Episode 58
Megan Winkelman Creasman, MD

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 policymakers that ensure medicine remains an equal opportunity profession.

Nicole Kim:
Hello, and welcome back to the Docs with Disabilities podcast. In this episode, Dr. Meeks is joined by Dr. Megan Creasman, a resident physician in Weill Cornell's Internal Medicine program on the Primary Care track. They discuss the ways in which Dr. Creasman experienced different forms of disability throughout her medical training, how these experiences have influenced her interactions with colleagues and patients, and the importance of positionality in considering diverse disabled perspectives. We begin with an introduction from Dr. Creasman.

Megan Creasman:
My name is Megan Creasman. I am an internal medicine resident at Weill Cornell and I am currently applying for rheumatology fellowship.

Lisa Meeks:
Welcome to the show, Megan, or I should say Dr. Creasman. I had the pleasure of working with you over several years and getting to know you, and it is my absolute pleasure to be speaking with you today and I know that your story will resonate with a lot of learners. Can you tell us a little bit about your disability?

Megan Creasman:
Absolutely, and thank you so much for having me, Lisa. I have an autoimmune disease. I like to be vague there because I think that different diagnoses carry a lot of different associations and specificity that, especially if you're in the medical field, other medical providers may glom onto in different ways, and so in order to really focus on my illness experience and my particular disability needs, which change frequently, I like to just say I have an autoimmune disease. I first started experiencing symptoms when I was 20, when I was in my third year of college, and then had to take several years between college and medical school due to pretty significant fatigue and pain before I was able to go to UC San Francisco, where I met Lisa.

Lisa Meeks:
That must have been really difficult, to go through that diagnostic experience. Was there anything in those interactions with rheumatologists that was kind of in the front of your mind as you entered medical school and were thinking about what you wanted to do, how you wanted to practice medicine?

Megan Creasman:
Absolutely. So, I had the strange and also I would say really exciting opportunity to start my medical training kind of on the tail end of 4 to 5 years of really significant interactions with the medical system. I went to, god, I don't even know how many doctors, over 10 different doctors. I had so many procedures, so many tests, lots of blood work taken. I eventually got funneled into rheumatology and ultimately had a really wonderful experience with a rheumatologist who took an incredible amount of time and thoughtfulness and really synthesized a lot of the data that other doctors had been experiencing in silos, I would say.

So, I came in with a really strong patient perspective and feeling really passionate about how difficult it is to navigate the healthcare system, even as a white woman with already a lot of medical knowledge given that I was premed and college educated parents who were taking time off work to help me navigate the system as well. So I felt so strongly about really thoughtful patient care but also health equity kind of from the get-go.

Lisa Meeks:
Yeah, and for patients with disabilities, there's so much fear there already of the unknown. Usually, what precipitates someone visiting a rheumatologist is exactly kind of the trajectory you described which is: something is going wrong, the body is responding in ways that it hasn't before, there may be pain associated with this kind of new symptomatology, and people are frightened.

So you layer on top of that fear that is additionally driven by socioeconomic status. Perhaps the symptomatology is impairing someone's ability to work and they have to work to survive, so they're worried about their livelihood. If they don't have insurance, they're worried about how they're going to pay for all of this, and are they actually going to get the work-up that they need depending on their insurance coverage?

You think about a person of color in that position and, is someone not going to believe them, are they going to think that they are just trying to get out of work? I just think there are so many opportunities for exclusion when it comes to rheumatological-based diseases and disabilities, and so I think you make a really good point. As someone who's well educated, who had good insurance, a white female going into the space, it's already hard, but it is made a lot easier by some of the privileges that you would have held in that space. And thank you for acknowledging that. I don't think many people think that deeply about it, and it's a real issue across all of medicine but in some specialties even more so, and especially for women.

Megan Creasman:
Absolutely, and rheumatology could be such a wonderful safe-haven place, in that women are far more likely than men to develop most autoimmune diseases, and African American and Latino women in the United States are at higher risk for many rheumatologic diagnosis. So this could be this place where you could come even though most of medicine has these preexisting stereotypes about women in pain, about people of color in pain, and rheumatology could be this place where those people would have more of a voice and not be dismissed. I think that that's the case with some really wonderful rheumatologists, and I also think that that is not the case in many places. What I kept thinking when I was going through my workup was, *this is impossible. This whole experience is impossible, and I can't make it through another door.* And then when you contrast that with all of the privileges I had, it doesn't mean that I understand the experience of somebody who is in a different body or different socioeconomic class going through the same thing, but that this was really, really hard, and if it's really, really hard for me, it's really, really, really hard for someone else.

[Music]

Nicole Kim:
In the next section, Dr. Meeks and Dr. Creasman transition to a discussion about the steps that Dr. Creasman took in medical school to manage her disability. Listen or read along as they discuss her process of seeking accommodations and how medical trainees might be made to better understand the experiences of their disabled colleagues and patients.

Lisa Meeks:
So we were talking about you going into training and what you brought from that experience into your medical training. Many of our listeners are students, and their focus is certainly on providing great care and disability-informed care, but as well many of them are people with disabilities themselves, and I

happen to know from my experience hearing stories, reviewing litigation, that for students with autoimmune disabilities, that these students have highly disparate experiences depending on where they train. And I think, for the most part, you had a really positive experience, and I'm wondering if you can share with our audience what made that experience a positive experience, and what types of accommodations and techniques and approaches you used as a learner with an autoimmune disease when you're in a flare, to be able to move forward in the curriculum.

Megan Creasman:
I am in retrospect really grateful that my hand was forced pretty early, in that I first interacted with you in the disability services department before I started medical school, and that was because I needed to request a one-year deferral of my admission because I was too sick to start. And that was a really stressful experience, but it also left me no choice, and I'm really grateful for that because it meant that, from day one, I was in your office. And I remember, Lisa, you were probably the first person I met at UCSF because we met before I started classes so that we could assess my needs and figure out what next steps to take.

In terms of the accommodations that I felt were really useful… let me try to break it down. So when I have flares, my hands are frequently affected, and then my hip and knee joints can be quite affected and, along with that pain and stiffness, I'll get a lot of fatigue. And so, a big part of what we were working on was how to prevent myself from being in positions where I would flare up by trying to space out my really physically demanding parts of residency so that I still completed everything but that they weren't necessarily back-to-back. And then also finding ways for me to use my hands and my body in thoughtful and conscientious ways in the exam room.

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And I remember once we just went to an OSCE exam room and were playing around with all of the physical exam tools and maneuvers, and you had gotten a bunch of, like, foam handles and different little devices from Amazon that we were just playing with to see what gave me a larger grip and what felt better in my in my hands and with my body.

We also were really, *I* was really worried, about the anatomy lab. The anatomy lab at UCSF is beautiful. It's at the very top floor and it looks out over the entire Bay Area but it's also very cold, and cold is something else that causes my joints to start to ache and seize up a bit. And then the anatomy exams can be quite physically draining and that you're having to stand and walk between the different setups so that everybody goes to a different setup and where there's an arrow pointing at a part of the heart or part of the lung or whatever it is that we're being tested on. And what we did there was, I would take that exam at a separate time, and the wonderful staff at the Anatomy lab would just set up seats at each station so that I could sit down to look at the objects or look at the organs and do my exam in that way. And those things, everyone reassured me, were no big deal, very easy, they're happy to do it, and made a huge difference in me being able to demonstrate my knowledge and progress through school.

Lisa Meeks:
If you think about it, all we did was really look downstream to the older population, and this is part of the natural decline of the body, is to have some loss of functioning in different areas. And we pulled it up to try to adapt it for use in medicine and it just took a little bit of creativity. But for the most part, thinking back, I do not recall any of your accommodations that were either extraordinarily expensive, extraordinarily time consuming, inconvenient — there was just nothing difficult about it, which is also why, when I hear these stories from other schools across the country, I'm just flabbergasted, really, at how something that I think is so easy is translated into a very complex issue. I learned a lot working with you and I believe our faculty learned a lot as well. And all of that knowledge and everything that we went through in those simulation labs just informed the work in a really meaningful way such that it could be translated to other cases and other schools and other students to really help everyone.

Megan Creasman:
I love that, and I think that your attitude towards my accommodation process, which wasn't just, *what do you need*, but also, *let's figure out what you need*, really infected the way that I lived my whole life. Because I didn't just need to figure out how to grasp the stethoscope comfortably when I was having a flare, I also needed to redesign my kitchen and the handles in my apartment, and having someone who thought that this was fun and interesting made it a lot easier to put the effort in in my home life, which was just as important because if I was doing things that led to a flair in my home life, that was going to spill into my academic life.

I also distinctly remember a hands-on simulation that was designed, I believe, by Anna Chang at UCSF in the Geriatrics department, who's wonderful, and it was a simulation in being old. And we had to put on these thick gloves and try to button and unbutton a sweater to simulate the stiffness of arthritis; we had to have the lights off in this set-up room and try to navigate the room without tripping. And it was a simple exercise but was really meaningful to my classmates, and even more meaningful to me because I felt really seen and identified with those patients, and it felt like this moment where… somebody was saying that having experience navigating the world differently is an essential component of being a good doctor. And even if you aren't born with an illness or don't develop a disability as you are in your physician years, there are ways to prompt that type of thinking in the healthcare population, and that's worth the time of every first-year student at UC San Francisco School of Medicine.

Lisa Meeks:
Yeah, Dr. Chang is a great educator and I do think that that is important. Simulations also have limitations, right? I think it can reduce the assessment of symptoms and impact as well. And I'm thinking about… you're doing this for an hour or so and it's great to see how that might feel. But also thinking about the emotional toll that it takes on someone, especially if it's around their livelihood and, I think in the U.S. at least, many people get a lot of their personal self-worth from their livelihood, “what makes me, me,” kind of thing. And so, the limitations that would weigh on someone's psychological well-being and making sure that that's talked about. I also wonder if in that — I know it was a geriatrics or gerontology course — I wonder if there was ever any awareness, or if you had an opportunity to talk about how this may not only be for older people. What are your thoughts on those two things, or if something did occur?

Megan Creasman:
Absolutely. I think those are two great points. To the latter, I felt that it was a stepping stone towards talking about the challenges that I have with mobility, and I would sometimes joke, you know, like, I'm really an old woman, and all of my Hulu and Amazon ads are for products aimed at an elderly population because they have some great products for people with arthritis. And it was a way to start the conversation with my colleagues informally about how disability is not just old people, and also that, no matter what age you are, it's challenging to lose something that you previously were able to do or even have to figure out a new way of doing it. It's frustrating. And so, I think that there are definitely opportunities to take the small frustrations of doing some simulation like that and remind people that you're not just doing this one activity once a day. You know, every 5 minutes, you need to do something with your hands and nobody expects you to move more slowly or have difficulty with it, and it can absolutely be life limiting and career limiting if you can't get the accommodations you need.

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Nicole Kim:
While Dr. Creasman describes becoming acquainted with the disability services office early in her medical training, asking for accommodations was not always a frictionless process. Follow along as Dr. Creasman and Dr. Meeks discuss Dr. Creasman’s published piece in JAMA reflecting on an experience that brought her internalized biases to light, as well as the anxieties that often come with disclosing disability and seeking accommodations.

Lisa Meeks:

So you wrote a paper, it was published in JAMA, “A Piece of my Mind,” which is one of my favorite outlets — and I encourage anyone who's experienced disability as a health care provider to take a stab, if you feel comfortable writing up your experience for this incredible column in JAMA. Your title was, “How Pregnancy Unmasked My Internalized Ableism.” Can you tell us a little bit about what prompted you to write this commentary?

Megan Creasman:
I got pregnant at the beginning of my second year of residency, so I had completed my intern year. And at the end of my intern year, I gave myself pyelonephritis because, like many interns, I wanted to work the hardest and be the best and you never feel like you have enough time in the day, and I just wouldn't pee for hours and hours and hours and I ignored my physical discomfort and got a UTI that developed into pyelonephritis. And I went into my vacation, spent my entire vacation getting antibiotics and recovering, and then went straight back into work. And it was only a couple weeks after that that I got pregnant, and I was very sick throughout the pregnancy. I hated being pregnant (laughs) to be honest, but I was vomiting, I was having knee pain and hip pain, and wasn't sleeping well. But as I was experiencing those physical symptoms, I found it so much easier to talk about and to ask for help, and I found myself giving myself so much more permission to find what I need. And it was that insight that prompted me to do more reflection and for me that means writing. I was journaling about it and that's where this piece came. And what I ended up realizing was how strong my internalized ableism is, in that there's some part of me that still doesn't quite believe that I deserve to be accommodated and that I *am* providing value in the medical field. And I think that there's other versions of this with imposter syndrome in medicine that's very important to recognize but outwardly and when I actually am conscious I deeply believe in having people with disabilities in the healthcare workforce and I've done research and writing and speaking on that topic. And yet, having the contrast to the way that I was thinking about my pregnancy and interacting with my environment as a medical professional while pregnant, I could see my own ableism rearing its ugly head.

Lisa Meeks:
I really appreciate your continued honesty in this space about saying, *hey, I am still navigating the world as an ableist person even though I'm a person with a disability*. I see this so often in the disability community where I would have learners that would say, *well I have this physical disability, but it's so easy to accommodate because you know exactly what you're accommodating, I don't know what I would do if my brain didn't work*. Or people that had learning disabilities or psychological disabilities that would say, *well you know I know how to compensate for this, but I can't imagine having a mobility disability or physical disability of some sort. I can't even imagine how that individual navigates medical school*.

And so still within the disabled community, there are these deeply held belief systems, which is what ableism is, that leads you to believe that for a reason they are limited in their capacity to do anything without having any knowledge about their actual ability or functioning. And so it's really interesting because that's another way that I see it expressed. For you, the way that you were all of a sudden noticing it was that in some ways you still harbored fear of bias and judgment and that people wouldn't believe you if you were to ask for an accommodation related to disability, verses when you're pregnant, ansd you have this outward kind of expression (laughs) of the pregnancy, you had no issue asking for what you needed to be healthy during that time.

Megan Creasman:
What you said just really resonated with me. I'm thinking of a team I was on during the very beginning of my third trimester and just telling the attending, *we need to stop bedside rounding unless we bring a chair for me because my bones can't handle this*. And that's something that there are many times in the past that I should have said that because I was having, actually, a lot more joint pain and a lot more inflammation and just didn't feel safe advocating for myself in that way. But when you have this giant bump and this slightly more socially recognized reason for a young woman to need an accommodation, it felt a lot more possible.

Lisa Meeks:

It's so interesting, and I just want to provide a bigger context around what you just said, and feel free to correct me if I'm not presenting this in the way that you would or jump in at any time, Megan, but you had a really good experience in undergraduate medical education, and you had a really good experience in residency: you were able to bring your authentic self to the residency application process, to asking for accommodations. So, what you're saying about this fear was still occurring in a really positive context. I think about all of the people who are entering situations that are not positive, that actually can be combative or certainly not welcoming, more exclusionary, if you will, and how much fear they must have in that space when fear exists for those that are coming into the space on pretty good terms.

Megan Creasman:
Absolutely. I can't quite emphasize enough, the anxiety of asking for what you need has not gone away for me even though I truly have had an incredible experience having my needs met as somebody with a chronic illness and mobility disability throughout medical school and in residency with really wonderful administrators and leaders telling me that they wanted me at these institutions and they had my back and that they would do whatever I needed. The anxiety is still so real, and I've tried to kind of unpack where does that come from, and why was it so much easier for me to make those requests with pregnancy. I also want to mention that I don't think it's easy for many women to do that. I think that many women who become pregnant during residency feel like they have to prove that they're still committed to medicine and are afraid of asking for accommodations in that context, so not to gloss that over.

And I think part of it is being concerned about not being believed, and I think people with invisible disabilities have gone through that with medical providers and have been traumatized by those experiences before getting the ultimate diagnosis where somebody says, *oh actually you are really sick and we do need to do something*. And then I think there's also just a culture in medicine and residency in particular that whenever you're asking for something to be changed, you're making it harder for other people or you're taking something away from your colleagues, and that's the worst thing you can possibly do, which really almost always is not true. Our systems are not as fragile as they appear, but especially when you're an intern and you're starting out, the systems in place appear incredibly rigid and, unless you have a lot of privilege and confidence and all of these people who are in power telling you that the system is not that fragile and that we can make things work, it just feels like this insurmountable barrier to getting accommodated, and that you would rather try and fail without accommodations than face that anxiety.

Lisa Meeks:
I don't think we've had an interviewee bring up that anxiety, but that anxiety really drives decision making for many students. And it's not an anxiety that is a one-time ask, right? You have to disclose in medicine repeatedly. Depending on what institution you're attending, you might have more or less advocacy from the disability office or the disability resource provider, DRP as we like to call them, who will manage, almost like a concierge, will manage everything for you so that you can focus on what you should be focusing on, which is trying to balance medical school with social life and healthy physical activity and just having a life in general while still navigating medical school.

But for many learners that disclosure, to the DRP or to that official office, is just the first in a series of multiple disclosures to everyone they interact with for everything they could possibly need. And if you think about that anxiety and what anxiety does to our body and the amount of time that the anxiety consumes in our thought processes, then having to do that multiple times over the course of medical training. By the time you get done with medical training, I can't imagine somebody wouldn't be absolutely exhausted.

Megan Creasman:
Absolutely, that's the thing. The way people talk about microaggressions and facing microaggressions every day, all day, never knowing when it's going to pop up, and that burden that you have to carry as you work through the world… that frame resonates a lot because you could get through a whole day without having someone say or do something ablest towards you, but if you're holding your breath the whole time waiting for it to happen, that can be just as exhausting as a macroaggression that comes on where you're

being denied access to your legal rights. So it's a really big part of the experience of being a student and a trainee in medicine with a disability.

Lisa Meeks:
And to your point earlier about the privilege of being a white female in this space, just take everything you've said and layer on top of that being a person of color, being a person that's part of the LGBTQI community, any number of identities that are marginalized and that include macro- and microaggressions on a daily basis in interactions with patients and peers… It seems so all-consuming. And I think it's no wonder that many individuals who come to this space with these other marginalized identities choose not to disclose disability, because it's just too much work, it's just one more thing. So if they can keep from disclosing, they may.

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Nicole Kim:
In the next section, Dr. Creasman goes on to share her experience in residency with a disability of a different form and level of visibility. Listen or read along as she and Dr. Meeks discuss how she navigated using a mobility aid while working in the hospital, and how it affected her relationships with her patients.

Lisa Meeks:
Recently, you had an experience that I want you to discuss for our audience because I think it's an unusual experience for someone that has already navigated the majority of training and has done that as a person with a chronic illness that is not apparent to the rest of the world. If we met on the street, I might not be aware that you are a person with a disability. And then you get pregnant and, because of your disability and some of the side effects of the pregnancy, you find yourself having to now navigate the clinical space with a mobility device, and you chose a wheelchair, and that presents its own, newly apparent level of disability for you. Tell us about that experience.

Megan Creasman:
Yeah, thank you for inviting me to. To back up… so I developed a lot of pain in the last month of my pregnancy and was mostly told that pregnancy is painful (laughs), and that I should rest and, you know, it would get better after I delivered. And my program was incredibly good about helping me practice virtually for the last month of the pregnancy because of this. And at the time I didn't have a real diagnosis, but my OB was saying, *you put your health and your child's health at risk if you continued practicing the way that you are*. Then after I delivered, the pain still didn't go away, I had really terrible back pain, and finally, after trying physical therapy and having that make it worse, I got a pelvic MRI that showed that I had two sacral fractures. And the thought was that this was in the setting of transient osteoporosis of pregnancy, which is quite rare but more likely in women who have arthritis and women who have had prolonged use of corticosteroids, which are two risk factors that I had.

However, the treatment for this is to not bear weight, and it was really important to me that I go back to work immediately. I am applying for a rheumatology fellowship. I feel very strongly about becoming a rheumatologist based on my personal experiences, and if I'd taken more time off, I would have had to delay my fellowship application by a year. So, how do you not bear weight while also being a resident on a busy inpatient, in my case cardiology, step-down unit? I talked to my rehab medicine physician, and I talked to my program leadership, and we decided that the best solution for me to be back at work was to use a motorized wheelchair.

And so I went from navigating pretty much my entire adult life and my entire life as a medical trainee with an invisible disability to a very visible disability pretty quickly, and learning how to use a mobility device in the hospital and interact with patients and colleagues in a mobility device. And that experience was, at first, incredibly difficult – just figuring out the logistics was incredibly hard. I'm a bad driver, first of all, and the motorized wheelchairs take a little bit of getting used to, like getting in and out of elevators I found particularly challenging. And then when I was working with different residents all the time and different

attendings, there would be an unspoken question in the air. And I tried to send emails ahead of time informing them about the disability, but people don't always read their emails and don't know what it's appropriate to ask or not ask, so I had to really develop a script for explaining my use of a mobility device and how I thought it would or would not affect the way in which we progressed through the day and how we did rounds, etcetera, and really a lot of trial and error, and having to invite those colleagues to problem solve with me.

The other really interesting part of practicing in the hospital with a wheelchair was interacting with patients while being in a wheelchair. And I found there to be a wide range of responses. Most of them at some point just started ignoring it because they were focused on themselves and their own health conditions, which is entirely appropriate, and some would kind of call it out and we would have a brief conversation about it, and I would have to redirect the conversation to their health. But there is another significant portion who I think were really comforted by the fact that I was presenting in a wheelchair. They were really comforted by seeing somebody who was not entirely young and able bodied, and actually would make small references like, you know, *this is so hard and anxiety provoking, you might know how that feels* and actually inviting me into their experience in a way that, when I had an invisible disability, wasn't immediately accessible to that relationship.

I was eventually able to start walking again and stop using the wheelchair but left that period of wheelchair use with two main takeaways, one being that I think it really is an amazing way to connect to patients, and that we should have more people who have visible disabilities practicing medicine because it's really good for patients to see that. And then, also, it's entirely possible to have a physician practicing in a wheelchair, and I really wish that I had experimented with mobility devices earlier in my medical career. It's something that, Lisa, I know that you really promoted at different points and urged me to consider when I was having a lot of pain and I never quite felt comfortable trying it out. And I think that it would have made it easier to focus and not be so distracted by pain on rounds, etcetera, and that, again, I think the internalized ableism and what I thought it meant to be in a wheelchair really prevented me from getting what I needed in those moments.

Lisa Meeks:
I think, you know, it's hard. And I know that for students with chronic illness, especially those that have a trajectory where the functioning will decline over time, I really try to get them to embrace a mobility device. A lot of people will start with, you know, something really small, then progress to a scooter… I think at some point you used the cane that turns into a chair, that's one of my favorites. And I try to get them to kind of engage with these devices progressively so that this particular situation doesn't happen, but also because that's a whole new level of your identity. It is saying to the world, you know, I am a person with a disability, essentially, and there's the emotional stuff that comes with that. So yeah, I do try to do that. I think it's so interesting to see your experiences and the differences of experience. But it also really reinforces this idea that patients are almost reassured in some way. Like you said, they know you've been there, and so knowing that you've had that experience as a patient is really calming. I've had physicians who are deaf, and I did have a physician once that was a wheelchair user and I immediately, obviously, had very piqued interests, but also immediately felt calmer and I don't know what that is – it's some sort of magic. But knowing that somebody's had an experience as a patient is certainly reassuring.

Megan Creasman:
When I am practicing without any mobility devices, I never bring up my own health experience because that's not the point of the interaction. The point of the interaction is that patient, but I so frequently find myself thinking, *oh*, *I feel you* or *I know how that is* and keeping it in my head. And I think that when there's a visible manifestation of the disability available to the patient, they can hear that internal voice in a different way. And, like you, I would be very comforted by that in a provider.

[Music]

Nicole Kim:
As the conversation comes to a close, Dr. Meeks asks Dr. Creasman to share advice with disabled healthcare trainees and others for navigating their training and transforming environments in medical education to be inclusive of all learners.

Lisa Meeks:
We have multiple stakeholders who follow our show, including disabled learners that are not in a health professions program yet, they're just considering it; we certainly have a share of learners with disabilities who are in medicine or nursing or one of the other health professions programs; and then we have a fair amount of faculty and leaders who also follow this show. And so when we ask for advice we give you an opportunity to speak to whatever stakeholder you think is the most applicable, or multiple stakeholders, and just give them advice about how to navigate this space successfully, what do they need to know, or how to be more inclusive for learners.

Megan Creasman
I think that ableist actions, or policies, or lack of actions, or lack of policies, are often fueled by fear, and particularly a fear from people in leadership or administration that they're somehow going to get it wrong, they're going to get the interaction wrong or they're going to say the wrong thing, and that that is worse than trying. And so, I think my advice for leaders in medical education and leaders of training programs is to try not to be afraid of getting it wrong. This is something that you may not have experience with, and that's okay. There are so many ways to get training on how to provide disability-informed education and run your program in a disability-informed way, and Lisa Meeks is my number one source for those resources. And if you are going into the interaction and your learner is going into the interaction believing that both of you are there with good intention and want to produce successful physicians, there isn't a wrong way to do that. So not letting fear of the unknown stop you from making progress for the people who you spend your entire life and career trying to support and raise up. And then for learners, this has to be different for everyone and tailored to who you are and where you are, but I would encourage you to reconsider, at some regular interval, how much you're comfortable disclosing, and whether you're comfortable disclosing more, or disclosing in a different way. And there are different moments throughout your training where you're going to be forced to do that. For example, when you are applying to residency, there will be a moment where you will be making a decision about how much to talk about your disability and how it informs your motivation to be in the field that you're choosing. I have found personally that finding the words and the parameters of what I feel okay disclosing has helped me tremendously, and that over time, those parameters have grown. And so I'm really glad that I have reassessed at different moments my comfort, and I think that doing so continually may surprise you and ultimately help you.

Lisa Meeks:
I think that's a wonderful sentiment to end with. And we haven't heard the last from Dr. Creasman — she will be back and serving as a co-host on the podcast in the near future for a special episode. So I am so excited that we got a chance to chat, and you agreed to be on a panel earlier this year and did an amazing job. And I think having that lived experience, being able to contextualize your experience through the lens of your privilege and being aware of just how the greater academic medicine and medical training environment may be different depending on how you're navigating it, whether that is as a person with a disability that is not apparent or a person with an apparent disability. So I encourage anyone who's looking for panelists to reach out to Dr. Creasman, and we will have her article in the show transcript for you to review, but it is JAMA, “A Piece of My Mind,” and I encourage everyone to take a look. Thank you so much Megan for being with us today, and it's so nice to catch up with you.

Megan Creasman
Thank you so much Lisa. You know that I adore you and love talking about this with you.

[Music]

Nicole Kim:

To our guest, Dr. Creasman, thank you so much for joining us. We are grateful for your openness in sharing your experiences navigating the demands of different stages of your medical training with various disabilities, and for your insights into the ways in which institutions could potentially lower barriers to providing learners with the accommodations they need.

To our audience, thank you for joining us for this episode. We encourage you to subscribe to our podcast, check out our previous interviews, and tune in next time.

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- *Aspire by Blue Dot Sessions*
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