

## **Diversity**

**by Stanley K. Yarnell, MD**

In my presentation today, I will tell you the story of my own personal experience as a physiatrist with a disability, which I hope to use as a springboard to develop three points: the first is the qualities that physiatrists with disabilities bring to the table for both their patients and for the institutions where they work. Second are those programs or tools physicians with disabilities may find helpful in terms of career development, and third, I want to address the manpower issue.

To begin, I want to tell you an amusing personal story that occurred a few years ago. I started losing my vision when I was twenty, and I started to use a stick when I was thirty-eight. By then I had established a rewarding practice that was part private practice and part academic. I had Stanford Physical Medicine and Rehabilitation residents rotating with me at St. Mary's Hospital in San Francisco. About ten years ago, my resident was Dr. Doug Ota. Dr. Ota broke his neck in a diving accident while he was in medical school and he uses a wheelchair. At that same time, I had a patient, Don, who had been hit by a car with an incomplete paraplegia and a moderately severe head injury.

When Don first arrived, he could track with his eyes and follow simple commands, but he was unable to speak. After a week, he began to speak and the extent of his cognitive deficits became apparent. Nevertheless, he continued to make good progress and one day I overheard him talking with his physical therapist. She was asking him the usual orientation questions. Finally she asked if he could remember the name of his doctor. There was a pause and then Don growled out in his monotone, "Well, I've got two of 'em. One of 'em is blind and the other is in a wheelchair. It's a case of affirmative action run amuck." And I gave him full points for getting the right concept.

Don's remark once again reminded me that I, like other disabled physiatrists, was in a unique position. I was straddling a line, with one foot firmly planted in the medical community's camp and the other just as firmly planted in the disability community's camp. So how did I come to bridge the gap between the medical community and the disability community? By way of background, I was fully sighted until I was twenty years old, so thinking of myself as disabled and ultimately identifying with the disability community evolved over a period of many years. Even though I had a visual impairment when I started medical school, I wasn't in any way handicapped by it. It was not until 1978, just two years after I completed my residency in Physical Medicine & Rehabilitation at Ohio State, that I lost enough peripheral vision to become legally blind and had to stop driving. But otherwise, my visual impairment still had no impact on patient care.

I began inching toward the disability community's camp in 1984, when I decided to join the board of the San Francisco Independent Living Resource Center, ostensibly because of my concern over the difficulty getting attendant care for my patients. But in short order, I came to value the comradery of my fellow disabled board members. Additionally, I sought out other physiatrists with disabilities, like Stanley Wainapel, Glenn Reynolds, and Julie Madorsky, for their advice and wisdom.

Then in 1987, I had yet one more attack of optic neuritis, which had a devastating impact on what residual vision I had left, making it extremely difficult to read standard print, and it really affected my mobility for the first time. I started using a stick. Here I need to interject that in addition to my private practice, I was also the part-time medical director of a small Pediatric Spinal Cord Injury Unit at Shriners Hospital, a unit I had helped set up three years before. At the very time I was struggling to keep my emotional footing and trying to determine what adjustments were possible or not, the administrator called me to his office to tell me he and the head orthopedist felt that I was a medical legal liability, and asked me to step down.

I was shocked, then humiliated and angry. I had always thought that I was good enough at what I did that any reasonable person would recognize it and want to accommodate me. But this was before the Americans with Disabilities Act (ADA) and since Shriners Hospital for Crippled Children received no federal funds, it was not subject to the 504 regulations of the Rehabilitation Act of 1973. Meanwhile, my private practice at St. Mary's was thriving, and my initial instinct was just to walk away from Shriners, and pretend the conversation had never happened. But I knew that I could never look my patients in the face again and tell them that they had a right to work.

So I called up one of my patients, Mary Lou Breslin, a polio survivor and the executive director of the Disability Rights Education and Defense Fund (DREDF), for advice. Though DREDF usually tackled class-action suits under the 504 regulations, they rallied the staff attorneys, sued the hospital on my behalf, and came up with a remedy that was acceptable to me, including the provision that Shriners Hospital work with DREDF to develop policies and procedures to accommodate disabled employees in the future.

At that point, my self-identification with the disability community was fixed. I became more involved with the boards of other community-based disability nonprofit organizations, including the World Institute on Disability, a research and public policy center for disability issues, the majority of whose staff and board are disabled. That's how I came to bridge the gap between the medical model of disability and the social or civil rights model. At any rate, it's my story and I'm sticking to it.

You'll recall that I have three issues that I want to discuss today, and the first is the values that physiatrists with disabilities bring to the table for their patients and the institutions where they work. You'll notice that they share a lot in common with what you've already heard from the previous speakers. First, disabled physiatrists typically serve as role models for their patients. My patients and their families valued my advice precisely because of my own personal life experiences as a successful disabled physician. Second, I think that non-disabled physicians and administrators, who had never worked with a disabled physician before working with me, transformed their own negative attitudes of and low expectations for disabled people. They also achieved a level of comfort, acceptance and inclusion that comes from working with a colleague with a disability.

Finally, I believe most physiatrists with disabilities aren't afraid to scrutinize their particular institutions' governance and service lines through the lens of disability awareness and disability rights and to verbalize them during committee meetings. Judy Heumann, past disability advisor at the World Bank, talks about the importance of viewing institutional policies, product

deliverables or services through the lens of disability rights. Likewise, medical institutions, whether academic centers, hospitals, or governmental agencies, benefit when the powers that be view policies affecting employment and recruitment, product delivery, including competent medical students, residents, or quality patient care, and research protocols through the lens of disability. Psychiatrists with disabilities frequently do it intuitively, just as women are more likely to view the same issues through the lens of women's rights. That's not to say non-disabled physicians don't share such a perspective, but it's not always one of their top priorities.

The second issue I want to address today are the programs and other tools that may help with career development for psychiatrists with disabilities. They include mentoring, informal networking and collaboration.

As the other speakers have mentioned, mentoring is a useful program for career development, and it is especially true for physicians with disabilities. Brenda Premo, current executive director of the Office of Disability at the Western University of Health Science in Southern California, emphasizes the importance of hooking up the disabled osteopathic medical students there with a mentor who "looks like themselves," which is to say, someone with the same kind of disability.

Just before I retired, I had the privilege of mentoring a blind medical student, Jeffrey Lawler, who has just completed his residency in Psychiatry. It was truly a case of the blind leading the blind. I was his first blind preceptor and Jeffrey felt that he learned more practical skills in terms of the physical exam, medical documentation and organization than he had learned in any of his other clinical rotations, in spite of the fact that his sighted preceptors were all very supportive and empathetic. They supported the recommended accommodations for his vision loss, but according to Jeffrey, learning from my accumulated failures and successes was extraordinarily helpful.

Brenda Premo is aggressive about locating mentors that "look like them," but having spoken with some recent medical-school grads with disabilities and a number of other directors of disability offices at other medical schools in California, it is clear that "look-alike" mentors are not available or even a consideration. Medical schools need to be strongly encouraged to promote and support formal mentoring programs through their disability offices.

Informal networking amongst physicians with disabilities is another useful mechanism for career development for physicians with disabilities. This is not just my thought, but universally agreed upon by all of the psychiatrists with disabilities I spoke with before I prepared this talk. Birds of a feather flock together. Colleagues like Julie Madorsky, Glenn Reynolds, Stanley Wainapel and David Hartman, a blind psychiatrist, have been extraordinarily helpful with their practical tips and insightful observations. New technologies like my computer-screen reader and the Internet make informal networking easier for today's generation of psychiatrists with disabilities, and I would propose that staff support from the Academy could do a great deal to support more effective networking.

Finally, collaborating with disabled people in community-based nonprofit disability organizations has also been extraordinarily valuable. My involvement with the boards of various disability organizations over the years has given me the language of the disability movement and greater insight into the concepts of disability awareness and disability rights. That knowledge

gave me the confidence to speak up at the various hospital committees on which I served. Additionally, I worked to bring disability experts from community-based nonprofit organizations into the educational events sponsored by our department or the hospital when relevant, and everyone benefited. The Academy's newly constituted Diversity Counsel may want to develop comparable educational partnerships with regional disability organizations at future Academy meetings.

The third and final issue I want to address this morning is the manpower problem. In order to have adequate physiatrists in positions of leadership throughout the medical community, there need to be more disabled physicians to begin with. Period! Joel DeLisa has written an incredibly articulate article on this very issue, which appeared in the *Journal of Physical Medicine & Rehabilitation* in 2005. In it, he notes that approximately 20% of the nation's workforce have a disability, while the number of practicing physicians with disabilities is estimated to be 3 to 10% of the physician workforce. That includes physicians like me who acquired their disabilities during the course of their professional life, sometimes associated with the aging process. Furthermore, he states that though no statistics are available about the number of students with disabilities entering medical school, there have been estimates that only 1% of all medical students have a visible disability. In preparation for this talk, I called upon my network of contacts to determine what the numbers actually are for the medical schools in California. Here are the results.

You can see that Stanford has the largest percentage of disabled students with 5.8% of the total enrollees. At the bottom of the list is Loma Linda with 1.25%. At all seven of the medical schools, most of the students with disabilities had what would be considered hidden disabilities, such as learning disabilities, psychological disorders and other, meaning chronic, illnesses, like diabetes. There were only 5 students with a visible disability in all of the medical schools, only ¼ of 1%. The numbers are even more dismal than Joel estimated.

This brings me back to my patient Don, who grumbled that he had two doctors, one blind and the other in a wheelchair, a case of affirmative action run amuck. Well, if most patients had two disabled doctors, he might be right, but the truth is that there need to be more disabled students admitted to our nation's medical schools. Dr. DeLisa has put forth some sound recommendations that could help remedy the situation, not the least of which is that the Association of American Medical Colleges needs to revisit their expectations and goals for medical training and residency programs to bring them into line with 21<sup>st</sup> century technology and ADA standards. The goal is, after all, to turn out an undifferentiated doctor, one who has the basic skills and knowledge as well as insight into his or her own personal strengths and limitations, so that he or she can choose a rewarding career path after graduation. Not all students have the eye-hand coordination to perform micro-vascular surgery after all, so why perpetuate the myth that all graduating students are equally skilled. Finally, practical hurdles that students with disabilities face in the application process to medical school can be daunting, and I think we need to work with the disabled students and medical schools to find ways to make sure applicants feel supported rather than presented with barriers that others don't have to confront.

To sum up, disabled physiatrists bring unique values to medicine, including role modeling for patients, promoting acceptance and inclusion by helping transform negative stereotypes about disabled workers, and helping institutions scrutinize their operations and policies through the

lens of disability. My second point was that mentoring, informal networking, and collaboration with community-based disability organizations are all useful tools to help disabled psychiatrists develop rewarding careers. And finally, we need to do more to recruit greater numbers of students with visible disabilities for entrance into medical school.

Thanks for your attention.

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California Medical Students with a Disability

Institution	Disabled Students	Type of disability
Stanford University	5.8%	2 mobility, 25 learning
U. C. Irvine	2.5%	1 mobility, 5 learning, 5 psychological, 3 other
U. C. Los Angeles	2.5%	1 visual, 7 learning, 6 psychological, 3 other
U. C. San Francisco	2.0%	9 LD, 1 psychological, 2 other
Western U. Health Sciences	1.6%	1 mobility, others unknown
U. S. C.	1 or 2%	Unknown
Loma Linda University	1.25%	8 learning, psychological, & other

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References and Resources for Diversity and Career Development and Leadership Program

1. Saleh, Naveed. (2009, April). The Experiences and Challenges of Accommodating Physical Disability Differ from Trainee by Trainee and Institution by Institution. *The New Physician*, 58(3), 23-26.
2. DeLisa, Joel, & Thomas, Peter. (2005). Physicians with Disabilities and the Physician Work Force: The Need to Reassess our Policies. *American Journal of Physical Medicine and Rehabilitation*, 84(1), 5-11.

3. Saxton, Marsha. *Access to Medical Care: Adults with Disabilities*. A video and downloadable training guide available at [www.wid.org/cape](http://www.wid.org/cape).
4. Interview with Judy Heumann in Disability World.
5. Steinberg, Annie G., Iezzoni, Lisa I., Conill, Alicia, & Stineman, Margaret. (2002). Reasonable Accommodation for Medical Faculty with Disabilities. *Journal of American Medical Association*, 288(24), 3147-3154.

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