Stephen Morrissey ([00:00](https://www.rev.com/transcript-editor/Edit?token=NKoMI-MEJdbm1suvM254QD8Q-hE0MhhyLGJlcqlp7itgHZtaHAPkOFmnNwbdpnhU4SlxQvSzBlMtfFw5NTHSB9iGJeA&loadFrom=DocumentDeeplink&ts=0.27)):

A quarter of Americans have disability, but only about 5% of allopathic medical school students identify as disabled attitudes about who's qualified to become a physician and unrealistic expectations for physicians and trainees may deter chronically ill and disabled people from entering the medical profession. I'm Stephen Morrissey, managing editor of the new England journal of medicine. And I'm talking with strategic, Rastogi a medical student at the Stanford university school of medicine who also has a doctorate in microbiology and immunology. Dr. Rastogi has written a perspective article about the barriers faced by clinical trainees with disabilities, Dr. Rastogi in your prospective article, you describe how one of your classmates who also has a chronic illness asked for your advice about training on the wards. How much of the guidance that medical students with disabilities receive comes from school administrators and how much comes from other students as in that case?

Suchita Rastogi, Ph.D. ([00:54](https://www.rev.com/transcript-editor/Edit?token=N8P2X5IIjd7YGldmzSDQgILQEX4RPRhxADqeuOLarrpeFNfPlkA80QCDGCviAOKK8XNFbBQ6vEBVuXfALfTpJJGdnWI&loadFrom=DocumentDeeplink&ts=54.38)):

That's a very good question. And I don't know if I have a systemic answer in my experience. Most of the advice I have received has come from the community surrounding disability inclusion at Stanford, which is composed of medical students and physicians who identify as having disabilities. I'm fortunate to have such a community at the school at Stanford. These communities are called the Stanford medicine ability is coalition and medical students with chronic illnesses and disabilities. The guidance I've received from administrators tends to be more of a learning as you go type of process, where there are certain policies in place. And then there are other policies where disability might not have been anticipated. And so we learn as we go along

Stephen Morrissey ([01:49](https://www.rev.com/transcript-editor/Edit?token=BSEnOA5rqsqKkrB3ry0MgE1FOWWA53Xxmng5pvJ7H_41EBT9r3_AnFwqJNbc5YGYHO75tMLn5oHrphtvrD9EIstL9TU&loadFrom=DocumentDeeplink&ts=109.94)):

In your experience, how has medical training compared with doctoral training as a person with a disability has one been harder to navigate than the other.

Suchita Rastogi, Ph.D. ([01:57](https://www.rev.com/transcript-editor/Edit?token=AUUckXdmVrh8pGxV8HdkDA1hfc5I7na2aegcb8ayYDETHdb6gIQIqxcl7vey637hYYnlsc7S4pcygUeHJ1OAtjQQXA8&loadFrom=DocumentDeeplink&ts=117.8)):

There are several differences in house training is structured between clinical and doctoral training in the clinical world. There is a great deal of structure and that translates to many points at which people can be referred to the institutions accessibility office. There are many opportunities for that many checkpoints at the same time. There's less continuity in who is mentoring the student and in the training environment, especially in the clinical years. And there's also relatively less control over one's time as a student. So all of that translates to an experience where structure exists, but the flexibility surrounding disability is not necessarily built into that structure. There is certainly a lot of awareness in the medical community about disability inclusion in schools, and it's routinely included in syllabis and alluded to in clerkships. But there also comes with that awareness, some entrenched conceptions of how disability relates to medicine in terms of whether it's acceptable to have a disability in order to deal with patients or whether it's compatible with clinical competence.

Suchita Rastogi, Ph.D. ([03:15](https://www.rev.com/transcript-editor/Edit?token=6AwhZlnDjSqC-GOPZxgMOPC1FrX_NDr4E4cjP5RktxxxjBB6VwFTUcPtlHqpwE27N9-eGzv1U7_s4lpLt4D9JWjykvo&loadFrom=DocumentDeeplink&ts=195.82)):

So that's the medical side of things. And my experience on the doctoral side of training, the training environment is stable because students are mentored in an apprentice style of training where they join a lab and they stick with that lab for a good five or more years. And the stability is nice because students know what to expect in their training environments day to day, but there is a skewed power dynamic where one's academic future depends almost entirely on the student's relationship with the principal investigator of the lab. And this means that the student's experience with disability and inclusion of disability really depends on that relationship with the lab and the mentor with which they train. In addition, in my experience, principal investigators aren't necessarily trained to consider disability inclusion. They, I imagine are focused on publishing papers and such. And so disability awareness is in my experience a little bit less prominent in these circles.

Suchita Rastogi, Ph.D. ([04:31](https://www.rev.com/transcript-editor/Edit?token=TnHjl-Mk0lXjSZL5gmm5hWoGMiNAm1kQTsy1iOBCAw0NI-bbk4Lq1UOW0_hklaTZY7Jcl20oU1R0nrl5m78ubL5OUDU&loadFrom=DocumentDeeplink&ts=271.03)):

And in general, PIs might not necessarily be aware of the resources that exist for students with disabilities and may not be trained to recognize when students might benefit from being referred to the institution's accessibility office. And there is a lot less structured in securing and enforcing accommodations in doctoral training as well, particularly because there's so little coursework and it tends to be through coursework that students get referred to the accessibility office. And there's also a fragmentation in terms of the structure of a program in that students might not know who necessarily to go to when the time comes to request an accommodation.

Stephen Morrissey ([05:15](https://www.rev.com/transcript-editor/Edit?token=ay2spIFlnKaqu-nhmhDPJX_PcimTIBFmUsZjiz0oWD3KcdECM5ZzR8N5nPYhSStQY4VSPjuhWbciZhSsUn20BatrKcA&loadFrom=DocumentDeeplink&ts=315.63)):

And even on the medical wards, you write in your article that supervisors haven't always respected your approved accommodations or even known about them when you started a rotation. So how have other students and clinicians reacted and treated you when they learned about your disability and about related accommodations?

Suchita Rastogi, Ph.D. ([05:33](https://www.rev.com/transcript-editor/Edit?token=pqxbuOFPjp4dz24o5lPImTmVIlQv5c1ecHimgvAjyb6RZDD1WP48mRf6h5NUm3o7KVfb2wKl7XehGyVILfKbhJQQNkA&loadFrom=DocumentDeeplink&ts=333)):

I have received a range of reactions, some supervisors and attendings and residents have been extremely accepting and have gone out of their way to clarify how accommodations that I've requested would translate in the particular training environment, in which I'll be working with them. In other cases, I've had to justify why I have needed accommodations and sometimes certain boundaries, professional boundaries have been violated in those conversations, including requests for more personal information that shouldn't necessarily be shared in a professional environment. In some cases, students can receive outright pushback where a supervisor refuses to honor an accommodation. And in those instances, I think better mechanisms must be put in place to educate all faculty on what is, I guess, the need for an accommodation and educating people on the fact that accommodations aren't some special advantage afforded to students, but really a necessity that enables the student to function. And something that provides equity in the training environment

Stephen Morrissey ([06:53](https://www.rev.com/transcript-editor/Edit?token=_RwBHE_dAu3R-LdD3-DkNN0uNdo9pfxMl2Ku6Y3kb_WmbMf61BPHuepugtEOnVRuF1tr5Gc_y4w0DKN7J1cT9vmzc0Q&loadFrom=DocumentDeeplink&ts=413.41)):

Has having a disability effected the way that you connect with patients on the wards.

Suchita Rastogi, Ph.D. ([06:57](https://www.rev.com/transcript-editor/Edit?token=CZUN1TAAr8sQyhii_Df6fzjbAwYEkNyWtxymZpbcj2nc8cqMVSl0W6Hj4NIP-VOYNH6FXc0fIhbia29aGAnVpYK7vHs&loadFrom=DocumentDeeplink&ts=417.91)):

Yes and no. So yes, because my interactions with patients are heavily shaped by my experience with illness. I am a patient myself and I have a clear conception of how I want to be treated as a patient. And I also have experiences of when I was treated well, versus when I would have liked better care and I can translate those experiences to my patients. And that I think is a great strength. In addition, my motivation to practice medicine has completely shifted since acquiring my chronic illness. When I entered medical school, I wasn't aware I had a disability and the signs hadn't completely manifested yet. There was a certain level of care that I could afford to patients at that time, but I really had no conception of what it meant to be ill and how that translated to real life. And now that's very different. And now that I'm on the other side of that understanding, I feel driven to provide the best care that I can to patients knowing what it's like to go through that process. Now, what has not changed is that I can still interview patients. I can still perform a physical exam. I can still present a case to my team. I can form a treatment plan. I can participate in all aspects of the patient's care. So the level of engagement has not changed. I think the motivation in how and why I engage has changed.

Stephen Morrissey ([08:39](https://www.rev.com/transcript-editor/Edit?token=1_aOXsr0xOpJSYzM4neKAertxY1yQOIN0W-iqo3dVw_MP_shGalLRxRIlL2V_ullVTutsXv1K0em_y5wo5YJzUvoGU4&loadFrom=DocumentDeeplink&ts=519.43)):

Does it have an influence on your career planning are certain specialties, less accessible to trainees with disabilities?

Suchita Rastogi, Ph.D. ([08:46](https://www.rev.com/transcript-editor/Edit?token=hvrCwhPrO0pGuIUUsvYxgJJ1DbvkxMXkDsuFsaBczwKaIzPbuJiYXPmlGuD4iZkz2wW7siVF281ndBNy1bPiRMt9tSo&loadFrom=DocumentDeeplink&ts=526.66)):

Yes, I would be remiss if I said that it did not affect my career planning. Chronic illness is a certain of disability where one's condition can fluctuate. And so in planning my career, I need to be cognizant of finding a career that affords me the flexibility that I need in those instances, when I may experience unexpected developments in my condition. And that is very different from some other types of disability where the disability is constant. There are several other considerations that come with disability when planning one's career self knowledge is key because like any other student, I need to take stock of my strengths and limitations and choose a specialty that is sustainable. Given those considerations, it's especially important for students with disabilities to gather information on whether one's needs, match, what each institution and what specialty and each career path can provide. But additional considerations that come into play include the culture of an institution, workplace or specialty.

Suchita Rastogi, Ph.D. ([10:02](https://www.rev.com/transcript-editor/Edit?token=6IZSWAvCwoiNo2SAbfrhA8wtGrysAQ-tGZMfK3mNrqig-XpR5k06FWykz2HJrW4W59zRPxMbEfR1pGXsN83WuzOGCws&loadFrom=DocumentDeeplink&ts=602.52)):

And you had mentioned accessibility of certain specialties to individuals with disabilities. I can't comment on any one particular specialty that's more or less accessible, but I can comment on the culture. And that includes creativity and cultural humility and the ability to adapt to the trainee and to be able to accept the trainee for the value that they do provide, even if they might not go about a physical exam or a patient encounter in exactly the same way as somebody, without a disability. The end result may very well end up being the same. And it's important for specialties and training programs to remember that other considerations include confidentiality and disclosure, that is whether to disclose one's disability and when to disclose and how much to disclose and to whom to disclose. And it's important when applying to identify the correct channels through which to disclose this information and institutions need to have those channels clearly designated and ideally separated from the individuals evaluating students for various positions.

Suchita Rastogi, Ph.D. ([11:19](https://www.rev.com/transcript-editor/Edit?token=qdY9Bhtxfhw_zMP2Yc0TIeaSmbn_XYkfbIZXinR5mmfHAZb2dcOBHzwSVE4FHG5t5C1Mr7jfZbLTjwJxftvCjb9cPyY&loadFrom=DocumentDeeplink&ts=679.5)):

And I guess the other thing to consider when career planning is one's concept of what a practicing physician looks like. And when I say that, I mean, medicine doesn't have to be practiced in an academic institution. It doesn't have to be practiced in a private practice. Medicine can take many different forms. And I think coming into medical school, that wasn't something I was aware of. But as I continue to network with individuals with disabilities who are now faculty many have forged, extremely creative and innovative paths into medicine where they're still able to see patients, but they're not operating in the same way as one train sport in a residency program.

Stephen Morrissey ([12:07](https://www.rev.com/transcript-editor/Edit?token=VsMbjIj14WuBA12gPLUhOc6_E_vyj_rCb8QUpFv9zUgAn5VRKIU3n3Zmn2w9KPl1zNdfXYXbWRDEzqEm39dDGUQfQ_k&loadFrom=DocumentDeeplink&ts=727.41)):

Finally. And you've begun to talk about this subject already. You write in your article that systemic change is needed to dismantle structural barriers in medical training for students with disabilities. So what steps should medical school administrators and supervising physicians take to promote equity for students with disabilities?

Suchita Rastogi, Ph.D. ([12:25](https://www.rev.com/transcript-editor/Edit?token=IHjpvM8BgEuFtXuQSjQXn0zZKfC90BG4cti-b1S-5CngZGaZ4Ox7_m7rYilwP96xlkRZI0B8t_kTb_Djsvz8aaArE00&loadFrom=DocumentDeeplink&ts=745.56)):

So strategies for systemic change, the ones that I've focused on in my article, mostly consider clerkships and how best to make those accessible. And so I'll list those, but I might not dwell on them as the article gives more insight into these points. So to make clerkships more accessible, first of all, there are individuals at various institutions called a disability service providers. And these individuals are the key players who vouch for students with disabilities and help them arrange their accommodations and investigate the training environments that they will occupy in order to identify disability related needs. And it's key for these disability service providers to be knowledgeable of clinical expectations, to be ideally dedicated to a medical school that they're serving so that their time isn't divided amongst too many different departments. And these individuals need to have the resources to make logistical arrangements, to enforce accommodations.

Suchita Rastogi, Ph.D. ([13:33](https://www.rev.com/transcript-editor/Edit?token=kHpZDU-Lo9n7nwj_eOvlY8Aoem8V5zi0TT-oGfHR-hPMFB5EW9WGNRu3goDeD1R2rw8l0phkawlrXxzA9Ay-TRhYF7c&loadFrom=DocumentDeeplink&ts=813.81)):

And they also need to be given the clout to do these things without too much pushback. Other considerations for clerkships include policies that provide adequate and timely mechanisms to adjust accommodations in real time to respond to instances in which accommodations are incorrectly implemented. And these mechanisms should ideally involve a point person for each clerkship that works with the DSP to coordinate the accommodations. In addition, clerkship's policies should include adequate time for doctor's appointments and other self-care needs. And there needs to be mechanisms in place for students to be able to disclose not over and over again to their preceptors, but in a way that is discrete and is ideally driven by preceptors rather than students. And finally very important consideration is making clinical expectations for each clerkship known well in advance of the clerkships so that medical students and their DSPs have appropriate time to plan for accommodations.

Suchita Rastogi, Ph.D. ([14:42](https://www.rev.com/transcript-editor/Edit?token=owRimz_79D4dubncl2Nl_LX-SPCv12LewUmscFv1s5gFWxkoGzk-tGiWmL9Q0k8PWAznpDi6dta1XzLUQ89BE_ff6NQ&loadFrom=DocumentDeeplink&ts=882.09)):

And so that includes publishing sample schedules, call schedules, things as mundane as meal times or routes at specific clinical sites or ideal times to schedule doctor's appointments. These are all logisticals considerations that someone with a disability will need time to plan around in advance. So those are the clinical clerkships specific considerations, but at an institutional level, there are many other measures that we can take to make medical education more accessible. And the biggest thing I think is training all educators and administrators about best practices for disability inclusion. And this training should include anti-biased training, normalizing disability, and accommodations and assistive technologies, not just among patients, but among medical professionals, providing guidance to these individuals on which students should be referred to the institutionals accessibility office. And that includes training educators on how to recognize such students would benefit from those services. It also includes providing each educator a list of resources that they can refer their students to if needed outside of the accessibility office, educators should be trained on what to say and what not to say to students with physical and mental illnesses and disabilities, and they should be trained on how best to foster an inclusive training environment.

Suchita Rastogi, Ph.D. ([16:20](https://www.rev.com/transcript-editor/Edit?token=3IEnjIaBkZfHNNyp_HxScaVYQEnlphcjJnMmB6Cy-NyRQBnpLZvvpG424-BKROz2SEX9gnu_8WOH0_xaGGVx_Beqo0k&loadFrom=DocumentDeeplink&ts=980.54)):

All of this is really important and I recognize how much information that is, but there are several guides in existence for any faculty members or administrators who are curious. The university of California in San Francisco has faculty training modules on its website, the disability services website containing an excellent starting point on guidelines on how to train students with disabilities in clinical settings. And in addition, there's the docs with disabilities podcast, which is another great venue to provide training in the way of normalizing disability within healthcare professionals. Another very important way to promote disability inclusion at an institution is to restructure institutional policy and to do so in a way that treats individuals with disabilities as essential components of the system. And that starts with admissions, considering it a matter of course, that people with disabilities will and should apply to medical education programs and that they should be able to matriculate and succeed regardless of their disability status.

Suchita Rastogi, Ph.D. ([17:31](https://www.rev.com/transcript-editor/Edit?token=76G7e0oEnJpwp9MN2h314R5i4ymfi3Kg39jD2lD6BHuu7FrgeAkqy8flXvG7GDEoo3hF8oOcFGN2Jo5hcr8sEs1oTzk&loadFrom=DocumentDeeplink&ts=1051.22)):

It also comes down to the technical standards, which are the requirements that students need to meet in order to qualify, to apply and be accepted at a medical training program. And the way technical standards are worded can be written to be very disability inclusive or very disability exclusive. And so wording that in an inclusive way is important. And it also includes making the design of courses and instruction such that it prevents barriers for students with disabilities. A one size fits all model doesn't work in any educational environment. And that also applies to medical education programs. And so having blanket rules, doesn't promote inclusion and intelligent and thoughtful ways to design instruction in medical educational environments in an inclusive way. There's a wonderful book called disability is diversity, a guide book to inclusion in medicine nursing and the health professions that provides a detailed overview of how best to structure educational programs.

Suchita Rastogi, Ph.D. ([18:39](https://www.rev.com/transcript-editor/Edit?token=o77G26gFd1gKCQFoYFHNuYH4sc-npZ-MWq-A6EUR5PUrSBuz2JGVQXfhorFbP94cOF8N6IpRiiLzR41lnjOMw8gJczo&loadFrom=DocumentDeeplink&ts=1119.93)):

And finally, when thinking about institutional policy, not just in the medical education system, but in a hospital setting, we need to think of individuals with disabilities and include them in the policy, not as an afterthought, but as a vital minority within the community. And that goes for planning things such as disaster preparedness, COVID planning, and then accommodating other needs outside of one's education, including health insurance, disability, insurance structuring, appropriate leave of absence policies as well as policy surrounding internal and external examinations. So that's a pretty large overview. I would refer anybody who wants to get more involved in creating a more inclusive environment in the medical schools, which they teach or our administrators to refer to the resources I've listed in this podcast. A few others that I think provide an excellent overview of some of the barriers that trainees with disabilities face in medical education programs, as well as solutions on how best to accommodate these students and remove these barriers include Lisa mixes and Neera. Jane's 2018 AAMC report, which is called accessibility inclusion and action in medical education lived experiences of learners and positions with disabilities. And this is something I've cited heavily in the article and an additional resource to go to includes the AMC's webinars on diversity and inclusion. And when you go to the webinar page, if you search for disability, a long list of webinars, pop-up that delve into many of these considerations.