

LAW

CASE STUDY

Assessment for inclusion: Promoting equity and justice in Disability Assessment Boards in India

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Abstract

This case study involves a successful medical aspirant with 88% mobility disability who was denied admission by the Disability Assessment Board (DAB). After failing to get relief from the High Court, the candidate challenged the decision in the Supreme Court. The Court ordered a reassessment by another DAB but found their approach — based on the medical model of disability — unsatisfactory. Consequently, the Court directed an independent functional competency assessment conducted by a doctor with a disability.

The new assessment adopted a human rights model of disability while offering opportunities such as simulation labs and detailed discussions on clinical accommodations to assess his abilities rather than focusing on his disability. The Supreme Court endorsed the ability-based assessment, critiqued the National Medical Commission's guidelines, and ordered the candidate's admission. Additionally, the Court directed the regulator to revise the existing guidelines, considering technological advancements, disability justice, and input from doctors with disabilities.

Keywords: *reasonable accommodation, disability, undergraduate medical education, inclusive medicine, competency based medical education*

Background

The Stage

We didn't go up to the stage
no one asked us, actually
only by pointing fingers
they showed us our place
and we sat there;
'Great', they exclaimed.
And they went up on the stage
started narrating to us our own sorrows
but, our sorrows remained ours
never became theirs...

—Waharu Sonavane [1]

The above poem by an Indian tribal activist in Marathi and cited in the SC judgment, highlights how reform movements led by outsiders (non-tribals) often further marginalise Adivasis by assuming they need a voice and a "saviour" to be liberated, heard, and respected [1]. This pattern of "othering" is also prevalent in Disability Assessment Boards (DABs), where history shows that able-bodied doctors often make decisions without considering clinical accommodations, thereby widening the gap between "us" and "them".

Here, we present the case of the first author, Om Rathod (OR), a student with 88% mobility disability (muscular dystrophy) who aspired to become a doctor and successfully passed the National Entrance Examination Test (NEET) 2024 for medical admission. According to the National Medical Commission's guidelines for admission of students with disabilities in the MBBS course (which are akin to the Technical Standards in the USA and inherent requirements in Australia), candidates with over 80% (88% here) mobility disability may be admitted to medical courses on a case-by-case basis after assessing their functional competence to meet academic and practical requirements [2].

During counselling to select a medical school, OR appeared before a DAB in Maharashtra, but they declared him ineligible due to his advanced 88% disability. Seeking justice, he approached the Bombay High Court, but the court also relied on the opinions of medical doctors — the presumed experts — and denied him relief. Disheartened, OR challenged the decision in the Supreme Court of India. The Supreme Court ordered a reassessment at an Institution of National Importance in New Delhi. OR, who had never seen an airplane before, travelled on one at short court notice and experienced the following:

On October 7th, I reported at 9:00 AM but waited 1.5 hours without clarity on the assessment's location. I was moved between wards and another building for a full-body X-ray. The process overly focused on my medical condition, with tests like climbing stairs, using door latches, walking with a file, switching electrical buttons, and strength evaluations by the PM&R Department. No effort was made to discuss reasonable accommodations or support for pursuing the MBBS course. When asked if I could handle its rigor, I confidently stated that I had successfully managed similar challenges during my school education.

The next day, the Medical Board again asked about my assistive devices but made no effort to explore other tools or strategies that could support me in completing the MBBS course, especially given modern technological advancements. I explained that I use a wheelchair, crutches, and an electric scooter. However, the Board did not raise specific concerns about tasks they believed I might struggle with during the MBBS course. If such concerns had been discussed, I could have addressed them and explained how I am equipped to overcome those challenges. Given my progressive disability, I may require human assistance to perform certain functions, even with the use of assistive devices. The use of human support as a facilitation measure for persons with disabilities is a well-recognized form of reasonable accommodation. Unfortunately, this aspect was not discussed with me by the Board at all.

The DAB at New Delhi concurred with the previous DAB's negative opinion. The report noted that the candidate was reassessed using assistive devices (single-hand crutch and motorised scooter), but there was minimal to no improvement in most disability components. While wheelchair usage was considered for better ambulation efficiency, no clear guidelines exist for assessing disability with assistive devices. The report also highlighted that safety, efficiency, and agility of movements are essential for independent device use. Lack of manual support, which may not always be available, could impact the candidate's safety and patient care during MBBS skills training in labs and hospitals [1].

The apex court believed that the DAB had failed to evaluate the functional competence of the candidate and accordingly directed one of us (SS) to assist the Court on whether, notwithstanding the quantified disability, the petitioner can pursue the MBBS degree course. In arriving at his evaluation, SS was requested to examine the petitioner and to have due regard to such assistive devices and their potential to assist the petitioner in fulfilling the requirements of the degree course in medicine.

Approach to inclusion

The purpose of clinical accommodations is to ensure that learners with disabilities have equal opportunities while maintaining academic standards [3] and NMC course requirements, rather than diminishing or compromising them. Accordingly, OR underwent functional assessment, which began with a detailed student interview — an interactive process to evaluate OR's functional limitations and barriers. Tables 1 and 2 show the process and questions asked (adapted from Moreland et al [4]). OR expressed concern about being treated differently now, despite having navigated life with this condition successfully. He was surprised that the previous disability boards doubted his abilities without offering opportunities like simulation labs or discussing reasonable accommodations. He felt anxious that his capabilities are being questioned without even giving him a fair chance.

Table 1. Understanding impairment, functional limitations and reasonable accommodations on case-by-case basis

Disability	Limb Girdle Muscular Dystrophy (mobility-related physical disability) 88%
Potential functional limitations	Inability to stand for long periods; difficulty transitioning from sitting to standing.
Potential barriers to learning	Lack of accessible spaces.
Assessment focus	Cognitive, psychomotor, and affective skills, along with the ability to diagnose using patient history and examination, as outlined in National Medical Commission's five roles of an Indian Medical Graduate under Competency Based Medical Education.
Reasonable accommodation	Given the limited space in clinical environments, Om's current use of smaller/compact scooters is appropriate. This allows him to meet the demands of a busy ward, OPD, or OT independently and is far more practical than a manual wheelchair, which often requires human assistance.

Table 2. Iterative inquiry questions regarding student's disability-related needs to arrive at clinical accommodations

1.	How does muscular dystrophy impact your daily life?
2.	How have you mitigated this impact in educational settings (Class X, XII)?
3.	What worsens or exacerbates your condition?
4.	Do you anticipate needing to step out of the curriculum for disability-related treatment?
5.	Have you observed or do you anticipate additional barriers in clinical settings (eg, competencies)?
6.	Have you reviewed the MBBS curriculum? If not, we can review it together to identify potential barriers.
7.	Have you used assistive technology to manage your disability?
8.	Are you aware of adaptive equipment for navigating clinical environments?
9.	What are your biggest concerns about entering the MBBS programme?
10.	What is your understanding of reasonable accommodation, which you mentioned in your affidavit?

Functional assessment

He was then guided through the Physiology and Pathology central labs, shown procedural skills, and later assessed for competence at the Medical Simulation Centre at SS's medical institution. To ensure transparency, the process was video-recorded.

OR was first shown how to record blood pressure using a mercury sphygmomanometer, elicit reflexes, and use a

tuning fork to check for deafness. He successfully performed these skills after a single demonstration, showcasing eagerness to learn. When given a foldable crutch to assist in standing, he instead demonstrated his own innovative strategies for navigating physical barriers.

In the lab, OR accessed two out of three examination tables, indicating that an adjustable table would be a suitable accommodation. At the Medical Simulation Centre, he performed Cardiopulmonary resuscitation (CPR) after guided instruction, starting with a baby mannequin to ease him into the process. Despite it being his first simulation experience, he successfully performed CPR, administered intravenous and intramuscular injections, and inserted a cannula.

To ensure accessible clinical rotations, the enabling unit or disability access coordinator at OR's medical school should collaborate with him to finalise accommodations before the preclinical, paraclinical, and clinical phases begin. Suggested clinical accommodations for all MBBS phases are listed in Table 3.

Determining accommodations to be reasonable

Four questions were posed, based on frameworks by Laird-Metke et al [5] and Singh et al [6]:

1. Would the proposed accommodation fail to meet the National Medical Commission's (NMC) Competency-Based Medical Education (CBME) requirements?
2. Would it jeopardise patient safety?
3. Would it improperly waive a core CBME requirement?
4. Would it impose an undue financial hardship on the medical school?

SS answered "no" to all these questions after an interactive process with OR and a faculty member with quadriplegia, who works effectively using assistive devices like Dextroware© headgear and an intermediary. With no valid objections, the accommodations were deemed reasonable.

OR's muscular dystrophy did not hinder his learning or self-care. He adapted quickly to new situations, using creative approaches to overcome physical barriers. For instance, while initially unfamiliar with certain physical skills in the MBBS programme, he demonstrated confidence in mitigating challenges using compensatory techniques.

SS further emphasised that one of the key concerns DAB often has is related to progressive disabilities. In the absence of clinical accommodations, such concerns fall within the realm of ableism [7]. The pan-India group *Doctors with Disabilities: Agents of Change* includes several specialist doctors with muscular dystrophy who are working to their full potential in both government and private settings. In *Iyer Seetharaman Venugopalan vs Union of India*, the Bombay High

Table 3. Proposed clinical accommodations

1.	<i>Clinical accommodations in Phase 1 MBBS (Anatomy, Physiology, Biochemistry) of 12 months duration</i>
	Ensure accessibility through ramps, elevators, and height-adjustable tables for wheelchairs or mobility scooters. Use adaptive tools like voice-dictation software for note-taking and patient data recording, a reflex hammer with a modified handle, and an electronic sphygmomanometer.
2.	<i>Clinical accommodations in Phase 2 MBBS (Microbiology, Pharmacology, Pathology) of 12 months duration</i>
	Microscopes must be accessible from a seated position. Laboratory sinks should include hand-operated options rather than relying solely on foot pedals. Provide compensatory time during OSPE (Objective Structured Practical Examinations).
3.	<i>Clinical accommodations in Phase 3 part I (Ophthalmology, ENT, Forensic Medicine, Community Medicine) and electives of 12+1 months duration</i>
	Use veterinary stethoscopes with extended tubes for dexterity challenges. Electronic or Bluetooth-enabled stethoscopes, as well as camera-based tools, can transmit images for skin, oral, or otoscopic examinations. Reflex hammers and tuning forks can be modified with foam grips. Devices like the Welch Allyn CellScope or PanOptic provide wider grips for ease of use.
4.	<i>Clinical accommodations in Phase 3 part II (Medicine and allied subjects like psychiatry, Surgery and allied subjects like Orthopedics, Obstetrics and Gynaecology, Pediatrics) of 18 months duration</i>
	Optimise rounding routes for accessibility by removing unnecessary furniture. Allow standing-powered wheelchairs and ensure rounds follow accessible pathways for students with mobility limitations. Use simulation centres for practice with Operating Theatre procedures. Provide standing or hydraulic lift wheelchairs, customised equipment, and compensatory time during OSCE (Objective Structured Clinical Examinations). Adapt scrubbing techniques for surgery and use intermediaries to assist with routine, non-clinical tasks
5.	<i>Mandatory internship of 1 year duration</i>
	Allow remote visual access via monitors or seated observation for minor surgeries. Use plastic specula without screws, textured surgical gloves, and alternative suturing techniques with ropes. Simulation labs can replicate trauma procedures to ensure skill development in an accessible environment.

Court initially denied an MD in Psychiatry to a doctor with retinitis pigmentosa, a condition that progressively led to 100% visual impairment. However, the Supreme Court later intervened, allowing him to pursue Psychiatry, which he successfully completed (in February 2025) [8]. Similarly, another doctor with progressive vision loss completed specialisation at an Institution of National Importance and is now a faculty member at another Institution of National Importance. SS emphasised that OR's progressive condition should not limit his potential. After completing the MBBS programme, OR could independently decide whether to continue as a general practitioner or pursue a less physically demanding specialty.

SS criticised NMC's guidelines and DAB's restrictive assumptions and ableist attitudes, proposing pathways for inclusion in his detailed 15-page assessment report (compared to the DAB's one-page report [1]):

1. Rename Disability Assessment Boards as Ability Assessment Boards.
2. Include doctors with disabilities or those knowledgeable about disability rights in the Boards.
3. Adopt a human rights model of disability for assessments.
4. Issue clear guidelines on clinical accommodations.
5. Train Boards on conducting disability-competency assessments.
6. Designate Enabling Units as contact points for clinical accommodations.

Outcomes

Quoting Judith Heumann, Martin Luther King Jr, the United Nations Convention on the Rights of Persons with Disabilities, the Rights of Persons with Disabilities Act, 2016 and the General Medical Council UK's *Welcome and Valued* guidance [9], the Supreme Court of India, in a landmark judgment on October 25 2024, directed the admission of OR to a medical school [1]. The Court instructed the school to refer to SS's report dated October 20, which outlines the accommodations OR may require. The apex court further directed measures to protect the appellant from any victimisation. The Court noted that it was compelled to order a functional competency test due to the failure of the previous two DABs to apply the legally permissible standard.

The courts also criticised the NMC's guidelines stating that they have fallen into disrepute by promoting self-rejection among disabled medical aspirants and assuming that accommodations would compromise competence or be futile. This resistance to adapting standards within a system that historically marginalises disabled individuals — except as patients — contradicts a rights-based approach to disability law. The apex court referenced a critique of the NMC guidelines, previously published in the *Indian Journal of Medical Ethics*, to emphasise this point [10].

Currently, persons with locomotor disability exceeding 80% are evaluated for MBBS admission to see if their disability can be "brought below 80%." However, disability is not something to overcome but to navigate, acknowledge, and accommodate. The term "brought below 80%" undermines this principle, as functional abilities vary and must be assessed individually. Disabled persons are not objects of pity but integral members of society and advancing their rights and their capabilities is a national imperative.

The concern that including disabled individuals would "lower medical standards" ignores the flaws in existing standards. A

system lacking practitioners with lived experience cannot fully address the obstacles faced by a diverse population [11], as empathy and inclusivity are vital to improving the quality of medical practice [1: paras 22, 23, 47, 49].

The apex court thereby directed the NMC to issue fresh guidelines for admitting persons with disabilities into medical courses by including experts with disability or persons who have worked on disability justice.

Lessons learned

The Supreme Court of India has provided a clear pathway for inclusive assessment in medical education. The key question for DABs is whether a candidate with a disability, supported by modern scientific tools and assistive devices, can pursue an MBBS programme. In other words, DABs must determine if it is *infeasible* for the candidate to pursue a medical career with their disability.

The Court directed DABs to move away from the rigid benchmark model of calculating disability percentages and focus instead on functional competence [12], ensuring fairness, transparency, and alignment with legal and constitutional guarantees. To prevent arbitrary or inconsistent procedures, individuals must be informed in advance about the procedures, standards, tools, and other relevant aspects of the assessment [13].

The Court reaffirmed that the absence of reasonable accommodations constitutes discrimination [14]. It highlighted that including persons with disabilities in the medical profession would improve healthcare quality and uphold the constitutional virtues of fraternity and equality. The NMC was further directed to create a database containing information on accessibility and reasonable accommodations to assist future aspirants during the application process.

One of the most impactful aspects of being a healthcare provider with a disability is the level of comfort patients may feel when asking questions about their health issues. This sense of shared humanity can help patients feel less vulnerable and more willing to ask for support. This quality of deep, personal empathy can be felt in the care provided by physicians with disabilities to all types of patients — with and without disabilities [15]. This also support the hidden curriculum that all individuals have access needs, whether visible or not, whether acute or chronic impairment.

The humility that stems from the disability experience may impact a medical student's openness to learning. The tenacity and strength that persons with disabilities must develop, along with the corresponding humility felt in their patient role, often fuel their motivation and willingness to learn. In our population of underserved health care, physicians with disabilities not only comprise a diverse workforce but also help in mitigating health disparities experienced by the disabled population [16].

Next steps

This judgment is a watershed moment in the history of inclusive medicine in India. Not only has the medical regulator been directed to revise the guidelines for admission of students with disabilities in the MBBS course, but the Court has, for the first time, recognised lived experience as a form of expertise. Additionally, the Enabling Units (mandated by the University Grants Commission [17]) at medical schools — similar to disability resource/service providers in the USA — will serve as points of contact for applicants with disabilities seeking clinical accommodations.

As per the judgment, students must be informed about the Enabling Units and Equal Opportunity Cells through the information booklet for new MBBS students, the college website, and the Equal Opportunity Policy. Furthermore, the NEET application portal must include details about the accessibility compliance of various colleges to help prospective students with disabilities make informed decisions.

The above case study highlights a dual approach to promoting equity and disability justice. A top-down approach, driven by strong judicial support, ensures affirmative actions and compels institutions to adopt inclusive policies. Simultaneously, a bottom-up approach focuses on fair, rights-based assessments that prioritise functional competency over rigid impairment benchmarks. By identifying reasonable clinical accommodations, DABs empower candidates to succeed. Together, these approaches challenge ableist assumptions and foster an inclusive environment that values ability, innovation, and lived experiences, advancing equity and accessibility in the medical profession.

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Group Positionality Statement: Our varied positionalities informed this work. All of us are persons with varied lived experience of disability with different backgrounds. We are medical student (OR), lawyers (PD and RB), physician and researcher focused on disability in medicine (SS), founder of national collective on disability access (RB and SS) and from different socioeconomic status and four different states. We drew on these lived experiences to inform this scholarly work.

Conflict of Interest: OR is the petitioner in the Supreme Court judgment on *Om Rathod vs DGHS, 2024*; SS is the expert assigned by the Supreme Court in the matter of *Om Rathod vs DGHS, 2024*; PD is one of the Counsel for petitioner in the case; RB provided legal guidance after Bombay High Court decision.

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