Disclosure Series
Episode 128, Part 2: Medical Culture, Stigma, and What Prevents Disclosure

OPENING

[INTRO MUSIC BEGINS]

SOFIA SCHLOZMAN:
Hello, and welcome back to *Disclosure*, Episode Two. I'm Sofia Schlozman.

Last time, we heard stories about disclosure across medicine—across training, across roles, and across the many transitions that shape a professional life. We heard how decisions about disclosure are rarely simple. They're personal. Often complicated. And shaped by questions of risk, safety, and belonging.

But disclosure doesn't happen in a vacuum.

In this episode, we widen the lens.

Rather than focusing only on individual decisions, we ask a different question:
What is it about medicine itself that can make disclosure feel so difficult—and for many, unsafe?

We'll explore the culture surrounding disclosure—the stigma that lingers, the expectations that often go unspoken, and the institutional norms that shape whether people disclose, how much they share, and identity safety in professional spaces.

And we'll begin to consider a harder question:

If these experiences are shaped by culture and systems, what might it take to change them?

[INTRO MUSIC FADES]

GABE ABRAMS: SECTION 1: WHAT IS MEDICAL CULTURE?

SOFIA SCHLOZMAN:
Before we go further, it's worth pausing on what we mean by *medical culture*.

Definitions vary. But in this episode, we're talking about the shared norms, values, and expectations that shape life in medicine—how people are trained, how they're evaluated, and how they learn what it means to belong.

Many of these lessons are never formally taught. They aren't written into a syllabus or outlined in a handbook.

Instead, they’re absorbed quietly—through observation, through interactions with peers and supervisors, and through the everyday experiences that signal what is rewarded, what is questioned, and what is left unsaid.

For psychiatrist and disability researcher Dr. Erene Stergiopoulos, these quieter lessons—and the culture they create—are central to understanding disclosure.

ERENE STERGIOPOULOS:
There's this entire hidden curriculum. It's not the stuff that's on the slides. It's everything else. It's the language that people use. It's the institutional policies, it's the practices, the conversation after the lecture.

There's so many things in training that are implicit in culture that produce barriers to disclosure. Even just people saying, "Oh yeah, you shouldn't disclose because I heard my friend disclosed, and they got a really bad evaluation after that." So that's more of a social kind of cultural barrier.

Then you have things like having preceptors talk about patients in a certain way that’s either derogatory or assumes that patients are not able to perform the functions that we are in the medical profession. And so of course, if you also are a patient, if you have the same disability as that patient, why would you ever disclose? You're not considered part of the group.

The research that I've done on the cultural piece of this is looking at identity formation in medical education and the way that people construct their identities as both providers and also people with disabilities. What we found was that it's incredibly hard to do both.

It's a full-time job to be a person with a disability because you're managing your illness constantly. It's also a full-time job and a half to be a medical student, and so never the two shall meet. And medical culture is one where it assumes that doctors cannot be sick. That's the biggest fundamental cultural part of medicine that makes it so ableist. It sees doctors as separate from the people they treat. We can't be patients.

[TRANSITION MUSIC]

GABE ABRAMS: SECTION 2: THE BURDEN OF ACCOMMODATIONS

SOFIA SCHLOZMAN:
Medicine asks a great deal of the people who enter it.

And alongside the formal curriculum, there can be another lesson—often unspoken—that good doctors push through, keep going, and manage hardship quietly.

Within that culture, disclosure can feel complicated.

Dr. Sarah Cohen Solomon knows this terrain well. A pediatrician living with multiple chronic conditions, she spoke with us about how disability stigma shaped her experiences throughout training and into clinical practice.

SARAH COHEN SOLOMON:
I am a pediatrician at Prism Spine & Joint, which is a specialty clinic treating primarily Ehlers-Danlos and related conditions. It's a particular privilege to be working there because I myself have those conditions. And I have been working with my own body and all the challenges and hiccups that come with it for my whole life. It informs how I practice.

SOFIA SCHLOZMAN:
Today, Dr. Cohen Solomon works in a setting that was intentionally designed to be accessible. But, for much of training, this was not the case.

SARAH COHEN SOLOMON:
I'm at a place where the program, the clinic, is made for people like me. So right now it's this weird dreamland of not having to worry about accommodations. I'll go lie down in the corner when we're having team meetings if I get dizzy, for example, and nobody bats an eye, but that's the flipside of what I've experienced during the rest of my education and training because, unfortunately, disability is really poorly understood even in the medical field.

Medical doctors in particular are expected to be superheroes who never get sick and never have a bad day and work, work, work, work, work. There's no stopping.

For me, I started early to get my accommodations. I started when I arrived to medical school, like on the first or second week, I had an appointment with the person in charge of getting those disability accommodations and she was receptive to a point. I remember very specifically early on first or second year going to this individual and saying, "I know that when I reach my clinical time in 3rd and 4th year that I'm going to need some support on the wards," because all you hear about is long periods of standing and long surgeries. And I knew the connective tissue that I have been blessed with, it does not hold up well to that kind of physical impact and long periods of activity. I need to sit down. I need to rest. I need to take it at my own pace. And every time I talked to her about this, she would say, "You know what? It's too early. We'll think about that when it's time."

SOFIA SCHLOZMAN:
By the time third year approached, those conversations became urgent

SARAH COHEN SOLOMON:
So I started my third year rotations without clear accommodations and being told that I should have started this process earlier, which I really resented because I had started it earlier and it was not my fault. But every few minutes, she would be changing up what she needed. It started feeling like, "Does she know what she's doing? Is there a clear policy on this? Why does it keep changing?" I was starting to get worried.

SOFIA SCHLOZMAN:
Then came an email that made the risks of disclosure unmistakably clear.

SARAH COHEN SOLOMON:

The next day I got an email from the disability coordinator. It said, because of your POTS, which by the way was completely well controlled at that time, they said you're going to be a liability in the operating room. We are not going to be able to permit you to finish your third year of medical school, which means you will not be able to graduate. And it was so blatantly clear in the email, they said specifically because of your disability, we're not letting you finish.

I was thankfully alone when I read that email. It was lunchtime, and I felt my stomach drop. I thought I was gonna vomit. And then I realized that I had a sister in law school, and so I showed it to her and she looked and she said, "You need a lawyer. This is so blatantly discriminatory. I can't believe they put it in writing."

So I did get a lawyer, and things escalated very quickly. I had actually just failed step one at that moment. So I think within like three weeks, I had both the failure and the "you're getting kicked out." Needless to say I was very, very stressed. I ended up taking additional time off in order to retake step one. I did finish my year. And the irony is that when I was on those surgical rotations, people were really nice to me.

SOFIA SCHLOZMAN:
Dr. Cohen Solomon moved forward. She completed her third year, graduated medical school, and began residency.

But moving forward did not mean leaving those experiences behind.

The discrimination she encountered lingered, shaping not only how she moved through training but how she understood the systems around her.

And even when support was available, accessing the accommodations she needed came at a cost—requiring significant time, emotional energy, and financial resources.

SARAH COHEN SOLOMON:
It took me 70 hours of work to get all of the letters and forms signed. Unfortunately, because my condition involves connective tissue that is all over my body, I have multiple specialists who have different aspects of my accommodations in their hands, and that was hard. I was a resident. And what ended up happening is that it took them so long to get through the material that I couldn't take my boards in a location that was convenient. I ended up paying double because I needed a hotel.

So at every stage of getting accommodations, there is a disproportionate burden on the person who needs them. And I believe that is because the system is discriminatory against us "as a group."

SOFIA SCHLOZMAN:
These experiences take a toll.

And for many learners with disabilities, the barriers surrounding access and disclosure are not isolated moments, but a near-constant part of training.

SARAH COHEN SOLOMON:

To be told that because I disclosed, that made me the problem was really, I, I mean, it stuck with me. It was, it was hurtful. And unfortunately, it colored a lot of how I go into accommodations later because I knew that people could be that mean. And that kind of thing sticks with you. Because it is real.

[TRANSITION MUSIC]

GABE ABRAMS: Section 3: EXPECTATIONS, PARTIAL DISCLOSURE, AND SELF-PRESENTATION

SOFIA SCHLOZMAN:
Barriers to disclosure are not only institutional.

They're also reinforced in everyday interactions—through peers, mentors, and the cultures that take shape within healthcare spaces.

For Cheryl Harris, a registered dietitian with multiple disabilities, those cultural expectations carried particular weight.

CHERYL HARRIS:
I've been a registered dietitian for a little over 20 years, and I have a range of different kinds of disabilities. I have mobility disabilities. I have visual limitations. I have PTSD. And I'm also an ethnic minority. Most of those things aren't visually apparent when someone meets me. Most of those things would require disclosure.

There's a health halo around being a dietitian. You have to be healthy. It's part of the gig. You're supposed to quote unquote, look the part. If you don't have a healthy body, it's because you did something wrong. There's a lot of shaming, there's a lot of blaming. What I've heard several times is, "Your body is your business card."

SOFIA SCHLOZMAN:
Within this "health halo," Cheryl struggled to navigate disclosing in a way that felt safe.

CHERYL HARRIS:
This was very early in my career. I was invited to speak somewhere, and I said something about not being able to stand and needing accommodation and needing to sit while I presented. And then the speaking offer disappeared. I think it was because I said I had a disability. It made me have misgivings about disclosing. It really gave me pause.

SOFIA SCHLOZMAN:
After this event, Cheryl adjusted how she approached disclosure.

CHERYL HARRIS:

I partially disclosed. I would say things like, "Oh, I have a sprained ankle," because that's something where many people can relate, rather than me saying, “Oh, I have an autoimmune condition or a connective tissue disease.” I said something where I wasn't as worried about being judged.

And again, that was because of prior experiences. I would do something differently now. But it was coming from a worry about judgment.

SOFIA SCHLOZMAN:
Years into her career, Cheryl’s relationship with disclosure continues to evolve.

CHERYL HARRIS:
I think also as I get older, I am less concerned about people's perceptions.

I think that's because I'm more comfortable in my disability. I'm more comfortable in my career. I'm more comfortable as an advocate. Many of my disabilities are tied to the conditions that I'm speaking about, and some of it is knowing that many of the places and people that I'm speaking for understand that. In some ways, that helps me feel less judged. But I do know that there are going to be some people in some places that will judge me, and I just don't care. I'm just at a point in my life where I'm just not willing to spend the mental energy on who is going to judge me for things that I can't control.

[TRANSITION MUSIC]

GABE ABRAMS: SECTION 4: COLLEAGUES AND LANGUAGE

SOFIA SCHLOZMAN:
Earlier in the episode, Dr. Stergiopoulos described how medical culture is shaped not only by formal systems, but through everyday interactions.

The comments people hear. The assumptions they witness. The conversations that quietly signal what may—or may not—feel safe to share.

For one speech-language pathologist, those messages shaped her own relationship with disclosure.

In this next narrative, shared anonymously, she reflects on how hearing colleagues talk about disability influenced her decision not to disclose her own disability identity.

ANONYMOUS CONTRIBUTOR:
I’m a speech language pathologist. I've been an SLP for over two years now, and I work in the early intervention settings with kids under three, and I also have experience working in more traditional medical settings. I am autistic. I was identified later on as an adult. I've been impacted by being autistic in pretty significant ways my whole life. It's a lot to unpack.

I don't think that most medical professionals recognize that they more than likely have disabled coworkers. And when they're talking about disability, they are talking about their coworkers in a lot of cases.

In the setting that I work in, I work with a lot of autistic kids, and I love it. My problem with disclosure isn't that I am ashamed of being autistic. It is the experiences that I have of other medical professionals, other therapists, other coworkers, not recognizing that when they're talking about autism, they're not just talking about the kids they work with.

SOFIA SCHLOZMAN:
She specifically recalls a training session that deeply affected her.

ANONYMOUS CONTRIBUTOR:
When I was going through my evaluation process and learning about myself and thinking, “What are the next steps? Should I tell my employer about this? How would that go?" We were having this therapy curriculum – I’m listening to the presenters who were speech pathologists and board-certified behavior analysts that created this program, and having to sit through that for multiple hours, I felt like was kind of traumatizing for me to realize how deeply ingrained and explicit these thoughts are about autistic people from the moment that they're born. To me it doesn't seem like a safe time for me to talk about my own experiences with it.

SOFIA SCHLOZMAN:
This contributor also describes how emotionally complicated the decision to disclose can become.

ANONYMOUS CONTRIBUTOR:
A lot of people in the medical space avoid the word autism, and that also feeds into these negative feelings and assumptions about autism. I do the work that I can without being open about being autistic at work, talking, not overly positive, not overly negative, but just neutral about autism and crossing my fingers that it helps, but it's a slow process. And I really do think that the reason why I'm a good therapist and the reason why my families like to work with me, and my employers see me as unique from other therapists, is because I'm autistic.

I really do feel like that colors a lot of the way that I approach therapy. When I meet an autistic child, I'm like, “Ok, I get you, you get me,” and it's such a hard thing to explain, but it's such a tangible connection.

And I've already experienced children who behave differently for me than they do for other therapists. I really do think it's because I approach them as another autistic person who accepts them as they are.

[TRANSITION MUSIC]

GABE ABRAMS: SECTION 5: “ARE YOU SURE YOU WANT TO DISCLOSE?”

SOFIA SCHLOZMAN:
Dr. Davy Ran reflected on a paradox that can accompany disclosure.

People may respond with support, concern, or a desire to protect. But sometimes those reactions, even when they come from a good place, can unintentionally reinforce the idea that disability is something to be worried about rather than understood.

Here's Dr. Ran.

DAVY RAN:
There's such stigma against disability. People are like, “Oh, you told me? Is it a secret? “Oh, I won't tell anyone else. Don't worry. Oh, are you sure you want to disclose it? Are you sure you want someone else to know?” There's so much pushback from very well-meaning people because they know that there's stigma associated. Even when I'm not trying to keep it quote hush, hush, everyone around me is trying to keep it hush hush to protect me. It becomes very hard to find each other.

And I say this as well as someone who was also the co-leader of the student disability affinity group at my school. Even finding out that group existed used to be a huge struggle because people said, “Oh, we don't want to tell people that the group exists. We don't want to tell who's in the group. It might be bad for people. It might be stigmatizing.” And we really had to say, as the leaders, no, we need to make sure people know about this group so that people feel comfortable coming out, so that people feel that they have community and also so that people can pursue disability justice without it being assumed that you are hiding anything, that you have a disability, et cetera, et cetera.

That's been one of the biggest challenges of disclosure because even being as proud as I am, it's really hard to continually tell people, "Hey, this is who I am, and I'm proud of it, and it's awesome." And then hear, "Oh, are you proud of it though? Or do you want to keep it a secret?" It makes you feel bad. You don't wanna have that conversation again and again and again.

And even as someone who has this conversation constantly, I'm tired of it too. And if I'm tired of it, what does that say about all these other people who want to disclose but can't for all of these reasons?

SOFIA SCHLOZMAN:
These dynamics don’t only shape interactions among peers. They can show up in mentorship, too.

Dr. Neera Jain, a disability researcher and former disability services provider for medical students, reflected on how mentors sometimes try to protect learners from potential bias or discrimination.

But even well-intentioned efforts, she explained, can carry unintended consequences—and may reinforce the very stigma they are meant to help students navigate.

NEERA JAIN:
Students who talked to school officials about wanting either to organize a group or to politically disclose in some way were really frequently told, "Are you sure, is that a good idea? Maybe that's not a good idea. You should think about that."

I hope I didn't do that to students, but I know that conversations I would have about disclosure with students was always like, “It's your choice. You can do what feels right to you. Here's that logistical process of accommodations. Here's what you don't need to share,” and kind of highlighting the potential challenges of disclosing. And so, I'm sure people heard that and heard me saying, “You shouldn't disclose.” That wasn't my intention, but I'm sure that's the message that students received.

What students told me is, I'm constantly being told I shouldn't be proud. I should be afraid of disclosing. And when I'm actively told not to disclose, not to organize, not to have a public profile, that's telling me disability is shameful.

And I think that's a really important lesson that I was told. When I did that kind of work, I was like, “I'm telling you all sides so you can make a decision,” but perhaps that's reinforcing that stigma in ways that we didn't expect.

And I heard that from school officials, that line of, “We need to protect students from the stigma. They need to know the realities of the field. And therefore, we can't provide accommodations.” But that idea creates a world by saying “This is how it is.” It recreates that stigma. Whereas the students I talked to who engaged in political disclosure were really resisting that idea and saying, “No, that's not the world I want to live in. Maybe that's how you experience the world, but I'm not gonna do that.”

[TRANSITION MUSIC]

GABE ABRAMS: SECTION 6: LOOKING FORWARD: CHANGING CULTURE

SOFIA SCHLOZMAN:
As Dr. Jain reminds us, disclosure is rarely straightforward.

Medical culture can make disclosure feel risky. At the same time, the visibility of disabled students, trainees, and clinicians can challenge stigma and broaden perceptions of who belongs in healthcare.

Holding those realities together is not easy.

Dr. Sarah Cohen Solomon reflected on that tension in her own experience.

Again, this is Dr. Cohen Solomon.

SARAH COHEN SOLOMON:
I am not only valued because of how hard I can work and how many buttons I can push and how quickly I can push them. My stories bring value to the care I bring to patients. And I think that's a big deal, and I think that's something that people don't understand and don't talk about. And without that knowledge, we're stuck in a system that only values robots. And that's sad. That's really sad.

SOFIA SCHLOZMAN:
Throughout this episode, we've explored the risks, complexities, and possibilities that surround disclosure.

We've heard how medical culture shapes disclosure decisions—and how disclosure, in turn, has the potential to reshape medical culture.

We end with a reflection from Lillie Reed, a medical student at the time of this recording and now a psychiatry resident, on why disclosure matters, not only for individual clinicians and trainees, but for the future of medicine itself.

LILLIE REED:
I think disability is a new social justice issue for a lot of people, and one that people don't necessarily have the verbiage set around. What does it mean to have a disability and practice in this career? What does it mean to need accommodations?

Medicine is not exactly the most accommodating profession. Ask women who get pregnant during residency or people who have a death in the family, a wedding they need to go to. Simple life things can be huge issues within the schedules and requirements of medicine.

In that way, the culture of medicine, I think, is benefited by disclosure because the more people with disabilities are openly present within the field, the more, hopefully, there is a push and acceptance of the value of those people.

[TRANSITION MUSIC]

SOFIA SCHLOZMAN:
As we've heard throughout this episode, disclosure doesn't happen in a vacuum. It happens within a culture—one shaped by assumptions about competence, professionalism, and belonging, and one that too often positions disability at the margins.

In our next and final episode, we'll turn to what happens after disclosure: accommodations, access, and what meaningful support can look like in practice.

Before we go, we want to thank everyone who shared their stories with us. These conversations are only possible because of your honesty, vulnerability, and trust.

And for those listening who may be navigating these questions themselves, we hope these stories serve as a reminder that you are not alone.

Disability is not separate from medicine. It is part of the human experience, and it has always been part of our profession.

Thank you for listening to *Disclosure*. Until next time.

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[CONCLUSION MUSIC]

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