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Bridging the Divide in Cancer Screening for People with Disabilities: Barriers and Recommendations

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EXECUTIVE SUMMARY

People with disabilities represent one of the largest and most heterogeneous populations in the United States, spanning all ages, ethnicities, and socioeconomic backgrounds.[1] In fact, nearly one in four American adults (approximately 50 million individuals) lives with at least one disability.[2] Across wide variation in types of disability, studies have indicated that people with disabilities consistently experience disparities in healthcare access and quality, including lower rates of care satisfaction, higher rates of unmet medical needs, and reduced access to preventive health services.[3] Consequently, people with disabilities exhibit lower cancer screening uptake and are disproportionately diagnosed at later stages, contributing to negative health outcomes. Overlapping systemic and structural barriers have generated gaps in healthcare delivery that fail to adequately account for the needs of people with disabilities. Barriers across clinical practice, healthcare infrastructure, and health communication collectively limit timely and effective screening for people with disabilities. These challenges are especially evident in breast and cervical cancer screenings, where disparities are well-documented and show that people with disabilities receive fewer screenings for these cancers. Addressing these systemic gaps is essential to improving early detection, reducing preventable morbidity, and advancing equity in cancer care.

KEY FINDINGS

- People with disabilities face multiple, overlapping, structural, and systemic barriers that limit access to timely and high-quality cancer screenings.
- Access barriers to cancer screening include inaccessible equipment and facilities, difficulty with transportation to appointments, limited staff and provider training, provider bias, non-inclusive screening guidelines, and poor communication.
- People with disabilities experience significantly lower breast and cervical cancer screening rates leading to delayed diagnoses, more aggressive spread, larger tumor sizes when cancer is detected, and adverse health outcomes compared to non-disabled populations.
- Addressing the structural, informational, and systemic barriers to care are critical to improving low cancer screening rates among people with disabilities.

BACKGROUND

People with disabilities face significant disparities in cancer risk, screening, and treatment. Individuals with disabilities are often more likely to experience several risk factors associated with cancer, including smoking, obesity, and physical inactivity.[4] They are also more likely to have lower incomes and lower levels of educational attainment on average, both of which are well-understood predictors of minimal cancer screening uptake.[5] Studies further suggest that even after controlling for factors including age, race, and socioeconomic status, patients with disabilities may experience higher rates of breast, cervical, colorectal, and prostate cancers.[6] As people with childhood-onset disabilities (like cerebral palsy) are living longer than they did a generation ago, these numbers are expected to rise.

Despite these increased risks, guidance on cancer care for people with disabilities is limited. Women with disabilities, in particular, have consistently lower rates of preventive cancer screening than women without disabilities.[7] Given the population-level screening guidelines established for breast and cervical cancer, disparities in access and uptake among women with disabilities are more consistently researched and reported for these cancers than for other cancer types. For example, women with disabilities have a 22% lower likelihood of receiving regular breast cancer screening and a 48% lower likelihood of receiving cervical cancer screening compared to women without disabilities.[8]

Over the course of four conversations, Jane (a pseudonym) described her experience navigating significant barriers to breast cancer screening and diagnosis, as a woman with cerebral palsy. In June 2024, Jane underwent a screening mammogram that did not detect any abnormalities. She felt, however, that the technicians were unable to comprehensively perform the exam due to her seated position in a wheelchair and the accessory breast tissue that extended around her body. Despite a strong family history of breast cancer, Jane was not offered supplemental screening referrals such as an MRI, ultrasound, or genetic counseling. Her efforts to obtain further imaging were impaired by scheduling confusion, limited provider knowledge regarding accommodations for wheelchair users, and lack of insurance coverage. In December 2024, despite reporting pain and trouble breathing, Jane was reassured by physicians that her symptoms were unlikely to be cancer-related since cancer does not typically cause pain.[9] The clinicians' reliance on such generalized assumptions reflected "diagnostic overshadowing," the attribution of a patient's symptoms to their pre-existing conditions, rather than considering other causes.[10] Together, these barriers resulted in fragmented care and delayed Jane's official diagnosis by approximately 8 months. In August of 2025, she was finally diagnosed with incurable Stage 4 Breast Cancer. Jane's story illustrates how gaps in accessible screening practices, provider awareness, and care coordination can contribute to delayed diagnosis and treatment for patients with disabilities.[11]

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Rather than serving as an isolated case, Jane's experience reflects a broader trend within healthcare for people with disabilities. In fact, from 2010 to 2018, 83% of women in the United States without disabilities aged 30 years or older reported receiving a mammogram within the past two years compared to only 77.1% of women with chronic mobility limitations and 71.4% of those with complex activity limitations. Moreover, data from 1998 to 2010 suggests that women with mobility impairments are 50% less likely to pursue mammography screening compared to their non-disabled counterparts.[12] Similar gaps also exist in cervical cancer screening within the past four years during which the general population screens at 70.9% and those with disabilities screen at 63.5%. [13]

Percentage of U.S. women 30 years old and older who reported receiving a mammogram within the past two years (2010–2018)

Without Disabilities	83%
With chronic mobility limitations	77.1%
With complex activity limitations	71.4%

BARRIERS FACED BY PEOPLE WITH DISABILITIES IN CANCER SCREENING

Patients with disabilities face multiple, overlapping barriers to cancer screening that limit their access to timely and high-quality care.

For example, consider Fatima, a hypothetical patient, who was in a motor vehicle accident at age 26 and sustained a high thoracic spinal cord injury that left her paralyzed from the waist down. Before the accident, she had received an abnormal cervical cancer screening result that required follow-up care. When Fatima arrived for her appointment, however, the room was too small for her wheelchair, and the exam table could not be lowered. The provider seemed uncomfortable and unsure of how to position Fatima safely for proper examination. Moreover, her physician assumed that she was not sexually active, given her mobility limitations. Rather than discussing possible accommodations or alternative screening options, the provider stated the exam would be "too difficult" and advised her to come back another day. Fatima felt confused and embarrassed. Since no one explained that an effective self-sampling screening option existed or that serious consequences may arise as a result of delaying follow-up screenings, Fatima postponed care for over a year.

Fatima's scenario exemplifies the broader barriers many women with physical disabilities face when obtaining cervical cancer screening. At the provider level, limited disability-specific training, implicit biases, misguided assumptions, and poor communication result in clinician ableism, diagnostic overshadowing, and inadequate screening referrals. Structurally, inaccessible healthcare facilities and medical equipment, along with often contradictory and poorly implemented accessibility guidelines, also lead to delays in cancer detection and treatment. Together, these factors can perpetuate disparities in cancer screening and hinder informed decision-making for patients.[14]

Lack of Provider Training & Subsequent Communication Barriers

Many physicians report uncertainty about how to discuss cancer screening with patients who have disabilities, particularly when they feel they lack adequate training to address disability-related needs.

Implicit and existing biases among medical professionals towards people with disabilities can severely inhibit the quality of care provided to these patients compared to patients without disabilities.[15] For example, assumptions that women with disabilities are not sexually active and therefore do not need to be screened for cervical cancer is false.[16] A study surveying physicians across the United States found that only 57% of physicians strongly agreed that they welcome people with disabilities to their practice.[17] Moreover, **though participants felt they had greater knowledge of their own disabilities than their providers, their expertise was often dismissed**.[18] By undervaluing patients' understanding of their disabilities, providers foster negative experiences with patients. Poor provider attitudes, a lack of sensitivity, and limited knowledge about disability-related needs can lead to diagnostic overshadowing, providing insufficient information to patients about screening procedures and options, and the failure to refer patients to further screening procedures.

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Lack of Accessible Equipment and Facilities

Healthcare facilities remain physically inaccessible for many individuals with disabilities, in terms of lacking structural features like ramps and accessible scanners, as well as communications aids like braille on doors, informational packets, and American Sign Language (ASL) interpreters for deaf people.[19] Notably, focus groups of women with mobility disabilities identified the lack of functional, accessible equipment in screening facilities as a major barrier to care.[20]

Positioning during screening presents an additional challenge, particularly for wheelchair users who may be unable to stand, raise their arms, or maintain the positions required for screening procedures.

Standard screening procedures often require patients to stand, transfer, or maintain specific physical positions that may not always be feasible for individuals with mobility impairments. Furthermore, facilities with accessible equipment may not be geographically accessible, forcing people with disabilities to travel longer distances for appointments. This problem is magnified by the fact that many types of transportation are inaccessible for people with disabilities, leading to increased cost and scheduling burden for the patient.[21]

The failure to incorporate accessibility standards for medical equipment and cancer screening procedures into professional guidelines for physicians has limited their effectiveness. Although accessibility guidelines exist, they are inconsistently followed due to a lack of enforcement mechanisms or penalties for noncompliance.[22] Physicians often also lack knowledge of how to implement these guidelines in practice, further compounding barriers to care for patients with disabilities. While the ACR Practice Parameters for breast imaging are used frequently by clinics, they provide minimal direction for how to accommodate disabled patients. These guidelines fail to sufficiently address how screening procedures can be tailored to the needs of individuals with physical limitations or mobility restrictions. Other imaging and diagnostic procedures, including breast ultrasound and biopsies, similarly lack explicit recommendations for accommodating people with disabilities.[23]

Although the Americans with Disabilities Act (ADA) established accessibility standards for physical spaces, it did not initially address non-fixed medical equipment such as exam tables and mammography machines. Federal accessibility standards for medical equipment were later established under the Affordable Care Act (ACA) and finalized in 2017. However, enforcement remains limited; the Department of Justice recently withdrew rulemaking for accessible medical equipment, making compliance voluntary. As a result, healthcare facilities are no longer required to adopt these standards and may choose whether or not to implement accessible equipment, contributing to ongoing gaps in quality cancer care for patients with disabilities.[24]

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Lack of Knowledge About Cancer Screening and Available Options

Many individuals with disabilities are not cognizant of why cancer screenings are important and how to prepare for such procedures, which can reduce engagement and preventative care and increase anxiety and fear in patients. This gap is further exacerbated by inconsistent or insufficient communication from healthcare providers, as patients often report not receiving clear or reliable information about screening recommendations, options, or processes.[25] Accessible educational materials are often limited, with few resources available in formats that can accommodate the varying cognitive and communication needs that people with disabilities may have (e.g., braille, ASL).[26] Lower health literacy, often associated with socioeconomic factors such as education and income, can also further compound disparities in screening uptake.[27]

An instructive example of how screening guidelines can be redesigned to reduce these barriers, however, comes from cervical cancer screening. As of January 2026, The Women's Preventive Services Initiative (WPSI), supported by Health Resources and Services Administration (HRSA) and covered by the ACA, approved self-sampling with primary HPV testing for all women.[28] **Under these updated guidelines, asymptomatic patients are no longer required to undergo a speculum exam to be screened.**[29] By establishing patient-collected hrHPV (high risk human papillomavirus) testing as the preferred screening method for women aged 30 to 65 years at average risk, these guidelines demonstrate how screening policies can adapt to reduce physical barriers, improve patient comfort, and increase screening uptake. [30]

Some healthcare systems have already begun implementing this screening approach, with Michigan Medicine recently adopting patient-collected hrHPV testing as the default method for all asymptomatic cervical cancer screenings. In fact, a study found that 66.1% of women with physical disabilities believed that self-sampling, instead of the traditional speculum examination-based screening, would increase the likelihood they would obtain cervical cancer screening in a timely manner in the future.[31] **These patients preferred self-sampling due to increased convenience, autonomy, and a greater sense of empowerment.** Therefore, self-sampling offers a promising solution for people with disabilities, allowing them to collect samples in the privacy of their homes.[32] However, significant barriers still limit the widespread use of this screening method.

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Contradictory Screening Guidelines

Professional medical organizations are often responsible for establishing guidelines for cancer screening. However, inconsistencies within the guidelines published by these organizations may prevent people with disabilities from adequately accessing care. Recommendations for preventative screenings may often evolve and conflict, making it difficult for patients to navigate appropriate care and can foster uncertainty.[33] While the U.S. Preventative Services Task Force (USPSTF) recommends biannual mammograms for women aged 40 to 74, other organizations such as the National Comprehensive Cancer Network (NCCN) and the American College of Radiology (ACR) recommend initiating screening at age 40 with annual interval screenings.[34]

Breast and cervical cancers have historically been detected at later stages in people with disabilities, with larger tumor sizes at diagnosis and higher mortality rates compared to non-disabled patients.

In addition to conflicting recommendations, existing guidelines often fail to adequately address the needs of people with disabilities. For example, when standard screening methods are inaccessible, providers may rely on less effective alternatives such as clinical breast exams (CBE). While this screening method is often framed as a more accessible alternative to traditional mammography procedures, the U.S. Preventative Services Task Force (USPSTF) finds insufficient evidence to support CBE as a primary screening tool and cautions against its risks, such as false positives and unnecessary follow-up procedures.[35]

Even when CBE is used, wheelchair users are often seated upright rather than supine on an examination table, reducing the accuracy and quality of CBEs.[34] Consequently, CBE should be avoided on asymptomatic women regardless of disability. Moreover, if patients exhibit symptoms, they should be referred immediately to ultrasound or imaging as CBE will never be useful.

Patients forced to reschedule imaging or biopsy procedures due to lack of appropriate equipment or staffing support also face delays in diagnosis, which can extend for weeks and permit the progression of disease in the interim period. As a result, breast and cervical cancers have historically been detected at later stages in people with disabilities, with larger tumor sizes at diagnosis and higher mortality rates compared to non-disabled patients.[35]

CONCLUSION & RECOMMENDATIONS

Ensuring patients with disabilities are afforded high quality of care and timely screening requires an analysis of systemic barriers and gaps in care delivery. The following recommendations focus on improving provider practices, patient support, and accessibility in order to improve screening outcomes for people with disabilities.

1. **The Accreditation Council for Graduate Medical Education (ACGME) should mandate disability competency training for healthcare providers.**
    a. Implementing training tailored to the needs of people with disabilities can increase clinician confidence in treating these patients and encourage the recognition of patients as experts in their own care.
    b. Enhancing provider training can reduce diagnostic overshadowing, minimize patient-physician communication barriers, and encourage screening uptake among people with disabilities.

2. **Healthcare facilities should develop accessible educational and decision-support resources to help patients and caregivers.**
    a. Improving access to clear, layman-friendly information about cancer screening, including why it is significant, the options available (including self-collection of samples), and what the procedures entail, can help address communication gaps, increase patient understanding, and support more informed decision-making.
        i. This can include pamphlet handouts in clinics and billboard advertisements underscoring national guidelines for screening, such as the recent approval of primary HPV testing with self-sampling for cervical cancer screening.
        ii. Pamphlets should be accessible, with large font sizes and/or braille for patients with vision deficits.

3. **The Department of Justice (DOJ) and the Department of Health and Human Services (HHS) should collaborate to improve federal enforcement of accessibility standards for medical equipment and healthcare facilities.**
    a. Strengthening enforcement mechanisms can ensure that hospitals and cancer clinics are equipped with accessible infrastructure and adaptive equipment, minimizing physical barriers and ensuring patients with mobility impediments feel more supported in their care plans.
    b. Providing patients with tools that ease decision-making and help interpret guidelines can empower patients and mitigate confusion.
    c. Establishing clear regulations requiring timely communication, transparent information sharing, and prompt review of documentation among providers and insurers across a patient's care continuum can prevent delays in patient care.

4. **Professional medical societies and federal agencies should collaborate to establish standardized cancer screening guidelines tailored to people with disabilities.**
    a. Encouraging professional medical organizations and federal agencies to collaborate in publishing consistent, disability-inclusive guidelines for screening across organizations can reduce confusion for patients, ensure timely screening, and prevent delays in diagnosis.
    b. Promoting the development of universal screening methods, similar to the newly updated cervical cancer guidelines that prefer self-sampling, can mitigate the physical and emotional barriers to care.

5. **Cancer researchers should integrate Community-Based Participatory Research (CBPR) approaches when designing interventions that aim to improve cancer screening rates.**
    a. Establishing patient navigator programs that allow patients with disabilities to support current patients in navigating screening can build trust and ensure that patients have a support system.
    b. Including patients with disabilities in clinical trials and engaging them as partners in policymaking processes can ensure that interventions reflect lived experience, rather than top-down assumptions.
    c. Leveraging community organizations to disseminate messaging regarding updated guidelines, including patient-collected hrHPV as the new preferred method for cervical cancer screening can increase screening uptake.

Strengthening provider training, improving patient education, enforcing accessibility standards, advocating for the standardization of guidelines, and centering lived experience in intervention design are critical to promoting equitable access to cancer care. Together, these strategies aim to enhance patient-provider communication and institutional accountability, thereby reducing delays in diagnosis and increasing screening uptake among people with disabilities.

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