Peter Goodwin (PG): Good day, everyone. Welcome to the Josiah Macy Jr. Foundation's webinar, **Exploring the Barriers to Inclusion for Medical Trainees with Disabilities** - the first in a three-part series. I am Peter Goodwin, Chief Operating Officer and Treasurer at the Josiah Macy Jr Foundation. Before we get started a few housekeeping items. This session today is being recorded. The audio and video portion, as well as the presenter slides will be available next week on the Foundation's website, www.macyfoundation.org. The chat function on your zoom screen is currently disabled and will be throughout the presentation portion of the webinar. We will enable the chat function. Once we start the question-and-answer portion of the webinar, at that time, you'll be able to chat with all attendees and the panelists. Please feel free to use the chat function to share information or best practices, or to comment on responses to the questions. The Q and A function on your zoom screen is active and will be throughout the webinar. Please use it to post questions to the panelists that relate to the content of this webinar. And finally, we encourage you to continue the conversation on Twitter using #docswithdisabilities and #equityinclinicallearning. And now I am pleased to introduce the President of the Josiah Macy Jr Foundation, Dr. Holly Humphrey.

Holly J. Humphrey (HJH): Thank you, Peter. And welcome everyone. I am thrilled to have you participate with us in this webinar today. Let me begin by introducing today's panelists: Dr. Lisa Meeks is the Adjunct Professor at the University of Michigan's Medical School, where she is an expert in disabilities in medical education. As an administrative leader and researcher, she is helping to inform policy and practices and the very best practice in the area of disability inclusion for medical education training, and ultimately for medical practice. We are also thrilled to have with us today a student, Ms. Samantha Schroth, who's an MD/PhD student in the Medical Scientist Training Program at Northwestern University's Feinberg School of Medicine. And then finally, Dr. Ray Curry is Senior Associate Dean for Educational Affairs at the University of Illinois College of Medicine, where he is Clinical Professor of Medicine and Medical Education. As the Chief Academic Officer at the nation's largest medical school, he oversees educational programs across the schools four campuses in Chicago, Peoria, Rockford, and urban Illinois.

Now let's turn to an overview of what we plan to cover in today's webinar. I will provide a very brief background of how this webinar series came to be, together with

two of the many conference recommendations that emanated from a conference sponsored by the Macy Foundation. I'll then turn it over to our panelists who will cover the topic areas that you see illustrated on the slide in front of you. And then finally, we are going aim to leave time at the conclusion of the prepared comments for you to ask questions of our panelists. And so, let's get started. In February of 2020, the Macy Foundation sponsored a conference on the topic of addressing harmful bias and eliminating discrimination in health professions learning environments. You can find a full report of those recommendations at the link that is on the screen in front of you. The recommendations came about from the work of 44 people who attended the conference, and these people included leaders in medicine and nursing, learners, and healthcare administrators, and the recommendations themselves were in fact consensus recommendations.

They were informed by four commissioned papers and three case studies, and that final product was reviewed and approved by all participants. Let me turn to focus on two of the recommendations and a specific action step that came about from that conference. What you see on the screen in front of you are the recommendations themselves. One was to develop, assess, and improve systems to mitigate harmful biases and to eliminate racism in other forms of discrimination. A specific action step that accompanied that recommendation is for leaders of health profession schools to review their technical standards for learner performance, ensuring that those standards reflect a commitment to diversity, equity, and inclusion. These standards should seek equity in learning environments for health professions students with disabilities. On academic health center campuses, this should be an interprofessional effort. For example, it should include all of the health professions schools that are present on a single university campus.

And then the fourth recommendation in our series of recommendations is to increase the number of health professions students, trainees, faculty, and institutional administrators and leaders from historically marginalized and excluded populations. That's the background that we bring to today's webinar. And I'd like you to know at the outset that this is the first of a three-part webinar series on barriers and belief systems. This particular webinar is going to focus on the topic of entering medical education for learners with disabilities. And with that background, I'd like to turn this over to Dr. Meeks.

Lisa Meeks (LM): Thank you so much, Holly, and thank you to the Macy Foundation for hosting this three-part series today. We hope at the end of this webinar that you'll be able to describe the prevalence of students with disabilities and medicine and the benefits of training disabled physicians, identify the barriers for medical students with disabilities, particularly at points of transition of entry to medical school and entry to residency, and finally, to characterize factors and elements needed to connect admissions driven efforts to the learning environment and engagement with students with disabilities. There is so much information on disability inclusion, and we don't want you to have information overload. We are very grateful for the three part-series, which will address the distinct portions of topics that you need to know but know that there is a wealth of information available to you. We're going to start pushing out some URLs. And the first one will push out to you is the docs with disabilities [website](#), where you can find lots of additional resources. We'll also be pushing out resources today like articles and books and websites to help you with your disability inclusion efforts.

Raymond Curry (RC): Throughout the talk here today we'll provide links in the chat to topical concepts, websites, and papers. These will also be posted in the resource section of this presentation at the conclusion. We invite you to post questions in the question-and-answer section as you think of them, and we will return to them at the end.

Samantha Schroth (SS): One more comment before we really get started is an important note about the language we're going to use today. We are going to move between person first, saying "I'm a person with a disability," as compared to identity first language, such as "I'm a disabled woman." This is out of respect for the disability community who have varied language preferences. So, you'll hear us or read in the captioning, refer to disabled trainees or trainees with disabilities interchangeably.

LM: Now we want you to think back to the point where you knew you wanted to be a physician or a scientist or a researcher and think about who supported you in that decision. And were you able to grow in that idea of becoming a physician or a

researcher? Were there people that looked like you in the profession for you to look up to and were you allowed to even dress up for Halloween as a physician or a nurse or a practitioner?

SS: For individuals with disabilities who want to enter the biomedical workforce, these memories and the things that you would be thinking about are often very different. People with disabilities may actively be dissuaded from entering medicine and mentors or people who look like them within the field may be few and far between. And the prevailing message is that a physician or scientist must be superhuman, especially if they have a disability, able to leap tall buildings in a single bound. Oh, and of course do it all with no sleep, not eating and never seeing family or friends, but that's enough for a different webinar.

LM: So, the reality is that learners with disabilities face stigmatizing and oppressive attitudes long before they ever become part of our professional communities. And they have an inequitable access to our communities through lessened opportunities to shadow physicians and people, and even pre-med programs telling them they can't be a physician.

RC: We need to challenge the existing model of the way physicians work and work together. Physicians of the 21st century require skills and knowledge that are fostered through diverse learning and work environments. In fact, research shows that diversity contributes to creativity and to the development of problem-solving skills. More diverse groups have even been shown to outperform homogeneous groups in medicine and in other disciplines, something that should influence how we select members of our medical school classes.

SS: Both researchers and clinicians believe that medical students with disabilities, training among diverse faculty and colleagues, would positively inform medical education and practice, and better prepare graduates to work with patients with disabilities, including facilitating shared decision making and ultimately contributing

to innovation. Students with physical and sensory disabilities are more likely to enter primary care work with concordant populations and data also supports that these students with disabilities have significantly greater empathy than their nondisabled peers.

LM: Despite the known and perceived benefits of disability inclusion for the physician workforce, in 2021 only 8.3% of graduating medical students, 7.5% of residents, and 3.1% of physicians identified as disabled. And while this is a marked improvement from where we were even five years ago, it's still really small. Indeed, barriers to medical education still exist. In 2018, the AAMC paired up with UCSF to do some investigating on the landscape for disability inclusion. And we found several barriers. We delineated these into structural barriers and barriers that were part of culture and climate. And so, within the structural barriers, some of the things that we found were uninformed disability resource providers (or DRPs), lack of transparency in the process, uninformed decision-making, burdensome and arduous processes, and technical standards, which we'll also talk about today. And then in culture and climate, we found bias and stigma, clinicalized culture, and negative peer attitudes, and of course, restricted views of disability. Since that time, we've done a lot of research and unfortunately, we've uncovered many more barriers, including structures of disclosure, conflicts of interest in the system, lack of accommodations on board exams, threats of professional citations for disclosing disability, fitness for duty evaluations upon return, and shame and bullying in the educational space.

SS: But here's the thing, system structures and those cultures and climates Lisa was referring to are all made up of people. And people may have an outdated and restricted view of disability. I know I did. Therefore, the largest barrier to entry in medicine are the beliefs that inform the policies, practices, and structure on cultural barriers of an institution. And sadly, many of these are laden with ableism. I want to take a moment to introduce what ableism is. Some people haven't even heard of this phrase before. So, ultimately ableism is the discrimination of, and social prejudice against people with disabilities based on the belief that typical abilities are superior. At its heart, ableism is rooted in the assumption that disabled people require fixing

and that they are defined by their disability like racism and sexism. Ableism will classify an entire group of people as less than, and includes harmful stereotypes, misconception, and a lot of negative generalizations of people with disabilities. And you can see ableism in different ways throughout medical education. That we'll talk about a little bit more moving forward.

LM: So I do a lot of consulting for medical schools, and I talk to a lot of admissions committees and I hear things like, *what if we don't have the resources to support these students,* or *it's really inspirational what they've accomplished, but medical school is just so hard,* or *it's really not fair of us to accept them and then not have them match*, or *can they even be a doctor if they're disabled*. Almost all of these are driven by ableist belief systems, and many students actually thrive. Yes, medical school is hard, but it's hard for everyone. So, thinking that a person with a disability is going to have a hard time just because they're a person with a disability, that's at the root of ableism.

SS: We also hear about how admissions committees will discuss the availability of accommodations at their school, or they attempt to determine how reasonable an accommodation is. Whether an accommodation would fundamentally alter a program or pose undue administration or financial burdens, which is the definition of reasonableness that you're required by the Americans with Disabilities Act, these are not admissions decisions and should be adjudicated by an informed Disability Resource Professional or DRP in partnership with the program, as outlined in the American Medicine article written by legal scholars. These accommodation decisions are ancillary to the academic and personal characteristics that should be evaluated by admissions committees. An evaluation of the reasonableness of a person's request for accommodations should occur between an officer of admission and the student's matriculation. Indeed, disability equity and inclusion require schools to make clear distinctions between their admissions and student services operations. Another way we insert ableism into the entry process is through our technical standards.

LM: In fact, just getting in the door is the hardest part of being a person with a disability in medicine. And, you know, it's interesting because our research shows us that these students perform just as well as their non-disabled peers. They have MCAT scores that are just as predictive as their non-disabled peers and the performance and trajectory of these students, especially for those with sensory or physical disabilities, well, there are really no differences.

SS: So, how do you reduce this bias that is informed by ableist beliefs? Well, just like anti-racist training, you must define, show examples of, and make people aware of this type of bias. Therefore, anti-ableist training is a must for all admissions committee members. This is in addition to a holistic process that will value disability and reframe disability as an added value to medical school. Certainly, these students bring an incredible lived experience of being a patient in the healthcare system and often arrive with resilience and grit that are the results of navigating a disability in a world that can be difficult to access.

RC: Finally, how you communicate inclusion says a lot about your commitment. So, every school has a non-discrimination statement, but what does it mean to say, *we will not discriminate against you*. "We won't discriminate" is just not the same as "welcome! we want you and value your lived experience." Therefore, outreach efforts to identify, recruit, retain students from diverse background should include the recruitment of students who display grit, resilience, and passion for equitable healthcare, and who bring the unique lived experience of navigating life with a disability in an ableist world. In other words, students with disabilities.

LM: As you can see there is a multitude of papers on barrier to entry that have to do with technical standards. And technical standards were one of the biggest areas that were identified as being a barrier.

RC: What are technical standards? For learners with disabilities who are accepted to medicine successful matriculation may be stymied by restrictive and or outdated

technical standards. The term technical standards refers to all non-academic criteria that are essential to participation in the program in question, and they pertain to admission as well as to graduation. In 1979, the Association of American Medical Colleges put forward five key areas for technical standards which include abilities and skills in the following five areas: conceptual intellectual abilities, behavior and social attributes, communication, observation, and motor capabilities. Thus, the AAMC technical standards were intended to specify the minimum physical and mental abilities that were thought to be necessary to function as a physician. The Liaison Committee on Medical Education shortly afterward has a standard that you see in its current form here on the screen stating that all medical schools must maintain technical standards for their accreditation, but the specific wording and the means of creation, the scope and wording of such technical standards are left up to each school. In this context, I guess it's fair to say that technical standards are neither really technical nor standard.

SS: So, for me, technical standards were one of the barriers I had to consider when applying to medical school. I, as you can see on the screen, identify proudly as a person with a disability. I had a spinal cord injury back in 2013 and am now a paraplegic and full-time manual wheelchair user. It was ultimately this injury and my exposure to rehabilitation medicine and time in the hospital that ultimately brought me into the field of medicine as a career. When I thought about applying to medical school, I went looking for schools that would appreciate and value my diverse perspective and had communicated that with their technical standards. But then again, finding the technical standards was a process in and of itself

SS: Guidance from the AAMC and AMA asked medical schools to consider moving to functional standards, include clear guidance on their technical standards about how to disclose and request accommodations, and ensure that technical standards rely on current technology and medical standards. They should also give careful consideration to what is truly essential. Ultimately, many of my decisions about whether to apply to a specific medical school were based upon whether I felt that I could rightfully attest my ability to fulfill the school's technical standards. The

majority of applicants are able to base their important decisions on factors like school location, curriculum, research, school, culture, et cetera, but you know, myself and my peers with disabilities, we have to narrow our searches as we contend with the set of technical standards that may or may not have been recently reviewed or even thoughtfully considered as to their purpose and or necessity to fulfill curricular competencies.

RC: Prior to matriculation, medical schools require students to attest to their ability to meet the school's technical standards. Some of which explicitly forbid the use of certain accommodations such as intermediaries or interpreters. Though technical standards may only be used to disqualify an applicant if they're non-discriminatory, and if no reasonable accommodation, as explained by Samantha earlier, would allow an applicant to meet them, technical standards have thwarted matriculation and no doubt, even the initial intent to apply of many qualified applicants to medical school.

SS: So unfortunately, despite all of the guidance to date, new medical schools continue to perpetuate outdated and discriminatory, in some cases, technical standards. A 2022 study showed that 73% of technical standards from 15 brand new established MD- and DO-branded medical schools were actually elusive and hard to find online. Additionally, only 13% included language that supported disability accommodations and most, or 73%, use technical standards language that could be coded as restrictive for students with physical or sensory disabilities.

LM: Here's where I get to talk about something good. I've been using the same school's technical standards as my go-to, poorly worded technical standards for three years. They've always come through for me. And this year, when I went to copy and paste their communication domain technical standards into my PowerPoint presentation, I found that they changed their technical standards in 2021. So, then I went to my second favorite school to use as an example of what not to do, and guess what? They changed their technical standards too. I was actually spending the day thinking, oh my gosh, I might not find any bad technical standards, but alas on my third try, I did find them. And so, we're using actual examples. We won't say what

school obviously but using an actual example of a communication domain. As you can see, I've bolded some words. "Communication includes speaking, reading/writing, and perceiving nonverbal communication." The speaking is where we have a bit of an issue because it automatically discounts deaf and hard-of-hearing physicians. So, it also says that people must be able to effectively and efficiently, in both oral and written language, communicate. That oral language again is problematic because it discounts an entire group of people with disabilities. And finally, it says as members of the health care team, students must be able to provide audible and intelligible verbal information. Again, a nod towards deaf and hard-of-hearing individuals. And even those that stutter. We have several amazing physicians that stutter. So, these standards feel like, to me, a bit of a microaggression and an attempt to block out an entire population of individuals, but there's more. Included in those technical standards that said *students must have to have the ability to respond without assistance to alarms or other warnings*. I'm always one to give people the benefit of the doubt. And I thought, well, if you don't know, you don't know that you need to update your technical standards, but it seems pretty clear to me at this point that these technical standards are ableist-informed. And with over 30 years of deaf and hard-of-hearing physicians actively safely practicing medicine and contributing to the healthcare of deaf and hard-of-hearing individuals, I think it's time these be changed.

RM: This is an example of what we referred to earlier as functional technical standards. And they come from my own institution, the University of Illinois in Chicago, where we very recently followed Lisa's lead. In fact, we moved away from the term 'technical.' We call ours now functional and behavioral standards. The real key word there being functional. Here's the analogous language about the communication domain analogous to what you saw from the other schools that Lisa just presented, and they read, *students must exhibit interpersonal skills that enable effective patient care*. The outcome is the focus. This requires accurate evaluation. And again, the outcome is the focus. Students must be able to record information clearly and accurately. It does not say how they interpret patients' verbal and nonverbal communications. *Students must demonstrate effective communication participation and collaboration with all members of a multidisciplinary healthcare team, patients and those supporting patients in person and in the written record.*

Note the differences, especially the need to communicate in-person rather than orally. This allows for a sign language interpreter, for example, to facilitate communication to meet these standards.

SS: So how can you improve your technical standards or the technical standards that are at your institution? As mentioned, there are several articles on the topic and a great five step toolkit within the disability as diversity text that takes you literally meeting by meeting through the technical standards review and revision process. Remember this chapter also presents the concepts we've discussed today in even much greater detail and is a free download from your library. As well, The AAMC hosted a webinar exclusively on technical standards in 2020. That webinar is also available free for anyone you simply need to register for the webinar if you're not already a member.

RC: In the beginning, we described how systems, institutions, and the policies and processes that run these institutions are informed by individuals. These individuals come to the space with a myriad of experiences that shape their beliefs and behaviors. Indeed, in my previous position at Northwestern, I had the privilege of having two learners who were wheelchair users enter and graduate from the Feinberg School of Medicine. And as I was reflecting on this webinar, it did not escape me that Samantha's ability to be accepted and to thrive at that institution is partially due to the experiences that the institution had in the past and their ongoing commitment to disability and inclusion at the university level, not coincidentally led at the time that I was there by Tim Montgomery, another one of Lisa's collaborators in the leadership of the Coalition for Disability Access in Health Professions Education. And not surprisingly Northwestern has continuously employed a disability professional that has specific responsibility for the health science schools, where, as you can well imagine, many of the clinical requirements are much, much different than the typical college student would encounter in the classroom. They've employed a disability professional with specific responsibility in the health professions schools for as long as I can remember.

SS: A long time. And just like that, we're already coming to the end of our webinar, but we do have a final warning about the issue that occurs when disability inclusion is only a surface commitment, and Dr. Meeks calls this the 'front of the house, back of the house' disconnect. Indeed, it's pretty easy to find exemplars for policy and process language for websites and progressive technical standards. And perhaps you even admit a few students with physical or sensory disabilities. Yes, admissions teams can also employ anti-ableist training and as a result, admit more candidates with disability. So, when all of those things are aligned, are you now disability inclusive? The simple answer is no, but this is what is happening in a lot of spaces on issues of diversity, disability, and other marginalized groups as we're witnessing changes to language statements in policy and in hiring of those underrepresented medicine.

LM: Thanks, Sam. I love a good fixer upper show and I love helping schools. So, when I get emails saying, *tell us what to do, what kind of policies and procedures should we have? What kinds of technical standards should we have?* I get really excited. But the problem is you can fix something up and it can look beautiful and symmetrical, and you can have an open house and people will come. Applicants will come. You'll look great. But if you leave the back of the house looking like this when students actually matriculate to your program, they're going to have a terrible experience. They're also going to have a lot of cognitive dissonance because they anticipated a really good experience based on the front of the house that you showed in all of your materials. Disability inclusion doesn't happen overnight, and it needs to be a real commitment.

RC: The simple truth is that until disability inclusion becomes a comprehensive institutional commitment and every member of the organization is provided with guidance, training and messaging about the benefits of training physicians with disabilities, you will have rooms or entire sections of the house that aren't really prepared to embrace this population.

SS: A few final thoughts about how you can actually embrace disability inclusion moving forward. First, start with the basics. Do a self-evaluation using the AAMC considerations appendix in the back of the report, join the Coalition for Disability

Access in Health Professions Education to be part of a community of DRPs and faculty who are focused and committed to this topic. If you are a GME program, join the newly established DIGME listserv, a community of GME stakeholders who are seeking information and support to make informed decision in the training space. Avail yourself of all these resources, all of which are free and a click or two away. Make sure you don't set up the dreaded 'front of the house and back of the house' issue that Dr. Meeks was referring to and train your academic leaders at all tiers so that they can set the expectations for their own divisions. And then know and publish the process for disclosing disability and requesting accommodation. Make it easy for learners to find, and don't be afraid to bring it up in multiple stages in training. We just had some students begin their clinical training and to be reminded how they can request accommodations was very helpful. Finally, you're not going to know everything and that's okay, but embrace that you don't know what you don't know and just ask. Partnering with the learners and the communities of practice will help you make the best decisions that are grounded in best practice and case law.

HJH: Samantha, thank you so much. And Drs. Meeks and Curry, that was just a highly informative experience, not only for myself but for those participating in today's webinar. So, as promised, we have allowed a good deal of time to take questions from our participants. Please use the Q and A function that you see on your screens in order to pose a question to our panelists and our host, Peter Goodwin will be sorting through the questions that appear in the Q and A and will be posing them to one of our panelists.

PG: Thank you, Holly. I would also like to let our attendees know that the chat function has been enabled and you should feel free to use it to share information or best practices with all attendees who are with us today. Let's turn to the Q and A that are coming in. This first question is a two-part question for our presenters and that is: *has your research reviewed how the role of disability, cultural centers in medical schools, those that are led and designed by disabled students and staff, can contribute to challenging structural ableism?* And the second part is: *are there any*

examples of medical schools that are providing a dedicated space where people with disabilities can develop a shared culture?

HJH: Dr. Meeks, can I turn to you to tackle that question or those questions?

LM: As far as the research question, I can tell you that I'm not aware of any research that's looking at whether a cultural center drives change in the structural systems or barriers. We are looking actively right now in a study at whether policy is considered to be a driver of change and prevalence of disclosure, but not of those centers. I think it's a really interesting question. As far as exemplars of where there is a center, I'm thinking about all of the schools that I would say are exemplars for medical education and disability inclusion. And I honestly do not think that any of them have centers. I know UIC has a center. Ray, do you want to talk about that?

RC: Yes. And in fact, just a little smidge in history here, it used to be that the resource center for the University was one and the same with the Disability Cultural Center. And that, and a couple of other things that didn't sit quite right with a new provost, led to the DRC being part of the Office of Access and Equity, and then a new rejuvenated cultural center was created to be able to be more focused on the kinds of concerns you're just talking about. From the college of medicine perspective, being on the east campus a mile or more away, and I don't believe it's utilized much by the students in the health sciences colleges, but it is a thriving and very active part of the various cultural centers that they have at the University.

LM: And Peter, I would say that I want to punt it to Sam because what I do know is happening across the country and what I'm really just so excited about and so proud of is the student activism that's happening on campuses and the student groups that are forming in these medical and health science spaces. Sam, can you talk a little bit more about the student led initiatives?

SS: I think it's really exciting when you have students who are taking charge and who are really going to become the next generation of physicians and leaders. I'm involved with a few different organizations that are student-led. One of which is called the Disability Advocacy Coalition in Medicine or DACMED. And we are now a group of national chapters that all are interprofessional, so medical students as well as students who are in training for PT and OT and orthotics prosthetics coming together to talk about how we can better train students to work with patients with disabilities and what is ableism and how can we advocate for our patients with disabilities and how can we be advocates ourselves, whether you identify as having a disability or not. There are other groups out there that are student led that are a safe space for students who identify as disabled. And you know, that's a really great place in order to have mentorship and a place to say, *hey, this happened to me. How do you manage going through X, Y, Z clinical rotation?* Medical school is hard regardless of who you are. And so, when you can come together as a community and off of each other's experiences, it makes a huge difference.

LM: I think there are several research-oriented spaces that also do advocacy or informing policy. And that includes the Johns Hopkins Center for Disability Health, the Stanford Medical Abilities Coalition, which changed its name and I cannot remember it I'm so sorry, but it now, the acronym says SMADIE and then of course, MDisability at Michigan, the Docs with Disabilities Initiative, and we're starting a new research group nationwide and actually worldwide called Dream Disability Research in Academic Medicine. So, there's a lot going on I know of in the research space and a lot of that research is being translated to best practices and to inform policy.

PG: Thank you. Our next question is about residency programs. *Many times, residency programs are open to being disability inclusive, but almost always don't have clear ideas on how to go about accommodating them. Institutional GME offices are not as proactive as they could be. How should one go about this?*

LM: That's a great question. I'm going to jump in just because I want to share a quick resource. The ACGME has a new program called Equity Matters. And as part of that

we have two disability training modules, one especially focused on accommodations. They are out now. They were released on June 1st. And I believe we have that in our resource handout that the Macy Foundation will be giving you. And so that's a great space. Yes, GME is a wild west and there's no guidance. I absolutely agree with whoever posted that question. You are spot on. But we, the ACGME, myself, the Docs Disabilities Initiative, and Disability and Graduate Medical Education Group are all working to quickly bring you resources. We've just completed two training videos and these two training modules. And we also have one-pagers and just-in -ime items on our website and encourage you to go and check that out. But yes, we are aware of it. And we are working fast to get resources in the hands of the people who need it the most, because all the UME people are going up to GME.

RC: Maybe a reason, or perhaps the reason why it is the wild west; GME programs at most major institutions are numerous. There are very different needs and requirements and barriers from one program to the other and most GME offices, by and large, this is true in most major institutions, I would say, the GME trainees are looking to the employer, be it at the university hospital, be it a private hospital, whomever and whatever they have in place in terms of determining and providing accommodation. But there's a lot of variation. And you have people rotating at some other affiliated hospitals where we have no directional control at all if we're sitting at the university hospital. So, it you know, wild west is a good way to explain it. I do think that the path to making this a whole lot better is what you just described. I think as soon as the ACGME has gotten activated, right, as they have, they have relatively new Chief Diversity, Equity, and Inclusion Officer. And I think the DIGME and the Equity Matters Initiatives will help to energize the same kind of movement that has come about in medical schools over the past several years.

LM: And I see that somebody just signed up for the new listserv. And so, we encourage you if you're a GME person to sign up for that DIGME listserv. It will launch on July 13th. So don't fret if you don't hear anything between now and July 13th. We want to get a critical mass of people before we launch, and that's the official launch date of our new initiative. So, thank you.

HJH: Thank you for emphasizing that, Lisa. I want to jump back to Ray for a moment. In thinking about GME and in knowing your personal long, long history of experience in working with medical students who are contemplating their next step, applying for residency programs specifically, what is your opinion and or advice to those students who you counsel about residency programs that may be more welcoming in the truest sense of that word and the spirit that you spoke about early in today's webinar. And do you actively counsel students away from certain specialties?

RC: That can be a whole other webinar if you like.

HJH: Yes, I agree with that.

RC: I think the medical education community has focused very intensively recently through something called The Coalition for Physician Accountability on the transition from UME to GME. And I do hope that this becomes a focus in their work as well, because one of the fundamental things about accommodation in medical school has to do with the fact that it's an educational institution. And we live by the rules, the Rehabilitation Act of 1973, and the parts of the ADA that have to do with educational institutions, which can be very different from what one faces in the work world. Then you have the additional ambiguity and that no one can really decide if GME is employment or studenthood. I always compare it to light being a particle and a wave. You know, it's both. Students do need a lot of guidance in understanding what's going to be required of them in residency and make informed choices. And the status of disability awareness within GME programs as we've all just been highlighting really needs to pick up speed. I can give you, well, I won't give you some specific examples that have come about where even for nondisabled people, lack of awareness of what was required of them. Well, I will make an example because you won't understand what I'm saying without it. In my prior experience, being a part of GME administration not once but twice, I had to see ophthalmology residents let go from their programs; their contracts not renewed because they simply could not manage

the degree of fine motor movement that's involved in the microsurgery. The response at Northwestern, again very much aware of taking stock of these issues and trying to find solutions, was that the ophthalmology department had a simulator that the residents were using. And they made sure that every student who was even thinking about ophthalmology had some time on that simulator that was monitored and observed, and they could make sure that their fine motor abilities were going to suffice to train in ophthalmology. You know, multiply that many times over with all the different skills for disabled and nondisabled people and I think there needs to be a lot more attention at the residency contemplation level as to exactly what you're going to end up doing.

HJH: Ray. That was a terrific example.

PG: Thank you. Our next question is from someone who's interested in increasing faculty and staff with disabilities at their institution. *What advice do you have for institutions that want to increase their faculty and staff with disabilities, and where can we find best practices for processing accommodation requests at all levels, whether it be student, faculty, and/or staff.*

LM: Great question. We've written about this extensively and I realized I'm using the book to hold up my computer. So, I can't necessarily hold up the book. But it's the Disability is Diversity book. And in chapter four we have structures and advice on structures. And at the end of the day, the bottom line is that your institution will be looked at in sum, so the entire institutional budget for any accommodation needs. So, you should have a centralized funding system because whether you have it proactively, or whether you have it post ADA citation, you need to have it. And I would say, as far as, how do you increase? There are disabled people, qualified, brilliant, amazing disabled people wanting to go into academia, wanting to be there. Think about what you're doing to recruit and retain other underrepresented populations. You need to expect them to be there. You need to plan for them to be there. You need to connect them with mentors. You need to fund them appropriately, and don't give them the disability tax of having to then host every

committee known to man about disability that takes up, you know, 30% FTE, and they're not getting paid for it. And they're up at night and the weekends. And so their productivity goes down in whatever form productivity is for that particular area. So, you need to put the time and the effort and the money behind your desire to increase this population. It won't be hard to find people to hire. If you put all of these things into place. If you build it, they will come and they will stay and they will be innovative and amazing and productive.

PG: Thank you. This next question is whether or not the AAMC has either considered or been presented with the idea to ask about disability/ableism and mistreatment in its GQ and Y2Q.

LM: Thank you. I wrote those questions about four years ago, and they've been on, they've been on the AAMC, Y2Q now for three years. And the GQ, this is the third year, 2022 will be the third data collection. So, we actually have that data. And it's part of what we are analyzing; part of what you heard today about students with disabilities having greater levels of empathy than their non-disabled peers that came straight from the Y2Q data. So that's unpublished, we've finished our analysis, written up our manuscript and submitted it. And we have lots more. It is a wealth of data. And we're so proud to partner with the AAMC. They have in the last five years, been incredible partners to bring this information to the public and to address disability inclusion straightforward. So, thank you for the question, but if you Google Y2Q data and GQ data, you can actually find the PDFs; they're readily available online. And so that's where we got some of that data from that we presented earlier.

HJH: For those in our audience today who may not be familiar with those survey instruments. Those are national survey instruments used by the Association of American Medical Colleges to gather feedback directly from medical students at various points in their educational experience.

LM: And in our disability questions, we left an open-ended question. And boy, let me tell you, I have 4,000 data points that a wonderful Dr. Sturgiopolis and Dr. Jain are qualitatively analyzing cause my brain doesn't do that much work. And we will have incredible data and reporting out for you. But I would say that overall, the initial analysis would support everything we've said here today and increase that unfortunately, but many learners reported being really happy with their schools. There was, you know, a dichotomization of sorts where students at particular schools, and I think we all know who those schools are, are having amazing experiences. And then the rest of the students are like, we wish we were at that school. There are a group of students having really, really good experiences. And I applaud those institutions for, you know, everything they've done to build an infrastructure and to train, again, like Sam said, like Ray said, this is a lot of it is just a preconceived idea that because you are a person with a disability, you will struggle. You will have difficulties. You will not be able to make it. A lot of this is mindset.

PG: Thank you. We are approaching the top of the hour. So, this will be our final question in this webinar. *In your slide deck, there was a slide that showed a higher percentage of trainees with disabilities versus clinicians in practice with disability. Do you think this shows that the situation is improving, that there are more students with disabilities than previous or that attending physicians with disabilities stopped practicing at disproportionate rates?*

LM: I want to know who asked that question because I want to have a conversation with them. I love that they caught that. I'm writing about it right now. It is, you know, statistics are interesting, right? And so, the way we measured, we use the same question bank for all three of those reports. And I think it could be looked at very differently because how you measure disability, that was all self-reported by the way. And you didn't have to have accommodations. The numbers are very different depending on how you measure it. But I think a couple of different things are happening. One, I think there's this huge wave, and I think Samantha would support this, of people who are what I call disability proud, who are at the entry of medical school, saying, I am a person with a disability. Disability may have been what

informed my decision to enter medicine. I am smart. I am capable. I am here, and I'm not apologizing for being here. Love those students. I think that, you know, you feed off of that system, right? So, you start to see more students going in and these students are really activated. And so more students are applying. So definitely seeing an increase in application. At the same time that hasn't, I mean, as much as Ray and I were describing kind of GME, if GME is so problematic, imagine what the workforce looks like, and we have a paper coming out. I'm not allowed to talk about it, but we have a paper coming out that paints a horrific picture of what physicians with disabilities face in the living, working environment every single day. And I believe that absolutely people are leaving. People are leaving medicine who don't have disabilities because of poor working environments. So, it's not a jump to say that people with disabilities who may be experiencing harassment or bias and harm are also going to choose to leave and enter maybe either a nonclinical field or completely leave medicine. And that really saddens me, but there is a big dive there, and I'm glad you caught that. So, we're working on that. We have a lot of data we're sifting through, and we have some papers that are coming out and some papers that are, that are under review. So, lots of information coming in the next, I would say year, but you're right on to have captured that. And we definitely, definitely are seeing some movement.

RC: And all of the things being equal, just to put a fine point on this, you would expect the prevalence of disability to be increasing as people move into practice. And later in practice, just because of the incidents of acquired disability. So, that's another constituency that's probably not being well served with accommodation strategies et cetera, et cetera.

LM: We have a big announcement coming out July 13th, but I will give you a little sneak peek that one of the things that we have received funding for us to look at accommodating physicians who now have long COVID. So that number, and we we're collecting the data right now, in the physician workforce, in that national sample. And we've asked the impact of COVID. It's going to be really interesting to see what we get back and how many physicians now, because of long COVID are having to adjust

their practice or having to leave medicine all together. And so, there's just so much happening in this space, but I really want to thank whoever asked that question and, um, would love to chat offline. I think it's just all of this is so interesting to me.

HJH: Dr. Meeks, Dr. Curry, Samantha, the three of you together have made this a rich and wonderful webinar today. I'd like to not only thank you but share with our participants that this webinar has been recorded and it will be posted on the Macy Foundation's website in about one week. So, take a look at our website in about one week and you will have access to this recording. I know that we covered a lot of information and there may be segments of today's webinar that you'd like to go back and review or re-listen to, we will also make the many resources that were posted in the chat during the course of the webinar, we will make those resources available to you as well on our website.

And as you can see from the incredible conversation that we've had here today, there are a number of topics that we didn't even get to but I promise we're going to come back to many of the questions and comments that you raised in today's webinar and cover those in two additional webinars that are already scheduled and that we are advertising taking place first on July 12th at 3:00 PM Eastern time where we're going to specifically delve into the topic of assessing and evaluating trainees with disabilities. But of course, that leads into a whole host of other topic areas such as happened today. And then on July 26th, again at 3:00 PM Eastern time, we will talk about practicing physicians, and we'll have some practicing physicians with us as panelists who themselves have disabilities. And we will learn through their direct experience of both the joys and the real challenges of their work as practicing physicians. So once again, thank you for being with us today and stay tuned. There's more to come. That concludes today's webinar.