

DocsWithDisabilities Podcast #2

Dr. Erene Stergiopolous

Part 2 of 3 Transcript

Participants: Lisa Meeks, PhD, host

Erene Stergiopoulos, MD, interviewee

Introduction: Lisa Meeks

Doctors with disabilities exist in small, but measurable numbers. How did they navigate their journey? What were the challenges? What are the benefits to patients and to their peers? What can we learn from their experiences? My name is Lisa Meeks and I am thrilled to bring you the *Docs with Disabilities* podcast.

Join me as I interview Docs, Nurses, Psychologists, OT's, PT's, Pharmacists, Dentists, and the list goes on. I'll also be interviewing the researchers and policy makers that ensure medicine remains an equal opportunity profession.

In our last podcast interview, we started the conversation with Dr. Erene Stergiopoulos talking about her research, the unwritten curriculum in medical education for learners with disabilities and some of the barriers to full inclusion. In part 2 of this 3-part podcast series we have a conversation about everything from tackling barriers to licensure, social consequences of having a disability, and boundaries between learners and faculty in health science programs.

Lisa: What happens when a psychologist and psychiatrists enter a room and they're given a mic with free reign, you never know. It could be a glorious conversation with lots of depth and I know that my interviewee today I could talk to for hours. She is an amazing rising star, recent graduate from medical school, why don't you introduce yourself to our audience?

Erene: Sure. Thank you so much, Lisa for having me. My name is Erene Stergiopoulos I just graduated University of Toronto medical school and I'm starting psychiatry residency in July. I also do a little bit of research on the experiences of Canadian medical students with disabilities and do some student organizing as well.

Lisa: Today we talk about the impact of disability and taking a leave of absence on licensure. Unexpected consequences of disability on the process, delays and even impact on practice we begin with Dr. Stergiopoulos recounting her own unexpected barriers to licensure after extending her time in medical school.

Erene: On the Point of licensure. I am applying for my medical license right now and had no idea what the consequences of actually extending my medical school would be for my license. So, I've had to get doctor's letters, I've had to get letters from my dean, just to explain the extra time and it's something that I wish I had known in advance just to be able to give myself more time to get this all of this together because it's a ton of paperwork. Something that's not discussed ever when you get accommodations.

Lisa: And it's a ton of paperwork but even within the paperwork even within the paperwork there's privilege in the category of disability that you identify in, right, because for you, your category of disability, is probably more accepted by the medical community and there's clear indications for the projection of your care, um you're not going to be "a harm to patients." But think about someone who has a mental health issue and the overwhelming reality of the licensure issue, which is that I have to disclose a mental health history, I have to disclose any hospitalizations, they're supposed to ask if there's anything current that will impair your ability to provide care to your patients. But some states still ask about historical mental health care and if you have ever been to counseling ever [1].

Erene: Wow.

Lisa: Imagine if you're a medical student and in your transition to medical school, you seek help to attend to that adjustment or say you're married and you seek marriage counseling because navigating medical school as a married couple can be very difficult and you have to disclose all of this. And then there are consequences where you may have to have oversight from... a psychiatrist and oh by the way, it's not enough that you have a limited license now and you have oversight from a psychiatrist. You also have to pay that psychiatrist for that oversight, so now we're back to the financial implications. There were many students who would not seek help because of that.

Erene: That's a huge barrier. On twitter recently, I saw someone had screened captured, this was in the Canadian system, but I think it was for getting your um license beyond the graduate license to be a full stop attending doctor you needed to disclose any time you've been treated for burnout. I'm sorry, 50% of medical trainees have burnout. Are we going to profile every single one of them [2]?

And even thinking about disclosures on licensure applications, perhaps if someone had an extended residency due to a disability, that's probably because of the intense demands of residency, whereas once you're an attending, there's a lot more flexibility your time is much more your own so the fact that the standard at which practitioners or trainees are judged is not reflective of what the actual work environment will look like, once they're actually fully trained, fully licensed. So, it's again, it's this extra barrier that adds so much complexity and so much extra work to the trainee but that really might not be relevant later on.

Lisa: I imagine some of these barriers also serve as the origin of secondary disability. So, if you have a learning disability, chronic health disability and the stigma and the shame that go along with some of the maneuvers that you have to do... I know we were just talking about it's a 10-page application for disability services appropriate. Probably not. If you have to expend extra energy, cognitive and physical to navigate a space where you're not really sure what the climate and culture are you are not really sure what the process is... and the internalizing of it's me, it's me, so now I'm tip toeing even lighter and that can lead to secondary disability of anxiety. And then that its own issue and can parlay into other things like depression or sleep disorders.

Erene: I think that one thing, that from a student perspective, that I've definitely seen for my peers, for myself while we might have an accommodation once you've jumped through all the hoops and you have the documentation, one thing that's always still very tricky is actually disclosing that accommodation to an individual preceptor, because that's actually where accommodations finally take shape. That's where they get implemented, and so it can be really, really tough, especially in a clinical environment where you're at in your clerkship, you have a different preceptor every day and suddenly you have to tell your preceptor, "Oh by the way, I have an accommodation, I'm allowed to go home at this time today for an appointment."

And if that happens too many times in that rotation, how's that going to affect the evaluation? And so that is definitely a barrier to people actually even using their accommodation. So, they might have the official documentation and the accommodation approved by the school, but they might be actually hesitant to use it for their health or for their wellness because of the stigma attached to being perceived as a needy student or a lazy student, someone who's not willing to put in the work like there are other colleagues are. So, I think that's a really big barrier, I guess it's more of an attitudinal barrier.

Lisa: Yeah, or you have an interaction, you engage in that accommodation the first time and it goes so poorly because the preceptors are not trained. So, they received this and they're like, "How am I going to have coverage?" And they push back or they ask questions. And then it becomes, "Well, is it worth it to, tell the truth about what's going on? How much do I have to tell? Does private often sensitive information. It may be the interaction that leads to not engaging and not taking advantage of that accommodation. And then what happens when the learners' health starts to deteriorate?

Erene: Exactly.

Lisa: Who gets blamed? The learner.

Erene: Yeah, because they weren't being a good patient, they weren't self-regulating and self-managing.

Lisa: It all goes back to your research [3]. What is a good patient, what is a good doctor? And those two things, never the two shall meet, right?

Erene: It's also really honestly heartbreaking to hear stories of people who have been confronted by preceptors or by supervisors who tell them, mmm I don't know if this is the best program for you, because of this disability?

Lisa: We have the beautiful privilege and benefit of knowing so many surgeons with disabilities and if I know a learner or a physician that is a wheelchair user as an example, my first question back would be, "Sure what specialty?" Because I probably know one in every specialty. If you asked about a physician with a learning disability, I would probably have the same response.

We self-filter based on our interests, our strengths, our weaknesses, we all did, that's just human. So, of course individuals with disabilities were going to think about their disability and have that inform their decision but there's so much more than a person with a disability. They have so many interests and so many ideas about different areas.

Erene: I think at the student level it's also really, really discouraging to hear colleagues who've been told by their supervisors, are you sure you're cut out for medicine? That brings tears to my eyes when people describe that as something that they've experienced because probably that barrier that they face is what's going to make them an incredible doctor in the end of the day. Just by virtue of knowing how hard it is to navigate a complex healthcare system, knowing what it's like to be on the other side as a patient.

Lisa: I was sitting here listening to you, I'm thinking about people that have physical disabilities or apparent disabilities, and the barriers that might be very different for them. Can you talk about the barriers in each?

Erene: I think that for someone with an apparent disability, one of the biggest barriers is that physically they come across as a patient first, in a sense, they enter the floor, they enter the ward. A friend of mine jokes about this, people have this head tilt reaction if you are apparently disabled. So if you are in a wheel chair or you use a cane people will talk to you with their head tilted, it's the same thing when people talk to kids.

It's this sort of strange, almost condescending move that people make and it's trying to be friendly, trying to be engaging but it's this odd habit that people take on and I think that for someone to be in that position and to suddenly make your first day of clerkship, you're expecting to be treated like the rest of your colleagues and suddenly someone throws in the head tilt when they talked to you for the first time. It's cloying almost to have to take on that mantle every single time you enter the room but what if you don't want to be the trailblazer. So there's this incredible onus and responsibility I think that's So that can be a barrier because that's just so much extra work and so much extra emotional likely shouldering that.

I think another barrier for someone for learners and trainees with apparent disabilities is the fact that oftentimes just plainly their environments are just not going to be accessible to them. I think there must be a lot of back and forth with their learning environments, whether it's a hospital or a clinic, trying to ensure that they can

make it that day and get through the work. There just so much emotional tribulation, I imagine, and it's hard for me to talk about this because this is not my own experience, but just being on the cc'd person on those emails of how are we going to accommodate this person? This is going to be so tough. Oh, what kind of extra costs are we going to incur? And being the fly on the wall and those conversations must be incredibly, incredibly difficult.

Lisa: Around the accommodations. So and so needs a special this, or special equipment. But at the same time everybody tends to rally even if it's say, what is perceived as being either costly or time consuming, there's a rallying around this person that I think often doesn't occur with an individual with a nonapparent disability. And going back to something we were talking about in the beginning where programs, either think they're doing it right or think they're doing it wrong, unfortunately, so often when a program has a student with a physical disability or a sensory disability so an apparent disability, they hold them up as proof that they are inclusive.

And I like to point out that there are nine individuals to every one individual that has a sensory or physical disability who have disabilities, who have disabilities that they're not holding up and they're not rallying around [4]. And so, this kind of disparate approach to supporting a learner with a disability, =I don't think it's intentional. I think people don't know what they don't know, I believe that. So, let's talk about the barriers for not apparent.

Erene: I think one of the biggest barriers for not apparent disabilities, and I almost wanted to find that into two subcategories where one is mental health, and then the other category is sort of everything else. no, but it really is hard to think about them all in one cluster because they all face such different barriers. So, I think about a learning disability for example, where people must feel like learner's experience such incredible imposter syndrome already regardless of whether they have a disability or not. And then throwing it learner with a disability, especially a learning disability. And suddenly the imposter syndrome is just amplified so much more because there's so much guilt around accessing test accommodations, extra time, deferred exams deferred assignments, where everyone else in the sessions and like the culture of the social environment of medical school is a very collaborative one for the most part. But it's also an extremely normative culture where there's one way of doing things.

Lisa: Yes, yes.

Erene: I was just reading a paper the other day about specific wellness initiatives at schools and some of the most effective ones are thought to be the creation of learning communities. So, like small groups where people are studying together. Imagine for the student with a learning disability, how difficult that must be if they can't participate to their fullest in that learning community.

So, with, for example, a learning disability, so much of the social and learning experience, especially in pre-clerkship has to do with social learning with your peers. So being in study groups, being in an anatomy lab for a couple of days a week,

where, um your ability to participate is can be really determined by your ability to follow and kind of match all of the other students in your group.

Lisa: You're already behind the curve before you even began and the approach to learning is set up for the superstar student. And so not only are you already behind, but you're going to enter a learning environment where the learning is not created or the platform for the learning of the type of learning is not one that is created to advantage all students, and neither is the assessment and type of assessment. So, the student with a learning disability, lack social life missing out on activities, whether it's a study group, which in and of itself is a bonding experience right, they miss out on that because the way that they have to approach the material is different. Perhaps, they have to listen to the recording recordings of the lecture multiple times. Perhaps they use assistive technology to have their textbooks read to them or the articles read to them. Perhaps they have a very detailed system of underlining and rewriting and creating anagrams that may be the system that works for them, which by the way will map onto actual practice really well because they're always thinking outside the box. And I think students with learning disabilities in particular because they have to learn differently, especially students that have dyslexia, they learned very visually, they are able then to go into specialties where a visual understanding or a mapping or the ability to manipulate things in visuals space is highly regarded.

They're missing this key social component, right, the study group but it's not just a study group because of that extra time. They're also missing the, "Hey, we're going to grab a beer and a pizza, which can happen to individuals with apparent disabilities as well, I remember interviewing someone who said hosting events at bars and restaurants that they could never access. And then if you are deaf or hard of hearing, you can't, it's almost impossible to socialize. So, it sounds like across and between exclusion, and so you miss out on those lunches or the little mini moments where people bond.

Erene: And also, those moments lend a lot of social capital to students because it's through that, that you might have a lunch with a preceptor who might give you a letter later on or help you advance your career by giving you a research job. So, all of that extra time that's taken for managing one's own condition ends up taking away from those possible moments that would otherwise give that student incredible advantages in their career.

I think also a lot of ways that people really strong support networks, especially if that's something that's outside of medicine. And so, the more you have to rely on that support network outside of medicine the less time you have to go get the pizza and beer after studying group or even just hang out after class in someone's apartment, because you have that system around you already that keeps you well and you have to use that system and tend to it, right? Like having a family, having a support system isn't just like it's there when you need it. It's no, you're also there for them. And so, I know a lot of um the people that I've talked to through my research and also just anecdotally as a learner a lot of the people who I talked to with disabilities also have a really strong family, they might be married, they have a really supportive partner who is there for them when they need it. And so, it's not the same as someone who's coming into med school, they

moved to the city for the first time, they are in an apartment solo, they don't have really any other responsibilities, they don't have any pets, they don't have any partners and they can just socialize freely with whoever they want.

Lisa: So, we talked about learning disabilities and you made mention of the fact that you think that you cannot uniformly speak to all non-apparent disabilities that they all have barriers that are unique to them. Mental health is one and chronic health is the other, do you want to speak to those?

Erene: Sure, so Chronic health is something that I'm most familiar with, is someone who has a chronic health disability. And I think that the biggest barriers there have to do with self-disclosure and how much information you give to the clinicians around you, and this is something that we were talking about it, you risk kind of being seen as a patient or patient-ified essentially by your colleagues. Because they are doctors they know these conditions they know the side effects. And I think there's just this inherent curiosity in medicine. You're given a case, you're given these like key words, it's like, "Oh, here's a 29-year-old female." And sudden you turn into a case and I'm trying to think of what kind of barrier this is but I think it's just navigating this incredibly complex situation in identity construction as a professional where your trying to become a doctor and trying to become a good doctor but you're in two roles at once when people treat that way and they want to ask you about your medications and your side effects, where your also playing the role of patient, while also trying to become a doctor. And that's incredibly hard to navigate and there's a boundary there that ends up getting crossed a lot of the time because preceptors out of the goodness of their hearts really want to know as much as they can about the condition that this student is dealing with in order to help them and support them when really that might not be appropriate for the student to have to disclose that amount of information to the well-meaning preceptor.

Lisa: What I've heard in my interviews, is that there was a shift. And I don't think the faculty understand the depth and breadth of the power differential. I think they try to be very accessible but they don't understand that if they ask a question, chances are 99.9% that the students going to answer it, they're not going to say "you know that is really outside the bounds of your role as my faculty member you are not my physician" The relationship changes. And it can become almost parental If the learner looks even remotely unwell, which could have nothing to do with anything related to their disability and everything to do with the fact that they just got off of, night float and they say, "Oh, how has your medication working?" It's so deflating to experience that type of interaction when you just want to be a medical student, or you just want to be an employee.

Erene: When that is taken out of the learners' hands that is incredibly stressful. Because you can't control your own narrative, you can't control the way that you are perceived, the way your performance is judged, the more disability factors into someone's evaluation it just reinforces and ratify this idea that disabilities are imitations

to be overcome by the individual rather than barriers that exist in the environment because we haven't thought to make things equitable and accessible to everyone.

Lisa: Join us for part 3 of 3 of this second podcast when we conclude our discuss on forward feeding information, impression management, resiliency and mental health in medical education.

References:

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