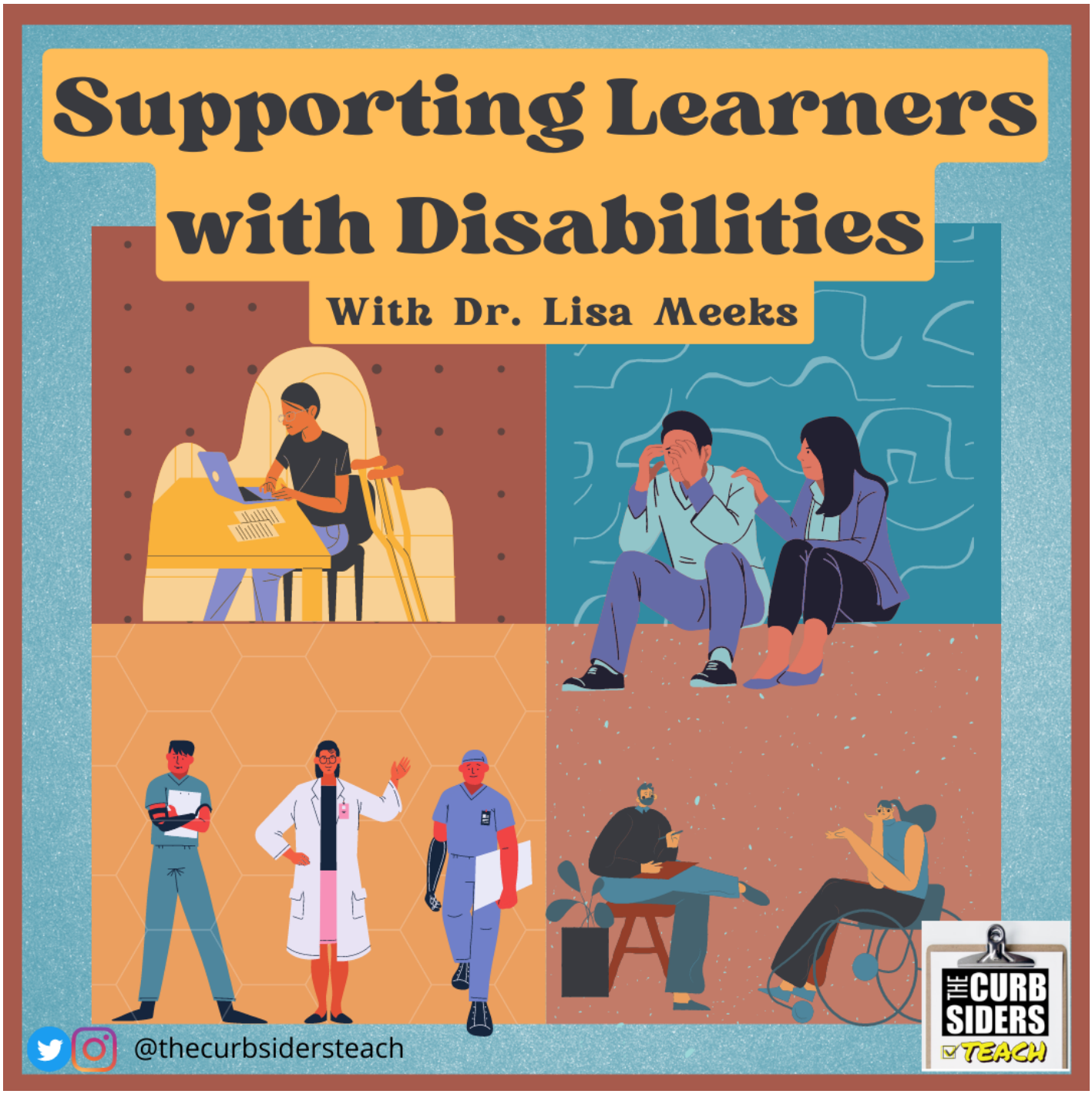
#23 Supporting Learners with Disabilities

With Dr Lisa Meeks



[Introductory music]

Intro [male voice]:

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[Wonky electronic noises followed by cheerful, slightly funky electronic music.]

Dr. Molly Hueblein (MH):

Welcome back to the Curbside Teach. We are so excited to share our last episode in season two, but we look forward to being back with you in 2023. I'm Dr. Molly Hueblein, joined by my co-host, Dr. Era Kryzhanovskaya. On tonight's episode, we'll discuss supporting learners across all abilities with Dr. Lisa Meeks. Before we get started with that, Era, will you remind the audience what we do on this show?

Dr. Era Kryzhanovskaya (EK):

Sure, Molly. We are *the* Internal Medicine podcast for all things medical education. We use expert interviews to bring you teaching pearls and practice-changing knowledge to inspire the next generation of medical educators. And tonight we had an amazing conversation with our guest, Dr. Lisa Meeks. We challenge our ableist approach in medicine. We review ways to support learners with disabilities, talk about best practices for entering students, ways institutions can improve and follow ACGME guidelines, and so many resources to learn more and just get better.

MH:

Lisa M Meek PhD is the lead investigator at the Meeks Research Group and Director of the Docs with Disabilities Initiative and host of the Docs with Disabilities podcast. She holds appointments in the departments of Learning Health Sciences and Family Medicine at the University of Michigan Medical School. Dr. Meek served as a co-PI and lead author of the AAMC Special Report on Learners and Physicians with Disabilities, and currently serves as disability lead for the ACGME Equity Matters Initiative. A reminder that most episodes are available for free CME credit through VCU Health CE for all health professionals at curbside.vcuhealth.org. All you have to do is create an account.

MH & EK [slightly out of synchronicity]:

So without further ado

MH:
Let’s get to it.

EK:
Let’s get to it. Love it.

MH:

Dr. Meeks, thank you so much for coming on the show, being our last guest of season two. We're so excited to talk with you! Do you mind if we call you Lisa for this recording?

Dr. Lisa M. Meeks (LM):
Oh, please do. It's my preference. [Laugh.]

MH:

Thank you. Well, we would like to just start with some rapid-fire questions to get to know you a little bit better. Could you give us a one-liner to describe yourself?

LM:

A 52-year-old faculty member at the University of Michigan Medical School—go Blue—focused on disability and medicine. I'm a lover of books. I'm a—a ‘GG’ to the best grandson in the absolute universe, wife, mother of two, love of hula hoops, music festivals, and big dogs.

MH:

Love it.

EK:

Wow. I love that. Well, speaking about books, maybe Lisa, you could share a book or movie or show—something that you've enjoyed recently that you’d like our audience to hear about?

LM:

Yeah, there's a great book that I gifted to many of my friends during covid. It's called *When Things Fall Apart, Heart Advice for Difficult Times*, and it's based on kinda Buddhist teachings about how we live our lives when things around us are falling apart and how we are kind of continually overcome by fear and anxiety and pain. And our MO is to run away from it, right? And the book talk teaches you—talks about—moving towards the pain, kind of situating yourself in it instead of running away, which can be really opening for our hearts and, and challenge us in different ways.

MH:

That sounds like a great resource for all of us in these times, so thank you for sharing that. Do you have a favorite failure that you'd feel comfortable sharing with us and and what you learned from that?

LM:

Just one? [Laughing.]

Oh gosh. Especially for the trainees, I want them to hear or read that there are so many failures, you know, by the time you've gotten to this point. But each of them is such an important, I think, opportunity for the place that I am today. It's a wise teacher, that failure, and it really forces you to slow down and take stock and reexamine. So I think it's something that's really good for us, actually. And so for me, it's not a failure, it's an opportunity for growth, *but* I have had many detours on the path to my career. And

the biggest detours or failures I think have been when I applied for a position or a fellowship or my first faculty roles and wasn't hired. And now all the time, I—I would say on a monthly basis, I think back to those institutions or those training centers and I think, oh my gosh, I'm so glad I didn't get that job. Or, I'm so glad I didn't get that fellowship because I wouldn't be where I am.

MH:

I love that. I feel like it's something we hear over and over again that you have this idea of what this is: I need this to have my career be perfect. And then when you don't get it, it's, it's really, really hard. But then after the fact that opens up new possibilities and actually sometimes is a blessing.

LM:

Mm-Hmm.

EK:

Totally. That reminds me of a very painful but very true adage of like, 'when one door closes, a window opens.' And I have had to painfully experience that, but when you were speaking about it, Lisa, I just felt it come to life, like kind of that there might be something that's just there waiting that's even better. And maybe on the topic of kind of things that—ways to improve and continuous, kind of, growth opportunities, maybe you could share with our listeners some meaningful advice or feedback that you received during your career.

LM:

Yeah, so especially to the parents that are listening, the parent-physicians, you know, we're always solving problems, right? Handling everything, coming up with solutions. And the dean of students at my institution that, that I was practicing at when my daughter went to college told me not to solve in—not to jump in and solve problems, and that there would be these challenges that occurred in the first year of being away from home. And that the best gift that I could give her was 12 hours between the time that she asked and the time that I responded and to kinda support her or give her space to develop her own response and problem-solving skills. And I have to tell you, is it, it, to this day is the best advice that I received. I applied that to my son as well, and they're—both of my kids are total bosses—but they have a confidence that comes from failing, right? And figuring it out after or being solution-oriented when they didn't have mom or dad to solve the issues. And life is full of challenges. So I would say that's the best advice that I got.

MH:

I love it. Era, do you have a pick of the week that you wanted to share?

EK:

I do. Molly, you know, this is one of my favorite times. So recently I was on a plane because I find I spent a lot of time on planes recently and I saw this movie called *Marcel the Shell with Shoes On*. I don't know if y'all are familiar with this little one-Inch shell. Well, basically it's a mockumentary kind of comedy-drama based on a shell which has had a YouTube video kind of presence for a long time. And it's this little shell that is living in an apartment that is, or in a house, that's kind of an AirBnB for people after the owners kind of separated and moved out. And anyway, it's a long story to say that this is one of the funniest laugh out loud movies I've seen in a long time. Like, there's so many one-liners about this shell. Like, one of her quotes is—or, one of his quotes is, 'my name is Marcel and I'm partially a shell. And as

you can see on my body, I also have shoes and like a face, and I love that about myself.' And it's these little one-liners y'all that just make me laugh. And it goes from kind of really big issues around friendship and family cuz he lives in this house with his grandmother and what happens around that. And, and also really funny kind of adult jokes and adult humor too. So if you're looking for something just totally random, kind of mockumentary Marcel the Shell with Shoes On, is really funny.

MH:

Cool. Is it kid friendly?

EK:

Yes. Because I think some of the jokes are like, very well done that takes an adult to kind of recognize them.

MH:

--So that it would just go over their head and they could enjoy the shell. Perfect. Yes.

EK:

I wanna, I wanna say that. I feel like I need to remember what it's rated. That's okay. But I think it's OK. [Laugh.]

LM:

I think Disney and Pixar have two sets of writers, right? They have one set that's writing for the kids, and then they have this other set that's writing the dry humor for the parents so that they can sit through all of these movies.

EK:

[Laugh.] Totally, totally. Yeah. Yeah. I think it's nominated for some show—for some like, best animated film, most emotionally moving picture award, things like that. Really highly strong cinematic powerhouse. Anyway, Molly, what's your pick?

MH:

I'll look into it. In the interest of time, I'll skip today, but let's jump into our case from Kashlack Memorial. We have Jennifer, she's a fourth-year medical student with Ehlers-Danlos Syndrome, type three, the hypermobile type. She lives with chronic joint pain related to her EDS and her condition limits her ability to stand around for long hours at a time. She requires assistive technology like dictation software and ergonomic keyboards to manage hand and arm strain. During medical school, she has had disability accommodations to allow her to complete her rotations with a flexible schedule and assistive technology. She's meeting with her mentor today and hopes to discuss how she should approach accommodations during residency and how she should vet a residency program regarding their accommodations during the application or interview season. So to start out, Jennifer is a person who's experienced a chronic medical condition that has impacted her interactions with the healthcare system and her understanding of health and illness. This can certainly provide her with a deeper ability to connect with patients with chronic conditions. And Jennifer has faced a lot of challenges in order to get to the meeting with her mentor today. I wonder, Lisa, if you could help guide us through the history of health professions education, interactions, and support or lack thereof for learners of varying abilities.

LM:

Yeah, I think, you know, the medical model for a long time really has—or the medical profession, sorry, has used the medical model of disability to kind of inform how we think about people with disabilities. And, and unfortunately this includes trainees and physicians as well. So, when we think about and we evaluate people through this model, it almost bifurcates our understanding of whether they're in the ingroup or the outgroup, right? It's an us versus them mentality with the, the outcome being that people that are patients are not also providers. So that's, that really kind of sums up what the thinking has been for so many years. And at the heart of all of this is this idea of, of ableism that people are less than if they have a disability or they're different and they require fixing. And if we can't fix them as a medical practice, as as a medical community, then they don't belong here.

And I think that's, that's been the biggest thing that has informed all of the barriers across UME and GME. And so there have been many physicians with disabilities, but fewer than there are now, that have gone through medical training and have become physicians. But when they were making their way to practice, most of them did so because of individual mentors. So somebody that believed in them, or an institutional facilitator who perhaps used their political and social capital or their privilege to sponsor the individual. So these success stories were first, few and far between, but when they were successful, it really wasn't because of the institution.

And if you fast forward to maybe 2010, there are several disability advocates and researchers, physicians, leaders, and especially in the PM&R space who were fiercely fighting for change and, and access change in things like technical standards. And they made a lot of progress. There were a lot of publications for a while, but I think that when the AAMC released their 2018 report on disability inclusion, there was kind of a sea change of thinking about this. And it really was brought to front-of-mind for medical educators and also situated in that DEI space. And I think that was an important shift. You know, in the years since then, like since 2018, I, I know our research team has done a lot, we have a lot of robust research on the topic, and this has helped expand attention to it. And then you had people like the ACGME come in and make regulations at the program level and at the institutional level that really kind of helps solidify that, hey, this is a thing and we need to be paying attention to it.

EK:

And I wonder, Lisa, thank you so much for that historical background. With including your own work and including the hashtag #DocsWithDisabilities and kind of the movement there. I wonder, how did the—what were the grassroots kind of startup for that? Or how did it develop and how has it grown and evolved in the setting of both the 2018 report and then these you know, standards that were put in place?

LM:

Yeah, well, I think following the report, we kept thinking, you know, we had interviewed so many people for the report, for part of the qualitative data, but we couldn't tell their stories. These, these were little snippets of, you know, who they were and what they had been through. And it was a real shame. I felt like we lost a lot of rich data in just presenting these themes and quotes. And so one of the things that I really wanted to do was help bring the idea of the disabled physician or the physician with a disability to the population and normalize it. To say, hey, there are literally not just 15 people. There are thousands of people with disabilities, and just because you don't know they exist doesn't mean that they're not here. And so two things happened at the same time. I shifted to Michigan and became a research professor, which gave me a lot of space and room to really focus on this.

And, we started the Docs with Disabilities campaign, which shared stories through a hashtag campaign and through the podcast so we could get more and more richer data and elevate the voices and the stories of the people that this impacted the most, which was the trainees and the physicians that were out there on the field. And I think the data is really important because it gives us an empirical story, right? When something is published it becomes magical [laugh]. So I always think about the story that we're telling in this data, which is for my, for my lab mostly quantitative. But when you pair it, almost like, you know, dressing something with rich tapestry and this of the stories of these people, it becomes even more enormously impactful because you have this empirical data, but you also have this extra, right, these stories that help explain what the data's trying to say. So I think that's one thing that has happened.

Timing is everything, right? And so the other thing that's happening simultaneously is that we are getting what I call a post-ADA generation of learners. And these learners are showing up having been accommodated, feeling comfortable being accommodated, feeling comfortable applying to and, and entering medical training. And they bring a sense of disability pride that I haven't seen in my—gosh, I used to say 20 years, but now I guess it's almost 30 years—of work. And this disability pride is, is underpinned with a clear understanding of their rights as well. So as these trainees enter our programs, we are being tasked with understanding our responsibility in this space, not only to be equitable and to provide the legal threshold for accommodation and inclusion, but also how important it is to build a just and equitable workforce.

So it's not just people coming talking about disability. They're talking about anti-oppression, they're talking about anti-ableism, they're talking about racism and supporting LGBTQ folks. So I think we're gonna see a whole different generation of physicians in the next four to five years. And I'm so excited for it. I think the language—you asked about the language and what we use now—you've heard me go back and forth between person with a disability, docs with disabilities, physicians with disabilities, and disabled physicians, disabled doctors, etc, etc. And I do this intentionally because there are two major schools of thought about disability language. One is identity first. So that would be, disabled physician. And the other is person-first or physician with a disability. And so my team, many of which—I think 90% of which—are people with disabilities feel that it's important to include the preferred language of both schools of thought on this topic. And given that our work is informed and studied and analyzed and written by people with disabilities, we also ground our work in both of these terms to stay true to the community and really to support and stay true to our team.

MH:

Well, thank you for clarifying that. I, I think in a couple other episodes we have talked about sort of that shift in this new generation of medical trainees and more in the sense of, of them being willing to open up about their mental health and open up about seeking treatment for mental health. And I, I think this is just an extension of that, that they're willing to share more of themselves personally. And I think that brings a lot of strength and value to, you know, our patients and to our whole communities. How do you see supporting learners with disabilities as, as fitting in as a core value into health professions' greater mission of promoting diversity, equity, inclusion, and anti-oppression?

LM:

Yeah, I, that's a great question. I—I'm sitting here thinking how does it not fit in, right? I think at its core, right, disability inclusion is, is anti-oppressive. And, and when we talk about anti-ableism or, or any of the isms, they're all connected. If you think about it, you know, almost all of the other isms are grounded in some form of ableism: the belief that a life is less than because of the group that you're part of. And all

of these systems of oppression work together to keep one another down. So the kind of, the saying, 'none of us are free till we're all free.' And I think that's really important in the JEDI or DEI or DEIA missions that we need to connect all the core oppressions and bring together the anti-ableism, anti-racism, addressing heterosexism, ageism, all of this. I don't think that, you know, we cannot have disability inclusion not be part of this because it is such an underpinning of all of it.

EK:

I love at Lisa, cuz you're basically reminding us, it's somewhat of a rhetorical question, like yeah—

Lisa:

Yeah—sorry— [laughing]

EK:

It is, it is a core value because they're all core values, and this is—

No, no, this is super helpful. It's a nice reminder of just the power and the impact they can have. And we get together and we think about all of these systems of oppression and how they work together and how it's really important to, for setting up the DEIA as core values. If we zoom in a little bit back to Jennifer's case in particular and Jennifer's been able to work reduced hours—er, and—per week, especially as part of her schedule. And now that she's thinking about what lies ahead in terms of residency and how she can start to think about specific accommodations that will allow her to complete the residency. I'm wondering if you could maybe share a bit about resources that might be available for students if they're in a program that have hasn't had the same support that Jennifer has had or hasn't had a strong disability support program or trained staff to kind of say that these are the support services you have access to. What can other students maybe turn to or or find out more about?

LM:

Mm, well there are so many, gosh. I think definitely one for the student level would be MSDCI International, which is an international group of, of medical students who have created kind of a community of support and sharing information. They've been amazing. And there are several chapters now across multiple medical schools. I think the, the other resource certainly is our website or our podcast, which was developed really to be a source of asynchronous mentoring for students in the pathway or for trainees or even physicians.

I know that the Stanford Medical Alliance for Inclusion and Disability something--it's called SMADIE—also has a mentorship group that is really robust, a place where physicians and trainees can go and meet with one another, share stories, validate each other's experiences, and offer hope and, and resources in the form of personal stories. So these may not be stories that people felt comfortable sharing on the podcast, but would feel comfortable sharing in kind of a, a peer mentor situation. So yeah, I think those are a couple of really good resources that students and trainees can reach out and take part in.

MH:

Wonderful. We will make sure to link those in the show notes. And I am just always so impressed when medical students can create initiatives like this and give their, their efforts and their time because it's just such a busy time in training and, and then to feel strong and motivated enough to pass that on and share

that is just amazing. Going into some of the, the more nitty-gritty things—some things like voice recognition software or ergonomic setups seem like pretty easy wins. But then kind of thinking logistically about how a learner working in many different settings, like different outpatient clinics, inpatient rotations, how does this even happen for someone like Jennifer? Like who's, who in the institution coordinates this? How is it paid for?

LM:

Yeah, those are good questions. So, you know, I wanna start by saying that recognition software, ergonomic setups, the seemingly easy win, I think that's really dependent on where the student or the trainee is doing their training and whether or not the infrastructure is there and there's a system there of taking in requests, adjudicating those requests, and implementing accommodations. So it may not be as easy for somebody in school X as it is for somebody in school Y, but I always go back to communication, right? The big C as being key to, to any relationship and to facilitating needs.

So first, if you're going to have communication, it should be with a disability expert. And unfortunately, again, not every school has someone that is a DRP or a disability resource professional. But what should be happening is that the learner or the trainee should be able to talk to the disability expert or an institutional representative and the PD and then together they have developed kinda the accommodations that are reasonable and appropriate for the setting. And then a coordinator or someone of that nature is communicating with the sites and the earlier the better. And let's just take a moment to thank all of our medical education coordinators cuz they really make the world go round. But I think it really does land on communication. People in those training sites need to be prepared for any changes that are gonna happen to the built environment or, as you mentioned, kind of, IT voice recognition or AT assistive technology or implementation. They need to know that it's happening.

But another part of that communication is how we frame things. And so I'm gonna tell you there's a lot—there are a lot of people who are guilty of framing disability with a problem mindset. So, there's an issue, there's a problem, it needs to be fixed, it's a challenge. And we come to the training site and we say, we have a student with a disability or we have a resident with a disability and they need all of these disability accommodations and you know, how are we gonna do this? Or, or asking the dreaded question, can we do this right?

But, what's actually should be happening is that this is an opportunity to reframe disability to the site to say, look, let's together sit down and talk. Let's expand our ideas about diversity. Let's bust stereotypes and change perceptions for patients and peers through this person training at your site. And what an impact can they have you know, they could have. Like how amazing is it that you get the opportunity to have this diverse resident or this diverse student inform the practice of medicine at your site and you can all learn from one another. We don't frame disability inclusion that way. We espouse to, you know, this value of diversity, equity, and inclusion. Yet when there's a struggling learner or when there's a person with a disability, we always fall back to that problem mindset. So I would say communication. Framing is really important as we go to the institution.

And then, who pays for it all? Well, the reality is that the institution that is training the individuals responsible, and it's not the department of pediatrics or the OB-GYN department or anesthesia. It's the actual big institution that should be paying for accommodations. This is a huge factor in reducing bias in who you accept into your training programs, right? If you have somebody that says, oh, well that accommodation is gonna cost $5,000, I don't have that in my budget, so I'm not going to match this or rank this trainee, that's a problem because you are making a decision now about disability inclusion that has nothing to do with the value this person brings, but rather the *potential* cost. And to be honest with you, it's probably a perceived cost versus an actual understanding of the cost. Because we know from

research that most accommodations cost less than $500. So to answer your questions directly, institution wholly pays for the accommodation. And communication, and reframing disability. That's what I would say.

EK:

Lisa, so many pearls. Thank you so much. I also love just the correlate to kind of strength-based communication where if we can approach conversations with people and thinking about the strengths that they provide and the opportunities that they bring to an institution, I think how that would change the way we think about it. And if we kind of zoom back into Jennifer's situation, I wonder how you would advise her—you're, let's say you're her mentor in this situation—to kind of think about residency programs that may be most supportive and how to really kind of evaluate or discriminate from a just kind of, what support is offered standpoint and maybe it's listening for strength-based communication and kind of that, that type of approach. But are there other tools that you might offer Jennifer or our listeners in that way?

LM:

Oh gosh, yeah. I think it all goes back to whether or not you have that disability person who's this objective source of information to bounce ideas off of, to have honest conversations about matching into specialties. I think that when you're advising somebody, it's important to have a relationship and a trust and not have that advice be grounded in kinda stereotypes about what a person with a particular disability can do or not do. So I would say if there was an advising situation that you would want Jennifer to understand lots of the variables that will inform whether or not she can continue the level of accommodations that are needed, right?, for her success. And so that's going to be based on how many people are in the residency program, what are the procedural skills that need to be done, what kinds of hours are required in the program, and does she have a support system around her?

So those are things I would want her to be thinking about. You know, if you're—we're in California right now. If, if Jennifer's saying I'm gonna go to New York where she has no friends, no family, no community, that's gonna be really hard because we know that not only is she going to be stressed, she's got a, a disability that will have an exacerbation of symptoms with more physicality, right? So she's definitely gonna stress her body and we also know that in residency she's probably going to have some stressors on her mental health as well. So having a community is really important. Knowing that if the larger the residency program, the more likely they are to accommodate things like release from overnight calls so she can take care of sleep hygiene, which will really help with reducing the amount of flares that occur. If it's a bigger program, there's probably more coverage so that if she does get sick, she's not making the absolutely horrible decision about whether or not she calls out or somebody else that's struggling has to call out. Y'know, she also needs to consider how all of the factors of the particular specialty and whether or not that specialty is a good fit for her long term. So there's so much to consider and if you think about it in the absence of career advising that is informed by the knowledge of disability and, and employment law—which is what she will shift into as she enters residency—she's gonna be trying to make decisions without a lot of information to base those decisions on. And that's gonna be really difficult and stressful for Jennifer.

MH:

Well, I wish Jennifer really had you as a mentor cuz you offer a lot of wonderful advice. [Laughter.] Her disability seems invisible. How would you recommend that she disclose this or when should she disclose

this? If it's during the interview process, if it's after matching. And maybe you could also just talk a little bit about the rates of invisible disabilities to appreciate how this impacts our learners.

LM:

So, I think the rates, we just published a paper and JAMA Open called *Program Access, Depressive Symptoms, and Medical Errors Among Residents with Disability*. And in that paper we highlight very clearly in the table that the majority of disabilities are invisible disabilities. And so, for program directors, DIOs, you know, chief residents: you will likely not know if a person has a disability.

So it's really important that you have welcoming language and a clear directive of how somebody could request accommodations. As a person who doesn't have an apparent, necessarily, disability. Although she may, she may use a cane, a cane seat, um, she may have the option of disclosing or not disclosing. And I would be remiss if I didn't acknowledge that disclosure of disability is very frightening, that there's a lot of ableism in medicine that she may very well not match at a program because of someone's preconceived ideas about what she is or is not capable of doing. And so there, there are a lot of consequences to disclosing, especially prior to the match.

But there are a lot of actual benefits to disclosing during that process, which is finding a mentor and finding someone who you can be very honest with; a, a PD that you kind of resonate with and one that believes in your ability and your, I think, the value of what you bring to medicine. And just being able to create that honest communication to say, look, this is—I'm moving my life somewhere, right? And I have however many years of training, I want that training experience to be positive and I want for my physical health to be intact at the end of that training experience.

And so for the people who have decided, and many of my students from UCSF, many who have talked about their disabilities or been interviewed on the podcast, for my students that decided to bring their full self to the match process and to in—as part of their personal statements or as part of the reason that they entered medicine, you know, kind of enveloping the, the disability story or disability narrative in there—they have all wound up matching at places that really, really wanted them, knew that they were a person with a disability, and saw that as a plus. And those individuals did really, really well.

You know, I don't have empirical evidence of this, but I—but what I can say is for those residents that really struggled with this decision and decided not to disclose and continued to dis—to struggle in residency with whether or not they should disclose at any given point, their experiences were not as positive. There are, well, I have a, I have an episode coming out that is from a former student at UCSF who is now a resident who talks about her residency experience. And then we have another episode, episode 30, I believe that was a joint interview between Julia Cron and Lauren Meiss, and Julia was the PD and Lauren was the trainee, and they got on the podcast and they talked about the benefits of disclosing, you know, prior to the match—disclosing in your interview, and having that understanding of what is and is not possible.

So I, I think to each's own, there's lots and lots of reasons why people will disclose or don't disclose. And I will tell you, you're asking me what advice I would give Jennifer. My advice to Jennifer would be that she has to do something that she feels comfortable with. I can't make that decision for anybody. And I think the best job that I could do is to sit and do a series of pros and cons with her. The other thing that I would do if I were her mentor is I would look at her specialty and do an evaluation of milestones, do an evaluation of board exam requirements. What are the procedures you have to, to do to be board certified? And I would just make sure that she was well-informed so that she didn't match and have to then reenter the match to go into another specialty. And I would be willing to pick up the phone and call residency programs and get kind of a gestalt, right? We look at the website that doesn't always tell us everything we need to know, but I would be the kind of mentor that would be willing to pick up the

phone and just call and do kind of a cold call of disability and see what the program's reaction is. Sometimes you can get a lot of information just by what people say when they're not primed or scripted.

EK:

This is like the 90th time that we are gonna remark that, Lisa, you're, you're the person that we want at every institution and how much you would be such a valued mentor. So even in this hypothetical scenario with a hypothetical Jennifer. And now we turn to maybe a rhetorical question number two, which is thinking about how supporting learners with disclosed disabilities actually supports all learners at that institution or that particular program. And maybe you can kind of expand on that, Lisa.

LM:

Oh gosh. Well this is where I get very kumbaya-ish and I blame that on UCSF.

Speaker 3:

Well that's why we put that question in there to allow for some kumbaya. This podcast has been kumbaya-deficient until now.

LM:

I think COVID really showed us what happens when we all have access to things that have been previously considered disability related. So just think about captioning. I mean, at 52 and somebody who loves—like I said—loves music festivals, I've probably done some damage to my ears and I rely on captioning for my brain to process things quicker and easier because I'm hearing it and seeing it. And I think many people, especially with how distracted we became, really relied on that captioning when they logged into Zoom. So it improved the access—and we talk in terms of access to information—it improved access for everyone.

Think about, you know, the traditional example, right, as a, a ramp versus stairs. Everybody can use the ramp, but not everybody can use the stairs. And ramps are great for parents pushing strollers and they're great for somebody that has a temporary disability and they're great for not tripping and needing less maintenance and, you know, just a number of things. So—

But for me, and I think grounded in my research, is this idea that for the learners without disabilities to train alongside a disabled learner or a disabled student and to have that experience of, this is my peer, they're my equal, right? We are working towards a shared goal. This close contact is the single best way to reduce stereotypes about a population of people. Same thing for race, sexual identity, you know, sexual orientation, gender identity, first generation, whatever group you want to talk about. We all carry these stereotypes, right? We're all ableist to some extent. We, we all rely on stereotypes to process information really quickly, but they don't serve us well in these types of situations. And by working alongside somebody who is day after day after day challenging this deeply ingrained stereotype, it's one way to finally get to a place where we can look at disability differently.

And for the peers, they are going to be treating patients with disabilities. So if they have a different mindset about disability, if their stereotypes have been challenged, or even if their stereotypes have been eroded or even attenuated—like, let's, we can—if we can reduce them a little, I'll be really happy. If we can get rid of them completely, I'll be ecstatic.

But that information and that experience carries over into their patient care. And so the realization that one in four patients is a person with a disability and knowing the absolute horrific outcomes for people with disabilities and medicine—lack of access, you know, poor health outcomes, lack of access to

screening—I just see it as being an all around win-win, not just in universal design of instruction or universal design of learning, but in really breaking down the stereotypes that we have about disability.

MH:

I love it. [Laughs.] Let's zoom forward a little bit. So it's about a year later and Jennifer has matched in a primary care program that she's really excited about because everyone should go into primary care.

LM :

[Affirmative, almost-laughing sound]

MH:

Dan is her program director, and Jennifer shares her disability status with him. Dan has not worked with many trainees with disabilities and honestly isn't sure how to support Jennifer. He looks into it, but he cannot find a clear process for Jennifer for her to pursue, to obtain accommodations. You highlighted this in your recent paper that we'll link to in the show notes, but a significant number of large institutions do not have a clear GME policy on disability. Only 68% did and even more failed to have a clear process for disclosing the disability and obtaining accommodations. So Dan's clearly not alone in feeling in the dark here. What are some best practices that program directors, site directors, supervisors, and institutions who don't have clear policies can try to institute?

LM:

Yeah, so I wanna give just a little update on that paper—it was 2020 JGME. I believe it's open access—is that, we're trying to replicate the study because we're now four years out from the ACGME kind of, regulation that this exists. And our initial kind of, you know, digging into about 12 schools showed that nothing had changed. Now, I know we just got out of a pandemic, but *literally* nothing had changed. That paper came out, the— we were like, 'well, maybe our findings are too proximal to the launch of the regulation.'

But four years later, we were finding the same kind of lack of policies. So we really wanna encourage the audience for those that are PDs or have some sort of administrative roles, please, please, please at the very least be compliant with the ACGME requirement to have a disability policy. You want people to disclose.

But in another JGME article that was titled, *Realizing a Diverse and Inclusive Workforce, Equal Access for Residents with Disabilities,* and again, open access, our team outlined several steps for residency programs to take and move forward um, kind of with their disability as diversity agenda and also would help with being compliant with the ACGME regulation. So it included increased transparency of policies and processes. So I'm a learner, I'm looking at your training program and I'm thinking, am I gonna belong? Is this going to be another fight? Right? Do I need to pull out my sword? Is one of my interviewees said, to, you know, to slash the dragons, again. Like, instead of that, have everything available for learners and use language that isn't grounded in legal compliance, but rather that invites application from this incredible diverse workforce this incredible diverse group of trainees.

And how can you do that? Well, you have language on your website that speaks to this as part of your value system. You also have the policy and the process readily available. The single most important thing I think, for full access, that that is protective of the trainee is to have a confidential and specialized disability expert that informs the process. So somebody like me, or a handful of people in the country right now that are working in medical schools or training programs that understand clinical medicine and understand disability law and accommodation. That person is really central. And if you can't have that person, get connected to a group of people that do this work. Understand program and institutional

obligations. I think sometimes people don't even know that accommodations are a thing in residency training. And under the ADA, we have a section that speaks specifically to employment law.

And yes, accommodations are reasonable and appropriate in residency training. And there's some great resources, some great trainings that I'll tell you about later. And then enhance knowledge of the benefits, right? It's not just why would we admit a disabled learner? Because it's illegal to discriminate against them. That should not be your driving force. This is a really valuable part of the population where our research has shown, back to the— I'm a big primary care person myself—but back to that call for more people in primary care, people with disabilities are more likely to match into primary care and more likely, importantly, to say that they want to match into primary care when they come into medicine. So it's not that they couldn't match into a specialty, this is their single goal, is to go into primary care.

We also found empirically that students with disabilities are more empathic than their peers. And we'll be doing a follow-up study to see if that empathy erodes at the same rate that it does for their non-disabled peers.

But we need to be talking about the benefits, not just the, like, let's follow the law, but why do we want these individuals in medicine? What do they bring? So I think, you know, those are things that people should be practicing. And in that paper we also have a case study that we kind of walk the, the reader through so they can better understand what happens at all of these points when best practices are not employed; what happens to the trainee, what happens to the institution?

EK:

Well, it sounds like I have some reading to do and case studies to go through. So thank you Lisa. And if we were to get a little bit more granular, it sounds like Jennifer has disclosed her disability to Dan, the program director, but just wondering if you could advise us you know, who should learners disclose their disability to and how should accommodations really be communicated across this trainee's work environment? As you know, in residency, this gets rolled out for Jennifer.

LM:

Is it too cheeky to say not the way that it happens in most cases? [Laughs]

EK:

We're a fan of cheekiness. So yes.

LM:

Ok.

EK:

It's not too cheeky.

LM:

Good [Laughs.] Well, programs should work with the GME office to identify a confidential person. So as much as PDs have in many cases been helpful, there are also reports of it being a harmful situation to report to your PD. One, because it's an automatic disincentive, right? This is the person who's going to guide your career, and the last thing you wanna do is share confidential information about something

that may be highly sensitive or that you may carry a lot of shame about. Or, if you understand that the perception of disability is one that carries a huge negative connotation and stigma, you're not gonna be super excited to share that information.

So having a confidential contact person in HR or occupational health that understands that disability law and clinical accommodation is really important. I will tell you, most HR offices know one thing, and that's the Family Medical Leave Act. And it's kind of the solution to anybody presenting with a disability is go on leave, get it fixed, and come back when you can. Again, ableism at the core of that, which is this idea that if you are broken, you need to be fixed and you can come back when you're fixed. Many people have chronic—in fact, most disabilities are chronic or lifelong. You live with disability, you don't go away and fix it and come back. So making sure that there's somebody other than a colleague—oh my gosh, I think the worst reporting system I saw was to the chief residents. And I was like, that's so hard for a trainee. Right? Or a supervisor or anyone else that has an evaluative role over the resident's performance or any kind of impact on their career should not be the person who's making the final decision.

MH:

And just kind of thinking about specifics, residency program historically is very rigid in its scheduling and really limited in its ability to consider accommodations. For someone like Jennifer who has difficulty managing her joint pain when she works more than 12 hours, Dan worries about how to make accommodations happen with resident schedules when they may have to work up to 28 hours straight. How might you advise Dan, and are, is there a way for residency programs to ensure their trainees are able to perform essential functions but are also being evaluated and have the appropriate accommodations?

LM:

Hmmm. Yeah. So, okay. I'm gonna take us back to before we got to the place of Dan needing advising. There are all of these resources for Dan, right? And I want him to engage with those resources. But I wanna take us back to that critical missing point that I brought up earlier, which is career counseling. For somebody like Jennifer who needs a 12 hour hard stop, and this is a known factor right before she matches to residency, it would be fairly easy to identify and discern the unique differences and requirements of the various subspecialties so that she could make a decision based on understanding what reasonable access would be. And here's where primary care gets a little difficult because it's a lot of specialties. So even across three things like say internal medicine, OB-GYN and something like pediatrics, you're gonna have a considerable difference on the physical toll and the expectations for staying up 28 hours across not only these specialties, but across different training programs. So, unfortunately, 12 hour limits on your day is not likely to be reasonable in different settings. So I would need to know more information about what her specialty is, what type of setting she's in. There's lots and lots of things that contribute to whether an accommodation is reasonable.

Unlike in medical education proper, in medical school, this is something that's employment based. So depending on the essential functions of the job and how that's defined for the residency program, 12 hours may work, 12 hours may not work. And so this is where, you know, we really need to go back to that career counseling and say, somebody needs to be guiding Jennifer through this process and well before she matches into this program. Because while it is a little bit about Dan not knowing where to go, it's a lot about is this reasonable on its face in a specific specialty? And did Jennifer know that going in?

And that's kind of the most heartbreaking thing to me, is when people don't get any mentoring or guidance around this at all and find themselves in a residency program and things start to unravel and

then they don't have their contract renewed and they find themselves in this terrible limbo land. So I can't stress how important career counseling is when we think about the essential functions and how that's going to get adjudicated. I go back to the communication question, you know, when trainees and PDs and disability specialists are able to be open and honest in their communication and build trust, then you can address these things as a team and say, okay, what is possible? Like, say there's a specific training site within the training program that would allow you to do 12 hours, maybe you spend more time in outpatient settings, you know, what are the requirements of the program?

And by the way, PDs, they get some guidance from the ACGME, but they have a lot of latitude in what they do. So that's also really important to know. And some PDs don't know that they actually certify parts of their requirements and they can define what kind of, 'competence, means or doesn't mean within that program. So there's a lot more, and, and many PDs figured this out in calling, kind of, to become board certified. They, they actually call and have discussions with them relevant to disability access and disability accommodations. So things like the American Board of Internal Medicine will allow for accommodations to meet the board certification requirements. And that's something that I've worked with many internal medic medicine residents across disability type and the PDs, were not aware of that. So we had to work together and really inform the PD.

But I, I really think it's this, okay, if you've matched and here's where we're at and the 12 hours is something that cannot be adjusted, then we need to think about this creatively and think about whether or not there are ways to meet this. Does, does Jennifer work seven days a week? You know, with very little time off. Well, there are regulations that keep people from doing that. So we have to kind of work within this, this bigger system to figure out what, if anything we can do, and if this is a good match for Jennifer.

EK:

Thank you Lisa. And I think you mentioned a few resources for Dan already and I definitely wanna hear more if there are other resources that you wanna plug outside of, you know, we wish we all had access to calling you and clarifying what to do. But maybe as a double barreled question between what, which resources can Dan access, to kind of you having a magic wand or an ideal, kind of, creating power, and if you could imagine an ideal system where learners don't have to proactively kind of request accommodations or even proactively think, 'wow, which residency program is gonna be able to match this, you know, whatever system I need to support me?" How could we as a, as a health professions education world better support learners and trainees and doctors, health professionals, with disabilities?

LM:

Yeah. Well, Dan could, and should, reach out, but he has to know about it first, right? So this is great that we're being able to, that we're able to share this on your podcast. He should reach out to a newly formed group. It's called Disability in Graduate Medical Education. So, DIGME for short. It's a community of practice that includes DIOs, PDs, ADA coordinators, disability inclusion stakeholders, everybody who's involved in kind of the disability determination process and the implementation process in GME. And the community was formed, I think two years ago, by leaders that expressed interest in disability inclusion. And so together they created—it was 12 or 16 people—they created multiple resources. Things like just-in-time advice, one pagers, five-minute videos on the disability process. And they also curated a training for institutions. So if you wanna train your faculty attendings, if you even wanna give a talk to all of your trainees, there's a PowerPoint that can be used can, um kinda free access. And this resource can be found on the Docs with Disabilities website, under the initiative DIGME. And, lots of other resources, by the way, on that Docs with Disabilities website.

So another great resource is two GME modules that are part of the Equity Matters initiative from the ACGME. And these modules are 25 minutes long each. One module covers disability inclusion in GME and reviews things like the legal aspects of inclusion and what a program needs to do. It also goes through the interactive process, which I would say most GME institutions are not following. And you know, so it articulates that interactive process, but it also provides additional resources.

The second training module covers disability accommodations. So it is 100% specific to accommodation. Here's where we say, look, this is reasonable in this context, this is unreasonable. These are accommodations that are provided to multiple learners across multiple settings, and these are, are legally defensible. So it's going to be hard for a program to say, oh, we don't do that, or we don't do this.

I think people will be surprised by, kind of, the best practice and what's happening nationally at this level. But those two ACGME modules are great places to start. Again, they're free, they're on the ACGME website under the Equity Matters video library. So those are two resources.

The DIGME Group also has a Listserv that you can join. And the link to join it is on the website. This is where you can, you know, send out a question to *literally* experts on the disability part, but also incredible stakeholders on the training and education part. So together we can have robust conversations about what is reasonable. I also am a firm believer in not recreating the wheel. And so whenever I can bring groups together or codify, kind of, what's been done and we can work and build on that, that's best-case scenario because things happen in a silo in GME. But the reality is that if you have a question about disability, it has probably been done somewhere, or the question has probably been answered somewhere, or somebody has a legal case that you can look at. But there are lots, lots of options.

EK:

And I love that forum approach where it feels like there's like a kinda a consortium of thought leaders and people who are there, like, you know, who have been thinking about this, doing this work and implementing it, studying it, and can share, kind of, what's worked.

LM:

Yeah. And it's, it's completely free. And understanding what's been done is the first step in figuring out what can be done, right? So this crowdsourcing, I mean, we're in California, this is what we do, crowdsourcing and thinking outside of the box.

MH:

Wonderful. and I know that was kind of a two-part question. Is there anything else that you wanna add about kind of your ideal image of, of where this should go down the line, how, how you think we really could do, do this much better?

LM:

Yeah. I mean, I think I have an ideal model, but right now I'm really focused on harm reduction while we kind of move towards this aspirational place. And the first step in that is to educate yourself, right? I'm telling you the research shows almost 8% of residents are identifying as disabled. But my research also shows that less than half of them are asking for accommodations. And the ones that don't ask for accommodations, the ones that don't have full access, there are repercussions for that, especially to their mental health and to patient care. So anticipate that you will have people with disabilities in your program. And when you think someone's coming, you prepare for it, right? Think about access in all that you do. Do a self-evaluation of your program. That AAMC report has a specific section for GME where

you can literally do check a check mark system of, have we done this? Have we done this? Have we done this? So, great way to, to evaluate your, your practices too. Little things.

Opportunities to build in flexibility are fantastic. Coverage models need to be reevaluated. Ensure all of the—your—all of your meetings are captioned. Zoom has an automatic setting for that that you can set so that it's built into the system. Nobody has to ask for captioning. Make sure that grand rounds exist in a place where anyone can join in. So someone who's a wheelchair user or a scooter user—like Jennifer will likely be at some point in her residency if, you know, she's entered into a primary care specialty that requires a lot of physicality, she'll have to get a motorized scooter to be able to make it through residency. So make sure that Jennifer can be part of that discussion and that she can enter into the same entrance as her peers, not, you know, she has to go into the basement and then go through a labyrinth to come out, you know, where the podium is and sit in the one wheelchair accessible space. That's not access.

Make sure that you think about language when you're doing your rounding, when you're teaching cases. Think about how you position disability. Are you making disability kind of a fatalist identity? And if so, why would anybody say that they're disabled in your space and in your program? Make sure that when you have the learner in mind, you're trying to think about it, and from the lens of a barrier: are there barriers in your program? Are there barriers to accessing information? Are there barriers to physical spaces? Are there barriers to full inclusion in remote meetings? Do people know where to go and how to request information?

And then I would say some self-reflection. And so this is for the DIOs and the PDs, and thinking about how much of your decision making is centered and grounded in assumption and stereotype when it comes to disability. Really, really think about that. We teach evidence-based medicine. Are your assumptions about a person that is disabled and their ability to be in your program grounded in actual evidence? So I think those are the things that I would say. For now, what I want is for people to do, you know, the educational piece, educate themselves, try to actively practice anti-ableism, and at the very least, follow all of those best practices and be in compliance with the ACGME requirements.

MH:

Wonderful. And I think this is a great start for people who are maybe just starting to learn more about this. And I, I thank you so much for sharing all those resources. And again, we'll put them all in the show notes cuz it sounds like just a wealth of work has already been done in this space. And if we can just continue to spread the word, things can hopefully improve. Those almost were take home points, but do you feel like there are other take home points you wanna make? Main things for our listeners to go home with today?

LM:

I would say listen. You know, the podcast is an avenue for sharing these stories. Choose one. It could be random or it could be something you're interested and just listen to one story and—

MH:

—You're talking about your Docs With Disabilities?—

LM:

—Yeah, yeah, yeah. Listen to a story. Challenge yourself to think differently about disability. Or read the transcript of our podcast. And I, I would say too, that remember that this could be you. Disability is a group that anybody can join at any time. And you know, I often will ask physicians to reflect on the fact

that if they were to acquire a disability, would you wanna lose your livelihood or would you want your, you know, boss or your institution to be behind you and think about how things could be done differently so that you could continue to practice medicine and contribute to the educational space. What would you want if this were, you know, your scenario? And someday it, it will be. We're, we're an aging workforce and you know, whether it's reduced vision, reduced hearing, reduced mobility, we'll all get there at some point.

MH:

Wonderful. Well, thank you so much. This has been such an amazing conversation and we really appreciate your sharing your expertise.

EK:

I agree. And Lisa, is there anything else? You've mentioned DIGME and a few other websites. Is there anything else you'd like to plug, podcast or anything else?

LM:

Just, I think the podcast is fantastic. I can't believe how many listeners we have. I'm like, who's listening to this? [Laughs.] It's, it's just, it's—storytelling is powerful. It's, it's so powerful to change hearts and minds. So I would say if there was one resource, engage in that. Talk to a peer that's got a disability. Sit down, have a conversation with them, you know, actively challenge yourself.

EK & MH, overlapping:

Amazing. I love that.

MH:

Thank you.

MH:

Yeah, well that was just such an amazing conversation. Dr. Meeks is so impressive and just so well researched, so well read. And just really clearly lives and breathes this material. I was just really impressed by kind of how much is, is already out there in terms of best practices and things that we can improve. And I'm really excited to share those resources and look into them more myself because I, I think there are just so many changes that we can make and I, I appreciate sort of her harm reduction approach of, let's focus on the small things that we actually can change right now to make a better system for all of us.

EK:

Totally. Molly, I was just blown away from what, with all the resources she shared. And I also felt like she kind of presented the framing that we needed. When we in medicine approach everything from a problem mindset and how are we gonna do this? Can we do this? Can we accommodate? And then there's an opportunity for us to reframe this conversation and think about, wow, what strengths? What are opportunities? What amazing impact can these students, these trainees, these learners have? And so I think just coming to that conversation with that style of communication and that framing is one thing that I'm gonna try to do and take away from this incredible conversation with Dr. Meeks.

MH:

So this has been another episode of our curbside mini-series, the Curbsiders Teach. Get your show notes at thecurbside.com/teach. A special thanks to our whole team that made this season possible. A lot of work goes in behind the scenes. And so, a special thanks to Dr. Matt Watto and Paul Williams for their support in this project. Thanks to Dr. Stuart Brigham for composing our theme music. And to Clair Morgan of Nodderly for editing our audio. On our backside, we have Dr. Charlotte Chaiklin and Dr. Francis Ue helping out with some of our production producing with us. We also have our social media team, Andrew DeLaat on Instagram and [unclear] Jong Un, on Twitter. And they have also been amazing at helping us with our episodes as well.

EK:

Yes, we would not be where we are today without our incredible team. So thank you all and we're really committed to providing you with high value practice changing knowledge. And to do that we need your feedback. So please subscribe, rate, review the show on Apple Podcasts, or contact us at thecurbsideteach@gmail.com. And a reminder that this and most episodes are available for free CME credit for all healthcare professionals at curbsiders.vcuhealth.org [Curbsiders dot VCU health dot org]. All you have to do is create an account. I'm Dr. Era Kryzhanovskaya. Thank you for joining us today and letting us bring you a little nugget of medical edu-tainment. And just a reminder that if you have any feedback or suggestions for season three, please email us as well: the curbsidersteach@gmail.com [the curbside teach at gmail.com]. If you wanna join our team, we are so excited to have you. So please email us about that as well.