliarity with their specific impairment, despite being experts on the medical symptom that has brought the patient to the hospital. Gloria reflected on her teens when she had been hospitalised for pneumonia:

I was admitted, and then the doctor there told me: 'You're like a turtle to us'. That's the sentence he told me, and I'll never forget it. You are like a turtle to us; we don't know how to treat turtles. Because there's no hospital that specialises in muscular dystrophy, and because it affects so many bodily systems, often they don't know how to treat me.

Some patients feel it is their responsibility to inform the doctors about their condition. This places inordinate pressure on the patients, as they need to advocate for themselves while hospitalised:

It's kind of a weird situation that a lot of people with disabilities face – you come to receive medical service, and pay for this service, but you have to really educate the doctor about how to treat you. And not everyone can do this. I feel anxious about doing this. How can I be sure that I explain myself properly? (Brenda, a Deaf woman).

Patients' sense that the medical staff lack the knowledge to treat them recurred throughout the interviews and was clearly a significant cause for concern. Lack of medical knowledge and professional practice, as described here, can threaten patients' lives when becoming professional malpractice. However, not only does (lack of) medical knowledge affect the patient's condition; misconceptions, stigmas, and prejudices about people with disabilities can also affect the physical and mental health of people with disabilities in hospitals.

3.3 'Every Pain I Described Was Labelled': Negative Stereotypes

Stereotypical thinking by the medical staff can affect not only the patient's emotional experience but also physical health. Some patients described ignorance of the staff regarding the lives of people with disabilities, along with stereotypical assumptions

about their preferences and needs. Often the disability distracted the caregiver from treating the actual medical issue that brought the person to the hospital. Hope, a woman with two autistic daughters who raises a granddaughter with cystic fibrosis, described it as follows:

I remember [my daughter] lying in the delivery room, actually giving birth. And the midwife yelled at me, over her head: 'So what did you say she was suffering from? Asperger's syndrome?' And I wanted to tell her: 'She suffers from contractions, you stupid midwife! Really, what is she suffering from now?' I was once told that people with disabilities should not be told that they 'suffer from' because they might not be suffering. The state of 'suffering' shouldn't be assumed. And I felt at that moment that this was so true.

When a person using a wheelchair or whose disability is noticeable arrives in the hospital, the medical staff sometimes refrains from talking to that person directly:

Because I usually come with my mom, most people obviously choose to speak to her, talk to her and just talk to her. My mother naturally protects and supports me, and she often answers automatically, especially in hospitals and hospital settings. Sometimes I don't care that she speaks for me. But often, it does get in the way. If they suddenly notice that I understand, then they start hearing and talking to me. (Gloria)

When it comes to mental health disabilities, stereotypes are quite common and can lead to poor treatment. These disabilities also carry with them a high comorbidity rate of significant physical illnesses. Many people with mental health disabilities described how they were often ignored by the medical system. Alex became extremely sick because the doctor who treated him lacked medical knowledge regarding OCD and held some common stereotypes regarding people with mental health issues.

I take antibiotics regularly because of my respiratory illness. Because I have a background of an anxiety disorder – OCD – which of course does not affect my reality testing and does not cause hallucinations, he labeled me as if I were imagining things. Every complaint, every pain I described was labeled as OCD-related. I felt kidney pain; he told me to ignore it, that I was imagining it ... two weeks later, I was diagnosed with kidney failure. (Alex, a man on the autistic spectrum with cystic fibrosis, admitted due to pneumonia)

4. Discussion

Over the past few decades the social model of disability has sought to critique overly-medicalised approaches to the 'problem' of disability (Oliver, 1990). It is important to note, however, that neither the originators of the social model, nor the architects of the UN CRPD, who were so influenced by that model, denied that people with disabilities often have additional health needs, and their unique status within the health system must not be ignored (Stough & Kelma, 2018). UN CRPD Article 25 clearly states that governments must recognise that persons with disabilities have the right to the enjoyment of the highest attainable standard of health, without discrimination on the basis of disability and should take all appropriate measures to ensure access for persons with disabilities to health services.

The research findings highlight three primary barriers that people with disabilities face when hospitalised: (1) physical and service inaccessibility; (2) lack of medical knowledge; and (3) negative stereotypes. The two subthemes of *inaccessibility* arising from the interviews are physical accessibility and the issue of human service and communication. The Israeli Equal Rights for Persons with Disabilities law (1998) extends access requirements not only to buildings but also to services and proceedings provided inside them (Mor, 2017). The law's regulations also refer to the sequence of accessibility: arrival to service, receipt of service, and termination of service. This continuity principle means organisations must consider the entire service chain or 'patient journey', including parking, entry, waiting, reception, the various services at the facility (toilets, cafeteria), and receipt of the actual service. If even one of these components is inaccessible, the continuity principle is considered violated (Milberger et al., 2003; Mor, 2017). Indeed, our findings indicate multiple failures in the service sequence in hospitals. Patients described difficulty staying at the ward, during treatment, and even in the discharge process. These difficulties were due to both lack of physical accessibility and lack of human service accessibility.

A second significant finding is that people with disabilities in hospitals often feel that the medical staff do not know how to treat them most appropriately due to a *lack of medical knowledge* regarding their disability. This finding is significant as it addresses an issue that has not yet been studied with qualitative methods (Lawthers et al, 2003). The participants reported significant errors in patient care resulting from a lack of medical knowledge regarding disabilities. Any solution must provide physicians with knowledge regarding both the social and the medical aspects of the disability. Previous research has indicated a variety of ways in which lack of information or information transfer has harmed patients (WHO, 2011). The WHO Report on Disability and Health (2018) also defines inadequate skills and knowledge of health workers as a central barrier to equal healthcare for people with disabilities, showing that people with disabilities are twice as likely to find a care provider's skills and facilities less adequate and to be treated badly in the healthcare system.

The current research sheds light on the extent of the phenomenon and reveals some aspects of it that have not been mentioned previously. This finding is important because on a theoretical level it indicates a distinction between physicians' personal knowledge and the lack of procedures in the organisation that would enable physicians to gain knowledge. Therefore, as the average doctor has the knowledge and capability to treat and care for the average patient, in the case of people with disabilities, it is crucial to create a holistic approach to medical treatment, especially due to the need to integrate data from various health experts – relating to the specific medical condition, the impairment and disability. In many cases, the knowledge already exists, and the only thing missing is the formal procedure that would allow the physician to access and then make use of this knowledge.

Thirdly, stigma and discrimination associated with people with disabilities have been extensively studied in the literature (e.g. Buljevac et al, 2012). With regard to medical assistance, people with disabilities often feel uncomfortable talking openly

with health professionals and tend not to believe that doctors are doing their best to solve their health problems. In addition, many people with disabilities think doctors do not believe them when they complain about pain (Dorfman et al, 2019). This is consistent with the results of the current study that point to cases of people with disabilities being forced to deal with the stereotypical thinking, ignorance, and prejudice of medical staff. It is crucial to acknowledge the importance of stigma and the negative effects it may have on patient experiences. Whereas structural disablism is manifested in lack of access and social barriers that define what people can *do*, psycho-emotional disablism operates on the individual level, causing severe mental distress, and ultimately defines what a person can *be* (Reeve, 2012).

4.1 Limitations and Future Directions

This exploratory or preliminary mapping study sampled a small number of participants who varied in their inpatient experiences. As such, despite its potential contribution to future efforts in this understudied field, it has several limitations. First, it focused solely on the hospitalisation phase and did not explore experiences in the ER, for example. The participants also varied in multiple parameters that may have affected the findings, including type of disability, manner of admission to inpatient service (emergency or planned), the hospital setting itself, the length of hospitalisation, and early acquaintance with the hospital and staff. Second, our findings are based on retrospective examination of the participants' experiences, sometimes several years after the event, a factor that may have affected their description of these experiences. Third, most of the participants in this study were women, affecting the representativeness of our sample. Finally, this study drew exclusively on the participants' subjective experiences as narrated after the fact, without also conducting observations or considering objective data on inpatient procedures, real-time accessibility, and actual medical treatment.

In light of the findings obtained in the present study and its limitations, we propose deepening and expanding the current study on several levels. First, extending the research population to include additional disabilities, such as people with intellectual disabilities, and medical teams, family members, and caregivers. Second, examining the screening process, inpatient admissions, the inpatient stay, and the discharge procedure, as well as outpatient procedures, as part of the overall hospital service continuum. Third, examining patient experiences during or as soon as possible after hospitalisation. Finally, we also recommend examining the objective aspects relevant to accessibility of services throughout the hospitalisation continuum, thereby isolating significant factors, such as the familiarity of the setting, the uniqueness of the professional service, the distinction between visible and invisible disability, and the distinction between planned hospitalisation and emergencies.

5. Conclusion: Implications for Policy and Practice – Inclusive Healthcare in Hospital Wards

Despite the tentative nature of our findings, they do point clearly at several practical implications. To apply a truly inclusive and accessible service, hospitals must consider

all three dimensions addressed in the current study. Lack of medical knowledge can be remedied by providing relevant information. Such input must include professional knowledge about disability, administrative knowledge of how to access existing knowledge, and personal knowledge based on encounters with people with disabilities.

Both physical and service inaccessibility can be approached and mitigated by mapping the needs of people with disabilities when hospitalised and by training the medical staff to work with people with disabilities. This training should include providing professional knowledge about how to accommodate people with disabilities and encouraging personal encounters. Previous research indicates that opportunities to meet disabled people are associated with positive change in attitudes of medical staff, even when meetings are only conducted online (Shakespeare & Kleine, 2013).

Clear focus on these aspects while students are still in medical school or during their residency, complemented by annual refreshment courses, can go a long way in promoting inclusive care. The Israeli Health Services Accessibility Regulations were enacted to provide the best possible response to persons with disabilities (Ministry of Justice, 2013; Accessibility of Health Services Regulations, 2016). However, the regulations fail to address the content of the medical service and the professional knowledge required about the disability itself. The additional professional medical knowledge required in this context is highly significant and unique: it strives to ensure optimal medical response to a specific person with a specific disability or combination of disabilities, considering also their complex interaction with the medical condition in question. We hope the need for such knowledge is included in regulations regarding healthcare service accessibility that are still under discussion in the Israeli Parliament and adopted as a guiding principle in health policy in general.

According to the Liberati et al's 2015 patient-centered care approach, combining an approach that focuses on the individual as a whole with an approach that focuses on the organisation may pave the way for adjusted and inclusive care for people with disabilities in hospitals. We believe inclusive care is a fundamental issue affecting all healthcare customers. Improving the care provided to people with disabilities will improve it for us all.

NOTE

*1. Herein we adopt people first language in keeping with the UN CRPD.

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