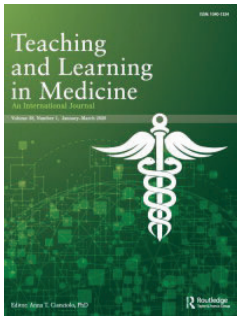

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GROUNDWORK

Barriers Before Entry: Opportunities for Improving Pre-Admission Guidance for Disabled Medical School Applicants in Australia and New Zealand

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ABSTRACT

Despite widespread calls for greater inclusion of disabled people in the healthcare workforce, significant barriers remain. These barriers exist even before admission to training, when applicants are considering study options and future careers. In Australia and Aotearoa/New Zealand (NZ), the Medical Deans of Australia and New Zealand (MDANZ) have developed guidelines for inclusive pre-admission practices, but the extent to which these are enacted is unclear. This study aimed to explore the extent to which Australian and NZ schools have adopted these guidelines and whether their websites communicate to prospective applicants in a way that explicitly recognises disability as a valued dimension of diversity. We used these data to develop a set of reflective questions intended to help medical schools improve their pre-admission communication to applicants. In January–September 2024, we conducted an audit and content analysis of all Australian and NZ public-facing medical school websites. Domains examined included the use of Inherent Requirements and/or MDANZ Guidelines for Inclusive Medical Education and how these documents framed program requirements from organic or functional perspectives. We also explored the accessibility of relevant information, the transparency of pre-admission discussions, and identified where schools framed disability as a deficit versus using positive and strengths-based language. While we found examples of inclusive practices, many schools could improve the clarity and framing of the information provided to applicants. Many schools framed disability as a deficit or avoided explicit reference to disability. Clear information regarding procedures for confidential discussion of applicant circumstances and access to accommodations prior to admission was often absent, potentially leaving applicants uncertain about the impact of disability disclosure. Only half of the schools referenced the MDANZ Guidelines. Those that used Inherent Requirements often employed organic framing which did not acknowledge the role of accommodations. Establishing the state of current practice illuminates opportunities to make medical programs more inclusive from the early stages of the student lifecycle. These findings illustrate the potential gap between policy and practice. Here, we identify the practical importance of reviewing pre-admissions communication through a disability-inclusive lens, and provide a series of recommendations and reflective prompts to support medical schools as they work towards more inclusive practice.

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Disability; admissions; inclusion: MDANZ; critical disability theory; medical students

Introduction

Disability inclusion in medical education

Equal access, participation, and achievement in education, training, and work are fundamental rights enshrined in the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD (United Nations General Assembly, 2006)) To achieve this, the Committee to the UNCRPD has recommended a "transformation" of education systems to address discrimination and persistent barriers to inclusive education (UN Committee on the Rights of Persons with Disabilities, n.d.). The

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UNCRPD also recognises the right of persons with disabilities to the "enjoyment of the highest possible standard of health" (United Nations General Assembly, 2006), a goal that increasing disabled people's representation in the healthcare workforce could help facilitate. Research shows when healthcare providers and patients share experiences of societal marginalisation, including disability, health disparities decrease and diagnostic accuracy improves (Doherty et al., 2024; Greenwood et al., 2018; Ireland et al., 2022). Increasing the number of disabled practitioners also improves patient experiences (Battalova et al., 2020; Iezzoni, 2016; Stergiopoulos et al., 2018) and has support within the profession (Australian Medical Association, 2023; Bernard et al., 2023; Ministry of Health, 2023) and the broader community (Mogensen & Hu, 2019).

Despite these apparent benefits, the proportion of the medical workforce reporting disability remains lower than population averages in many countries (General Medical Council & UK, 2019; Nouri et al., 2021). A range of barriers to success for disabled students exist across every stage of becoming a medical professional—application, selection, admission, study, placements, and transition to the workforce. Underpinning many of these barriers is the "capability imperative," (Jain, 2022) a cultural manifestation of ableism in medicine that demands that medical professionals meet inflexible standards of exceptional physical, cognitive, and professional competence, marginalising disabled individuals (Jarus et al., 2023).

The capability imperative in medicine may influence how medical schools communicate with prospective applicants. This early phase of a student's journey is often where they first encounter the norms and expectations of the medical profession and where schools may unintentionally send messages that discourage disabled students from applying. In Australia and Aotearoa/New Zealand (NZ), medical schools have access to consensus guidelines regarding how information should be provided to disabled students (Medical Deans of Australia & New Zealand, 2021). However, it remains unclear whether publicly available information on medical school webpages aligns with these guidelines. Evaluation of this information will offer insights into how we can best remove barriers to inclusion of disabled students at the commencement of their professional journey.

Information for disabled medical school applicants

The language used on institutional websites shapes the institution's norms and values and communicates who belongs and under what conditions (Rao & Hosein, 2017). Disabled applicants should have access to clear information on program requirements, reasonable adjustments, and whether disability disclosure is required before applying—and if such disclosure affects the likelihood of admission to these highly competitive programs. Public-facing sites also reveal an institution's culture around disability inclusion, indicating whether disability is framed as an individual deficit (medical model) or in a more positive, nuanced way aligned with social or political-relational models of disability (Kafer, 2013; Lawson & Beckett, 2021).

Some Australian universities use Inherent Requirements (IR) statements to identify the abilities, attributes, skills, and behaviours students must possess to successfully complete a program (note that in this document we use the term program to refer to the set of academic requirements leading to the award of a degree or accredited qualification). IR guide potential applicants and mitigate risk for universities (Brett et al., 2016; Corcoran et al., 2022). Similar to North American Technical Standards (TS), IR are widespread in Australian health-related disciplines (Brett et al., 2016). In contrast, NZ institutions less commonly use IR, despite a similar legislative landscape (Claiborne et al., 2011).

Shifting discourse around disability has prompted critical appraisal of TS, IR, or equivalent documents, internationally and in Australia (Gordon, 2022; Kezar et al., 2019). Landmark studies by Zazove et al. and Stauffer et al. (Stauffer et al., 2022; Zazove et al., 2016) reviewed TS use in the United States (US). Both studies critiqued the prevalence of *organic* framing in TS: descriptions of what a student must do that focus on the body itself (e.g., cognitive, physical, or sensory capabilities) rather than on meeting the learning outcome (McKee et al., 2016). Organic framing excludes disabled individuals by failing to acknowledge the possibility of accommodations or alternative methods of attaining learning outcomes. In contrast, *functional* framing in TS focusses on *what* competencies a student must demonstrate rather than dictating *how* they must accomplish the task, which allows for flexibility (Kezar et al., 2019; McKee et al., 2016).

In 2021, the Medical Deans of Australia and New Zealand (MDANZ) released the "Inclusive Medical Education: Guidance on medical program applicants and students with a disability" (MDANZ Guidelines) (Medical Deans of Australia & New Zealand, 2021), intended to replace organically framed IR. The MDANZ Guidelines explicitly adopt an inclusive, strengths-based approach and encourage early and open dialogue (Issakhany & Crampton, 2023). The Guidelines include a series of reflective questions intended to support early conversations between applicants, medical schools, and student support services.

Similar to the 'Welcomed and Valued' resource of the General Medical Council in the United Kingdom (UK) (General Medical Council & UK, 2019) and the newly released consensus statement on Core Competencies by the Association of Faculties of Medicine of Canada (Holmes et al., 2025), the MDANZ Guidelines employ a functional framing aligned with a social-relational model of disability (Issakhany & Crampton, 2023). While adherence to the Guidelines is not mandatory currently, implementation enables schools to more effectively demonstrate the extent to which they meet the Australian Medical Council Accreditation Standards for Medical Schools (particularly *4.1.4: The medical education provider supports inclusion of students with disabilities*) (AMC, 2024).

However, the value of guidelines, policies, and procedures lies in their enactment, not merely their existence. It is therefore timely to consider in a holistic manner how medical schools use these guidelines to support prospective disabled applicants at one of the earliest and most influential points of their contact with the institution.

This study seeks to answer the question: **To what extent do Australian and NZ medical schools implement the MDANZ Guidelines in providing information to disabled applicants?** In particular, we focussed on: (a) whether they have adopted the MDANZ Guidelines or modified IR to reflect current best practices (Kezar et al., 2019), (b) the clarity and transparency of the information provided, and (c) how disability is framed, particularly whether it reflects a deficit-based or strength-based model. Understanding current practices will help identify barriers to inclusion for disabled students that may arise even before the application process begins.

Methods

Theoretical framework

We have taken a disability-affirming stance in this work, drawing on several key models and theories to help us interrogate how medical schools construct disability in their public-facing information.

In applying a social model (Barnes, 2019), we shifted our attention from individual difference to the barriers created by institutions and environments that allow or disallow human difference. This model focusses on how medical school websites either enable or obstruct access. The political-relational model (Kafer, 2013) extends the social model to examine the power relations and professional norms that can sustain exclusionary practices in medicine and the contextual relations that create disability. In this framework, we examined how policies and language shape disability in each school context. Critical disability theory (CDT) exposes how ableism is embedded in structures and discourse, framing our analysis of whether schools' language reproduces deficit-based framings or supports more functional, inclusive approaches. Finally, the neurodiversity paradigm (Shaw et al., 2025) positions cognitive and neurological variation as a valued aspect of human diversity. Applying this paradigm to our work challenged us to question our concept of disability and further explore how exclusion and disadvantage might arise from systems and structures that privilege certain ways of being, learning, and working. Together, these frameworks allowed us to examine not only whether medical schools in Australia and NZ adopt the MDANZ Guidelines but also how their language and practices position disabled applicants in relation to the profession. Drawing from CDT, we use the term 'disabled students' rather than 'students with a disability' to highlight that it is exclusionary environments that disable people, rather than their bodies or minds in isolation. However, we also acknowledge that language is deeply personal and some individuals and communities may prefer person-first language (e.g., *students with a disability*), identity-specific terms (e.g. *autistic students*), or alternate terms (Andrews et al., 2022).

Study design and data extraction

Drawing on the study design used by Zazove et al. and Stauffer et al., who examined US medical school TS (Stauffer et al., 2022; Zazove et al., 2016), we conducted a document analysis of each of the 23 publicly accessible institutional web pages for medical schools in Australia and NZ. As this work involved solely publicly available documents and website text, institutional ethics approval was not required.

We accessed all web pages during January and February 2024 and checked them in September 2024. Using a Google search, we retrieved each site corresponding to "X University School of Medicine" and followed internal site links to identify each medical school's pages that included admissions and program information. Where relevant information was not readily available, we used the university website's search function to identify sections or text containing key terms, including 'disability,' 'inherent requirements,' 'inclusive medical education,' 'reasonable adjustments,' and 'accommodations'. We entered the text from each web page, in addition to the IR or equivalent guidelines, into an Excel database.

Data analysis

Following data familiarisation, we developed a framework for content analysis using the process described by Goldsmith and by Bengtsson (Bengtsson, 2016; Goldsmith, 2021). We developed the coding framework through a combination of deductive and inductive processes, including domains identified by Zazove et al. and Stauffer et al. (Stauffer et al., 2022; Zazove et al., 2016) in addition to new domains arising from our interpretation of the data or modified to the local context. Two researchers (LG and BM) reviewed, discussed and refined the initial framework iteratively prior to coding or indexing the data and comparing outcomes to establish reliability. This was followed by charting to summarise the data. In the data interpretation phase, the researchers met to discuss the patterns evident in the data and explore them in the context of the Australian, NZ, and international higher education and health professions landscape. Insider/outsider perspectives were particularly valuable in this phase. Researchers with lived experience of disability or health professions education provided insider perspectives that illuminated contextual nuance or more subtle forms of exclusion. Those with outsider perspectives afforded critical distance and a broader perspective, helping to challenge assumptions. To further contextualise and balance these perspectives, we informally discussed our data interpretations with colleagues across the health professions as well as with current and former students. This strengthened the reflexivity of the process and reminded us to frame our conclusions and recommendations in a practical and constructive manner.

The framework incorporated five domains: framing of disability, ease of finding information, clarity regarding disclosure, information source (MDANZ or IR), and information framing (Table 1). Example text for each domain is provided in Table 1 and synthesised from multiple sources to maintain institutional anonymity; therefore, it is not representative of any one school's phrasing (Franzke et al., 2020).

The first domain examined the websites' language about disability, with schools coded as having no specific reference to disability, disability framed as a deficit, or positive framing of disability. The second domain evaluated ease of access to relevant information, including the number of links necessary to locate IR or guidelines.

The third domain explored the clarity provided to applicants regarding what actions the school expected of them. The fourth domain coded whether the school provided IR or MDANZ Guidelines as the source of relevant information. Finally, we categorised the IR or guidelines as either *organic* or *functional* (McKee et al., 2016). Where both IR and guidelines were provided, the coding reflects that of the IR.

Author positioning

In conducting this work, we were aware of our outsider/insider status (Dwyer & Buckle, 2009). The research team includes disabled individuals and family members of disabled people. All team members are university educators and/or researchers holding various roles, including program design and delivery and leadership positions. This provided insight into the practical considerations of medical schools as they navigate disability inclusion; however, we also were aware of the potential for perceived conflict should the research uncover areas of medical school practice that require development.

Results

We evaluated all 23 medical schools in Australia and NZ in this study. All but one are public institutions, and all schools are allopathic medical programs. Medical education in Australia is approximately evenly distributed between undergraduate and graduate-entry pathways, whereas both medical schools in NZ offer undergraduate programs. Cohort intake sizes range from approximately 80 to 350 per year. Deidentified data for each school and a summary of results are presented in Table 2.

Domain 1: Framing of disability

Nine schools did not explicitly use the term 'disability' on their program or admissions pages. Instead, these schools used terms including "inherent requirements," "inclusive guidelines," "participation requirements," or "expectations of medical students," without specifying their relevance to disabled applicants. This omission (combined with the need to navigate multiple steps to find information) can make it difficult for applicants unfamiliar with this terminology to identify relevant details.

Eight schools referenced disability but used a deficit framing only, noting that disabled students may require additional support or adjustments or need to consider if they could meet the program requirements. Only six made positive statements regarding welcoming, valuing, or encouraging disabled applicants. Widespread use of higher education terminology (like "Inherent Requirements") or discipline-specific phrases

Table 1. Coding domains, definitions, and example phrasing for analysing the implementation of the MDANZ guidelines for disability inclusion in medical school websites.

	Definitions	Examples
Domain 1: Framing of disability		
No mention of disability	"Disability" not mentioned on program page or linked pages (e.g., admissions)	*The inherent requirements outline the essential skills and qualities necessary to start the Medical program. This information will help you determine if you are suited to pursue this degree.*
Deficit framing	"Disability" mentioned only in the context of referring to the potential challenges of studying or the availability of reasonable adjustments	*Students with disabilities may not be able to complete their program if they cannot meet the essential requirements of core or compulsory programs. Before enrolling, we encourage students to review these requirements and the available support services.*
Positive framing	Affirmative statement regarding inclusion of students with a disability	*XXX University is committed to inclusivity and encourages applications from students with disabilities and from diverse social and cultural groups.*
Domain 2: Ease of finding information		
Easy	Available on main program page	Link to IR or guidelines on main program page
Moderate	Available within one to two links from program page	Link to IR or guidelines on admissions page + up to two links
Difficult	Required a text search from the program page	Search for IR or guidelines retrieved a document not linked directly from the program page
Not found online	Neither IR nor guidelines available online	Search for IR or guidelines retrieved no results
Domain 3: Clarity regarding disclosure		
None	No information provided	
Very low	Information required for reference or familiarisation only, or no instructions for applicants provided	*For information, download and read the Medical Deans Inclusive Medical Education document.*
Low	Applicants recommended to engage with IR or guidelines and/or reach out to the school	*We encourage prospective students with disabilities or ongoing health conditions to reach out to XXX University.*
Medium	Applicants requested to engage with IR or guidelines and reach out to the school; contact details are provided or process is detailed	*We offer reasonable adjustments to support students with disabilities. If you have concerns about completing a medical program due to a disability, please contact us early for advice. This will help you make an informed decision about applying.* *Students must meet the inherent requirements for graduation from the medical program, with appropriate support and reasonable adjustments provided when possible. Students will be given the opportunity to show how they can meet these requirements considering their disability.*
High	Applicants requested to engage with IR or Guidelines and reach out to the school, contact details are provided or process is detailed, and transparency is provided regarding: - the **rationale** for disclosure (for example, to an admissions committee or a disability support service); - whether disclosure was a **requirement** of application; - whether disclosure was **separate** to the admissions process; and, - whether the institution would work in **partnership** with the applicant	*You can enrol even if you are unsure about meeting all the inherent requirements. It's important to note that the University cannot restrict enrolment or discriminate against students based on their disability**.** If you're concerned about meeting a listed inherent requirement, you can contact Disability Services to discuss your specific situation. We will work with you to address your needs while protecting your privacy.*
Domain 4: Information source		
Guidelines	MDANZ Guidelines are provided	N/A
IR	Inherent Requirements are provided	N/A
Guidelines + IR	Both MDANZ Guidelines and IR are provided	N/A
None	No source provided	N/A
Domain 5: Framing of information		
Organic	Some or all of the information provided is framed as organic standards focussing on specific abilities, with no reference to reasonable adjustments	*Good gross motor skills are essential for performing healthcare tasks efficiently and safely. These skills include lifting, carrying, pushing, pulling, standing, twisting, and bending. Students must be able to consistently and safely perform these tasks to prevent injuries to themselves and others.*
Functional	The information provided uses functional statements and refers to possible reasonable adjustments	*Medical students will be required to show their ability to gather information, perform appropriate procedures for their level of skill, and understand and fulfill their role in assisting during medical emergencies. They may access appropriate adjustments or assistive technologies in order to meet these requirements.*
N/A	Neither the MDANZ Guidelines nor IR are provided	

Table 2. Coding results for each school ($N = 23$) across the five domains of implementing the MDANZ guidelines for disability inclusion in medical school websites.

	DOMAIN				
School	1. Framing of disability	2. Ease of finding information	3. Clarity regarding disclosure	4. Information source	5. Information framing
1	positive	easy	high	IR	organic
2	positive	easy	medium	Guidelines	functional
3	positive	easy	very low	Guidelines	functional
4	positive	easy	very low	IR	organic
5	positive	moderate	low	IR	functional
6	positive	difficult	low	IR	organic
7	deficit	easy	medium	IR	organic
8	deficit	easy	medium	Guidelines	functional
9	deficit	moderate	medium	IR	organic
10	deficit	moderate	medium	IR	organic
11	deficit	moderate	medium	IR	organic
12	deficit	moderate	low	Guidelines + IR	functional
13	deficit	not found	very low	none	N/A
14	deficit	not found	none	none	N/A
15	none	easy	medium	Guidelines + IR	organic
16	none	easy	medium	IR	organic
17	none	easy	low	Guidelines + IR	functional
18	none	easy	low	Guidelines + IR	functional
19	none	moderate	medium	IR	organic
20	none	moderate	very low	IR	organic
21	none	moderate	very low	Guidelines	functional
22	none	difficult	none	Guidelines	functional
23	none	not found	none	none	N/A

(like "take a history") can make it harder for potential applicants to identify and interpret relevant information.

Domain 2: Ease of finding relevant information

The majority of schools provided relevant information (in the form of MDANZ Guidelines or IR) either directly on the program page or within one or two links. For two schools, the relevant information could be found only via the institutional search function. The remaining three schools provided neither the MDANZ Guidelines nor IR.

Domain 3: Clarity regarding disclosure

Our data suggest that disabled applicants accessing most medical schools' web pages would not find information regarding the implications of disclosure prior to application, including whether such information would be kept separately from admissions decisions, in line with anti-discrimination legislation (Commonwealth Government Act, 2016). Five schools provided information to guide applicants but offered little context or guidance on how applicants should engage with this information or take further steps (very low clarity rating). Five schools recommended familiarisation with the information and encouraged further discussion but did not provide contact details or a clear process (low clarity rating). For the nine schools rated medium for clarity, where applicants were requested to make contact, key information was missing regarding whether pre-admission disability disclosure was required and how such disclosure would be kept confidential and separate to admissions decisions. Only one school was rated as providing high clarity, encouraging disabled applicants to reach out for further information but specifying that this was optional and would not influence admissions processes.

Whilst many schools referred to the provision of supports or reasonable adjustments, relatively few used language indicating they would work in partnership with potential applicants. The language around disclosure also differed in the locus of expertise regarding a disability's potential impact. In some cases, applicants were invited to reflect on their circumstances and/or work with disability resource staff or school staff to identify whether accommodations would be of assistance. Other schools required that the "*disability and/or condition is identified and assessed*" by the institution, positioning the authority and decision-making capacity with the institution rather than the individual.

Domain 4: Source of guidance to applicants

Less than half of the medical schools provided a link to the MDANZ Guidelines or incorporated their material (often to inform updated IR). This indicates low uptake of a consensus document from the peak body intended to address the need for updated disability-affirming IR. Four schools provided both IR and the Guidelines, and three provided neither.

Domain 5: Framing of guidance to applicants

Eleven of the 14 schools providing IR framed them organically rather than functionally (Kezar et al., 2019). The four coded as *functional* had drawn on the Guidelines and were closer to recommendations by scholars of TS/IR (Kezar et al., 2019). Schools with *organic* IR were less likely to specifically reference reasonable adjustments, and most did not link directly to information about accessing these adjustments.

Discussion

This study explored the extent to which Australian and NZ medical schools have adopted the MDANZ Guidelines and provide clear, inclusive information to disabled applicants. Our analysis revealed that whilst many Australian and NZ medical schools' public-facing web pages demonstrate aspects of inclusive practices, significant potential exists to enhance the experience for disabled individuals who are considering their enrolment options. Most school websites demonstrated elements that we rated more positively, but we also found several opportunities to improve the clarity, accessibility, and inclusivity of information for prospective applicants. Even schools with positive, inclusive framing of disability (e.g., Schools 2 and 3) could have offered further information about the impact of disclosure and whether it was required or merely recommended. At the other end of the spectrum, some schools made few or no references to disability and if they did reference it, did so with a deficit framing. These findings are not only relevant to the local context but are illustrative of the frequent gaps between available guidelines or recommendations and enacted procedures seen internationally (Stauffer et al., 2022).

Framing of disability

Potential medical students' application experience starts with the language used on program web pages. Schools omitting the term "disability" from program and admissions pages suggest discomfort around appropriate language use, despite many universities offering relevant information elsewhere on their websites. Pages that are silent on disability, or mention it only in compliance-based language, may also indicate that disabled students are marginal or burdensome. This silence either renders disability invisible or only conditionally acknowledged and may inadvertently exclude applicants with disability (Shrewsbury et al., 2018).

There is considerable variability in higher education students' language preferences, with some preferring person-first, others preferring identity-first, and many preferring alternative phrasing (Lister et al., 2020). This nuance is important, with students reporting the language used by the institution would impact the likelihood of disclosing a disability (Lister et al., 2020). Furthermore, some students may not identify as 'disabled' or as 'having a disability.' Evidence from a large sample of students in Australia suggests that a key factor underlying non-disclosure of disability is students' perception that their self-identity does not align with a disabled identity (Grimes et al., 2019). This may be particularly relevant for neurodivergent students, as the growing narrative of the neurodiversity paradigm, informed by CDT, supports self-determination in how individuals define their identities and a move beyond language focussing on accommodations for deficits (Botha et al., 2022; Egner, 2019; Shaw et al., 2025; Shmulsky et al., 2021).

This aligns with established findings in medical education, and higher education more broadly, illustrating exclusionary systems, stigma, and ableism render claiming disability a troubled process (Brown et al., 2021; Brown & Leigh, 2020; Marom & McNeney, 2025; McNaught, 2013; Meeks et al., 2021; Stergiopoulos et al., 2018). The way institutions recognise and describe disability determines whether it is legitimised or valued in institutional structures and discourses (Jain, 2024). This aligns with CDT's focus on language as a point at which systems of power and marginalisation take effect. When admissions pages explicitly recognise disability as a valued dimension of diversity, they affirm that disabled students are welcome and expected in the profession.

Further language considerations relate to the use of specific terminology, which may be opaque to an applicant with limited familiarity with higher education or the medical context; this includes terms such as "Inherent Requirements" as well as medical terminology such as "take a history" or "auscultation." This opacity compounds the intersectional barriers to access for those with less social capital or without connections to healthcare or higher education (Horner-Johnson, 2021). Furthermore, invoking such concepts pre-admission asks applicants to determine their ability to conduct technical skills they have yet to learn. Clearly labelling and contextualising information, as well as reviewing content for unclear or specialised terminology, will assist with accessibility.

Ease of finding relevant information

Whilst some of the websites included a link to the institution's disability support service in the information provided to prospective applicants, in many cases

these websites were targeted at current students, with some even requiring a university login to access the full range of information and services available. Similarly, there was a paucity of information regarding the availability of reasonable adjustments for the admissions process itself. This is important given medical programs often require exams, interviews, written submissions, or other processes. While information about adjustments might be available on websites of third-party providers administering some of these tasks, the lack of information from schools, even regarding in-house processes like interviews, was notable.

Clarity regarding disclosure

Whilst several schools called for, or encouraged, applicants to discuss their circumstances prior to admission, only one school was rated as providing high levels of clarity regarding this process. This suggests many opportunities exist for improving institutional web pages' clarity. A useful first step might be to explicitly acknowledge that engaging in discussions with the school prior to application might constitute a disclosure of disability.

However, disability disclosure occurs in a space that illustrates some of the tensions in the legislative landscape. Institutions in Australia and NZ cannot mandate disclosure on application, deny access to courses on the basis of disability, nor approve a curriculum that may exclude a person with disability, requirements that align with social models of disability (Nuske et al., 2023; New Zealand Tertiary Education Commission & Achieve NZ, n.d; Australian Human Rights Commission, n.d). However, higher education institutions commonly require students to disclose a formally diagnosed disability to access adjustments, a practice more in keeping with medical models of disability (Nuske et al., 2023). In addition, this approach, whilst widespread, appears inconsistent with the protections afforded to those with imputed disability in the UNCRPD GC4 (UN Committee on the Rights of Persons with Disabilities, 2025), the Australian Disability Discrimination Act (1992) (Commonwealth Government Act, 2016), and the Australian Disability Standards for Education (2005) (Attorney-General's Department, 2005). That is, institutions are required to provide reasonable adjustments to students whom they might reasonably believe to have a disability (imputed disability), even in the absence of a diagnosis. The MDANZ Guidelines promote early discussions with disabled applicants but do not suggest that disclosure should be required or in any way linked with the application process. The Guidelines stop short of recognising imputed disability, which may be a focus of future revisions.

Potential applicants need clear information that outlines whether disclosure is required or recommended in the pre-admission context, to whom disclosures should be made, and how information will be used. This includes whether disclosure will have any bearing on their application or admission or on their future studies and experience in the program. Such discussions can justifiably be framed as opportunities for exploring possible reasonable adjustments and for developing a shared understanding of program expectations.

Pre-application discussions, therefore, may represent the first of many disclosures within the higher education context, a complex process of navigating risk, stigma, and potential benefits (Eccles et al., 2018; Evans, 2017; Stanley et al., 2011; Valle et al., 2004). Requesting disclosure before application requires applicants to take this leap before establishing a relationship with the institution. Disclosing a disability before application may feel like a significant risk, involving issues around self-identity, the potential for discrimination in the selection process, or ongoing impact on the learning experience (Eccles et al., 2018). To achieve safety in disclosure, students need to trust the institution (Wang, 2014). When trust is undermined, or students have a negative experience of disclosure, the perception of stigma will increase and lessen their likelihood to disclose in the future (de Cesarei, 2015). Using medicalised language and/or a deficit model to frame information on web pages, as we observed on many of the reviewed pages, is unlikely to engender trust and safety. Furthermore, using language that positions institutional actors as the authoritative decision-makers to determine disability and appropriate accommodations undermines a collaborative approach. Through a CDT lens, we see that safety in disclosure is not an individual issue but a systemic problem arising from the power imbalances and ableist structures ingrained in higher education (Eccles et al., 2018; Stanley et al., 2011).

A positive approach to pre-application discussions might frame these as exploratory processes, with educators as experts in program requirements and reasonable adjustments and the prospective applicant as expert in their own experiences and needs. To ensure effective and safe conversations, educators need training in disability inclusion and support from disability resource professionals with discipline-specific knowledge (Meeks et al., 2021). Disability resource professionals also need to be adequately resourced to support discussions with both potential and enrolled students

and to ensure nuanced discussions about the specifics of medical programs (Meeks et al., 2021). And critically, applicants need agency and opportunities for partnering with institutions in this process to advocate for their own learning needs. Schools that positioned pre-admission discussions as collaborative, constructive, and confidential were closer to achieving this ideal.

Sources of information for applicants

Appropriately framed resources such as the MDANZ Guidelines can support effective pre-admission discussions and provide structure or prompts for reflection. However, using *organic* IR as information sources for potential applicants remains problematic and exclusionary, extending the idea of disability as a risk to competence (Shrewsbury et al., 2018). Such documents may dissuade disabled applicants from engaging in further discussions or applying to study due to their framing of specific, essential embodied actions or qualities that may appear to exclude disabled people. In the Australian context, IR are not a requirement of most higher education governing or accreditation bodies (with some exceptions, including nursing (Tai et al., 2024)) and therefore the legal standing of these documents remains unclear, even to university administrators (McCandless et al., 2024). The continued use of IR may be reflective of residual inertia or risk aversion in the higher education and health professions sectors, where assurance of student capabilities is encoded in accreditation systems and regulatory frameworks that can be slow to evolve (Brett et al., 2016; Corcoran et al., 2024; McNaught, 2013; Tai et al., 2024).

Recommendations and reflective questions

As in the North American context, where comprehensive information is available to guide educators and disability resource professionals (for example: *Equal Access For Students With Disabilities: The Guide for Health Science and Professional Education* (Meeks et al., 2020)) Australian and NZ medical schools have access to local information and guidance (including the *MDANZ Guidelines* and the associated self-assessment tool for programs to evaluate their disability inclusion practices). However, our data demonstrate that there is often a significant gap between policy and practice. The development of consensus guidelines has not resulted in uniform adoption or effective use of these guidelines, a relevant issue for any program or governing body when evaluating implementation and use. To support this process, we have identified key questions that arose from our analysis. These questions are intended to guide program staff in evaluating their own public materials and could be applicable across the higher education sector (Table 3).

Table 3. Key questions to prompt medical educators' reflection on pre-admission guidance in public materials regarding disability inclusion.

- *Is information on the program's requirements clearly accessible, non-exclusionary, and described in a manner appropriate for applicants unfamiliar with higher education or discipline-specific terminology?*
- *Is information regarding possible adjustments and support structures clearly accessible prior to application?*
- *Are disabled applicants encouraged and provided with clear pathways (including contact details) to access further information and initiate discussions regarding program requirements and possible adjustments?*
- *Is it clear to potential applicants whether these discussions are confidential, constructive, collaborative, and clearly separated from selection processes?*
- *Is it clear to applicants whether disclosure is a requirement of application or enrolment or when, to whom, and why they may choose to disclose?*
- *What training and resources do staff need to effectively carry out collaborative discussions with prospective disabled applicants?*

Limitations and future research directions

In conducting this work, the research team was mindful of their insider/outsider status, it being particularly difficult to dissociate from insider status when examining public-facing websites. Researcher familiarity with the architecture of higher education web pages and the language of both higher education and medicine made it possible that there were additional barriers not evident to the researchers. This study also analysed only publicly facing information, which is an incomplete reflection of school and institutional practices regarding disability inclusion. Future studies could explore other aspects of the student lifecycle and correlate these data with enrolments of disabled students. We also must acknowledge the challenges of modifying and maintaining institutional websites, often jointly administered by multiple organisational groups within complex higher education institutions.

Conclusion

This analysis explores the ways that institutional recognition of disability—how disability is acknowledged and framed (Jain, 2024)—might shape the experiences of prospective applicants well before they enter medical training. The language used on admissions pages communicates the culture of the

medical school, including who belongs and under what conditions. This study highlights the critical role of implementing inclusive guidelines, such as those developed by MDANZ, in moving away from opaque and exclusionary language. Institutions that adopt these frameworks comprehensively (rather than tokenistically) are better positioned to support disabled applicants through accessible, strengths-based communication and collaborative disclosure practices. Positive initial interactions establish trust, respect, and safety, shaping the ongoing student experience (Wray, 2013). Institutions and educators can significantly impact disability inclusion early in the student lifecycle through simple amendments to public-facing information, for example, ensuring that disability is explicitly named and framed in a positive rather than deficit-focussed manner. Just as pre-admission information gathering is the first step in the student lifecycle, improving disability inclusion in program information is the first step in addressing ableist cultures in higher education and medical training.

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