

**Peter Goodwin:**

Good day and welcome to the Josiah Macy Jr. Foundation's webinar, Exploring the Barriers to Inclusion for Physicians with Disabilities, the third 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](http://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 will be chatting with all attendees and the panelists. Please feel free to use it to share information or best practices, or to comment on responses to the questions.

The Q&A function on your Zoom screen is active and will be throughout the webinar. Please use it to pose questions to the panelists that relate to the content of this webinar.

Finally, we encourage you to continue this conversation on Twitter using [#equityinclinicallearning](https://twitter.com/equityinclinicallearning) or [#docswithdisabilities](https://twitter.com/docswithdisabilities). Now I am pleased to introduce the president of the Josiah Macy Jr. Foundation, Dr. Holly Humphrey. Holly?

**Holly J. Humphrey:**

Thank you, Peter, and welcome everyone. I would like to begin by introducing today's panelists. Dr. Lisa Meeks is assistant professor in the Department of Learning Health Sciences and Family Medicine at the University of Michigan Medical School. She is also director of DocsWithDisabilities Initiative and co-host of the DocsWithDisabilities Podcast.

Dr. Meeks is an expert in disabilities in medical education. As an administrative leader and researcher, she is helping to inform policy and best practice in the area of disability inclusion for medical education, training, and practice.

Next, I'd like to introduce you to Dr. Christopher Moreland, who's an associate professor of internal medicine and associate residency program director at the Dell Medical School at the University of Texas-Austin. As a clinician educator for over a decade, his teaching and mentorship have been recognized with awards at the institutional, regional, and national levels. His research and publications actually address policies and pathways in healthcare workforce diversity for people with disabilities, as well as health disparities affecting deaf and hard of hearing people.

He currently serves as president for the Association of Medical Professionals with Hearing Loss, a nonprofit committed advocacy and mentorship for deaf and hard of hearing healthcare students and professionals.

Next, I'd like to introduce Dr. Diana Cejas, a pediatric neurologist and faculty member for the Carolina Institute for Developmental Disabilities at the University of North Carolina at Chapel Hill. Her clinical work and research focus on improving care

delivery and health outcomes for children and young adults with neurodevelopmental disabilities.

Since surviving cancer and a stroke during her residency, Dr. Cejas has devoted much of her career to patient advocacy and to improving communication between healthcare providers and the disability community, particularly young, disabled patients of color.

She shares her own story and other commentary on disability and health via essays and other works of nonfiction. Her work has appeared, or is forthcoming, in the *Journal of the American Medical Association and Neurology*, as well as prestigious literary magazines, including the *Iowa Review* and *Passages North*, as well as anthologies, including *Disability Visibility: First-Person Stories from the Twenty-First Century* and *A Measure of Belonging: Twenty-One Writers of Color on the New American South*.

Finally, Dr. Christopher McCulloh is a board-certified general surgeon and currently finishing a fellowship in pediatric surgical critical care at the University of Michigan. He has also completed a fellowship in pediatric minimally invasive surgery at Nationwide Children's Hospital, Ohio State University, and has extensive research experience focused on pediatric surgical diseases, in particular necrotizing enterocolitis.

His research publications and presentations have received numerous awards at the international, national, and regional levels. He has also served on the diversity, equity, and inclusion committee of the American Pediatric Surgical Association and is currently on the DEI committee for the American College of Surgeons.

He has a spinal cord injury that requires the use of a wheelchair, which he sustained prior to medical school. He has spoken and published at length on accommodations for disabled learners in procedural medical specialties.

Now let me give you an outline of what we plan to cover in today's webinar. I will begin by providing an overview of how the Macy Foundation's webinar series came to be. Then I will turn it over to Dr. Meeks and our panelists. We aim to leave a significant portion of today's time for this webinar for the question-and-answer period with all of you participating today. So let me begin with that background information.

In February of 2020, a group of faculty, residents, students, and leaders from medicine, nursing, and healthcare came together in Atlanta, Georgia on a conference that we had arranged on the topic of addressing harmful bias and eliminating discrimination in health professions' learning environments.

Out of that conference, we developed a series of recommendations that all of the conferees agreed to and signed off on, as well as a publication in *Academic Medicine* with all of the papers that were commissioned for that conference, as well as additional papers that were part of the special supplement. You can find all of those resources, both the conference recommendations and the supplement to *Academic Medicine*, on our website at the Macy Foundation.

Now what you see in front of you is an acknowledgement that it was 32 years ago today when the Americans with Disabilities Act was signed into law. This landmark

legislation protects the civil rights and liberties of individuals with disabilities. Since that time, July has been a month when we celebrate disability pride.

Today, we are so grateful to have as our panelists three physicians with disabilities, so that we can learn from their experience and to engage in a conversation with them about how our training environments can improve the climate for disabled physicians and how they have navigated their work environments, because ultimately those environments are the same environments in which patients and their families receive their healthcare. I personally am a learner in this space myself, and I invite all of you to become learners with me.

At the Macy Foundation, we have created a list of resources and educational tools, and these will be included along with the recording from today's webinar on our website within the next week.

And so, while we celebrate July as disability pride month and today as the actual anniversary of the Americans with Disabilities Act, we want to have 365 days a year, 24 hours a day as opportunities to do better and raise awareness and create the kinds of learning environments that will be inclusive for everyone in there.

But let's not stop here. Let's find meaningful ways to improve access in our training programs and celebrate diversity every single day. I wish to take a moment before we begin today's webinar to acknowledge and thank Dr. Lisa Iezzoni, professor of medicine at Harvard Medical School, who was a conferee at that conference that I mentioned earlier in February of 2020.

Dr. Iezzoni helped all of us who attended that conference better understand the complexity of the issues of those with disability face every day in their journey to becoming physicians and as practicing physicians. She not only helped us outline the challenges and the issues, but she helped us outline a path forward to remain true to our commitment to create inclusive learning environments, especially for those with disabilities.

Now on the next slide, you see the titles of this three-part webinar series. Today is the third webinar in this three-part series. You can find the recordings of the first two webinars on our website. As I already mentioned, you will see the recording from today's webinar within the week.

So this series is one way that the Macy Foundation is supporting the inclusion of trainees and physicians with disabilities and elevating their stories. Each webinar is informed by and includes people with disabilities. The Macy Foundation believes that disability is an important part of medicine's greater commitment to diversity, equity, and inclusion. We invite you to engage with the many resources that are available on the topic of disability, as well as inclusion in medicine, many of which are on the resource list and, as I've mentioned, on our website.

We are all responsible for disability inclusion and access, and we must do our part to change the landscape and the mindset from one of exclusion and deficit to one that truly celebrates the talents of our colleagues and of all of our patients with disability. Now it gives me great pleasure to turn this over to our distinguished panelists, beginning with Dr. Meeks. Lisa?

**Lisa Meeks:**

Thank you so much, Dr. Humphrey. I also want to thank the Macy Foundation and Dr. Iezzoni for bringing this to the Macy Foundation, but for recognizing and celebrating this special time of year and also to talk about the need to be vigilant year-round about equal access.

In this series, we've discussed barriers and belief systems for physicians with disabilities, but we've spent a good deal of our time talking about the trainee population, students and residents. Today we are so lucky to be focusing solely on physicians in practice.

Alright. So we've discussed the prevalence of students and residents with disabilities, but it may surprise you to find that when using the same methods, the same questions about disability identity, we find a much smaller percentage of the physician workforce self-reporting disability. Indeed, a recent study that used a sample of over 6,000 physicians found that only 3.1% of these physicians self-identified as having a disability.

As you can see from this slide, the decline is fairly steep, moving from 8.3% of students graduating medical school to 7.5% of residents in training, almost going down 50% to 3.1% for physicians in the workforce.

I want to take a moment just to thank the partnership that we have, thank the people at the AAMC workforce studies team, because through this partnership, we were able to gather more information about physicians with disabilities and to share that with you.

This slide outlines significant differences in individuals who disclose disability. For example, individuals were less likely to identify as heterosexual or straight. They were more likely to be members of a racial or ethnic group that is considered underrepresented in medicine. They are more likely to have served in the military or be on active duty.

As well, in looking at categories of disabilities, this mirrored what we see in the trainee population. Most commonly reported are chronic health conditions. About 30.1% of the physicians that disclosed were identifying as having a chronic health-related disability, followed by mobility, and then psychological. Other disabilities, things like being deaf or hard of hearing, having adult attention deficit disorder, a visual disability or learning disabilities were less prevalent. Physicians with disabilities were significantly older than those without disabilities, as would make sense.

In slide 10, we list some of the many benefits of individuals with disabilities being in the physician workforce, including increased empathy. We have a paper coming out soon that we'll talk more about that. Informed patient care, being able to understand or situate themselves in the patient's experience as being a person that has also been a patient, facilitating shared decision-making, contributing to innovation, and we hope that our panelists will be able to speak more to this today, and then practicing concordant medicine. I do want to say something about this in particular.

While we do see that physicians with disabilities tend to go into medicine to treat individuals with a shared disability, we do want to note that physicians with disabilities

should be able to enter medicine and be able to serve a population that is important and exciting to them, and that does not always mean that this needs to be a concordant population. Indeed, I think the benefit of the lived experience of being a patient will serve them well in supplying care to any group of patients.

Then we do know, especially from our recent research, that individuals with disabilities are more likely to enter primary care. And so, you will hear straight from our panelists today more about this. Thank you. I'm going to turn it back over to you, Holly.

**Holly J. Humphrey:**

Okay. Thank you so much, Lisa. I'd like to invite those of you participating in the webinar today to use the Q&A function if you would like to submit your own question. But to get us started, I would like to ask a few questions of my own to today's panelists.

So I know that residency training is really hard for everybody. And so, I'd like to begin by asking our panelists if they could comment on what their biggest challenge was during residency training. So, Dr. Moreland, let's start with you. Dr. Moreland, if you can unmute yourself, we'll have a chance to hear you.

**Christopher Moreland:**

Yes. Thank you, doctor. I'd like to respond to the first part of the question. Looking back, my biggest challenge to entering residency was specific to my being deaf. That is my specific disability. And I share the common challenge of having a disability.

Also, managing the overload of information that new residents have to process learning the systems, learning the processes, networking, learning about medicine itself, and developing a framework for all of those things as I encountered them newly as a new resident.

On top of that, I didn't realize until after residency that as a deaf person working with interpreters, sign language interpreters, during that time, I had an additional challenge of managing the process of working with the interpreters. This is not something that was a shared experience during training.

For example, if I needed to invest time, it might be to do relationship building, to figuring out how to identify and implement interpreting services, how to make sure that those would be effective throughout my training, regularly communicate with my program director and others in leadership, other stakeholders, including the interpreters themselves. This is something that I continue to have to do throughout residency.

Additionally, there was the process of ... I'll phrase this as frequent education of my colleagues, nurses, and even patients about working with interpreters. Of course, eventually I integrated that practice into my workflow, into the regular portions of my day. It became very commonplace. I've heard from other residents and healthcare professionals with disabilities that we do figure out how to find the time and energy to effectively manage those accommodations as we progress in our training.

**Holly J. Humphrey:**

Dr. Moreland, thank you. That was a very comprehensive answer. As I said, I think residency training is hard for everyone, but you took us through a really rich explanation, not only of what it was like in terms of adapting to a new system but all those extra challenges that you faced and obviously overcame. Let's turn to Dr. Cejas. Can you tell us first what your biggest challenge was in your residency training and then the biggest challenge as a person with disability during residency?

**Diana M. Cejas:**

Absolutely. I just want to echo I really appreciated the comments that Dr. Moreland made. So much of that resonated with me, although we obviously have different disabilities. I think that my biggest challenge in residency was also partially related to my disability, but partially related to some other multiple intersecting identities that I have, and that was really struggling with confidence and also feeling like I earned the spot that I had earned to be in the position that I was in.

I think that there's a lot of debate about whether imposter syndrome is a term that should actually be used since it is such a common feeling among racial/ethnic minorities, among women and other gender nonconforming individuals, among really anybody with any kind of marginalized identity. Whether we should really be talking about it as an imposter syndrome or the fact that, really, as we're navigating through these spaces that are not designed for us to work in, we're also having to grapple with the fact that there's outside pressures. There's always someone who's going to be questioning you, whether you fit, whether you are able to do the job that you're able to do.

So as I was trying to learn to navigate these systems and trying to just do a good job as a resident, I always, and even to this day, would question what I'm doing, trying to make sure that I'm doing a good job, trying to make sure that I'm actually reading what I'm supposed to be reading, working as hard as I need to be working, and all of that stuff. At the same time, there still seems to be this little voice that's like, "You're not good enough. You're not working hard enough. You don't belong here."

So I don't think that I can 100% separate that from my disability, because, of course, as I had to learn to ask for accommodations and as I had to just figure out how in the world I could do some of the things that I needed to do with some physical limitations that I have, I'm also recognizing that I'm having these same kinds of confidence or imposter syndrome issues or whatever you want to call them because I'm a Black woman in this space, because I'm a Latina in this space, because of who it is that I am in this space.

Then just thinking as a person with disabilities within residency, I think, similarly, one of the biggest challenges that I had was knowing when to ask for help and knowing who was safe to ask for help. I found myself, especially ... I had my illness while I was in residency. Especially in those first few months where I was still feeling very vulnerable, I didn't know who it was okay to talk to, because I quickly learned that people that I thought I could trust or who I thought were in my corner weren't.

So having to figure out, okay, who can I actually talk to about this? Who's going to see me asking for accommodations as a reasonable request? Who's going to see it

as something of me trying to game the system or get something over on somebody? It really was a learning experience and was really difficult, some emotions that I had to deal with around then. But I'm lucky in that I was able to find my champions. It just took me a little while.

**Holly J. Humphrey:**

Wow. Dr. Cejas, thank you so much for the vulnerability you just shared with all of us. I want you to know that the issues related to intersectionality turned out to be a very major set of issues that came up at that conference that led to all of this work, because if we're really going to be serious about addressing harmful bias and eliminating discrimination, you're immediately going to come upon exactly what you just spoke about, the issues related to intersectionality.

Now I want to ask you one follow-up question, and that is you talked about something that I think is very common and that is who is safe? Who can you trust? Who's going to really help you? For those who may be listening to this webinar, they are likely asking the same question. Do you have any pointers? Given everything you went through, do you have any pointers for how you figured out who was safe and who you could trust to really be your advocate?

**Diana M. Cejas:**

Yes. I think the way that it ended up working for me was I had to start ... I don't know if it was putting out little breadcrumbs or putting out feelers to see how people felt about disability or chronic illnesses. I remember in particular when I first started feeling the most safe was I needed some dictation software to help with writing some of my notes. I was so nervous about asking. But I remember just breadcrumbing, putting out a little bit of information to my program director first.

Then at a given point, I was just like, "Forget it. I'm just going to tell you what's going on and we're going to see what happens." As soon as I asked him for the software, he was like, "Well, do you want to just use the kind that I use? That's fine. It was no big deal."

I think that as I went through training, I would do the same thing, where I would just test the waters with someone, see what they came up with. I think that, more often than not, there were times when people who I was talking to had the same kind of relief that I did, because I would find out they maybe had some personal experience with disability, or their mother did, or someone else.

So I would share a little bit of my story and then all of a sudden they would flood me with information about theirs. I was like, "Okay, here's someone that I have this rapport with. Here's someone who understands what I'm going through." And so, I was able to come up with a little bit of a network.

**Holly J. Humphrey:**

Wow. That is so rich and wonderful and gives us all, I think, a lot of hope that those people who can be advocates and allies really are out there. Let's turn to Dr. McCulloh,

because I think all of us think of training in surgery as pretty grueling and very rigorous as residencies go and certainly as practice goes.

So, Dr. McCulloh, what was your biggest challenge in residency training? Then what specifically was your biggest challenge as a person with a disability in residency training?

**Christopher McCulloh:**

I think, like Dr. Cejas and Dr. Moreland have already said, we have some very similar threads between all of our experiences. Actually, in particular, I want to say I really liked your comments on the imposter syndrome and trying to get rid of that idea. I think that does a lot of subtle damage to people.

The biggest challenge I think is just the sheer volume. Like you said, it's the volume, it's the time, it's everything else. I mean general surgery is five years, and then I wanted to pursue pediatric surgery, which is an even longer road. So it's just the hours and the time they're exhausting, even without adding on a disability on top of that.

The biggest challenge, I think, that was disability related, I would echo some of the same feelings of not knowing who you can be completely confident in and who you can open up to. Part of that for me was in learning to be open with myself as well and figuring out what resources that I needed to ask for.

I think one of the hardest things for me with respect to my disability was that I came into everything and wanted to prove that I could do this and I don't need any help and I don't need any special treatment or anything like that. In a lot of situations, that actually ended up making things harder for me, because by not being upfront with myself about what I needed ...

For example, I would be not wanting to ask to reposition or do something differently in an operating room because I didn't want to be seen as asking for extra help. Well, the end result is that something was not optimally set up for me. I would fail because I wasn't doing things in the right way.

So not that I would fail and it caused any harm or damage, but people would see me struggling in a way that if I had simply said, "Well, let's adjust the table in the operating room," then it would be a lot easier for me and I would be a lot more successful.

So that was a really hard lesson for me to learn was how do I accept the disability and ask for help and be vocal about asking for the accommodations that I need, which ultimately are what is going to facilitate my success in the long run?

The other thing I think that was interesting from a surgical perspective is that I had to learn not only that this was a learning process for me, but it was a learning process for all of my mentors and my teachers and everybody else. They had not worked with a learner who was disabled before.

In surgery, people are used to doing something in a very particular way. They always do a procedure the same way. Attending surgeons always teach the procedure in the same way to everybody. So when somebody comes in and says, "Hey, I can't do



it the way everybody else does it. I need to do it differently," that's actually asking them to step out of their comfort zone, which is very hard when you have, as you said, something that's very rigid and very structured as surgery.

It's a similar thread, I think, is that I not only had to learn about myself, but I had to learn how to manage those relationships and those experiences and how to explain what my needs were to people before I was in the operating room, in that situation, in order for it to be successful. Otherwise, the whole experience would just be wasted time.

**Holly J. Humphrey:**

Well, I think you made so many wonderful points there, one of which, I think, has to do with your teachers and mentors. Did you find that for the most part they had the spirit and the growth mindset of learning with you about what accommodations you needed and which ones to ask for, or was it hit or miss, some people being more open and willing than others?

**Christopher McCulloh:**

It was definitely more hit or miss, but I will say that the place where I did my residency program, it was far more of a hit than a miss. It was reflective of the culture at the institution that it was very supportive from the top down, from the program director and the chairman all the way down. That made a big difference.

I've been in a number of different institutions and I've seen the way things work in different places. I think more often than not, people want to be supportive and they want to be helpful. Sometimes they just don't know how to do that. But then there are some people who are just so rigid that they're looking for reasons to discount a learner with a disability. Those are the people that I think are harder to win over and those are the people who we have to show them that disabled people can be successful in these fields, too.

**Holly J. Humphrey:**

Yes. That is a beautiful segue to the next question that I'd like to pose, and that is all three of you are examples of individuals who successfully made it through your residency programs and you're all practicing physicians today.

So what, if any, accommodations do you use in your everyday practice and what was the process like once you started asking for those post-training? Now I know, Dr. McCulloh, you're, I think, still in your fellowship. But, anyway, we can all talk about what accommodations you're using today and what was the process like once the training period was over. So, Dr. Moreland, let's jump back to you and learn from what your experience was.

**Christopher Moreland:**

Thank you. So you're asking specifically about accommodations after training, correct?

**Holly J. Humphrey:**

Yes. Yes. In your everyday practice with patients.

**Christopher Moreland:**

Sure. That's a fantastic question. In my current work, since medical school and residency, actually including medical school and residency, my entire career, I've worked with sign language interpreters essentially as my sole accommodation. It's interesting that we're talking specifically about accommodations after training, because I think it's important to emphasize that our accommodations can change over our careers depending on our status, the type of work that we do, the activities that we're engaged in, how familiar we are with our practical needs. Things evolve from residency into practice.

So to answer the last part of the question, about the process of obtaining and establishing accommodations, I'd like to point to my hospital medicine division chair as an exemplar for really an ideal implementation of accommodations. We have regular conversations about creative ways to implement a place for interpreters within the organization. Different organizations and different people have found a variety of different ways to make that happen within our group.

We decided to hire two staff interpreters to work as designated interpreters, specifically with me. So they work under the same employer essentially as I do. So instead of working through a community vendor, they're hired specifically and directly by my department.

That has a host of benefits, including a developed, shared experience within the organization, a mental model for all of us to function within. They are included within the organizational chart. They are key players that support my career trajectory and my professional activities after the services have been implemented.

In other words, from the leadership of our division, there was a clear commitment to supporting the faculty in general, which included me, and finding ways to thrive not just to survive within the environment, and to pursue excellence within our work.

**Holly J. Humphrey:**

Interesting. Listening to you describe that, Dr. Moreland, it makes me wonder to what extent this was a topic when you were being hired. I'm sure that many of our listeners are thinking about how do they navigate these conversations when they're interviewing for a position? To what extent did this come up when you were looking for a job?

**Christopher Moreland:**

Sure, sure. I think that's one of the most common questions that, in my experience, my own experience as a mentor to other people with disabilities, as they enter health science education professions, that's one of the most common questions that comes up, is how do I manage this conversation while I'm looking for employment?

Ideally, the discussion about accommodations and how they will be created is held until after a job offer is made for legal reasons, as well as just ideal ways to handle

the situation. Encouraging the employer and educators and administrators to focus on the qualifications for the position, how that person meets the essential demands of that position with or without accommodations. Then they have a discussion about what those accommodations might look like after the job offer is made.

That places the person who has the disability in an interesting position, because they're trying to get the job that they're applying for, obviously. So obviously that becomes awkward. They don't want to be in a position where they have to critique the institution making the job offer about how they're handling the circumstances surrounding the accommodations.

So we need to start having this sometimes subtle, sometimes explicit dance as we navigate those discussions, focusing on the job, the qualifications, and the experiences themselves. I think that awkward tension for the applicant is especially true immediately after training, when they're applying for their first job ever. It becomes a little bit more manageable over time and with experience as someone develops the experiences that they have requesting accommodations.

There's a lot that can be shown about the culture of an organization and the leadership and their own philosophy, which will be shown by how they respond to the questions that are posed.

**Holly J. Humphrey:**

That is such a valuable review that I'm sure many of our listeners are going to benefit greatly from. So thank you for going through that, Dr. Moreland. Dr. Cejas, let's turn to you and find out what accommodations you use in your everyday practice and what the process was like for you once your training was over.

**Diana M. Cejas:**

Yeah. I really appreciate the comment that Dr. Moreland made about how your needs for accommodations can change over time. Mine certainly have. As a matter of fact, sometimes my needs for accommodations will change depending on the day, depending on the week, depending on my level of just ... How much sleep I've gotten the night before.

So for me, when I first had my illness, my biggest need for accommodation was to have some kind of equipment to be able to finish my notes. I'm a neurologist, which means I write some very long-winded notes and I needed to have something that could help me just be able to complete it, because I had such a hard time using my affected hand. Plus, I was also having some issues with this, my dominant side, because of the surgeries that I'd had.

So, initially, for me, that meant dictation software. That's something that I've continued to use really since I first became ill and started going back into practice. But it's not something that I have to use quite as much these days, because I am better at typing with one hand and using my second hand a little bit as a ... It just pecks one letter. But the rest I can usually do with my right hand.

It is easier for me to type when I'm trying to use this left hand with keys that are a little bit bigger. So in addition to having dictation software, which I must say my chair and my division chief, when I asked for accommodations, and one of the first things I mentioned was a dictation software, it was no question because everybody in the department uses dictation software. So it wasn't even about me necessarily needing something special. It was just me getting on board with the rest of the team.

Then when I would explain that I would need something like a keyboard with higher keys, same thing. It was like, "Well, okay. Well, we can go and get you this kind of keyboard," that they happened to have. It wasn't like there was any special request that I had to make. It was just about finding the right kind of equipment for me.

Now I imagine that things might continue to change. I think that we all know how exhausting some days can be. When I'm a little bit more tired, I get a little bit, I call it, strokey. My team's like I'm less able to mask my symptoms. So it's a little bit harder for me to type. It's a little bit harder for me to even talk a little bit. So that's days when I'll rely more on the dictation software, or I will use ... I have a swipe function on my phone and they helped me figure out how I can use swipe within the electronic medical record software that I have on my phone. That's actually the easiest thing for me to do outside of using the dictation software.

But, again, with all of these, I just told my division chief that I needed something and they said, "Okay, fine. Let's go to it." That was, I think, really nice for me.

I also didn't have these conversations until after I was hired, but even then it was like, "Okay. Well, these are some things that we're going to have to do." I'm not sure if it is because there have been other people that have requested these kind of accommodations before me. I think that might have been the way that the entire department got the dictation software, which is nice to know that there was somebody anticipating that people might need them.

I'm not sure how things might change for me as I continue to get older. I assume at some point, I've had problems with this dominant side before, I need to go to physical therapy every once in a while. I'm sure that I'll probably have problems that arise as I age. But just knowing that I have an open-door policy with my division chief and with my chair so that they just know that if there are things that change or if there's something else that happens, something else that I need, they're willing to listen and work with me.

I think that's one good thing about being a neurologist who's had a neurological condition in the department of neurology is that they understand how I might need these things over time. So it's been a pretty soft landing for me.

**Holly J. Humphrey:**

That's extremely helpful and so wise to be forward-looking in how things may change over time. So that's an important theme that I think both of you have raised. Dr. McCulloh, do you have anything that you would like to add to this? I think you're still doing your fellowship. So maybe you're actually looking for other jobs now. I'm not sure exactly where you are in that process. So we'd love to hear from you.

**Christopher McCulloh:**

Well, what I can tell you at least about accommodations, from my perspective, I had to start early on in medical school when I had an interest in surgery. If it wasn't for a physiatrist who took a very personal interest in my progress, I don't know that I would've been able to even start residency at all.

One of the things that I had to figure out early was adaptive equipment in the form of a standing wheelchair and how I was going to use that and get into the operating room and be able to move around the operating room independently while remaining sterile. I spoke to a practicing plastic surgeon who was disabled, who had done it before me, and he gave me a ton of advice. I worked with a physiatrist at medical school in Case Western, and we actually got a grant from the Nielsen Foundation to obtain a standing wheelchair that was to be purchased for the university, for them to use for training students who are disabled.

So now actually Case Western has this standing wheelchair that any disabled student can use if they want to get into the operating room. That enabled me to even go through my surgery rotations in medical school. But the thing is that this was property of the university. So then I had to go and get my own chair, which was going to be my property, which I needed to ... This is not something that I could be applying to residency programs and asking for them to provide at the same time.

So I went out and we started this process when I was in the end of my second year of medical school at Case Western. It took us a year and a half, but we eventually got the funding from the State of Ohio to purchase a standing wheelchair for me. The funding came through midway through my fourth year and the chair was delivered probably about two to three months before I was scheduled to start residency.

Had it not been for Dr. Nemunaitis, he was the physiatrist at Case who had put all of this together, I would've not been able to even start my surgical training to begin with.

So that was the first part. Going through residency training has just ... I've had to learn different ways to do procedures and develop using harnesses and other things to reposition my body.

I got lucky enough when I came to the University of Michigan that I also met Dr. Karin Muraszko, who's a pediatric neurosurgeon, who also is disabled. I got designs for her custom chair that she uses. And so, I was able to take those designs and then get another second chair built up, which has helped me to do bedside procedures and things.

So it's been an ongoing process throughout my training. As far as the people that I work with, they've learned how to adapt to that equipment as well. So that's the very brief overview.

**Holly J. Humphrey:**

Yeah. Wow. Well, you've all had such wonderful allies that you've discovered along the way, and that, again, it's very encouraging, I think, to all of us listening to you. I want to go to the next question because I've personally been really eager to hear what you have

to say about this. So we would love to know how patients respond to you as a physician with a disability and what insights do you think that brings to the patient-physician therapeutic relationship? So, Dr. Cejas, let's start with you.

**Diana M. Cejas:**

Sure. So I am at the point which my occupational therapist told me not too long after I had my stroke that eventually I might get here. I can pass as non-disabled at this point. I mean a lot of my chronic health conditions are invisible. If you're not paying attention very closely and you are not a neurologist, you might not necessarily look at how I hold my hand or how I'm able to carry my body or how I walk. You might not necessarily notice my scar, especially if I have on a collared shirt. So sometimes patients can't necessarily tell.

But there have been times when patients either notice something about me. In particular, I'm thinking about some interactions that I've had with some of my patients who have things like cerebral palsy. I actually not too long ago had a patient who I came into the room, he was holding his hand up the way that I hold mine up, just because that's the natural place that both of our hands like to sit, and the mother noticed immediately that that was how I was holding my hand.

She was just giving me the eye throughout most of the visit. I think it was that she wasn't really wanting to ask, but the child asked, because children are going to ask these kinds of questions. He just mentioned he noticed how I was holding my hand. I said, "I noticed how you're holding your hand." He was like, "I have cerebral palsy." I said, "I had a stroke." And that was it.

But the mother burst into tears because she had never seen ... I guess none of his doctors ... And by this point he was nine or ten years of age, but had never had a doctor who had a disability, particularly one like his. The child was just like, "Yeah, this is cool. Okay. We're going to go back to doing what we were doing and talking about what we were talking about."

But I think that the mother really appreciated that her child was able to interact with me, just because even though we had different kinds of backgrounds, we had, I don't know, similar kinds of issues.

So I think that, one, being able to be a kind of ... I don't exactly know what to call myself, a model, or just an example of being a disabled person who's able to work in this space and do this kind of stuff, that can mean a lot to patients.

Then also I think, even more so than some of my physical conditions, I've really been surprised ... Or not surprised, but heartened by the response that I get when I do disclose my disability, which I do sometimes depending on the situation.

In particular, lately, I think I've been disclosing more often when I'm working with patients who have either chronic pain or rare conditions. I'm also a patient with migraine with aura. I understand how stigmatized that condition is and other chronic pain conditions.

So sometimes when I'm working with a patient, particularly if we're really struggling to get their stuff under control, I take a moment to be like, "Hey, I'm really

working with you. I understand how this feels. That's not me putting anything over on you. That's me saying I really do understand what this pain feels like. I really do understand why it is that you get so upset when people say it's just a headache or walk it off or something like that. I have this connection with you. I know what you're going through. I want to be a partner here for you so that even if we're not able to get things under 100% control, at least we can get you back to doing whatever it is that you're trying to do and how you're trying to live your life."

So I've certainly had some patients. There's one in particular who every time I see them, we talk about these things, like how they cope with their migraines, how I cope with my migraines. They felt more confident asking for accommodations for themselves because of some of these conversations. So I think, again, having an example of a person that is in this kind of position of authority or whatever, I think that that can mean a lot to the patients.

I also think that it means a lot to me personally, because it's nice to be able to work with children and young adults who were the kids and young adults that I was, and I didn't get the chance to see that kind of role model.

**Holly J. Humphrey:**

Yeah, that's really powerful. Dr. McCulloh, what about you? You also work with children. What's come up in your interactions?

**Christopher McCulloh:**

I think I've had a lot of the same experiences as Dr. Cejas, where kids will ask questions and you ... They ask those unabashed questions and you answer them. Then you just move back onto whatever you guys were talking about.

Some of the experiences that I've had, I think some of them have been experiences that have been told to me and not things that happened myself. One of the ones that's very memorable is, one, I was in my standing chair. I was standing up at one of the sinks, scrubbing, about to go into the operating room, and one of the OR nurses came by and told me later on that day that they were bringing a patient in to a neighboring operating room. This was in a children's hospital. It was a girl who was about, I think, nine or ten years old.

Obviously I couldn't have known at the time, but as they were wheeling her into the operating room, she saw me in the standing wheelchair and was just standing there staring in awe. Well, part of the reason for that is because she uses a chair herself. And so, this was a new site for her to see that somebody who also was using a chair was able to be one of the surgeons, was able to be operating and taking care of patients. The nurses said that she was asking all kind of questions and was just amazed that this was a possibility.

Something like that, people seeing things and seeing that that's a possibility for them too, for kids, that can have a huge impact. That has a huge impact on the kids who are not disabled, who see disabled physicians and see them as people who are still

providing quality care for them. That can change their perception of disability as they grow into being adults as well.

I've had experiences with other trainees. I was taking an intern into a patient room and examining a child who has a chronic condition and was nonverbal. I was asking the parents all the questions that we would normally ask them.

When we left the room, I didn't even realize that I was able to speak the language of disability and asking about all the different issues and things that they face, and what's the child's eating situation, tube feeds, all the accommodations that the child needs. When I'm examining her, is the patient going to experience pain? Is she going to tell me that she's in pain? We left the room and the junior resident said, "I wouldn't have even known how to ask any of those questions that you asked."

**Holly J. Humphrey:**

Ah.

**Christopher McCulloh:**

So that not only is an experience for the patient themselves, but for the trainees and for the younger generation of physicians as well. And so, I think patients overall, to get back to the original question, have responded extremely positively. I thought coming into this as someone with a visible physical disability that there might be concerns by parents about someone taking care of their kids and operating on their kids who's disabled, and it's been quite the opposite, is that it's been overwhelmingly a positive effect on them.

**Holly J. Humphrey:**

We have some great questions here, and we are getting short on time. So I want to turn to a question and invite you to comment on it, any one of you who'd like to wave your hand at me and tell me you'd like to comment. That is how do you handle colleagues and supervisors who doubt or question your conditions if the condition is mostly invisible? Would any of you like to tackle that?

**Diana M. Cejas:**

I can maybe speak a little bit about that. Although I have to say I have been very lucky, I think, in that now that I'm in my current faculty position, I have not really had this issue with my colleagues. I tell them I had a stroke, they're like, "Oh, okay. That makes sense." Again, I don't know if that's because I'm in the space with a bunch of neurologists and they're just like, "Yeah, okay. That looks about right," or they're just believing me. I'm not sure.

But I do know that when I first was in training and first had my illness and was coming back to work, I did struggle a little bit with some of my colleagues, not necessarily not believing that I had had my issues but more necessarily believing that I needed the support that I said that I needed.



I really struggled with that because literally I had all of my cancer and all of my stroke care in the hospital where I trained. I specifically remember people coming up to my room, even when I was still in the ICU and intubated and seeing them looking at me through the windows. There's a lot of different stuff that we can talk about with consent and boundaries, but I remember knowing that literally everybody in my program, from interns to faculty to what have you, knew about my condition and knew about what was going on.

At the same time, when I first started getting to the point where I was like, "I need to ask for accommodations. I need to have some help," I remember getting some pushback. One person in particular that I really respected, who literally was one of those people looking at me through the ICU window, who was just like, "Well, neurological injury takes a long time to heal. You just need to practice some more." It's like, "I'm telling you, I can't physically do this. I'm not saying that I don't want to do my job. I'm telling you that I need the accommodations to be able to do my job." You saw what happened. You know what happened to me and still you're doubting the fact that I'm telling you what it is that I need.

So how I handled it in that case, at first, obviously getting very upset about it. Later, I just realized that what I had to do was go up the food chain. So this person certainly wasn't the highest person in the department. So first I went to my program director, told them about what happened. I'm very glad for the program director that I had because he was one of the first people who was going to go fight for me.

But we continued to have issues come up with this person, where I would ask for accommodations, or I would need to go to have a PET scan or something like that and try to get everything cleared and everything done, but still there was always questions as to why I was taking personal time to do these things.

So I think with all of it, I just learned that I need to be able to have somebody that can fight for me in instances where I cannot fight for myself. That tended to be people that were further along who could just handle the situation.

**Holly J. Humphrey:**

Yeah. Dr. Cejas, thank you so much for taking that question on. I think that it's a very common question when the disability is invisible that the support that you receive may be highly variable. I think your experience just spoke to that issue.

I am really sad to say that we are at the top of the hour. That means we are going to bring today's webinar to a conclusion. I cannot thank today's panelists enough for the contributions that they made by sharing themselves and their experience with all of us today. I think it was just an incredibly rich conversation that could have gone on for much, much longer.

I'd like to remind all of the participants that a recording of today's webinar will be available on the Macy Foundation's website within the week. Again, I'd like to thank our panelists and a very special thank you to Dr. Lisa Meeks, who is the author of this entire three-part webinar series. So thank you all. Let me turn it back to Peter Goodwin.

**Peter Goodwin:**

Thank you, Holly. For any questions we were unable to take during today's webinar, feel free to contact us at [info@macyfoundation.org](mailto:info@macyfoundation.org) and we will follow up with you. As a reminder, the conference recommendations that Holly referenced earlier are available on the foundation's website, where you can also sign up for periodic email alerts from us.

We encourage you to continue this conversation online using [#equityinclinicallearning](#) and [#docswithdisabilities](#). Thank you all for joining us today and participating. Have a good day.