

CLIME Together Symposium: Disability and Healthcare Transcription

00:00:04:19 - 00:00:36:07

Heather Feldner:

All right. I think we are going to go ahead and get started. Hello, everyone. Thank you so much for being here this morning. I am beyond excited to welcome you all to the 2022 CLIME Together Symposium. My name is Heather Feldner. I am one of the conference co-chairs today. I am an assistant professor in the Department of Rehabilitation and Medicine, also core faculty in the disability studies program and a co-director of the Center for Research and Education on Accessible Technology and experiences or CREATE for short.

I am a middle aged white woman with shoulder length, brown hair streaked with gray. I wear dark rimmed glasses, and today I'm wearing an oatmeal-colored sweater. In the background is a light blue wall filled with artwork from my young son. I use she/her pronouns and I do not currently identify as disabled or with a disability, and that both shapes and significantly limits the perspectives that I bring to these topics in my work.

And I'd also like to introduce Dr. Heather Evans, who is our CLIME Together Symposium co-chair. And she's going to introduce herself now.

00:01:16:07 - 00:01:45:16

Heather Evans:

Hello, everyone. Welcome. My name is Heather Evans. I use she/her pronouns. I am a white woman with short, graying brown hair. I'm wearing triangular eyeglasses and a black top with pink flowers. I identify as disabled, Crip, and a person with chronic illness. I am a faculty member of the disability studies program, and I'm also an acting assistant professor in the Department of Rehabilitation Medicine here at UW. I'm the director of research at the Northwest ADA Center, and it is very much my pleasure to welcome you here today.

00:01:54:01 - 00:02:30:15

Heather Feldner:

Thank you, Heather. And we go by Evans and Feldner since we both decided to be Heather's working on this project together. So, if anyone needs to refer to us through the session today, please go ahead and use our last names as you see fit. I would also like to acknowledge that we are meeting today on the traditional and unceded lands of the Coast Salish Peoples of the lands which touch the shared waters of all tribes and bands within the Suquamish, Tulalip and Muckleshoot Nations and as visitors we honor with gratitude this land and the past, present and future of our indigenous family.

And as we think about how we can all contribute to a more diverse and equitable society today, we approach that broader aim from the lens of becoming anti-ableist in medical education. And I'm privileged to engage in this space as an ally. And in an email to me - just last night, the timing was

perfect. A colleague of mine described anti-ableism as one of my love languages. And not only was that just the most beautiful high compliment, but it really resonated with me as I thought about the time that we have together today. Not only are we engaging in that love language, of course, but also practice and action. And I really welcome this opportunity to learn and grow with this community, one that has really shown to be meaningfully engaged in this process, both learning about ableism and reflecting on our own ableist practices, defining ableism, and calling it out along with its intersection with the other isms, as well as dismantling it to advance access, whether that be in medical education or whether that carries forward and becomes amplified in health care service delivery for people who identify as disabled or with a disability or with a chronic health condition. And so, with that, I'd like to thank you all for being here today and thank this incredible planning committee that it has just been such an honor to be a part of. And as a reminder, we do have live streamed captioning today as well as ASL interpretations services.

00:04:14:13 - 00:04:38:09

Heather Feldner:

We will continue to put the captioning link into the chat as we go. And with that, it is my great honor to introduce our plenary speakers today and recognize with gratitude their expertise and willingness to be here and share their work and perspectives. Dr. Lisa Meeks is joining us from the University of Michigan. And Dr. Neera Jain is joining us from the University of British Columbia.

They are CO-PI's and coauthors of the Association of American Medical Colleges special report entitled "Accessibility, Inclusion and Action in Medical Education Lived Experience of Learners and Physicians with Disabilities." And Dr. Meeks is also co-founder, and Dr. Jain is a board member at large of the Coalition for Disability Access in Health Sciences and Medical Education. And so we're extremely excited to have them here today.

They're going to be presenting their keynote talk and throughout the talk, if you do have questions for Dr. Meeks or Dr. Jain, you can feel free to use the chat to enter your questions at any time. And Evans will be facilitating the Q&A after they're finished with their plenary. So, Lisa, Neera, I will turn it over to you all.

Thank you so much.

00:05:32:01 - 00:05:32:22

Neera Jain:

Thank you, Feldner! Lisa, before we start, shall we do a quick visual description to orient folks to who we are I'm Dr. Neera Jain, and I have long, wavy, dark brown hair. I wear dark framed tortoiseshell glasses. I'm wearing a yellow sweater and some horn earrings. And in the background, let's just plain wall with some windows and Hilma af Klint painting to my right, inspiring me every day.

And I a multiethnic woman of color. My family comes from India and the United States with unknown origins. And at this moment, I am a non-disabled person. I come to this work as an accomplice, learning

every day and unlearning from disabled people with disabled people. And as a person in this world and currently a settler in Canada, but I come from the United States.

Lisa, do you want to do a quick description?

00:06:49:03 - 00:07:25:18

Lisa Meeks:

Sure. I am a white, middle-aged woman. Wearing light tortoise rimmed glasses, blonde hair that is currently up and purplish shirts and purple multi-colored jacket. And behind me is my bookcase with lots of books on this topic today and pictures of my family which continue to inspire me. I am a woman with a chronic illness, so I identify and in a gray space of disability whether that is my current status or not, depending on where I am with my health.

And it's my pleasure to be here today as well.

00:07:32:19 - 00:07:58:16

Neera Jain:

Thanks, Lisa. I'm just going to start sharing my slides, our slides. So thank you so much again, Feldner for that introduction. This is Neera again. And on behalf of Lisa and I would like to thank the symposium organizers for all the work that has gone into today's event and to all of the participants for taking the time and making space to be here today.

And we're really glad to be sharing this space with you and for the organizers for choosing this bold topic. Lisa and I are really excited to have the opportunity to really speak directly about ableism and to label and name ableism as something that we ought to all be thinking about before we get really into our content today. And I want to acknowledge that I'm speaking today from the traditional ancestral and unceded territory of the Musqueam, Squamish, and Tsleil-Waututh peoples. I'm a grateful, uninvited visitor on this land.

00:08:40:16 - 00:09:02:23

Lisa Meeks:

And in recognizing the land upon which I reside, I want to express my gratitude and appreciation to those that have lived and worked here before me. And whose stewardship and resilient spirit make my residents possible in the traditional homeland and of the Great Lakes tribes. I also want to acknowledge all of the thousands of Native Americans who now currently called Northeast Ohio home.

00:09:06:11 - 00:09:35:20

Neera Jain:

And if you don't know, we encourage you to consider whose land you currently occupy. You can begin this exploration at Native-Land.ca and beyond our gesture of land acknowledgment, we encourage you to consider the ways that colonization is interlocked with ableism, and therefore any work of disability inclusion and anti-ableism must necessarily consider decolonization and indigenization.

00:09:38:08 - 00:10:10:04

Lisa Meeks:

And today we're going to present to you in what I call kind of a seesaw manner. We will go back and forth on important points, but taking this picture a little bit further, Neera will often be at the top of the seesaw, bringing you kind of a bigger picture to consider. And then I will take a turn and try to ground us in what we already know in the literature and through current and previous research. So today we have several learning objectives.

And at the conclusion of this talk, we really hope that you'll be able to define ableism and provide examples of how it manifests in medical education. And beyond that, kind of how it manifests in your space, outline known barriers to students with disabilities that they face in medical education and the resulting impact. Describe the tensions between an equity and a justice-oriented approach to disability inclusion and apply solutions to your course development assessment practices and your interactions with disabled students.

00:10:44:10 - 00:11:17:01

Neera Jain:

Thanks, Lisa. So medical education remains an inhospitable setting for learners with disabilities, and this is despite 49 years of disabled people's legal rights to equal access to education and medical education's professed commitment to diversity, equity and inclusion. Today's focus on ableism represents an important shift in the way we conceptualize the challenges we face in the process of disability inclusion.

Ableism highlights the socially normalized or taken for granted values, beliefs, and ideals that underpinned disabled people's ongoing exclusion in medical education. So, a focus on ableism calls on us to name and perhaps draw a more complete picture of the elephant in the room in order to interrogate the often-unspoken norms and ideals. Identify by their utility for modern education and practice goals and encourage alternative ways to move forward towards more just equitable and inclusive educational environments.

Professor Fiona Kumari Campbell describes ableism as a system. She defines ableism as a network of beliefs, processes, and practices that produce a particular kind of self and body. She calls this the corporeal standard that is projected as perfect the goal and therefore essential and fully human. So, in

this system, this standard for bodies and minds is held up as normal and desirable, and a device is in force between that standard and those who fail to live up to the standard and thus are labeled disabled.

00:12:44:20 - 00:13:20:19

Neera Jain:

So these normal ways of being quote unquote normal are being they're privileged, and the social order is organized around them. So ableism creates a hierarchy of value wherein some bodies and minds are treated as valuable and others as disposable or excludable. Scholars argue that ableism works with and reinforces their systems of power. So for example, Bailey and Mobley explained that racism, sexism and idealism share a eugenic impulse. And we can see this in the way that constructions of ability are most readily assigned to whiteness and men. While disability and assumptions of inability have been attributed to women and people of color, to justify their denied citizenship. If we think historically colonization and slavery used ableism to create a lesser group, less worthy, able, smart, capable to justify that equal treatment.

Colonization attempted and continues to attempt to erase or deny First Nations and other indigenous understandings of disability and impose ableist social arrangements. And this interconnection in between ableism and other forces of marginalization means there are intersectional implications. Those who occupy the intersections experience ableism differently. Recognizing this interconnection between ableism, racism, colonization, heterosexism and classism, and other forces we can probably name suggest that joint action and cross movement organizing are necessary to dismantle damaging systems of oppression.

And this is something we'll come back to later in this talk. In his book Crip Theory, Robert McRuer theorizes that ableism operates through a condition of compulsory able-bodiedness. He builds this idea from Judith Butler's work and heterosexual hegemony and that of other queer theorists. So, by situating that particular kind of body mind as desirable and necessary for participation, ableism compels us all to reach for the standard, which he suggests is always out of reach.

00:15:16:18 - 00:15:51:06

Neera Jain:

But through our constant reaching for the standard, trying to embody it, trying to to access it we entrench its dominance. Still, the possibility for subversion exists in the times when we resist reaching for it, when we make it visible when we flout it, we question the standards power and we reveal it as false. And with this way of thinking about ableism in mind, it's important to consider that ableism affects all of us, disabled and non-disabled.

Expectations for bodily perfection and for proving physical and cognitive ability for being hyper productive and capable are arguably all manifestations of ableism that are ever present in our societies. Ableism becomes institutionalized when that corporeal standard or a norm for bodies and minds is reproduced in systems, policy, and practice. A clear example is architectural design. This image comes

from my friend Amy, who took this picture while being carried down the stairs into a lecture hall where she was invited to give a lecture on disability and social justice. So she uses a wheelchair, and the lecture hall did not have an accessible entrance to the front of the room. So ideals of who uses academic space, who will be presenting in the academic classroom. Who's the teacher? Who's the student? They're all inscribed into physical spaces. So we can read ableism into our campus spaces as well as our policies, practices, curricula and interactions.

Campbell explains that thinking with ableism requires us to turn our gaze back to what the study of disability tells us about the production, operation, and maintenance of ableism. And this helps us to achieve Graham & Slee call to make visible and deconstruct the center from which all exclusions derive. So what does that often Invisible Center look like in medical education?

So, building on that idea of compulsory able-bodiedness. In my research that examines how disability inclusion operated at four U.S. medical schools, I developed the concept of the Capability Imperative, which illustrates a hyper-ableist cultural logic of medical education. The capability imperative, I argue, sets expectations around performance and behavior for quote unquote good physicians that justify exclusionary institutional arrangements and seeks to produce a student who can conform to these expectations.

I illustrate the capability imperative through three motifs. First, the physician as selfless, superhuman seen through technical standards that specify an undifferentiated physician and the expectation that physicians show no weakness and have no needs. So, for example, students learn to show no weakness from clinical educators on clinical rotations. Students witnessed overworked and sometimes unwell physicians who remain stoic in the face of difficulty. One student explained, "People don't complain outwardly... I see residents that are stressed but are never going to tell their attendings or even their peers. It's that culture of you just need to suck it up and do it. Sometimes I can see on people's faces that they are really struggling and what are you going to do? You ask how they're doing, and they say they're fine. And I do the same. I'm fine. The less people know about me, the better. I don't want them to know. Then everyone else knowing she's struggling" and I ask the student, if people knew you were struggling. What would that mean? And the student said, "You're not competent enough and that's still the culture." So this stoicism was learned and perpetuated and tied to capability.

So the second motif is what I call the real world of medicine. Heavy quotes around real world. It's a vision of static training and practice environments beyond medical school that suggested a constrained or impossible future for disabled people in the profession. The real world frequently materialized through discussions of residency training requirements that were understood as a limiting factor. And this idea is exemplified in the following quote from a school official recounting deliberation around admitting a student with a physical disability so they said, "This is medical school. She will be cocooned here. She will be coddled. But when you put her in the real world in a residency program that's fast paced, how is she going to survive? Are we doing her a favor by accepting her in medical school, knowing that when she goes out into residency, they'll eat her up and spit her out." So while the real world was presented as a fixed and knowable disability, inclusion was framed as unpredictable medical medicine, exclusivity is known while inclusive possibilities are not. The imagined real world amounts to a restrictive vision of medicine informed by situated knowledge that's built with limited exposure to successful disabled physicians.

And this notion of the future erases current possibilities and cuts off the possibility for innovation. The final motif is the malleable student who is expected to fit a singular path through medical school and individually preserve their well-being. And this often renders disabled students miss fits in the medical environment crystallized in one student's depiction of constantly battling time. The schedule, the pace the volume, the way of doing learning often doesn't match disabled students physical or cognitive speeds.

00:21:27:21 - 00:21:51:21

Neera Jain:

And so, for example, one student described this temporal mismatch as follows. "For me, small group learning was just awful. People would be reading something and before I had the chance to finish they would just scroll beyond it and move on to something else, and it's like, okay, so now I'm not learning anything, so basically it feels like I'm out of tune with the rest of the group and there's nothing I can do about it." And I get criticized for it. I'm trying my best to do better, but people just get tired of it. So it's like being out of sync with the group because of my condition is just frustrating. So here the expectation for certain speed and manner of engaging did not allow the student to participate meaningfully in group learning process. This quote reflects not only the student's frustration, but that of their peers.

There was an expected synchronicity and group member functioning that multiple students encountered, which created discord in their groups, notably this student attributes the problem to my condition rather than the structure of the exercise or group standards reflecting their internalization of the malleable student expectation. Students who did not fit are constructed as problems rather than the environment or culture So what are the implications of ableism in medicine, as illustrated through the capability, imperative perspective and current learners must be understood as able to meet these implicit and explicit demands fitting into current systems in order to enter and progress through training. Thus continue fully reproducing a constrained vision of the physician and a realist vision of practice dominates. Current conditions are figured as static and unchangeable, even necessary. Disabled medical learners and school officials must negotiate around these cultural ideals to seek their inclusion and to include students into the system of medical education and the need for negotiation limits. Disability inclusion any move toward inclusion is an act of resistance. We're always pulling against hyper ableist ideals that remain centered and prioritized.

00:23:51:12 - 00:24:20:07

Lisa Meeks:

Thank you so much, Neera. Now let's discuss the current landscape of medical education in more detail. In 2018, the AAMC commissioned a report led by Dr. Jain and myself on the landscape of disability and medical education. And as part of this inquiry, we spoke with trainees and physicians with disabilities at various stages of education and practice across several specialties and disability categories.

And their stories and their struggles were remarkably similar. Since the time of this report, in a mere four years, the barriers have been uncovered. Many more barriers have been uncovered in research.

Many of these are sub elements of the larger themes that we saw, but important and concerning barriers. Indeed, when you think about it, it often amazes me that learners with disabilities actually graduate and or thrive in these environments.

And these are all overseen by ableist beliefs. So the students in the AAMC Report study and since that time continue to tell us that they navigate medical education under a cloak kind of hidden but in plain sight. They work hard to present their strengths and their desires. They are often hyper affable in the process, feeling like they want to be viewed as the nicest person in the cohort and to not create any trouble in the process. They often sacrifice their personal health, missing critical appointments to avoid asking for permission to be absent from class or clinical rotation. And they may also miss out on forming peer or personal relationships due to the amount of time it takes to self-accommodate or navigate the environment. For those same reasons, many forgo engaging in hobbies and they face additional financial implications.

They may have to pay for prescriptions or mitigate the impact of disability by outsourcing things like housework or grocery shopping, or may spend a great deal of their financial resource is on things like test preparation. In the absence of accommodation in the medical education environment, these students are cloaking their needs for accommodation. They're dealing with pain and discomfort.

They're taking time to complete items in the absence of accommodation, which goes into their sleeping hours or their personal hours. And of course, the driving fear of this is that they will face very real stigma and bias in the environment because of their identity as being a person with a disability.

00:26:44:01 - 00:27:08:18

Lisa Meeks:

So when I think about how this works, you can see in this slide that I think about how we as a society continue to kind of perpetuate this view, right? We can we contribute to the ableist persistence of ableist views in medical education and how they shape the processes and practices, which in turn of course serve as gatekeepers to the action.

So societal expectations tell us that disabled people are usually unemployed and certainly not able to be the superhero that we think of a physician as. So this gets reinforced by admissions committees and faculty. And that shame and stigma for those that actually make it into medicine persists. But because of the reinforced ideals of societal expectations with regard to disability.

Very few, if any, trainees actually make it through the cycle. This illuminates the need really, and why we're here today to enact active anti-ableist training and medical education. And for me, I think very specifically in admissions, which is often the gatekeeper in the system, like the one that I just described. Even if students gain entry, there's a good amount of motivation to avoid disclosing a disability. So just to talk to you a little bit about some of the things that we see that you can change one mechanism for conflict or one barrier to disclosure is conflicts of interest in the system.

So this is when an individual who holds an evaluative role or a role in trainee promotion review as the trainees primary documentation as part of the request for an accommodation. And we do recognize that

many of you and many stakeholders in medical education will need to be part of the decision-making process and will need to inform whether an accommodation is reasonable or not.

But when when you are absent someone that has expertise about accommodations, clinical accommodations and disability and the primary documentation as being viewed by faculty or people in charge, this can be really jarring to the individual with a disability who may be presenting highly sensitive documentation. And this creates a conflict of interest because you are also evaluating this learner. In these situations, learners will often decide not to disclose if they know that this is the path for decision making.

These students, you know, when the dean of students or someone like that as well, not just faculty, is somebody who's serving as the arbiter of accommodation determination. Students are often also disincentivized to disclose because the dean of students is often the person writing something like the medical school performance evaluation or letters of recommendation for residency. We all know how competitive residency can be so uninformed.

So that's one barrier to medical education. The second barrier is having an uninformed decision-making process Now, this is a big one, and we've written about it extensively. And Uninformed System is one where the arbiters of decision making. So your disability people are absent any knowledge of medical education, curriculum, or assessment requirements are based or emerging accommodation practice as a process.

00:30:25:20 - 00:30:54:17

Lisa Meeks:

The multiple settings assessment styles that you have in medical education, these folks, the ones that are highly qualified, also have a really good grounding in education, in disability law and case law. And this would and this would require someone to understand the disability law that oversees not only education but employment, so that person could help shepherd the learner from UME to GME.

Okay, I want you to think about this. Most of you are physicians or involved in health care to some extent. Can you imagine trying to diagnose a patient in your specialty without having all of the relevant information? You'd be missing critical pieces to direct the patient care. And, you know, I would argue that it's really the same when you have someone in place to make decent disability decisions that doesn't have all of the information. Many of you might have even received accommodation letters where you find yourself asking, does this person even understand medical education?

The bad news is that very few of these DRP's exist. You can see here on this slide that best practice is not always practiced. In fact, best practice suggests that medical schools or training programs have these specialized disability specialists who we call DRP's or disability resource professionals. And they should lead through something that the law requires called the interactive process.

This describes kind of the process of accommodation, decision making, including disclosure, documentation, review and investigating potential accommodations. And this person should have considerable knowledge of medical training, including all of the competencies for the medical degree. So, you can see by this slide, we're not doing so great for medical school. This study found that 34% of

medical schools were not aligned with the structural considerations that Neera and I proposed in the 2018 AAMC report.

Of those that were not aligned of the 34% that were not aligned 12% of these schools were delegating the responsibility of disability review and determination to the student affairs office or the dean of students. So we've talked about how that can be a conflict of interest and 4% utilized an internal committee made up of faculty members with evaluative roles. And again not in keeping with best practice.

00:33:02:15 - 00:33:32:11

Lisa Meeks:

Lack of transparency is also another barrier when people don't know where to go or how to disclose that accommodation. And this is a huge barrier in GME. You can see that unfortunately we're not doing particularly well in this area either. I hate to bring back bad news about UME and GME, but this 2020 study found that only 38% of the top GME programs.

So that would certainly include your organization included a specific disability policy and language that encourages disclosure and only 59% maintained a clear procedure for disclosing disabilities and requesting accommodations. So almost half of this of these GME institutions that we evaluated did not have any direction to the disabled learner about how to disclose or what to do. As you might imagine, the lack of any sort of information about how to do this sends a very covert message. And that could be you don't belong or we don't anticipate having disabled people in our training spaces. So finally, a burdensome process is another barrier for these learners at the UME and GME level. This includes creating unwarranted complexities for students or trainees limiting hours that they could actually seek assistance. All of you know that trainees across the, UME, GME continuum have very little time.

So when an office is only able to assist a learner between the hours of eight and three, it's pretty unlikely that the learner will be able to engage that office as well, requiring multiple meetings or taking a long period of time to adjudicate a disability decision. I've had residents tell me that they've waited six to nine months for a decision that is not legally defensible.

We'll start there. But also you might imagine that in that six to nine months a learner would just give up on actually getting the accommodation that they need for access. And the NBME Step 1, accommodation process is another barrier. This is a barrier, actually even though this particular article talks about step one. This is actually a barrier across the step one, two and step three continuum.

I have many residents telling me that when a disability is uncovered in medical school, especially right before they leave for training, that the failure to have been accommodated previously in medical school and on the step one and two can also be a barrier to getting accommodations on the step three. But here we recite some of the findings from a study by Petersen and colleagues of students who actually applied for accommodations on the step one exam.

And these findings tell us that almost half were denied those accommodations, even if they had accommodations in undergraduate. This leads to additional delays in a student's progress and can result in significant financial and human resource costs for the school. The qualitative data in the study was evaluated actually by Dr. Jain and found that students and staff alike experienced high levels of

frustration with the process of requesting accommodations, and that they felt that the process was not transparent and with highly uncertain outcomes for learners. So another harmful practice within the UME and again in the GME community is the belief that a leave of absence is the only option for trainees with psychological disabilities who are struggling. Now, I'm here to tell you that many of your colleagues in UME, GME, working alongside you in the hospital, are individuals with psychological disabilities who are at the very same time somebody with a mental illness and somebody who's very effective and very capable of doing their jobs. And so when we think about how we work with learners who have mental illness or psychological disability when we default to a leave of absence, rather than considering how we might modify the environment similar to what Dr. Jain was talking about earlier, or how we might bridge some gaps through accommodation, we really lose a lot of really qualified wonderful healers that it could be part of our physician workforce. Taking a leave of absence is not an end all, be all solution. In fact, it can exacerbate mental health symptoms and lead to a downward spiral for these trainees. The spiral would include things like a loss of health insurance, isolation from their peer group, and mental health support. I mean, many of these trainees are on our health policies and and insurance, and many of them are losing income as well, especially at the trainee level.

So defaulting to a leave of absence has, you know, certainly substantial and measurable impact. But it also has another thing that happens in this process is that when you default to leave of absence, what you do is essentially continue to re stigmatize the idea of mental illness and instead of thinking about how we can change some of our structures.

And in fact, I would argue this isn't the place or the talk for it, but I would argue some of our structures actually contribute to the development of mental illness and and learners that are unwell in our systems. But definitely it contributes and perpetuates the stereotype and stigma that if you are a person with a mental illness, you do not belong in medicine. Kind of tethered to this. Trainees also have some difficulty in I don't know what the process is at UW but many institutions are now refusing to provide documentation to support disability accommodation and for their are learners that have mental illness. And so this just puts one more barrier between the learner and the program and the training. When this happens, I'm not sure why people do this.

00:39:38:13 - 00:40:34:17

Lisa Meeks:

They believe I think at times it's a conflict of interest, but this is actually a huge support for the learner, is to have access not only to a mental health provider, but to someone who will provide that much needed documentation to engage accommodations. And then finally, we talked a little bit about disclosure and why people don't disclose. Neera and I are just finishing some research that shows that indeed those with cognitive disabilities including psychological disabilities, ADHD, learning disabilities, are less likely to disclose their disability and in any training environment. And I do believe that in part it's due to some of the downstream consequences that they will face, especially for your trainees, which includes having to report some of these things on the state licensure requests. So I'm going to turn this back over to Neera so we can go back up on that seesaw.

00:40:34:17 - 00:41:09:01

Neera Jain:

Great. So now that we have mapped that ableist train that disabled learners must currently navigate, let's consider our responses. And here I want to suggest that that like our talk today with that seesaw, we want to think on multiple levels. Ableism is a complex problem that requires multilayered action. So how have we responded? How can we respond, and what are the implications and tensions therein So I would argue that our current approaches to inclusion are informed by an equity framework.

These approaches recognize that different learners might need different things to enter access and perform in medical education. So as represented in these images, we have three people a tall person, a shorter person, and a person using a wheelchair. All are in front of a fence trying to watch a sporting match. When we give them all the same kind of box to see over the fence, this overwhelmingly helps the tall person. The short person can barely see over, and the person using a wheelchair isn't helped. But if we recognize their difference and aim for the same outcome, seeing over the fence, then just the short person needs two boxes. The person using a wheelchair needs a ramp platform with individual tools. They can all see the game over the fence. If we consider all medical students, applicants, trainees as the same and offer them the same tools or evaluate them in the same way, we perpetuate inequity, but by recognizing difference and providing individualized tools, we can create a level playing field.

The individualized tools offered to disabled people in our current system are accommodations, but the way institutions activate equity differs. This equity approach is at its heart, driven by disability rights legislation. And while these laws are designed to contest ableism, they're also subject to interpretation within that system of ableism we've been talking about, and this is an ongoing tension within the U.S. legal system as schools take different approaches to inclusion that reflect and enact existing program culture, they enact and reflect different ways of understanding disability and inclusion.

00:42:54:19 - 00:43:40:00

Neera Jain:

So, I conceptualize the kind of spectrum of approaches as two kind of ideal types generally the compliance approach and the spirit of the law approach. And these responses differ in the way they interpret legal standards strictly or liberally. The law can act as a ceiling or a baseline for change the different how they perceive inclusion as a risk to the profession and educational standards, or an opportunity to evolve the profession and in how they understand disability as an individual or medical problem that results in lesser functioning or is a dynamic interplay between an individual impairment and the social environment.

So working from these differing fundamental assumptions shifts how inclusion operates. So under the compliance approach, the need for inclusion and institutional response is seen as because of a person's disability, the person has a problem that requires change and accommodations are viewed a court accordingly as charity, a nice thing to do or legal obligation. Equity and inclusion are there for guarded with access gains made to prevent lawsuits. The risk mindset sets up an adversarial relationship with learners and the institution must gatekeep accommodations and rigidly interpret standards to maintain

control. Now, while this approach is generally lawful and operates within an equity model, learners are only included to the extent they can overcome these deficit-oriented assumptions and fit into existing environments with minor adjustments. Unfortunately, this tends to be a more dominant way of working in many schools and tends to be kind of the position that people gravitate back to when things get complicated.

In contrast, in the spirit of the law approach, while individual accommodations remain the primary method of inclusion, they're understood as a way to reach that unknown to to level that unequal playing field. So it's about recognizing barriers to participation and finding ways to lower those barriers or find ways to support individuals to surmount them. So in this model, we may see schools innovate the accommodations they offer, implement opportunistic universal design, and proactively consider accommodations and access improvements. Because disability is considered part of beneficial diversity. Their scope to innovate and interpret policies to advance access. And this asset orientation and may drive greater institutional investment and broader action. And we see this kind of approach, I think, in the spaces where that kind of qualified DRP the an investment in somebody who is knowledgeable about disability and also knowledgeable about medical education.

That's where we start to push past a pure compliance approach to starting to innovate and iterate in the ways I've described. So even in our current equity approach to inclusion, there's a spectrum and how this might operate in general. Both approaches focus on including disabled people into the existing system. And as such, there's limitations to both where retrofitting, when when the capability imperative is not dismantled, when we're not thinking about and problematize that system and how it's informed by ableism, we're really retrofitting and responses tend to still be driven by compliance, even when individuals aim to work within a spirit of the law orientation.

Powerful institutional actors tend to ask, what do we have to do at the end of the day? And this keeps us within a narrow frame of inclusive action and promotes an austerity mindset for what is possible. Disabled students are treated ultimately as what Titchkosky called the location of trouble and individualized equity approach triggers change at the point of the individual, rather than centering the disabling effects of the environment, regardless of intention.

That's how the system is built. This approach can also breed resentment. Changes might help a lot of students, but are only offered to some who cross an invisible line into disabled and students to our multiple marginalized tend to be more disadvantaged in an individualized process. They have more difficulty accessing disability evaluations. So what the research tells us, and they perceive heightened consequences to disclosure and accessing accommodations and ultimately the systemic barriers remain intact.

Each student must individually ask for and negotiate changes. It's highly dependent on individuals and institutional memory, and that is to often short. Individualized and minor improvements occur, but the center rarely shifts fundamentally. And this equity approach, folks, focuses specifically on the needs of students who meet the specified designation of disabled. Recall what I said earlier about ableism and what Lisa just said about medicine potentially being itself a disabling environment.

It harms everyone ableism harms everyone that works in tandem with other systems of marginalization. So we might ask our disabled learners simply canaries in the coal mine early or heightened signs of a

much larger disabling system and dangerous problem. Who else is affected or will be affected? In an equity approach is that sufficient, this individualized impetus for change?

00:48:57:07 - 00:49:17:16

Neera Jain

Is that sufficient to dismantle ableism? If we shift to thinking about this from a justice perspective, we might consider further actions to take. This image returns to the idea of a group of people attempting to watch a sports match over a fence instead of trying to get them to look over the fence. The three people dismantle the fence. This, of course, suggests a need to dismantle structural barriers, going back to theories of ableism, as some scholars suggest that to truly address ableism, we need to break down this false binary of abled disabled. The dividing practices that create both disability and non-disability and together create ableism. Now this is the work that is more difficult. So, what might an approach look like that's grounded in systemic anti-ableism. Possible alternative is what I call the transformative approach.

And this is an idea because it doesn't exist yet. And so it's a kind of a thought experiment of what could this look like? And I think this is something that we actually need to be talking about reaching for, considering what would a different system look like. Some things that I've thought about such an approach would operate from the principle that social justice guides all aspects of medical education.

It would be founded on intentional inclusion from the start and would see disability as part of normal human variation. Disabled people are expected and valued learners. So such a program would dismantle concepts of a standard learner in the design of the program, assuming all kinds of ways of being and doing and building inflexibility accordingly. So here the environment would be the key site of change rather than at an individual level.

And change would be ongoing and iterative, starting from intentional, broad inclusion. But understanding that there's always this is always a work in progress. So ongoing feedback and evaluation would continue to push inclusion further understanding that diverse learners add value to the profession. In this way of working, we would intentionally seek to increase disability representation and design from intersectional experiences of disability.

And this approach would assume differentiated graduates, allowing learners to demonstrate proficiency in variable ways. And this would move away from offering some students exceptions to standards, to designing diverse ways for learners to move through educational programs and meet educational standards. And we might make those standards much more flexible. It requires creativity and solution focused support for all learners that aims to consider their strengths, interests, and possibilities to engage in professional environments from the outset.

And of course, those professional environments would shift and look different from how we think of them now. So while there's exciting possibilities in this idea of a transformational alternative there's also tensions. A flexible by design approach will likely create at least initial discomfort as it challenges ideas of fairness That assumes sameness in graduates and in practice rather than differentiation.

00:52:23:07 - 00:52:57:14

Neera Jain:

Focusing on transformation and if we only focus on transformation, it risks leaving current learners in the lurch. They need urgent improvement now within the current paradigm and a transformational alternative amount to a kind of revolution. We need to rebuild our systems fundamentally. While we have seen transformative moment through time, the possibility of a total rebuild may feel well out of reach, especially when changes in the current paradigm have been so hard won and already feel like compromise.

And you look at those statistics Lisa just shared and you think, Gosh, how could we have a revolution if we can't even get a qualified DRP on board? So how do we move forward? The First Nation scholar, Dr. Tricia McGuire Adams told me that in these tensions, we should consider a harm reduction approach. We should work to make immediate improvements for learners who desperately need better conditions now within the current paradigm. But we must not fool ourselves into thinking this kind of iterative, incremental change is sufficient. We must simultaneously be working to imagine and reimagine and build the new liberatory paradigm that we need.

00:53:45:15 - 00:54:18:02

Lisa Meeks:

What can you do immediately to improve the landscape? Well, as I said, and we this is a very clear message. The landscape is dictated in part by who is in charge, who is adjudicating those decisions about which student gets accommodations and which do not, and what those accommodations entail. So having a qualified person who is well steeped and well versed in medical education is important.

Hiring a confidential disability resource provider. Now, the AMA recently came out with a report, and in that report they specifically said to both the UME and GME programs, you need to hire employ someone specifically for your program. So hopefully schools are doing that. We know of many medical schools that are hiring for both UME and GME, and in some cases an individual to oversee UME and GME.

Increase transparency in your policies and procedures. This is simple for UME because usually everything is focused on one area. So making sure that if a learner is a potential applicant or someone who's matriculated or at any point in the educational pathway for UME, that if that person has a disability and needs to understand the process that it is very clear.

I encourage institutions to actually try to find that information themselves and to see just how hard it can be and what types of messaging that reinforces. For me, it's a lot more difficult because of course, you have multiple specialties within your organization. So having something centralized within the GME office or that comes directly from the DIO is quite helpful.

You can find exemplar language for this process and more advice in that AAMC report. Reduce the burdensome processes. Think about again, go to your website, try to figure out what it would take for you as a trainee to disclose a disability and request accommodations. Look for inefficiencies in that

process and ways that you can increase efficiency in some simple ways by having off hours at night or weekends.

Having an integrated system whereby learners can upload information for you instead of having to mail it in or bring it in. Try to make it as low in the burdensome scale as possible. And then to understand your institutional obligations. While neither Neera nor I really push meeting your legal requirement we want you to exceed those legal requirements by a lot. A lot. We do want you to have a basic understanding of your obligation under the ADA. In both areas, employment and education, to make sure that the institution is at least meeting those obligations and understands as well the accrediting body obligations from the ACGME, which there are about three requirements that apply to the GME space enhance your knowledge of the benefits of inclusion to patients.

Unfortunately, we're focused today on the educational space, but Neera and I often talk about what this would do to the system at large. In other words, having disabled providers in the space will inform merit medicine and medical education in a new and more deeply thought-out way such that we think that eventually it will improve the quality of access to and health outcomes of people with disabilities and that there is actually a publication that we have talked about a lot from the University of Washington, and you'll hear more about that today.

And then connect mental health and disability access. I think schools are trying to do a good job and residency programs are trying to do a good job of providing mental health and wellness services to their learners and trainees. But we need you to connect this with the idea of disability access for those that need accommodations and have those teams work together And then finally, and I cannot state this enough, you need to employ anti-bias training in both your UME admissions and in your GME process.

00:58:30:03 - 00:59:02:02

Neera Jain:

Sorry about that. Technical difficulties. So the solutions that Lisa has just described have demonstrated benefit. We've seen these changes qualitatively improve student experiences within our current paradigm. They can test ableism by shifting the way equity-oriented interventions work on our campuses. But returning to our discussion about frameworks for change, how can we reach further towards justice to transform rather than just reform the center?

So the disability study scholar Alison Kafer argues for a politics of Crip Futurity in which we imagine disability and disabled people's lived presence and possible futures differently. To do so, she says, we must challenge the rhetoric of naturalness and inevitability that currently dominate perceptions of societal barriers to inclusion. So in this way, the medical student experiences and medical learner experiences that we've just shared must not be seen as natural and inevitable consequences of living with disability.

Or the natural and inevitable conditions of studying and practicing medicine. We need to get beyond that. Rather, we must see them as the consequence of decision making that has not fully considered or prioritized disabled people in the structuring of medical education. So how can we shift that? How can we reimagine medical education as a place where disabled people thrive now and into the future? So

remembering that ableism as a central organizing force in our society, this means ableism is the norm, even if we don't intend it we have been socialized to think and do from ableism. Our social systems are oriented this way. This is often invisible to us. To become Anti- ableist, we must begin to actively recognize and resist its workings. Professor Missy Martin, who's a mentor to me from New Zealand, calls this catching yourself in the act. It's a process of noticing. This is an ongoing and everyday process. Of learning, unlearning and then learning anew. We need to start seeing how ableism operates. So, drawing from Ibram Kendi work in anti-racism - an important first step is to reflect and self-educate.

We ought to do this before we jump into action. Something I know is really hard to do when we want the solutions right away. We need to first learn about ableism and disabled people's lived experiences. Consider the ways that you have internalized ableism in how you think about yourself, others, and the world. And this is something I am constantly reflecting on.

We need to learn the history of ableism. Where do these ideas come from? Where have they lived in our societies and where do they live now? So, for example, how have eugenic histories and prisons shaped medicine and medical education? How does the system benefit from these ideals and how do they still inform our approaches to disability inclusion and medical practice today?

So, for example, we need only examine our pandemic moment to find troubling examples of eugenic ableism and health policy and practice. The system wants to work this way. We have to resist it becoming anti-ableist is the active work of recognizing and resisting ableist ways of thinking and doing struggling for anti-ableism power in our spheres. Of influence and training ourselves to think and work with anti-ableism ideas.

So we need to find ways to bring these anti ableist ideas into being. Now, how can we create crypto spaces of care and possibility where learners can be all of themselves and where disability is valued way of being? For example, in our classrooms, labs, clinical spaces, and programs we are all responsible for and part of spaces and communities where we can insist that this is the way we start working.

Now, how can we use our power to support and resource disabled learner led shifts in our schools while recognizing that disabled people should not be left responsible for fixing ableism. How can we bring anti-ableist lenses into our meetings? Bringing attention to the way ableism is centered in our collective thinking. And this may look like the ways we do or don't talk about disability.

How can we think beyond incremental change to transform it of change? For example, taking a two pronged approach to address complex systems problems that exemplify and intertwined equity and justice mindset so first, use your power to address the immediate problem for the person or people in front of you. Then work on a systemic shift for sample. Dr. Laura Bulk imagines schools or universities creating a justice, equity, diversity and inclusion fund available to investigate systemic problems as we identify them and build systemic solutions that resist ableism and smooth the way for disabled learners, practitioners, researchers, faculty and staff. And while we focused on disability broadly today, we must enact the understanding that ableism is interconnected with other forces of marginalization. Our work in ableism must be thinking always of intersectionality. How does exclusion affect those who occupy the intersections of marginalized social identities differently? How can the ways we work center those at the intersections?

The activist framework of disability justice developed by the disability activists in arts collective Sins Invalid calls on us to work across movement. This suggests we must bridge the silos in how we think about interconnected problems of exclusion within medical education, working on problems in tandem and recognizing that any work, for example, to dissolve racism is also the work to dissolve ableism.

How can we more clearly acknowledge and activate this way of thinking in our work? While medical education can feel like a deeply entrenched and immovable culture, we must recognize that medical education is in fact always already changing and recreating. How can we more actively seize these moments for change, recognize them and seize them as opportunities to center anti-ableism that allow us to do this transformative work?

So, for example, a building or lab renovation, a curriculum redesign, a lesson refresh, a policy update, a training, a meeting with your advisees or your residents, your students when negotiating a car contract or making a purchase. All too often these changes, these moments are not grasped. They're made under urgency. Or without sufficient space to do the deep work necessary to foster real change. Doing the background work to educate ourselves about ableism now will prime us to bring new lessons to urgent work. But also, how can we figure out anti-ableism as a grounding foundational principle with which we evaluate our institutional work? What if we asked at every point of change, how has this work advanced anti-bullying them at our medical school The change is within our grasp.

It's up to us. Do we dare create anti-ableist futures in medical education and practice? What will you commit to doing in the next week, month, and year to advance the school? We leave you today with a provocation that we hope will spark your imagination and propel you forward into that anti-ableist future. Here and now. What would medical education look like if we assumed disabled people make excellent physicians?

So, we thank you for your time and attention today.

We look forward to discussing these ideas and dreaming new futures together with you. But first, some resources to take you on your way.

01:07:14:06 - 01:07:39:02

Lisa Meeks:

We've mentioned a lot of best practices in this presentation for you, UME and GME. And here there are pictures from left to right of a few books and resources and reports on the topic. All of these are available through your UW library. So no need to order them individually. And they are all earmarked for different stakeholders. So starting from the left, it's more about leadership.

And then in the middle, geared towards DRP's and towards the end, medical education stakeholders, faculty leaders, etc. So I wanted to make you aware that as of June 1st, the ACGME has launched its equity matter system, and this is designed to bring resources to GME programs and GME stakeholders on discrete topics that are central to diversity, equity and inclusion.

I am the lead for disability and I am proud to have worked with partners to bring you to training modules, one specific to accommodation and one specific just to the concept of disability inclusion. And

then we invite you also to listen to our Docs with Disabilities podcast. We are now at a meeting yesterday 46,000 followers strong where physicians with disabilities share their stories and advice for those in the pathway to medicine, either at the UME or GME level.

But they also often speak to other stakeholders like faculty and administrators. And so you'll find a robust offering of different topical issues in medicine that have to do with disability. And most recently we have our BIPOC series, which looks at the the unique struggles and barriers for those at the intersection of race, ethnicity, queer identity, and disability. And then as well, our Docs with Disabilities Initiative, which is going to have its launch July 13th, that includes several different groups, but that is at docswithdisabilities.org

And specific to those of you in the GME space, our DIGME group Disability and Graduate Medical Education is launching a listserv July 13 that is designed specifically for disability related questions about disability inclusion and accommodation in the GME training space.

01:09:36:15 - 01:10:02:04

Neera Jain:

And I just want to shout out that podcast is an amazing resource. I used it in a course that I was teaching with medical students and had them listen or read a transcript as part of their learning and it's just such a powerful space to hear directly from learners and practitioners and I think can be used in all kinds of interesting ways - so definitely tune in. And finally, we just wanted to offer a few kind of high level resources on ableism and disability that we encourage you to explore to advance your learning. So, the first is the book Disability Visibility. If you don't already know about the disability visibility project, it's start. I remember when Alice Long started this as an idea and it's just exploded and all kinds of exciting ways. Check out the website DisabilityVisibility.org, and Alice's book brings together different pieces of writing by disabled people that are modern and very challenging tales of disability and them in the world today. Emily Ladau's book, *Demystifying Disability*, is a great starting primer for folks who, as the tagline says, What to know, what to say and how to be an ally.

So great starting book for learning, advancing your learning about disability, and my personal favorite academic book about ableism is Jay Dolmage's book, *Academic Ableism*. Jay Dolmage's if you don't know, he's a professor in Canada and he is a rhetorician. Rhetoricians are the best writers. Everything is very clear. He challenged himself to write a book about ableism that embodied principles of anti-ableism and by being clear using plain language, which unfortunately a lot of people as I'm writing does not do.

So this is a great step and it really unveils the challenges of academia in relation to how ableism is built into academic spaces. So with that, I think we're ready to turn it over to Evan's to moderate some questions. Thank you.

01:12:07:02 - 01:12:34:10

Heather Evans:

Yes, thank you so much. Drs. Neera Jain and Lisa Meeks for all of your work on this issue and for this incredibly informative talk. I do want to invite folks to send questions or even comments through via the chat function, and I will do my best to facilitate those questions. And I am checking it now. Again, questions or comments.

That was such an incredible incredibly useful, I think, journey through demystifying some of the basics, identifying some of the issues and really concrete helpful advice on where we can start. I, I don't want to take up all of the opportunity here, but I will jump in with a little bit of a question of my own. I think that it was so helpful it was so helpful to hear your recommendations, the idea of imagining new futures.

And I'm wondering is, is there any space or discussion about analyzing even what what the Hippocratic Oath is for physicians? And you know, thinking of that idea of doing no harm. And I'm wondering if all of the great resources that you've put together, if that is a potential thread through of a maybe, maybe in some ways symbolic, but a large way of really shifting norms.

I don't know if either of you have thoughts or information about that.

01:13:50:11 - 01:14:21:22

Neera Jain:

I love that question. I think it's probably an invisible thread that needs to be made more visible And it just sparks for me what I think about when folks talk about patient safety. So something that we didn't say today but is part of that capability imperative in my mind is the reliance on patient safety as something that shuts down conversation and is often attributed or assumed of disabled folks as physicians.

And there's a lot that we can say about that. In fact, it's not something that's borne out by by data that disabled people are harmful physicians. But I also want to question safe for whom and is medical practice currently safe? And when we look at the equity research, the inequities in health outcomes for disabled folks we know and folks of color and other groups, indigenous folks, we know that medical practice is not safe, but we don't talk about that as a patient safety issue. And so I always want to challenge folks to think about how will disabled practitioners make for a more safe patient care.

01:15:13:20 - 01:15:42:09

Heather Evans:

Thank you so much for that response. We have a couple of questions coming in. One question is "I'm curious to hear when it comes to accommodations or conversations with DRP's, whether learners should start with the dream, right the ideal optimal accommodations when they may not expect their department to be able to fulfill per current practices or trying to really recommend that they start with and ask for something that's more quote unquote reasonable."

What is your advice based on your research and how you've seen these processes play out?

01:15:50:19 - 01:15:53:04

Lisa Meeks:

Neera you know, I'm like chomping at the bit.

01:15:53:07 - 01:15:54:04

Neera Jain:

Do it, do it, do it.

01:15:55:01 - 01:15:55:06

Lisa Meeks:

Well, you know, you should ask for what you need. And that that would be my response. The issue is, and this is why I take exception to the unqualified DRP, I mean, systems all operate within systems, right? There's no like one thing that will make a system work. So, I tell you to hire a DRP but if the DRP is influenced or, or, you know, somehow in that power differential with the dean or the faculty they feel like they cannot push back.

Then it becomes it's still a problematic system. So, I would say you have to ask for everything that you need. Don't, you know, reduce what you need. However, a medical student has never gone to medical school before, so while they are an expert in their disability and how it empowers them in their everyday life, they're not an expert on how it's going to, you know, present as barriers in the educational system.

And so without a person who can help them understand and almost like an interpreter interpret what the pathway through medicine is going to be like and help identify preemptively some potential barriers, you're going to have pinch points in a system where even if you ask for everything you think you need, you might not have asked for enough. I think the other thing that is so important, and there's a school that just redid their technical standards, UIC, and one of the things that they have in there, and I've told Ray Currie is the associate dean, I've told him I'm going to steal it but I will give him full credit. They define the process as they define the whole process of accommodations. But one of the things they say in there is it is iterative in that it will be a constant exploration of your needs throughout your educational experience because we know that disability changes, we know that people and when they get into new systems, new environments may face new barriers.

We also know that depending on your disability category, Heather, you and I, as people that may not at one point be disabled and another day may be completely unable to do or perform a fine motor skill or whatever it may be, you know, there will be times where a secondary way of assessing you is necessary. So I call this kind of priming accommodations for potential need.

And then how do we avoid putting you in a situation if we think about mental illness, how do we avoid placing you into a situation through the use of preventative accommodations so that we're not having to do these reactive accommodations? So it's like systems and systems and systems and systems. And I

know it was meant to be an easy question the answer is ask for everything that you may need, but also understand that you won't know everything that you may need. And this is why that trust and collaboration between partners is so necessary.

01:18:54:09 - 01:19:19:17

Neera Jain:

And if I can just add to that, I think that idea of presenting the dream within our current system is actively discouraged. So part of the work that we need to be able to do is to make presenting the dream possible and feel safe. Because what I hear from learners, and this is even at schools that are you know, more inclusive is that they are always measuring what they're asking for. As Lisa said, they're taught to cloak what they need. And so even if you think they're presenting the dream, they may not be, because what I know is learners are always holding back. And so, we need to find ways to signal that we really do want to hear your dreams. We believe that it's possible and we believe that inclusion is possible. Let's work through this and you're not going to be kicked out if we hear something that sounds difficult. So I think that's part of that process as well.

01:20:02:07 - 01:20:37:09

Heather Evans:

Well, yeah. And your your responses really resonate and want I know that we're getting close to break time, but there's a couple of really great questions and so I want to get your thoughts on one comment is knowing that anti ableism or anti disability bias in medical education - how are ways that we can encourage our pre-med students to disclose their diversity of body mind so that we can allow this to actually enrich their application for admissions and be more successful at having med school courses that better reflect our disabled patient communities.

01:20:39:13 - 01:21:10:22

Neera Jain:

Yeah, this just reminds me so much of working with students. I'm remembering at Columbia we would send out these things, these diversity hiring processes, and students would say to us, do they really want to know, is that real? Am I going to be held back if I if I join that program? So we really need to do more work to think about how to project a safer and real genuine engagement with it. So it's not just in your admissions process, but how you talk about disability, how you talk about diversity, throughout your messaging, throughout everything that a student might look at and your practice. Lisa, I know you have more. You've been working on this with admissions in particular. Yeah.

01:21:29:07 - 01:21:55:11

Lisa Meeks:

I would encourage if this is an area of interest, the AMA just did webinar on this, and it focused largely on messaging and then we just finished up a one in a series of three webinars with the Macy Foundation. And in the first webinar, which focused a lot on admissions, we also called out like, it's great to build all of these things so that students come to you, but what happens if you don't follow through through the entire organization?

So I would encourage you to do that as well. One resource we didn't highlight, but that's relevant here is the AAMC has been amazing partners. We have a total of 13 webinars with them that we've done over the course of like the last eight years. People just don't know about them, but there are two specific to admissions at the UME level and then transition to the GME level.

And I do want to acknowledge it Neera and I are like Pie in the sky people. We are super advocates, super cheerleaders for the space. I do want to say, though, that there's a lot I want to validate learners desires not to disclose because there's a lot of consequences, both social consequences and measurable consequences to admissions, measurable consequences to performance They're not entering a non-ableist space and they're not entering a space that will necessarily be healthy for them.

And so this self preservation is strong. And I just want to any time we're saying, oh, students should disclose. It's like, I want us all to remember that there's very good reason for them not to disclose. And I would say that and we see in our research actually that many choose not to disclose. So I just want to make sure that we know that you're as narrow talks about the you know, that we're constantly fighting an Anti-ableist mindset even people who are disability forward or disability friendly still have ableist views.

And so it is kind of like a little bit of walking through a minefield for a student with a disability to decide how much to disclose, when to disclose, who to disclose to. It's hard. And so those that do disclose and that start that process should be really should get a lot of positive feedback about that choice. It's it's a hard choice.

01:23:56:15 - 01:24:21:15

Heather Evans:

Thank you. And I am as we always are looking at the clock, but I can't help it. There's one more question that is so dear and near to my heart that I'm not looking at our organizers as I continue to eat up some of our time. Someone very rightfully noticed that they say, thank you so much for this excellent presentation as we work to expand diversity in our students and faculty.

An important part of this is for us to recruit faculty with disabilities. And I think many of us who work in this field have talked about this. And I'm particularly interested, Neera, from the Canadian perspective, where it's not a dirty word to disclose disability identity along with things like race on applications. What are your thoughts about ways in which we bolster representation of disabled faculty in our institution? That can begin to shift these norms in the ways that you're talking about?

01:24:55:08 - 01:25:19:13

Neera Jain:

I mean, I think the things that we've just talked to absolutely apply to and to faculty as well this doesn't go away. We are we know that there's already disabled faculty among us who aren't disclosing because it doesn't feel safe. And I remember talking to a disabled faculty member who is quite has a lot of power as a department chair. And they said to me, you know, if disabled faculty are having a difficult time with a burdensome process to access accommodations, how can they be out and supporting things and and making the change in our systems that we want them to because they themselves are having trouble working through the system. So we need to think about the full spectrum.

I would say Canada is not the utopia I hoped it was neither with New Zealand when I was there. Lisa brings up a really important thing. Centralized accommodation funding. I think if I could scream that like what's her name did at the Oscars, centralized accommodation funding. Do it live it, be it. I'm actually negotiating a faculty position right now, and this came up for me. I'm trying to figure out who pays for accommodations for research assistants. Does it come out of our grant funding? What does it mean if our institutions expect peers to pay for accommodations for our research staff out of grant funding? What does that mean for someone who isn't committed to hiring disabled folks to do that work? It's a real disincentive. So we need to think about this throughout the university structure. We need to make it a less burdensome process. We need to resource sets. The centralized fund is what I've seen as the best way to take that thought out of people's heads. I don't need to think about what this is going to cost me. I can think about what is this person going to add to our community.

I'll say also that, you know, one thing I have seen in Canada, Canada has some programs like the Canada Research Chair program where institutions are incentivized to hire diverse folks into those positions. So if we can make it easier for that to be a priority, that's great. A challenge is getting people to identify and to feel safe identifying in the process. But I've seen jobs that say we will not hire anyone who does not meet one of these equity categories, period. You will not get an interview, you will not be considered, don't bother applying we need to up our diversity quotient at this institution. And I think that's pretty bold. Often it's a sign of an institution that hasn't done enough.

And so they're being pushed to do it. But look, I'll take it where it comes. So that's my diatribe. I don't know if you want to jump in.

01:27:55:14 - 01:28:01:17

Lisa Meeks:

I think we're going to move on because we're a little late in the schedule. But yeah, there's a lot we could say about that, but.

01:28:02:10 - 01:28:31:02

Heather Evans:

Yeah. Thank you again, both of you so much. And we are going to take a ten-minute break. So, we're going to come back at 1042 and and pick up right here. I just want to say thank you again and invite everyone to share your appreciation through applause. Or through the chat. Thank you both very much for this talk, this incredibly informative.

01:28:43:11 - 01:28:44:12

Speaker 5

Hello, everyone.

01:28:53:04 - 01:29:44:19

Speaker 2

Hello and welcome back Thank you again for joining us this morning for the CLIME Symposium on Dismantling ableism in health care and medical education. So as you just heard, it is so important to include the experiences and voices and expertise of individuals with disabilities themselves in all aspects of health care and a medical education. And so next, we are going to hear from three members of our community who have very generously agreed to share their experiences as patients, as medical students, and as a doctor living with disability.

01:29:45:08 - 01:29:57:19

Speaker 2

So we're going to see a video that with three of our community members, Allison Mello, Carlos Anthony Fernandez Reidy and MB Velasquez.

01:30:09:19 - 01:30:42:00

Allison Mello:

I am a sister, a daughter, a wife, a friend, a teacher, a person with a visual impairment. And I desperately want to be a mom. In March of 2021, my husband, Mike and I were sitting on our terrace glasses of cool white wine sitting between us amid discussion: Children? Yes? No? Get more dogs? Dink lifestyle? Everything was on the table.

But as people with visual impairments, the decision weighed more heavily on us. I know that Mike will make an excellent dad and I know I will make a great mom because I have a great mom. But the issue is in convincing the medical professionals who would be on our prenatal and pregnancy journey with us, that we will be great parents.

We decided to wait a year a year to reflect on whether we would let well-intentioned - so they say medical professionals be the barrier to whether we decided to become parents in the blindness community. They are the big bad wolf lurking around the corner. The kindly doctor or nurse who has the best of intentions but really has the lowest of expectations of people with disabilities.

We learn it young... the doctor who doesn't speak directly to you when you're the person of interest in the room but rather aims questions and remarks over your head to the parent, to the partner, to the random person you struck up a conversation to in the office waiting room because somehow blindness means a lack of speech or cognition.

Or there's the doctor that grabs you by the hand, the shoulder the back, wherever they can get contact because they've somehow lost the ability to speak and guide you towards the equipment or room that they are vehemently gesticulating to. He simple "left," "right," "straight ahead" with just do the trick. Or there's the doctor who confuses blindness with a hearing impairment and thus begins to speak very loudly and slowly to you. "Do you need help with that when you get home?" , "How are you going to do X, Y, or Z without any help?", "You did that all by yourself" - These are the condescending questions that have jaded me, evoking a snarky distrust of medical professionals that I'm supposed to divulge sensitive information to. My husband Mike got into a fight at a bar and he broke his middle and ring finger, and the doctor took it upon himself without telling my husband to start the paperwork, to put him in a rehabilitation clinic for the next few days because he didn't believe that Mike had the ability to take care of himself when he got home.

My husband can walk his happy a** to the bar, get in a bar, fight over a girl, and then walk his wounded a** to the doctor's office and pay for his treatment. I don't know why he needs help when he gets home. But I don't know how we can have a child because I will be a show pony, they will be waiting for me to slip up to prove them right that a blind person cannot be a mother.

They are not waiting for me to prove them wrong because babies are taken away from blind parents or they're held under the microscope of social services because of the low expectations of doctors and nurses that we're supposed to be helping them. But I feel it in my bones. I have to be a mom from playing family in the dollhouse - three story dollhouse my parents got me when I was four years old for Christmas, too, holding squishy newborn family members in quiet hospital rooms to snuggling with baby cousins after long afternoons playing pirates in the backyard to comforting one of my preschool students when they're having a nasty tantrum because they've had a rainy day recess for the fifth day in a row in May.

So I comfort myself by reciting a motherhood resumé of sorts Job? Yes. Marriage? Yes. Savings? Yes. Extra room and space? Yes. Support Network and friends? Yes. I work with children. My husband works in tech. My brother is a lawyer and we have enough savings if we needed legal action, if it's necessary. And oh, my gosh, I am so envious of those people who do not need to go above and beyond the American markers of success to prove that they have a right to start a family.

In March of this year, Mike and I sat at our terrace table, sipping the same brand of wine, and we made a decision we would be speaking to our GP about prenatal care and we didn't care if we came off aggressive. Are you all in ready to support blind parents on their journey to parenthood? This is our family on the line. We are not the problem. The problem is the system. If you are not in, will find someone else.

01:36:43:15 - 01:37:07:09

Carlos Reidy:

I was less than two weeks old the first time I was rushed to the E.R. We were living in Guam and the wait time for an ambulance was at least 20 minutes. I was turning blue, my breath slowing to nothing. So my mom banged on all the doors of our neighbor's, begging someone to drive us to the hospital. On arrival, I was rushed inside, and later the doctors told her that if she had waited those 20 minutes, I would have died.

I spent the majority of my childhood at doctor's visits and indoors due to severe asthma with midnight visits to the E.R. So common that my parents were on a first name basis with the majority of the hospital staff. As a result, I spent almost every second of that time dreaming of being a teenager and later adult that could do all the things I could not at the time. Like run, swim, play outside in the grass and participate in sports that I would no longer have issues doing normal things like everyone else because of my messed-up body. That didn't work right. As the years went on and meds changed I slowly but surely improved until sixth grade when I was put on a new medication that over the summer changed everything.

By the time seventh grade rolled around, I finally started to feel normal, able to run, swim, play and participate in sports to some degree. At the same time, though, after all the dose, after all those doctor's visits, I actually learned to find comfort in hospitals and clinics. I associated them with safety, care and wellness given that I would enter afraid and unable to breathe right? and then go home feeling better. Over time, this association turned into a desire to provide that for others, and that desire became my dream to become a doctor. So, from eighth grade onward, everything I did was in pursuit of that dream. Little did I know that achieving that would mean, in a way, giving up the one thing that I had had, the one dream I'd had as a small child and felt I'd already achieved.

I spent the next 15 years studying nonstop. All of my extracurriculars were geared toward my goal, and I sacrificed many trips, hangouts, parties, and trading opportunities to stay in and keep my nose to the grindstone. Then an undergrad, during those arduous days and nights, I began to get my aches and pains in my neck and my neck and upper back from sitting, standing and riding for hours at a time.

I just saw it as par for the course. So I take some NSAID's and keep going, pushing through the pain. I thought I was young, relatively in shape. What was the worst that could happen? Fast forward four years of near-constant studying later and after graduating from undergrad, I've been working as a scribe and studying to the MCAT. Those aches and pains continued over time and even worse, and with scribing during the day and the studying at night and on the weekends.

Just as before, though, I pushed through the pain and assumed there'd be no lasting issues. You know what they say about those that make assumptions? It started small, with occasional shaking pains shocking pains, running up my arms and my fingers occasionally going numb. Then it progressed to weaken grip strength, where I could no longer write with a pen and paper without my hand, letting go of the pen or pencil, followed by severe hand cramps.

At first, my PCP thought it was just my tennis elbow or carpal tunnel so I used the recommended braces and took over-the-counter meds, which helped a little, but didn't stop the progression of whatever was going on. It continued to worsen and almost spread up my entire arm, eventually causing transient numbness and weakness in both of my arms, along with constant aching pain and intermittent sharp shooting pains going through them.

That's when I saw specialists and was told that while they weren't sure what was going on at first, one thing was certain. My symptoms were clearly linked to overuse, and therefore I needed to give up something. So as much as I liked it, I had to quit scribing so I could develop whatever physical ability I had left to MCAT studying.

I thought the symptoms would improve, but alas, they continued and required me to take countless breaks and numerous amounts of medication and over the counter methods to alleviate the symptoms just enough that I could keep going because I worked way too hard for far too long to give up when I was almost there. I just kept telling myself that once I took the test and got a good enough score, I could take a break until med school started and my arm stuff would get better because again, I was still young and could bounce back from anything. Right. I eventually took the MCAT and did well enough to get into medical school. My first choice, medical school. I was beyond excited. I'd done it. My long-awaited dream was on its way to becoming a reality, and I could finally start to do the things I'd been putting off. However, unlike undergrad, even after having a bit of time to relax and decompress, the symptoms never fully went away.

I saw doctor after doctor, and their best guess was that I had something similar to bilateral thoracic outlet syndrome caused in this instance by repetitive physical stress from the countless hours of studying. I was told that outside of surgery which was not a 100% cure, that will not impossible injuries such as these tended to be lifelong. It was then that it finally hit me I had spent so much time of those last 15 years studying, volunteering and pushing through the pain and pursuit of my dream to become a doctor.

That I forgot the gift of a healthy life I was given. Despite my entire childhood being spent limited to a chronic illness I somehow forgot how fragile the human body could be at times. And though I've finally gotten into medical school after those years of hard work, I had to ask myself, Was it worth it? Which was the calling to help others the way I had been, help was worth losing the healthy body I dreamed of. There were times where I had to ask my 50 something year old mom to help me open jars or list things.

I had to get rolling carts and rolling bags because I couldn't hold things in my hands and use normal backpacks anymore because they put too much strain on my shoulders and that I couldn't even hold my baby nephew anymore in my arms for more than a few minutes at a time for fear of accidentally dropping him because I'd become so weak at that point.

Was it worth the loss of all that? The loss of independence, self-reliance, and normal adult human functioning I wish I could say that once I got into medical school, things got better, or at least improved slightly. But they didn't. In fact, due to COVID and having medical school over Zoom for over a year, some symptoms worsened. I even developed some eyestrain issues that were mild and rare during my MCAT studying days, but had now progressed to happening all the time, including photophobia and double vision with prolonged screen use or just persistent eye contact and brightly lit rooms, hence tinted glasses, as you see.

So though from the outside, I might look like every other medical student out there who for some reason brings all of this equipment with him when he studies and wear sunglasses indoors for no reason. On the inside, I'm still taking every day as it comes, pushing through the discomfort and pain, hoping that someday things will settle down. And by some miracle, I'll get back to that place again, where my body works the way it does for other people in my position, my age.

And to be honest, I don't know if the sacrifice I unknowingly seem to make to get here was worth it. But I worked far too hard and gave up more than anyone will ever know to be here. And I won't let whatever is going on inside me or the assumptive stares and judgmental opinions of others stop me from making it to the end.

Because as I'm sure most people would agree, we may not get everything we want in life. But when life gives you lemons well, you know the rest.

Thank you.

01:45:27:01 - 01:45:27:12

MB Velasquez:

You know the rule of threes. That luck happens in threes. Well, I'm going to tell you a little bit about my trifecta and leave it to you to decide whether it was good or bad luck. So ever since the fifth grade, I remember the story that my mom told us over and over again how when she and my father first started dating this is back in the sixties, she would sit on the green, lush, perfectly manicured lawn of the Naval Academy waiting for my dad to get off work.

And during that time, she would watch the midshipmen do their afternoon drills. She said that that is when she dreamt that maybe one day one of her children will fulfill that dream and be one of those midshipmen there at the Naval Academy. So I watched my older brother pass through. Not really interested in sports, but I was. And then my sister went a little bit boy crazy through school, and I didn't have that problem.

But at the time, I didn't realize why. So, I put my head in the books, and I was determined to be that child that my mom wanted so badly to make her dreams come true. I did everything right. And, you know, I got the scholastic aptitude down. I even got the senatorial nomination from Senator Slade Gordon from Washington State to be an official candidate for the Naval Academy. And the physical aptitude test was next. And that you know, took a lot of sweat and working out when I passed it. So as finally down to the last step to be through those doors at the Naval Academy, I got my appointment time.

It was called the DoDMER, which I know sounds scary, but it stands for Department of Defense Medical Examination Review Board. It's the last step before you get to matriculate. And I thought finally a test I don't have to study for like I could do this. Breathe, breathe. OK. So, I brought my mom to the test. I remember she was so proud. I think she told the clerk that check this in that this was for the Naval Academy. And so I was a little embarrassed, but she sat in the corner while they examined me, and she's

sitting tall and proud And then they told me I had to do this methocholine challenge. It's like, what is that? I'm a high school kid, right?

They put me on a breathing machine and basically it was measuring the volume of my lungs and the capacity. And I was like, OK, this is this is fine. You know, big curves And then they administer the methocholine and that is when my curves went from big and beautiful to little teeny teeny curves, and I felt like I was breathing through a straw.

So I was like, oh, please. I was breathing as hard as I could, but my curves wouldn't get bigger. And I looked over at my mom, and her head is in her lap. She's not even looking at me anymore. And I just when I felt the first trickle of a tear, knowing like, wow, it's just great. I've been working for this, I was medically disqualified.

That's pivot number one. I was humbled I didn't even apply anywhere else in the state of Washington because my brother went to WSU and my sister went to UW. I wanted to go away. So I scrambled and got a spot at USC in Southern California, a little bit of money for her to play in the marching band and academics. Because I was so into basketball, I wanted to still be involved. So I asked Coach Stanley if I could be a basketball manager and she said, We already have one. But did you play in high school? I was thinking, What does that have to do with anything? I'm from a small town in Washington. She said, Well, OK, well, why don't you just try out since you played in high school, I think.

Wow. OK, so I worked out with the team. I got to lift weights and do all these crazy track workouts. By the time tryouts came around, I was one of four people trying out, and surprisingly they kept me. I remember that - like, it was like, you all are too far below scholarship players, which is what I expected to hear.

But she said, But MB, we want to keep you because we think you have something to add. And so whatever. That was my great. Got it. So here I am playing at a D1 school. I'm on the travel squad, and we just had our PAC Ten opener, and I was excited because I actually got into a game just last week prior because we were up by 50 points in the fourth quarter and everybody "Put MB in." So I was like, Great. I'm actually on the court. And so that practice, right after we played most of the Oregon schools, I remember I was taking an outside shot because, you know, I was shorter than everyone else on the team, although I've never been taller in my life in the roster, I think they inflated my height a little bit, but I didn't make that shot.

But I went in for the rebound and my teammate Lisa, about a foot taller than me, clears the rebound and swings it. That is when I ate her elbow hit the ground, I see stars and I don't know it got me. It is my claim to fame - speaking of stars, since I recently saw her in a Coke commercial, if you look at the right elbow that's my bite mark and that is my trademark.

But this is number two, six surgeries in seven years later, I ended up finishing my bachelor's degree at UW. Humbling, yes, but pretty satisfied. I felt like it was a good recovery. After blending pizza in a blender to squirt it through your wires, you know, I don't know what could be more humbling, but I survived it I pursued psych research after that, having to remap my life, maybe follow the girl to New Mexico and then a few years later, I end up with not a psychology doctorate, but a medical doctorate and train and family medicine.

Are pretty good. I'm working for IHS. My mom was proud of me again. She even moved down with my dad from Washington. To be with me in New Mexico is a happy family, brother and sister joined.

And a year after I finished residency I had the dreaded worst headache of my life, not having any idea what it was. I went to my primary who decided to get a scan when I joked about how it's probably a slowly leaking aneurysm- no it's something that wasn't even on my differential when the radiology resident told me that I had a sizable tumor up there, I felt like you know how. How, what? Say that again. I don't know. All she could say was I would if I were you, I'd call the cancer center in the morning.

So not knowing what this was doing entail. I had to redraft my plans because I needed to be somewhere where I can get treatment and that's what brought me back to Washington. I was lucky enough after my experience with IHS, I brought that to you to work in urgent care. I worked full time. I was able to schedule all of my shifts around the week that I knew I was going to be on chemo where I wasn't quite feeling well, never had to take sick days.

I just kept working and after eight months of that, the overachiever in me returned. But this time in my head, that's when I found out I was growing a different kind of tumor on the other side. This one non cancerous, small, but growing. So that's when I got my dose of radiation and gamma knife. I did have to take time off for that I came back in a slow return to open up the clinics in the San Juan Islands on Orcas and Lopez It was great pace for me.

Got into the groove again, playing with the community band. I was finally growing up in medicine well, the big day that my fate was decided, I believe, came when my friend was dropping me off at my car that we left while we went out on a boat in a gravel parking lot. She was in a rush, had to get her kid, so I went to the truck, got my backpack out and shut it really quick.

Boom! What I didn't realize was she had a bike rack mounted on the trunk and a slant. So, in the head, I'm in the gravel. We're seeing stars again. And then I see her rear reverse lights come on as I'm laying there thinking, Oh, no, this is really going to be how I go. I beat brain cancer, but now but luckily, she must have heard me yelling because she came running and assessed everything was kind of OK, I'm not bleeding.

So we end up just giggling because it's unbelievable. I however, with this pivot number three, I see that it has given me the realization to embrace the shift that it's brought professionally. Instead of having to work through headaches, I was able to find ways to work around headaches and the cognitive deficits. So I'm reinventing myself. Best job in the World - Faculty Advisor for the Queer Medical Student Association, EDI Trainer- I'm working on bias reduction in the curriculum, ways that I can actually slow down enough to figure out that I have this intersectional lens now as a queer woman of color with a disability that I can still find ways to doctor and contribute. So when I reflect on how I've changed from these injuries, I have gratitude for the adversity as well as for the stable condition.

Now it's just every six months my MRI's and I feel fortunate to be where I'm at with this lens now of disability and accepting my own limitations. I feel like when life through throws that full court press at you that keep the dribble alive, eyes up the court and just regain composure. So I'm grateful to be able to share and now maintain a healthy respect for and distance from elbows and bike racks and always so grateful to be here today.

01:58:15:12 - 01:59:04:08

Heather Evans:

Thanks Evans. And I just want to take a moment to both acknowledge and express our collective appreciation for our storytellers, recognizing the courage that it takes to step into the kind of vulnerability that is required to share your own story. As someone who studies disability identity and the multitude of ways that disability disclosure is a deeply fraught endeavor, I just want to say that we really appreciate the willingness to cast off the cloak as Doctor Meeks described earlier and bringing your experiences into the open.

So I would like all of us to give a round of appreciative applause. Thank you, Allison, Carlo, and MB for giving us the gift of your story. So just a moment to say thank you.

Now transitioning here to share with you some additional insights from the insider's perspective of living with disability, while also being a practicing physician. I am delighted to turn the conversation over to Dr. Conrad Addison and my friend and colleague, Dr. Heather Feldner.

01:59:45:01 - 02:00:16:18

Heather Feldner:

Thank you so much Evans. This is Heather Feldner speaking and I am very, very privileged to continue this conversation with Dr. Conrad Addison, who is a physician who received his training right here at UW as well, and I just our conversation will really reflect on and deepen all of the perspectives that we have heard here today regarding ableism and allyship and internalized ableism.

And we're really excited to dive into this this next section here and Conrad, thank you so much for your partnership in planning this day with us as a part of our team and for sharing your experiences. So we why don't we start by you telling us a little bit about yourself.

02:00:38:05 - 02:01:09:19

Conrad Addison:

Yeah. Thanks, Heather. Really happy to be here. So I was a E13 Montana way of me so kind of prior to curriculum redesign did a first year in Bozeman and then was in Seattle and I at the end of my third year in medical school, I had a mountain biking accident. I sustained a cervical spinal cord injury and that was kind of a big shift for somebody who hasn't really thought about a lot of these disability issues, not for any other reason that you don't have to.

Life is pretty good. So that really threw a wrench in kind of my medical journey, so to speak. So I ended up being hospitalized for about two months. I took quite a bit of time, time off just to focus on recovery and kind of will delve into it. But about a year after that injury was able to return to clerkships and actually kind of graduate one year behind.

I ended up matching one match cycle behind or just expanded. So I went on. I completed an intern year in Billings with the idea that I do radiology and discovered no offense to radiologists I just I like in-person people not 2D renderings. So, I actually kind of stayed in that training program, finished internal medicine and I'm currently in Salt Lake City doing a sleep medicine fellowship at University of Utah.

02:02:06:00 - 02:02:16:22

Heather Feldner:

So thank you. And could you share a little bit more about your experiences when you were ready to resume your training after your recovery?

02:02:17:16 - 02:02:37:12

Conrad Addison:

Definitely. So I and I think one thing that's been alluded to in this, I think there's there's the medical piece, but there's also the life piece. I think a lot of disabilities become apparent kind of at the age where people are in medical school or maybe there before. But even if these are longstanding, they require a lot of kind of social fabric. And a lot of that for me was not only recovery physically doing a lot of physical therapy, things like that, but just figuring out how am I going to reorient my life, how am I going to do things like get around how much figure out, you know, can I do things like cooking, et cetera, caregiving. So around six months, I kind of had enough time and thought to myself, like, I you know, if I if I'm going to prevent this from becoming catastrophic, I need to move forward.

I had about six and a half months of training left, and so I figured, you know, even if clinical medicine isn't something that, you know, I have capabilities for as a realistic possibility, I really should get this degree. Sell my soul work for McKinsey do something, but you put in the effort. It was kind of felt like the right thing to do, get a little bit of purpose keep moving forward. So, I had gotten in touch with the dean's office, student affairs. I think that's kind of how it was set up at the time. I don't know where things are now, and we set up a meeting. And so just to be kind of specific in the particulars, I had an emergency medicine rotation, neurology, a chronic care, and then kind of three and a half months of elective left.

And that was it, which is kind of fortuitous that it it seemed like something that was palatable and doable. So they kind of link in with the disability services. And I was excited thinking, okay you know, this is January maybe one year out, I can go back. And I met with disability services. And actually the first question they asked me was, well have you thought about transferring? And I was kind of blindsided by that. Like, no, but also why? Why would that be a thing? And then I kind of asked and I said, well, you know, the mission statement is, I mean, similar to very various other institutions to create an undifferentiated medical student. And maybe that hearkens back to the formation of WWAMI at a time where, you know, interns could go and practice and need to finish your training.

So, really you wanted this medical student is capable of doing lots of things affiliated part of the workforce. And to me, that felt just a little bit antiquated. Like, you know, that's not the way the

majority of modern medicine works, first of all. The second of all, my life is kind of here. I've spent this last year reorienting and I have a lot of social fabric. I've managed to kind of be helped out in a lot of ways and are very grateful. But I I don't know where I would even start with the transfer process. And the second question was what timeline do you see this unfolding over? And I, I think said nearest point a lot of times, are you the medical student you don't know what you're going to know. You're not an administrator. You're kind of in a unique situation. I said, Well, I've got six and a half months of clerkships I'd like to get those done. I'd like to do that. And like a one calendar year timeline seemed doable. And they said, well, maybe this will take a lot more time than that.

That was kind of the first time in my mind that I guess I had thought about, like, Oh, this will be this would be a little bit maybe maybe harder than I thought. And so that's kind of.. That was the experience resuming resuming training I guess.

02:05:55:04 - 02:06:43:08

Heather Feldner:

Yeah, that is. And that's such a surprising response in and of itself, but especially from an office that is intended to support students with disabilities with their needs. And so that is just really unacceptable in terms of how we think about moving forward in that situation. Can you describe I know we've had conversations about how you engaged in self advocacy throughout this process, but also how other allies and accomplices' kind of came in as you were navigating this process to return back to your training. Can you talk a little bit about that?

02:06:43:12 - 02:07:03:21

Conrad Addison:

Yeah, so I, I think that was kind of a realization when I was like, okay let's get creative. You know, the onus is on me and that's okay I think, you know, there's for every person with a disability, I mean, you've met one person with that disability. I think there's a lot of uniqueness and a lot of nuance.

And I think, you know, I'm uniquely qualified in one thing and that's my own experience. And so I kind of realized, okay this is not me. As far as allyship, I had reached out actually to a number of physician mentors that had been mentors prior to my injury or kind of supporters through that injury time and just kind of said, hey, this seems you know, a little strange and maybe a little obstructionist, and I really want to get this going, you know, can you help?

And part of that, too, is actually just figuring out who the stakeholders were in clerkships, reaching out to clerkship directors. I'll give you the ER credit, Josh, and then Jamie Shandro at the time really helped me a lot of credit of kind of working together to say, hey, what are these requirements? What are our technical standards? Kind of what are ways that we can give people a choice. I think similar to parenting, you give a kid a choice, you remove the ones you don't want off the table. And I really feel like that kind of collaboration of a lot of physicians really was something that kind of moved the ball moving forward. The neurology department was great. I was kind of to give credit to radiology department was probably

the biggest ally of all. I, I think they really said hey, we've, you know, we've seen this before. There's Peter Poulos, who Lisa has done the podcast with this is a cervical spinal cord injured radiologist at Stanford. So people knew him. They said, oh yeah, well this is possible. So we don't know how this is going to look, but we can do it. We can set up a rotation we can do it on extended hours. And they were really willing to kind of listen to me and say, what do you need to be successful? And this will be a great first rotation back. And I think it was them kind of picking up the ball and saying, Yep, everything's in place on our end. Like we just need a green light to kind of move forward.

That really kind of was the I guess, the catalyst, catalyst for kind of getting that approval from you know there's kind of a curriculum review for people who needed to sign off on this. And I think that gave a lot of reassurance. I, I don't think any of this is malicious and none of it's meant to sound like a customer service complaint, but I think there is a lot of how do we make sure that there's learning standards that are met while also kind of meeting the needs of an individual. And I think some of the time delays that people experience are just people feeling like they need to make a big decision. And sometimes that's just easier when somebody said, nope, we're doing it like it's already kind of been decided and it's ready. I think that just lowers the activation energy. As far as training moving forward, I've been the recipient of a lot of allyship.

I think there's a lot of things to think about. And when you're in when you're in training, you don't necessarily have time or energy to think about a lot of things one of these things actually is a physician back at UW system, and a chief resident. We had a team room or a conference room that's actually kind of a public space, and I had been waiting for people to let me in because I have a hard time opening doors and driving through them with my wheelchair.

I did that for two and a half years and he was somebody who just said, Wow, this is a public space. Like, I think we'd be better served as an institution to get a door opened here and kind of without without consulting me, just got it done, which was a huge relief. I think there's definitely the mindset of, you know, nothing about us without us, but sometimes basic things like that are really nice for you to not feel like you're the squeaky wheel or kind of need to take all accountability for all things and I think there's been a lot of people just been very supportive, and I've been able to call on to say,

Hey, can I pick your brain about this? Or, you know, how can I approach this issue of this accommodation I'm getting? So I've been very lucky that way. And I think that UW really is a kind of at the forefront of that attitude of nationwide.

02:11:13:14 - 02:11:40:12

Heather Feldner:

Yeah, I really that that's so powerful to me, that example, because I think it speaks to what Lisa and Neera we're talking about in terms of addressing the real immediate needs in a given situation as expediently as possible. But then also thinking about like what does this vision look like of a future down the road where where these processes are already in place and we don't have to scramble to be thinking about meeting needs. And I and I appreciate your comment also too, in the sense of recognizing the invisible labor that it takes to advocate for yourself, but also to kind of build solutions based on your

own experiences and, and that when certain things are already in place, that that lessens that invisible labor. Thank you for that. Let's talk about the other side of the coin, your experiences of ableism.

You already gave the one example of coming back to the remainder of your training. Where were other areas throughout your experiences where ableism was played a role?

02:12:25:09 - 02:12:48:04

Conrad Addison:

Yeah, I think that's a really good question. And again, this is not meant to be any customer service complaint. It's just kind of one experience. I think there was a lot of kind of what was alluded to in that first discussion of physicians or stakeholders who said, well, you know, sure we can we can graduate you through and we can do this thing.

But if you can't be technical standards, if you go into the real world, you know, how does that how does that work? And we're really not doing you a service and is this the right thing to be doing? Is this I think there was a lot of community and maybe didn't need to be. And so I was interested in that kind of alluded to the process with required clerkships of, OK, who's the clerkship director? What are the standards I go through? I create a list of things that I think are possible, kind of the wish list. But also I think in that was just give me room to fail because I don't know what I don't know. And we can say that something's going to work great. And it may rubber hit road and rapidly fall apart.

But I do think some of that ability to kind of have flexibility and an open dialog is something I stress is the most important. And it was interesting. So with chronic care, I figured I know a number of physicians that I have gotten in touch with who are physiatrist or physical medicine in rehab, who have injuries or various impairments. And maybe this being a nice rotation to do. And it was an interesting kind of discussion at the time with some folks in rehab because they just said, well, there's, you know, there's just a lot of physical requirements and you could do a palliative care elective and that that's probably better suited. And you know, if, if, if we do have you, I mean we can try better your chances for getting an honors grade or a grade. It's just going to be there is kind of a lot of which a lot of reasons not to do it, which I found very interesting I guess from a field where unanimously I feel like aside from that, my experience has been, you know, this is a specialty that's really about promoting people to live their best lives and reach potential and make accommodations and get creative.

So I was a little bit disheartened. And I as you alluded, I think there's kind of this tax. It's like, you know, imagine a river and if you have to pay so many tolls, you're just going to pull your boat out of the water. And for me, this was one of those where I was like, I don't have the energy to do this.

By itself. I'll do palliative care. And I think it would have been a rewarding, you know, rotation. And, you know, you look back, I not not the end of the world, I guess, kind of in that sense as well. So that's had to get approval for like a total package of here's the rotations, here's what we're going to do. And it was interesting. We think about the time frame. I'm trying to get all these directors in one place and all these stakeholders involved and there is a significant scheduling delay. And what was kind of told me at the time was, well, you know, you have time you're so young, you know, and you have to wait another year, what's another year? And for me at the time, kind of going through this injury was like, boy, time is

really valuable. And I need this kind of for me moving forward. And you have no right to tell me what one year of my life is worth, which just seemed like such a strange conversation. And so we had this meeting and it is interesting, and I think it just felt very adversarial, you know, kind of people wondering how this was going to work and people who really didn't have it like they weren't part of the rotations. They were just kind of like philosophically involved, but actually involved and that was just kind of a I just remember a very gross feeling kind of moving forward. I, I think instead of kind of a collaborative like, hey how do you see this going? Or, you know, ways that we can move forward, it, it just felt more like, well, these are your ideas.

But now that you present it, I have to think about it. And it was kind of, we've already delayed this meeting months. I think the academic institution of graduate medical education runs on this July to July calendar. I mean, you know, I think there's an imperative for institutions to move people through. And when something doesn't fit on that timeline, that was kind of a structure that felt very blessed that like I realize, you know, there's a reason for this.

But I also realized that, you know, if we're going to have a reason for that, we should have a reason to kind of expedite other things that allow learners to fit into that timeline. I guess just a few other things that come to mind. I think about in medicine, there's the the dreaded overnight ICU shift, the like 27 hour call and for me, initially, I just said you know what, I'm going to do this which was a really bad idea. I ended up kind of having some pressure issues with the wheelchair my second year ended up getting surgery. And so going back my third year, I had three months of ICU left. And I just kind of thought like, there's no way this is a good idea. And so I proposed an alternative. I said, look, I'll work six days a week 14 hour shifts. I'll do the same amount of hours. I'll even do night shifts. I don't care. I just can't spend this much time in a wheelchair. And again, it was, well, we don't want to give you this accommodation because then we'll have to maybe think about giving accommodations to others. You know what? If somebody has a sick kid or and to me it just felt like, boy, that's like an asinine way to think about this.

And it came down to them kind of wanting documentation. Why that was a bad idea, which I think when you're working with physicians, you should really know why this is a bad idea. But I think it is it's kind of a dual mandate of, okay know what's common sense. I know what to do as a human or as a physician, but what are these mandates that I feel like I have to execute as a program director or, you know, as an administrator to make sure that we are above bar or protecting ourselves from legal actions?

So I think there's a lot of gatekeeping. I think that feels like more and more there's more involvement of learners. But also I think there's an expectation that learners have these you know, detailed 20 point plans, and that's just not realistic. I think this needs to be a dialog and it's an evolving, evolving dialog, which is kind of the way forward. I know I think the model of harm reduction is really excellent, excellent way to think about that.

02:19:05:10 - 02:19:23:13

Heather Feldner:

So have you seen that shift at all in your progression through your residency now into your fellowship, looking for jobs after fellowship, what's changed what's stayed the same for you in terms of these experiences of ableism and allyship?

02:19:23:23 - 02:20:01:13

Conrad Addison:

Yeah, I think a lot. It's actually almost disorienting how short a time has passed and I feel like how much has changed, and I don't know if that's me paying attention, but I don't think that kind of fully explains it. So I will say, like as a student, even though you are the paying customer, you definitely feel that need to like, you know, somebody has this thing that I need which is medical training and the degree and I have to ingratiate myself or, you know, not be kind of a pain or a nuisance in order to get through that that gatekeeper I described. And in residency I think there's still some of that, but there's definitely I mean, you're you're getting paid, which is a novelty. I think there's more worth of you feel like you've made it a little bit more. You've kind of gotten the M.D. maybe you have more social cachet even within this kind of things. But it seems like every step of medical training for me, I just say that, that I feel like things have gotten better where people have given me more kind of authority over my own experience of like, oh, you're, you're probably going to know an idea on this or how should we approach it in a less adversarial way. I'll say in residency, I was very lucky - there was a program director in Billings who just in my interview said, look, we don't know how this works, but we're going to make it work. Whether that's hiring amanuensis or kind of if we have to deploy or if we have to expand training, like we'll just figure it out.

And that was huge and actually you know, that was accompanied with but specifically we were like, need this plan. And even in fellowship, I think it's when you've gone through medical school, gone through training and you have that resume of, okay here's someone who's managed to deal with this, so maybe we trust them a little more. But I really was like, hey, here's your point of contacts like tell us what you need. Tell us kind of how to proceed and even kind of that next step with employment. I feel really lucky at a job I've signed to next year. It's been very similar they're planning to redo their clinic. They send me plans of like, Hey, where do we need door openers? Or Can you comment on this? Or You know, what do you need to be successful? And I, you know, there's a kind of nuts and bolts part of me that says, well, you're your ability to produce an economic modicum of something goes up the more you are in training. So, it really behooves an institution to have a productive physician and work with them. But I think that's maybe the wrong mindset to have. And I think just societally, I know, you know, Lisa's podcast has been great for this. I think there's really been higher visibility. The AAMC report was huge. I think it kind of called into question. A lot of institutions are like, Oh, what are we doing? Where are we at? What is the status quo? Where are we going? And I think, you know, COVID has maybe shifted things. I think a lot of the kind of social justice movements have shifted this focus on what our culture and our society is such a more rich place when we bring more people to the table and how do we do that in a way that's going to kind of work and be respectful? And I just think there's so much to gain from that. And maybe, maybe that's me. But I do feel like public perception has maybe shifted in that way, which is really, really encouraging. And I think, you know, I think about Lisa's podcast or these stories or you talk with people, you know, that's really neat for people to see.

Oh, this was possible in this way, but I also think the academic literature has expanded, and that's really important because it kind of creates like a cookbook like how do we do this reproducible and how do we document it? I think one of the strange things to find out was that there was a physician at UW I think in the nineties, Glenn House and he's a Physiatriist, and he had a C-7 spinal cord injury and it was like all

institutional memory of that was gone. Like there was no one. I mean, I kind of found that after the fact there was like nobody had recalled how this learner had gotten through or who who did what or what accommodations were made and I even think there's kind of differences culturally within institutions of departments, you know, one departments willing to do one thing and one is not. And that changes. I talked to a resident who at UC Irvine, and she said, Oh, yeah, the fellowship or the program director was great when I got here, and then I switched and it was a complete cultural attitude change, my life as far as accommodations got significantly harder. And I think that just makes the case that the more we kind of put out there in the literature, the more we think about, hey, how are we as institutions or organizations going to write this down and think about this maybe in a more streamlined, centralized way?

I think the more opportunity there is kind of to involve more people with that and have more people be successful? Yeah.

02:24:27:23 - 02:24:32:23

Heather Feldner:

Absolutely. And I think I so appreciate that insight as well because. It speaks to this notion that accessibility isn't just a space that is welcoming and accessible. Right. But but it really depends on the people that are engaged in those in those spaces and and the investment in inequity that that you've brought up we've got a couple more minutes here. Do you mind if I ask you one or two more questions?

02:25:01:20 - 02:25:02:07

Conrad Addison:

Let's do it!

02:25:02:07 - 02:25:29:02

Heather Feldner:

Awesome. So we've talked a lot today already about the kind of sensitivity and tension around disclosure. You know, whether that's you know, so for somebody who has a an apparent disability or an invisible disability, and obviously there's consequences for both of those choices, whether or not to disclose. Do you have any thoughts on that?

02:25:29:15 - 02:25:53:07

Conrad Addison:

Yeah, I think my again, I'm speaking from my own experience. This is not this is not a recommendation. I think for me, my disability is obvious. Like I, I use a power wheelchair. I have a limited shoulder and

bicep function, but no hand function. And so I think for me initially, I mean, I felt this injury was very humiliating.

Some of that's kind of aside from things, but I was like, okay I just need to tell people because the less people are surprised and the more you front load them, the better reactions I seem to get. And that's actually turned into kind of a source of empowerment. I think when I wrote my first personal statement for residency, it was more about like, you know, trying to either downplay my impairment or, you know, talk about how well I could manage it. And in fellowship that just felt different of like, hey, here's my impairment, here's what I've been able to do. And, and I think it's actually been helpful to kind of weed out people who aren't interested or in incapable for whatever reason, whether it's institutionally or otherwise of dealing with that. And it's made my life a lot easier. It's kind of made the job search fellowships search very efficient in that way.

And so this is not like a recommendation that everybody needs to a disclosure because I think for me, I can't really hide it. I do think there's a lot of impairments disabilities where, you know, maybe it actually behooves someone not to if you're like, well, if I kind of in the canary in the coal mine and everything gets activated and suddenly it cascades out of my control. So I understand both ways. But I think the more we can kind of be comfortable in who we are and what our capabilities are, I guess the more can be achieved moving forward. So it's definitely been a point of kind of a good thing for me as it's evolved with disclosure and I do realize that there's a lot of vulnerability to that one, and especially if things are working fine.

I think about kind of relapsing remitting impairments where, you know, if everything's going good and you don't have to do all this extra work to get accommodations, what's the incentive? And I realize that you know maybe there isn't a lot.

02:27:51:04 - 02:28:00:23

Heather Feldner:

Yeah, absolutely. And it's a it's just a very tricky and individualized sensitive situations. Appreciate your thoughts on that. Yeah. Oh, go ahead.

02:28:01:00 - 02:28:23:20

Conrad Addison:

I'll just say, like the flip side of that is if things do go really wrong, I'm it's been really nice to have those disclosures in place and so that it's kind of like, well, think of it as like an insurance policy you're preventing against further losses. You might not use it, but it may be really useful if things change or kind of the status of an impairment changes.

02:28:25:09 - 02:28:58:05

Heather Feldner:

And hopefully be able to benefit others that will come after you as well. Right. Yeah. And that kind of leads into my last my last question for you to wrap us up here and then we will have some time for the audience members to ask some questions to all of us. And that is you have gone through this process and have are now transitioning into being an advocate for others and a mentor for others in in situations of disability and impairment.

How has that process unfolded for you and how are you staying connected to this community now?

02:29:07:00 - 02:29:31:00

Conrad Addison:

Yeah, it's a great question. You know, I relied heavily on physicians across the country who had impairments to try to figure out what's possible, what might be ways to approach this moving forward. And then kind of the more I've gone through this, it's people have gotten, you know, oh, I have a friend who has a student who has this question, can they get in touch and it's been a really rewarding experience. I think it's a great community and there are a lot of physicians out there. And the more visibility there is, I think it's such a valuable resource. I've had a number of learners contact me with kind of motor impairments about like how did how did you do this? And it's interesting I think I've thought about this even subconsciously for so long that maybe I have like a nice outside perspective. It's just an example of that and a medical student from a medical school out east who has kind of a progressive, lower extremity weakness, needs arm canes, and her whole thing that I think the school didn't know how to handle is how are we going to do surgery, how are we going to get you in there to observe and you know, have the most productive, you know, experience? And her thought was like, well, if I had arm canes, I could do that. I can manipulate tools or and for me, I was kind of like, oh, I've heard this physician used to standing frame in the O.R. and it never left the O.R. And she was worried about her arm canes breaking down with sanitation wipes. It's one of those things that like, Oh, you have a set that never leaves the O.R. That's not a big financial expenditure for the school. And so there's just different ways of brainstorming. And I think, you know, I learn all the time from those conversations from people who are, you know, wanting my perspective. And I actually feel like I gain valuable insight in that. And I think the podcast has been really great. I mean, 50,000 followers. That's amazing. And I think there's other kind of Facebook, email trains, et cetera. And so I think the more people get connected, I think this just has a chance to make medicine and medical training really a more inclusive place.

02:31:17:19 - 02:31:46:06

Heather Feldner:

And as we mentioned then, that carries forward into a more inclusive health care practice where people seeking medical care are being provided for by caregiver or by practitioners who share experiences or who have lived experiences. And that just, I think, continues to extend the community, which is just so inherently valuable to to what what this is all about.

So thank you.

02:31:47:06 - 02:31:51:00

Conrad Addison:

Yes, thank you.

02:31:51:12 - 02:32:09:06

Heather Feldner:

I we would love to share our appreciation for for your insights and your willingness to share your story with us today. So I would invite the audience to share their appreciation with some applause.

Thank you so much, Conrad. And I'm going to turn it back over to Evans for the final question and answer session.

02:32:22:20 - 02:32:51:09

Heather Evans:

Thank you, Feldner. Again, this is Heather Evans. And I just want to welcome folks, if you have comments or questions certainly for for Conrad, for Lisa for Neera any of us, I really do want to also acknowledge and appreciate that in the chat. There have been a lot of kudos coming in. For example, someone just thanked us for including all of the personal stories and insights here.

Absolutely. I also want to note that Lisa has included some additional resources for individuals and to let people know that the recording of this event, the transcript, and therefore all of the great resources that have been mentioned will be posted on the CLIME 2022 symposium website so that you can go back to them later for for reference so again, I just want to open it up and for questions.

Again, a lot of kudos coming in. Some of the reason that I agree to do this kind of facilitation in moderation is because it gives me space to ask questions, exercise a little bit of privilege there. So I will start off, Conrad, I do want to know, I really appreciate that, for example, for disclosure that you acknowledge that it's not a one size fits all you're not necessarily giving a recommendation.

I kind of feel like your counterpart in is someone who often passes as non-disabled, is part of the reason I really try to make a conscious effort to explicitly disclose in spaces. But I'm curious then that following up on you now as a mentor, but also as a bit of a role model, are there specific strategies, tips, things that you just automatically do to kind of create space for people that experience these kinds of differences or impairments, whether they're interested in medication or they're seeking, you know, seeking medical advice?

I'm not trying to prompt a checklist, but I'm just wondering upon reflection, are there bits of advice that you do try to intentionally share?

02:34:42:04 - 02:35:16:11

Conrad Addison:

You know, oh boy, that is a good question, I think the one thing I try to share about, you know, patients and other people is, you know, you are your most powerful self advocate, but also create space for people to share, I guess, what sort of obstacles they're facing. I guess I don't know if I can answer that with a specific recommendation but I, I do think there's just a lot of people who are okay with the self advocate.

And if there's ways we can remove the friction, I think that's great. But I, I really think like you, you really have to advocate for yourself. And I, I think yeah, I'm sorry, I don't have a more eloquent answer.

02:35:32:13 - 02:35:46:17

Heather Evans:

No, thank you for that. I know that it's often hard to come up with pithy short statements when you're, when you're just experiencing something and in a phenomenon of like, sure, these are the bumper stickers that I give out to folks. I appreciate that.

02:35:55:23 - 02:36:16:13

Heather Feldner:

And if we're not having any immediate this is Heather Feldner speaking. If we're not having any immediate questions coming into the chat, we also might be able to jump back to some of the earlier questions following Lisa and Neera's presentation too. If that is something that people are willing to do bounce back and forth a little bit.

02:36:19:07 - 02:36:38:00

Audience Member:

I have a question for Conrad. Thank you for sharing that. Is there anything that or anybody in particular that you felt that made a big difference in how you were able to space things or encourage you to talk or advocate for yourself? Anything that you.

02:36:40:06 - 02:36:49:02

Conrad Addison:

Yeah, I, I think, I guess is that question more about like with the disability process or like the physical infrastructure and accommodations.

02:36:49:14 - 02:37:13:20

Audience Member:

With disability process? Yeah. Anything that you can tell people that maybe on the other side, this is what helped me of you who have done that, even just support your, say something that will not discourage of what was said. You think it will be helpful for other people, as I understand everybody's different, but what do you think it will be a helpful tip for somebody on the other side?

02:37:14:09 - 02:37:38:01

Conrad Addison:

Yeah, definitely. I think - So I kind of as I mentioned, I think there was a lot of physicians at the University of Washington and I felt really lucky. I had a medical experience before this kind of to build those relationships without this component. And so then leaning on those relationships and I realize how it may be difficult for someone matriculated into medical school when they maybe they haven't connected with mentors or they don't have mentors. But I really think don't be afraid to just start writing. I call them Scud missile emails. Hey, I have this thing and I don't even know what the solution is and I don't even know what the problem is. But I know there is a problem and I need help and I need somebody to advocate and I felt like there was a lot of physicians who did that on my behalf at no reward of their own kind of personal gain.

But just because it was the right thing to do, I also think I would I would just encourage people that there really is a giant nationwide. Well, maybe not giant, but there is a community of physicians myself included or learners who are really willing to share their experiences. And I, I think kind of willing to put in calls to Dean's office or disability services if the question is why do we need to do this to lobby on that behalf?

And I also yeah, I think that's such a great resource to connect with people. I think there's a lot of probably kind of other people on the administrator- teacher side who feel like, how are we going to do this and also feel similarly lost. And I think sometimes just knowing that it's possible or that it's been done, this isn't a first. This is really reassuring for people. Kind of like a metaphorical handhold of like, oh, okay we can do this. We don't know all the specifics, but we can do this.

02:39:05:10 - 02:39:05:23

Audience Member:

Thank you so much.

02:39:11:06 - 02:39:43:17

Heather Feldner:

Conrad. I'm going to jump back in here. This is Heather Feldner again because I, I remember as we were putting this talk together, one of the other stories that you shared and we haven't gotten a chance to talk about this much today in the context, but it's very applicable is that idea of and Lisa, Neera did mention this in their talk as well, but this idea of minimizing the the potential skills and abilities that disabled trainees can contribute.

And I remember you sharing a story about that, the meeting that you had when you came back. And it was very adversarial and and a one of the attendees of the meeting came up and said something to you afterward and was wondering if you could just recount that.

02:40:03:12 - 02:40:20:17

Conrad Addison:

Yeah. So I mean, this was there, I think, very well-meaning, well-intentioned, but kind of after this, what felt like to me, it's kind of like a tense meeting and very kind of frustrating and disheartening in a lot of ways. And I was just very I was like, I just I just got to get on the bus and get out of here, and somebody pulled aside and just said, you know, I just I just really want you to know what you're doing is really it's just so kind of inspirational. I just remember kind of losing it and saying, like, you know, I have three fourths of the way through tuition. Like, this is not inspirational. This is survival. I need a way forward. And this has nothing to do with that. I like it. It just felt like such a misplaced thing. And I, I guess I understand where it comes from, and I'm not really offended, but I do think I think the bigger thing is just like you think about kind of what ways our limitations are going to drive innovation in medicine and allow providers to more deeply connect with their patients who are having the worst days of their lives there. Nobody wants to go to the doctor and that to me was like, no, that's like that's the overarching thing. This has nothing to do with inspiration or kind of that packaging, I guess. So it's just an interesting thing. And I think more people are realizing that there's been a lot more awareness of that, at least kind of in my experience. So yeah.

02:41:31:14 - 02:41:44:08

Heather Feldner:

Thank you. I so appreciate you sharing that. And that could be a whole other CLIME Together symposium on inspiration narratives surrounding disabilities. So yeah, I'm glad we got I'm glad you got a chance to share that as well.

02:41:44:24 - 02:41:45:16

Conrad Addison:

Appreciate it.

02:41:46:17 - 02:42:14:17

Heather Evans:

Yeah, this is Heather Evans, and I just want to I want to echo that. Thank you, Conrad. Thank you. To all of the presenters and storytellers who've been here today. We really appreciate Lisa and Neera, the two of you sharing with us this has been such a great and lively conversation. And again, to to echo MB, I am just sitting in gratitude and very grateful to be here and to be with this group. And then I am going to pass it over to Joshua for some closing remarks.

02:42:22:11 - 02:42:54:02

Joshua Jauregui:

Thank you, Evans. And thank you all. As we close, I just want to invite you now to stop and take a deep breath. I know it's been a very valuable morning and time together. And I think in that first step of noticing that Neera Jain called us to say, I want to invite you to notice what's been coming up for you, what has impacted you and what may have changed the way you think a little bit. And just pay attention to that and think that for being there I also now, as on behalf of the CLIME team I want to thank everyone involved for our plenary speakers for their expertise and really helping us push ourselves towards a more liberated health care education system. To those who shared parts of themselves with us through stories or as being interviewed for their courage and their vulnerability for our conference co-chairs, for their leadership and their vision, and for all of those people who have been participating in making this happen as a team for our interpreters, to Kent, our storytelling coach, to Jason, our technical support and most importantly to Amanda Garza, our CLIME manager, who's really made this all happen. Thank you so much. Thank you so so very much. And really to all of you for showing up, for being here, for opening up your hearts and minds to these ideas and to these stories. It is as we show up together, as is the way that we continue to move forward. And so now I just encourage you and invite you as you go into the weekend to keep your hearts and minds open to what you may be noticing and then move into that space of unlearning so that you can learn again a new thank you again for being here to our CLIME Together symposium this year.

And please look out for other announcements of how to be involved in especially for the links to this video recording and also further information for responses to the questions. Please feel free to reach out to any of us with further questions or needs that you may have and we look forward to seeing you again. Thank you all. Have a wonderful afternoon and weekend.