Episode 108:
ICAM Panel: Facing Ableism: What's Our Role in Building Inclusion

Host: Lisa Meeks
Panel: Abbey MacLellan, Zachary Ford, Marihan Farid, RJ Roggeveen, Michael Quon

Introduction

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 we are 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.

This episode features a live recording from the April 5, 2025 DWD panel, titled, *Facing Ableism: What's Our Role in Building Inclusion*, this panel was held at the International Congress on Academic Medicine in Halifax where a powerful panel of residents, clinicians, and disability advocates confront the often-unseen forces of ableism in medicine—sharing personal stories and professional insights that reveal how bias shapes medical education, clinical care, and institutional culture. Featuring the creators of the award-winning book, *Am I Ableist?* The conversation invites listeners to reflect, disrupt assumptions, and take action towards disability inclusion.

Now on to the panel….

Lisa Meeks

Welcome to everyone. It's great to see people still coming in. Isn't it amazing that ICAM invites us to do this? And this has just been such a great conference. ICAM is incredible, the leadership has just been so generous to me. Thank you for letting me in your country-*especially now*. I really appreciate it.

We are going to be talking about ableism today in our session facing Ableism. What's our role in building inclusion? And as you know, this is a special live recording of the Docs with Disabilities podcast. I am Lisa Meeks. I am honored to be here in Canada and honored to be with such an incredible panel, you are in for just a powerful and thought-provoking conversation today.

This session is about confronting a reality that many in healthcare have been conditioned to overlook, and that is ableism. It exists in our admissions policies, our clinical training, our patient interactions. And yes, even in our own assumptions. Today we are asking you to sit with some difficult and important questions. One of them, *Am I ableist?*

To guide this discussion. I'm joined by a phenomenal group of individuals, healthcare leaders, providers, faculty, and patients who bring a deep personal insight and expertise to this conversation. Among them are the creators of the award-winning book, *Am I Ableist*? That's the book that is on

your tables, as well as clinicians and trainees who have lived and worked at the intersection of disability and medicine.

Before we begin, just a quick note this is a live podcast for those that have just joined us, which means that by engaging in the Q and A portion of today's discussion, you are consenting to being recorded and your voice may be included in a future episode. All right, now let's get started. I'm going to invite all of these amazing panelists to introduce themselves, and I am going to start with the authors of the book, *Am I Ableist*?, who are to my left.

Abby McClellan

Alright. Hi everybody. I am Abby McClellan. I'm a first-year resident in psychiatry here at Dalhousie. Very passionate about humanities, about community advocacy, and that's been working with some phenomenal colleagues and friends to create the book *Am I ableist* and I'll let them introduce themselves.

Marihan Farid

Hi everyone, I'm Marihan. I'm a first-year resident in internal medicine here at Dalhousie. The three of us were actually in the same medical school class, so we're all first-year residents here at Dal. I'm very passionate about EDIA and medical education, and that's what brings me here today.

Zachary Ford

And my name's Zachary Ford. I am also a first-year resident at Dal in radiation oncology. Also, very passionate about social justice and leadership and medical education. It's an honor to be here today with everybody.

Lisa Meeks

To my right, we have individuals who identify as having a disability and practicing clinicians and future practicing clinicians. And we'll start with RJ.

RJ Roggeveen

Hi everyone. My name is RJ Roggeveen, and I am a second-year medical student here at Dalhousie University. I am a local disability advocate, and I have quite the passion for how ableism shows up in our care with patients. And I'm excited to share my experience from being a student and a patient and both sides of that stethoscope.

Lynn Ashdown

Hello everyone. My name's Lynn Ashdown. I am not a clinician but trained in medicine and almost finished family medicine residency. And sort of life took a different trajectory. I am someone living with multiple disabilities and very active in medical education, disability education, and disability advocacy. Thank you. Lovely to be here.

Michael Quon

Hi everyone. I'm also from Ottawa. I'm a general internist at the Ottawa Hospital. And similar to my colleagues, I've become a big advocate in trying to improve disability inclusion. For me, I've been most focused on improving the accommodations and accessibility in medicine for practicing physicians both at the hospital level as well as the PGME level in Canada. So, I'm happy to share more with you during the podcast.

Lisa Meeks

Exciting to have everyone here. So, I want to point out just on your tables, you'll see a book and this book. And this book will be available for downloaded is in the drive that we're going to share with you as well. But I want to note that the authors of this book won a curricular award from the American Academy of Developmental Medicine and Dentistry for the book, and that the book has been really well received in Canada and in the US. So, I just want to take a moment to congratulate this group and we're really excited… And it's a home group, you know, right here in Halifax. So, it's so exciting.

[Applause]

Okay. So, you, by virtue of you joining us today, it is fairly likely that you have a keen interest in this topic or that the title was provocative enough to get you in the room. How many of you have experienced working with patients or learners with disabilities? Oh, my goodness, a lot. The majority of the room. Okay, this is exciting.

We're going to do a quick gut reaction exercise. And this is a private internal exercise for you. It's not meant to cause you any distress. But I want you to get you thinking about the concepts of disability in medicine. So just notice what comes up for you right away. Not once it's gone through all of your social filters and your additional thought process. But I want to imagine that if you are a peer, that you have a peer coming in, if you're an educator, that you have a learner coming in and you are assigned to work with this learner, and the first thing you know about them is that they are missing a limb, what's the first thing that comes up for you? Just to yourselves not to share with the room, but think about the thoughts that you might have, the questions that you might have.

Do you think you would feel uncertain about how this person might manage the procedures or procedural demands of clinical medicine? Might you have concerns or worries that that person will not be able to do something, which will cause additional workload for others in your space? Might you be curious about how somebody with a limb loss would navigate this space, but don't really know the answers, don't really know how to ask in a respectful way. Or are you going to be confident that they'll belong just like everyone else, and that it's no big deal? These are some of the reactions that clinicians have when presented with this scenario. A scenario that is likely not going to require anything in the clinical setting. But think about why you might have that reaction.

RJ Roggeveen

I really like the gut reaction exercise because I think it does prompt us to think about the questions and bring 'em to the forefront of discussions that we just don't typically have. And so sometimes these reactions, we got to ask like, where do they come from? Are they from our personal bias? Is it that you're imagining it would be your first day with a disability and you're wondering how you'd manage? Are we thinking about the adaptations that come later on as you learn to navigate different spaces? And it also prompts the question of have we ever considered or questioned if a disabled colleague could do the job? And how do we decide who belongs in medicine, and who belongs in our spaces? And are we able to see patients and colleagues with disabilities as equals?

Lisa Meeks

And, you know, having these feelings, having feelings that come up that get you to question whether or not somebody will be able to fulfill the demands of medicine are not just coming up from you. There's a reason that you have these thoughts and actions. You're taught to have these thoughts and actions. You may not know it, but this is what our societal messaging is giving us and it's coming from a place called *ableism*.

Abby McClellan

So, then I think we got to talk about, well, what is ableism? So, the way that, at least we've understood it and how we've included it in our resource is there's kind of two parts to it. First part is this kind of overt discrimination, prejudice bias against people with disabilities. This can be very kind of explicit with maybe barriers that are there. But then there's also the more implicit or ableism that happens maybe underneath the surface, which can show up in our ideas and these biases that we might bring into encounters that, again, are subconscious, we don't know that they're there. And so, I think part of this conversation is talking about both the overt ableism that's kind of discrimination, and then also these ideas that we might be bringing to the conversation that we might not realize that we're bringing.

Mayihan Farid

And we know that ableism shows up both at an individual level as well as at a structural level. And one example structurally that we talk about a lot is within medical school curriculum. So, we know that within curriculum there's a tendency to promote what's called the medical model, where clinicians view disability as something to be fixed or something to be cured rather than focusing on things like disability pride, where we can appreciate that people's disability are integrated into their identity and into what they bring as a member of the team, and within healthcare.

Lisa Meeks

And as I said, ableism and medical training and practice comes in many forms, some overt, some subtle, but all of them, regardless of the intent or where they're coming from, they're impacting people with disabilities. It's impacting care, quality of care. It's impacting the experience that medical learners have in our institutions.

And I'm going to start with our panelists that identify as disabled. *Can you share a time when you encountered or had to challenge an assumption about disability in healthcare from a colleague or a patient or even from yourself? And how did that moment shape your perspective on inclusion and accessibility?*

Michael, do you want to start?

Michael Quon

Yeah, so that's a big question. I think this experience of facing ableism in medicine is very universal, honestly, for anybody who lives with disabilities. My own experience that I wanted to share that was one of those defining moments for me. So, I suffered a moderate traumatic brain injury at the end of my residency. And I was off for a period of time. And then I was working with accommodations well, I still work with accommodations, but I was working with more accommodations earlier in my reentry to work. There was one episode where I was feeling more efficient. I was feeling less symptomatic. I was requesting to take on additional clinical work in the emergency department doing like emergency room consultations.

And you know, this is clinical work that general internists are trained for extensively in residency. And I wanted to give it a try, but I knew I couldn't do so in the, the normal, "quote unquote normal full-time workload capacity." And so, I faced structural ableism in this hospital. Not unlike any other, many other hospitals in Canada, there were no policies to accommodate physicians with disabilities. And so, there was no process. So basically, I had to just reach out to my department head and make a request for accommodations. In this scenario, I requested reduced shift duration, and I requested daytime work rather than overnight work. Because both longer shifts and overnight work, for anybody who has experienced TBI know that that worsens symptoms. So, the response was ableist in a way, but I think representing more of structural ableism in that he was trying to think about the overall system and not really aware of what my rights were in this particular situation. And he responded, "well, I'm not sure we should really set a precedent in of offering you that type of accommodated work."

And it seemed at the time as though my request was a preference rather than a health limitation and an accommodation. And he was immediately going to the place of, "I'm concerned other people are going to request modified shifts and I'm going to have a hard time staffing my internal medicine department." So, that experience really stuck with me for a while and many other experiences I had. But that feeling of facing ableism, I mean, it is discrimination, as well. And I think it's important to use the words because based on the human rights code, that is discrimination. If you're not offered accommodations that, uh, you are deserving of that are, do not cause undue hardship. So, it's just fueled my advocacy in this work. And I'm happy to share that with you today 'cause I think it's productive in, in a way.

Lisa Meeks

Thank you so much for sharing. I want to point out one thing here, which is that that structural level of ableism is the assumption by the institution, by the hospital, by the training program, that you don't need to have a policy on disability because no disabled people could possibly be physicians, right? So, we see this not only here in Canada, but we see it in the US a lot where the expectation is that no one that is disabled would be able to do this work. So, there's this underlying assumption about ability already. And then it sounds like what was leaned into was this deficit model, right? That

you would be a burden without seeing the value of being able to employ someone to the, to their capability and keep them in their role, in their job. And so being questioned is something that I think is very difficult, but happens often for physicians, physicians in training with disabilities when it comes to how things could be done differently.

And in these ways, if you think about it, we are socialized, we are educated to think that disability is a deficit, therefore, one, why would somebody be here? And two, if you do have a disability, you are going to be a deficit or a burden to the organization. And so instead of optimizing the schedule, optimizing your ability to take on more work. It's situated that way. *Lynn?*

Lynn Ashdown

Perfect. So, I'm going to answer from the patient perspective and unfortunately, I experience ableism at virtually every healthcare encounter. Whether that's from an organizational perspective, from a healthcare provider perspective, from other patients themselves. But a few that come to mind. One would be I was being examined by a fifth-year resident and asked me if I was able to walk and I said, "no, I'm non-ambulatory." And then it came time for the physical exam, and he said, "okay, so how's this supposed to happen?" And I said, "well, I transfer to the table, and you examine me like every other person." And he said, "oh, okay, so you can walk then." And, and they said, "no, I can't." And he said, "well then how do you get on the table?" And I was like, "well, I use my arms." And so just that idea in and of itself that couldn't fathom that someone had enough arm strength to, to be able to transfer independently, but that also I was somehow lying in my encounter.

I get this a lot, unfortunately just being a, a very active healthcare user, lots of procedures and stuff, and I rarely get given post-op protocols in terms of exercise. And I always have to ask that. So, there's this assumption that because I have multiple disabilities, I use a wheelchair that like, okay, well we don't need to tell her about exercise limitations because she doesn't exercise. And, and so I always have to ask. And the reality is I actually meet the physical activity guidelines, which sidebar, those are ableist in and of itself because they're created for non-disabled people, but, you know, I always have to say, I do exercise, "so what are my limitations?" When can I start exercising again?

Often my wheelchair is treated like an inanimate object. But it is not, it is an extension of me. It is a part of my body. It is my way to freedom. A patient will come up to me and say, you're too young to be in a wheelchair. And I mean, A. I don't mind being called young, but just we have these assumptions in our mind of who uses a wheelchair and who doesn't. Whenever I'm, you know, waiting for diagnostic imaging, getting blood work done or something. There's an entire waiting room full of people and someone yells "so, what happened to you? Why are you in a wheelchair?" But what you're asking me in that moment is, what is my medical history? But you don't do that to anybody else sitting in that waiting room. There's this entitlement. People think that they're entitled to your story just because you have a visible disability. So those are just sort of a few kinds of the examples that I wanted to, to highlight.

RJ Roggeveen

I think I have a few of those similar in the patient side that translate over as a medical student, I, I see it when I roll into the hospital and I'll say, "hi, I'm a medical student. I'm looking for so and so" or I'm asking about a patient, and I get the initial reaction, "wait, what room are you in?" And I'm

like, “no, no, I'm, I'm a medical student. I'm not a patient here today.” There's just the initial assumption that people are coming into that interaction with.

And in medical school, something I've noticed is because this system hasn't really been set up to expect disability in our curriculum, there's times where equal opportunity for my learning can come in the form of, “oh, well this space isn't accessible, so we'll make an adaptation,” but the adaptation isn't giving me the equal access when we could work on how do I adapt to this space? A good example was in the anatomy lab. We were able to lower one of the tables so I could have access to the anatomy lab and be with my peers there and learn, but the exam couldn't be adapted there. The specimens were placed too high up, and it was unreasonable to place them lower down and the accommodation to that was, we'll have you write the exam online. And I think anyone that knows in person versus online, it's not, that's not actually a reasonable accommodation we made, but that was what was offered. And I was told for that whole year, like, “don't worry, this is the exact same learning opportunity.” And then in the following year, all the exams were put online for an anatomy lab. And there was an educator came into the class and said, “I know it's not the same opportunity and we understand.” And I was like, “you preached to me for a whole year that this was the same.” And I think it just highlights when we think about when we're making an accommodation, if you were to make that for everyone, would you account for that being an equal opportunity? Versus “well, we're making it work in this case.”

So, I see those show up at times and sometimes you're able to work within, within the system for it and other times it's a process of getting the accommodation in place and often hearing that, “oh, well, you have to understand it takes time, or that's an expensive request.” And I'm just going to say, wheelchair use wasn't developed yesterday we've had laws for years so that time has been in place for quite a while, but I'm often asked to be considerate of that fact. So, there's a few things I'd highlight around facing those challenges.

And then also finding mentors in the space. There are many people in our medical education who do agree that we should have a less ableist curriculum and access to the same opportunities, who are doing great work. And so, it's finding those people who can make those arguments with you and work with you to yeah, change the system for the better.

Lisa Meeks

Thank you all so much for sharing. I appreciate it. I'm going to turn now to our residents who wrote the book that is in front of you. As learners you're in a unique position to witness how ableism shows up in medical education, and that really kind of drove you to write this book, your experience going through medical school. Sometimes it does this in ways that aren't obvious. In what ways have you noticed ableism creeping into your coursework? There's the obvious overt way in which ableism is taught in medical schools, but in what ways is it more covert in your coursework, your clinical training, or the way disability is discussed in your education?

Abbey MacLellan

Well, I think I can speak on behalf of the three of us, but, and maybe even a lot of people in this room, depending on if you've gone through medical education or maybe you're in the process of, of becoming a physician. But we talk about disability all the time in curriculum, whether it be kind of

directly in lectures, maybe it's on the wards, maybe it's in research papers. Disability is this kind of constant concept that we're always talking about. But I do think that we rarely, rarely, if at all, talk about ableism. And we also don't talk at all about disability pride and so many other elements of what it means to have a disability. And so, I think throughout medical education, we have this very narrow and a lot of times inaccurate view about disability. If anybody else has anything to add.

Marihan Farid

Yeah, I just want to highlight that concept about disability pride. We talk about that a lot in the book, but the discussion we're having here today is about ableism. Our ultimate goal is to move from away from dismantling ableism and addressing ableism because we would be living in a society where we have disability pride and where we can really talk about disability, as everyone has highlighted that you, you're bringing different abilities and identities to a teamwork environment. So, as Abby said, in our curriculum, we, we talk a lot about disability, but never about disability pride.

Lisa Meeks

In what way has it come up in your clinical training, for example, the way that clinicians are talking about disability? One of the things that is so apparent in our studies is that the way that clinicians go about discussing things in the clinical setting is one reason this modeled behavior, if you will, is one reason that learners internalize these ideas about disability and place less value on the lives of their patients with disabilities or make assumptions about their patients with disabilities that lead to perhaps diagnostic overshadowing, incorrect diagnosis altogether, delayed screening. These are life-threatening behaviors that are grounded in belief systems, so, ableist belief systems about people with disabilities.

It's interesting, Lynn, going back to you as a woman that has a physical disability, you are actually the most at risk of having a diagnosis of cancer later in the stages such that you would not be amenable to treatment. And so, women with physical disabilities are actually dying not because of the, the disease or the pathology. For many women in women's health We get, we get screened. We, we do yearly evaluations, right? We have preventative care. And so, we're able to get that treatment a lot sooner. And if we do have some sort of a cancer diagnosis, we're able to treat it with, with much more success. But as you know, as many of you are clinicians, if you are diagnosed later stage four, you're less likely to have success. And so that's just one example of many of a way in which an ableist belief system, just the way you view a patient with a disability, can cause life-threatening harm to your patients.

In what other ways have you seen clinicians discuss disability on the wards that is ableist in nature that might perpetuate these ideas or cause harm to patients?

Zachary Ford

Well, I think that what you're mentioning really gets at this notion of when patients come in who have a disability, I think that it's really a lot of the time for, for clinicians is at the forefront of what they see and really being considerate about the fact that somebody who comes in with a disability

like you can be disabled and healthy. Your disability doesn't have to always be the reason why you're coming in to see a physician, and oftentimes it isn't. So, I think that it's, it's something that as a clinician, as a physician, something that people need to be cognizant of. Like you're saying, there's still screening programs that exist, and you need to be using those screening programs for everybody who falls under the categories of that screening program. There are more considerations that need to be taken, for sure.

Lisa Meeks

I want to go back to something that Michael said about structural ableism. And we're talking now about, you know, preventative care, right? We're talking about screening; we're talking about access to healthcare. However, you have to have accessible equipment to do that. Is the non-adoption of accessible equipment in a clinical space, a form of ableism?

To me, it's the outright expression that you don't value caring for every one of your patients, that you don't have an accessible scale. I am a cancer survivor twice. And I will often say that the first time I was diagnosed, it was because my BMI was a 16, I had lost a ton of weight, I was also really tired, and it was my weight loss that prompted all of the tests that came after. And the diagnosis. If you are a wheelchair user and there's not an accessible scale, how do you determine weight? How do you have that first indication that something might be going wrong? Weight loss. Weight gain, that's a huge symptom for many of the diagnoses that we'll make. But if you don't have an accessible scale, if you don't have an accessible table, how are you navigating the environment? To me that's one way I think in which healthcare sends a clear message that certain people matter when receiving care and certain people don't.

Lynn Ashdown

I can add to that. Shockingly even, in my institution, the, the preoperative area doesn't actually have an accessible scale. So, I'm always just winging it, right, <laugh> which doesn't give you sort of great sort of feeling going into the operating room, sort of winging what your weight is for an anesthesiologist, but, I take it upon myself actually to make sure, and sometimes I will make an extra trip to like the rehabilitation center or something like that so that I, myself, have an up-to-date weight.

I can think of an example where for some symptoms I needed a diagnostic ultrasound, and you can get it in the community fairly quickly and there was a blanket policy, *we don't do wheelchairs*, that was that. But then to get it through the hospital, it was like a yearlong waiting list. So, then A: the community diagnostic imaging place was about a kilometer from where I lived. Now you're asking the girl in the wheelchair who uses accessible transportation, which is not great to begin with, who then has to wait, you know, a year and, and all of these things, it hurts. I think one of the things I've started to realize is I actually have less tolerance for it now. In the beginning it was when, when it's like a one-off, you're kind of like, "oh, maybe this is just this one place," but this has a cumulative impact on you and every time, you show up somewhere like you're being inundated whether overt or not, these images that you just don't matter. You are a second-class citizen. And that's how we treat you.

Michael Quon

Thanks, Lynn. And I just wanted to add to the comments earlier about worsened outcomes with people with disabilities. And Lisa, I'll highlight your lab's research. I thought it was, I mean, a great example of ableism and the culture of medicine where physicians surveyed, I believe was maybe residents as well, who thought people living with disabilities had a lower quality of life than those without disabilities. I mean, concerning, in a major way that, that the physician workforce has broadly has that perspective of patients with disabilities. And just to add to the clinical context, I mainly do inpatient acute medicine and talking about the wards and perspectives of patients with disabilities. This is very much at the forefront where it's, it's not uncommon for clinicians, learners to refer to a patient living with a disability in that light of a tone or a manner that presumes they have a lower, worsened quality of life. And this, even this even can impact attitudes in terms of what level of intervention is offered to patients living with disabilities. And I mean, has definite influence on care that's provided, well not always, but can have influence on care that's provided in the hospital setting.

Lisa Meeks

So, I just want to say one thing. It's Lisa Iezzoni that did that work? A different Lisa, my mentor, the queen of all things, it's confusing us, Lisa's over there in the, in the US but it's great work. And it does highlight not only what you said about, you know, the perception of what quality of life is there for people with disabilities, but also that physicians said, readily, we don't want to care for patients with disabilities, this is too hard, it's too much work. There's not enough reimbursement. We don't have all the equipment. I was never trained. That's a good out and we should be training people more to work with individuals with disabilities. But it's something that is just pervasive in the workforce.

I wonder if any of you can speak to this, but when you do find a physician, we find another Canadian Erene Stergiopolous does some research on being the good patient, right? We have reports of people with disabilities who get dressed up when they go to the doctor, so that there's no question because they'll be assessed—you're not allowed to have a bad day, essentially. You can't show up in, in sweatpants. You've got to show up, you've got to look like you're doing well. You have to not ask for too much, right? Because then you'll be seen as a burden, and you might be taken off that physician's panel and god forbid you don't have a physician. So having a physician in a scenario where your care is suboptimal, because there are conditions to which you cannot fully engage with medicine, is better than not having a physician at all.

RJ Roggeveen

Yeah, it brings up a lot of thoughts for me as a patient. So, I ended up with my disability at 21 and I didn't know a lot at 21, but, and I really didn't know how to manage my own healthcare. And I made a lot of errors in many ways. You just, you're asked to do a lot in our system as a patient. Patients are, are asked to present themselves properly to their doctor, to present clear and concise information on what's going on, and then to manage all the appointments in between. And I know that that gave me also a bit of a bad rap between some of my, my clinicians and I, I could tell that that happened, especially when a couple years later I had kind of stepped out of the system.

I think patients with disabilities, sometimes are seen as doing better than we are because we do leave the system at times. We don't really want to be as into our care because of the trauma that can happen as a patient. And so, I stopped seeing my, my care providers and like really worked on personal things, but when I went back, I got the response of, "this is the best I've ever seen you, you look really well today." And I was like, wow. Like, it shows, I guess that I, they assumed I was doing well that whole time, but it was really because I stepped away from being a patient and managing my own care. I can say like, I'm 25 now, and I, as a medical student, I now understand how to be a patient, but we don't really teach patients how to be patients.

Lynn Ashdown

Well. And we actually, fundamentally, shouldn't be teaching patients how to be patients <laugh>. Let's just point that out, right? That, uh, patients show up as they are and that's enough. The one thing I do want to point out is that I have some tremendous healthcare providers amongst my team that, that help me. So, in terms of when I'm having trouble accessing care, I mean they, they really go to town and really helped me a lot. I also want to recognize I come from a position of privilege. I know how to navigate the system better than other patients with disabilities as well. I suspect I have less trouble accessing care than many other people with disabilities. But absolutely, you know, once I was referred to a neurologist in the community, but there were stares into the office, I mean, what neurologist's office has stairs to get in? I mean, look at the clientele, the patients that you're seeing. I could just sort of go on and on, but accessing care is an issue.

One thing that I think people forget about is that for someone with a disability, they're planning to get to the appointment starts long before the appointment. So, for example, I have morning care. Every morning, I have a personal support worker that comes to help me get ready. And, you know, the reality is, I mean, our healthcare system is kind of on fire and it's, you sort of, you have to take whatever appointment you can get, but if I say to the admin, the administrative assistant, well, you know, is there another time? This is when my PSW comes. And it's like, nope, has to be this, and that's that. There's just a lot of things, the trip to get to see your healthcare provider starts long before the patient is actually in front of you as well and arranging accessible transportation. I mean, there's so many things that I am setting up before you even see me in the office.

Lisa Meeks

We're talking today about the educational system and how the curriculum is presenting ableist ideas and views and perpetuating ableism as we are educating learners. And then we're talking about the effects of that on individuals that are patients that, that have that dual role as patient and provider or patient and someone who has a strong medical background and is emerging in medicine.

When I'm describing how ableism impacts me and impacts the people around me, I like to say it narrows your view. You hyperfocus on the disability to the exclusion of the whole person. And so, if you're thinking about diagnostic overshadowing or thinking that everything's related to a disability, then you have narrowed in on this person's diagnosis. This happens a lot for people who carry a mental health related diagnosis. Everything that's presented is related to the mental health diagnosis, even when it's not. But narrows our ideas when we're talking about applicants to medical school, it narrows your focus on the disability, and you start to problematize the learner before we've even looked at kind of the, the general more objective metrics for that learner. So, while it impacts the

way we train physicians, and while it impacts people who are experiencing this interaction with the environment, it absolutely impacts the people going through the training environment.

I do want to spend the next 10 minutes, the last 10 minutes of our time before we move to Q and A, asking our panelists what they do when ableist ideas come up.

And so again, we've all grown up with these ideas about disability. You get them from modeled behavior by family and peers, or depictions in these movies and books, academic books, and content that's spread widely through social media. Ableism is often subtle and deeply internalized. It's constantly reinforced in our society, and it does shape our perception in many ways that we do not recognize.

So, the way that I confront it is to do that, fact check. I'm a researcher, so I say, is there evidence to support what's coming up for me? Another way that I disrupt internalized ableism and ableist ideas is by surrounding myself with people who are smarter than me. That's a good rule, but also people who will check me if I say something. I know that my team has ~~both~~ the invitation to challenge me, right? The other way that I check it is to surround myself with disabled people. There are disabled learners, disabled medical students, disabled researchers, disabled clinicians on every single piece of work that we create, all of our scholarship and that helps us combat the ableism and the bias that will come up.

But what I'm wondering, and what I want to do is invite our guests to reflect openly and honestly about how they recognize ableism and how they combat ableism. Either that internal ableism or when they have a peer that says something or a leader or, a physician educator that says something ableist. How do you combat this? And in what ways can we share our ideas so that the audience can have some tools to do it for themselves?

Abbey MacLellan

I guess for me, I even think back at the beginning of med school when we came up with the idea to create this resource, you can just start to see how widespread ableism is in our society and in our healthcare system. And then immediately you're like, "oh, how am I going to start to do something about this?" But then the second thought came in of, "well, we got to start somewhere. We got to do something." And I think for the three of us too, when we even created the resource, we weren't coming into this as scholars in this field, but at the same time, we were kind of experts in the med student experience and knowing what med students needed to know. And that's kind of the lens we took in creating the resource of, there's a lot to be done, but we've got to start somewhere and how can we do this in the most thoughtful way? So, you know, knowing we might not get it fully right the first time, but we got to try and address ableism the best we can and learn as we go.

And I think that is kind of part of the metaphor with our, our book is on, you know, multiple iterations. As we learn more, we kind of revise it and make new versions of it because it's going to just constantly evolve as we know more and be able to do more. But I think that's the starting point of trying to start somewhere but then centering people with lived experience throughout the entire process but also trying to put in as much of the work as you can.

Marihan Farid

Yeah. So, for me, in a clinical setting, addressing ableism, something that comes to mind that's more recent we had a, a long discussion about infantalizing language in the clinical setting. And, Lisa, you mentioned calling people in rather than calling people out. So, I had a, a long conversation with a, a colleague about the problems with this infantilizing language and how it can undermine people's autonomy. And even in the clinical setting where people might perceive it as, uh, you know, endearing language perhaps that pointing out that you wouldn't use that language for, um, someone else, and that it wouldn't be professional, but having a conversation in a way where I'm kind of, I'm openly reflecting about my own biases and my own ableism and saying that before we started on this journey, there were, um, lots of ideas and lots of ways that I spoke and lots of language that I used, um, that was ableist and pointing that out before going into discussion, calling, calling people in rather than calling people out is the whole name of our book. It's, ***Am I ableist*** not, are You Ableist? It's inviting us to reflect on our, on our own assumptions.

Zachary Ford

Yeah. And as Abby and Marihan have really talked about already, it, I think that it's so important to have humility when you're going into conversations like that. Really being able to take criticism or take feedback from other people and, and not take it personally, but just take it with understanding.

I think that it's something that we do already a lot in medicine when thinking of medical diseases and I think that it's important to do that in all facets of life, as we all well know, as in the Canadian curriculum for med school, we have something that are called Can meds roles, one of which is a lifelong learner. And I think that it's really important to be a lifelong learner in, in all facets of life, definitely.

Lisa Meeks

Thank you. I told you what I did when already when things come up, um, personally or professionally, but one of the ways that Docs with Disabilities works to combat ableism is through a counter narrative. So if there's a prevailing narrative out there, that people with disabilities are too much work, they're going to have complications, it's going to be too hard, they're less intelligent, they're less capable, all of these things that people believe, we serve to offer a counter narrative, and we do that mainly through the Docs With Disabilities podcast, but also by sharing stories.

And one of the things that I have to say, RJ, is you are helping build a counter narrative that's stronger than anything I could say, because RJ is a student, um **[applause]** aw and on Instagram is working every day to combat people's assumptions about what a wheelchair user looks like going through medical school.

RJ Roggeveen

I found there's a lot of ableism that happens, but there's also like so many people I've been able to connect with who are combating that narrative and doing great work and research in the field. I

think for myself, part of me just knows that by showing up each day in the space is already helping people question and notice things that they didn't think of before. And I really do love when I hear from my preceptors or they're like, I hadn't actually considered this element, but here's how I have an idea on how to make it work; and I really like the collaboration I get to see.

At Dal we have a lot of narratives around calling in versus calling out. I really love that teaching. I think I took that very strongly when that was taught to us because it was a way of working with my educators and peers and saying, "Hey, do you have thoughts on how I can do this?" And it's really amazing sometimes when they do have, they're like, "actually, you know, when we're assessing this, and MSK is a really good unit to look at how we adapt that assessment." And just the other day there was the how we assess the knee. And they're like, "well, I think actually if you put your knees in this position with your chair and hang the patient's knee over here, like, this is how you can get this same movement, and we do that, but with our arms," and it just made sense. And so, I really love when my educators are willing to make that conversation and they're willing to say things. They're like, "I don't know if I'm going to say this right." And I'm like, "just say it like, let's, let's, let's hear it out loud rather than having it just circulate in our minds" 'cause I see the most progress with that.

Lynn Ashdown

In terms of internalized ableism. I am going to fully call myself out. I have a lot of it. And I have a lot of bad narratives that go through my, that go through my head a lot. And this is for me, I'm over a, just a little over a decade out from my injuries now I have both visible and invisible disabilities, and I am a disability educator, I'm a disability advocate, but the narratives that kind of go through my mind, can be quite negative at times.

I'll share with you just sort of a, a short scenario that happened just a couple of months ago. Um, my, my friend had recently gotten a puppy and so she brought the puppy over so that I could meet the puppy and, um, and whatnot. She was training the puppy not to go on couches. And, and so, um, in order for me to sort of play with the puppy and pet, I had to get down on the floor. And then she captured a few really nice pictures of me cuddling this puppy on the ground and whatnot. And then she sent to me after the fact, and I was looking at them and I said, "oh, wow, I really like these pictures." And then the narrative in my head was, "because I look normal", the wheelchair was not in the picture. And I like that picture because quote unquote, "I looked normal." Normal, you could argue for me, now is my wheel…. Like the change in perspective is actually "that looks abnormal." But these structures that we've grown up with, and I have some lovely friends. I, I know I say that a lot, I'm like, "oh, back when I was normal." And I'm trying to work on it. Um, but I do, I have a lot of internalized ableism, and I appreciate when, you know, I have some close friends that call me out on it.

Michael Quon

Hard to be the last here. But I'm going to feed off of Abby's comments. First off, who else is impressed with these, first year residents who have all written this book and have this deep wisdom?

[Applause]

Me and Lynn were talking about how we were not, that experienced or wise at that stage of our medical training. But Abby's comments spoke to me directly. This is a, this is a heavy conversation. I think it's important to acknowledge that, and it brings up a lot of feelings for all of us talking about these issues. I have been focused, myself, on trying to create a more inclusive medical workforce for physicians with disabilities, which will then lead to benefits to patients with disabilities, and so I'm taking Abby's mindset in that this is a complicated issue. There's a lot of there barriers at play to true inclusion of physicians and learners with disabilities. But let's start somewhere, right? And this is, this is what they did with the book, and this is what I'm trying to do with policy implementation and raising awareness.

So, because there's a receptive audience, and a lot of you probably are attuned to some of these issues, I think it's just important to highlight, working against structural ableism, we as physicians are protected by the human rights code to be accommodated for our disability to the point of undue hardship. That is the law in Ontario. And from what I understand in, in all provinces across Canada. There's a misconception that, um, physicians who typically are contractors are not protected in the same ways that employees of hospital institutions are. And in fact, the, that is not true. So, that is just deep structural ableism. The fact that there has not been policies while we're working on that.

And so, at the Ottawa Hospital, we, one of the things we've worked on is we've implemented a policy to accommodate physicians with disabilities in the Department of Medicine, which is, which is a very large department of over 400 physicians. And we are hoping that our work as the first policy in Canada, can hopefully be spread elsewhere. And for anybody who's allies and physician leaders in attendance, uh, please help consider using that form of anti-ableism to combat structural ableism in the workplace. And then building off that. So, our work at the Ottawa Hospital has led to good advocacy with the Ontario Medical Association, and they have since the first, by the way, this is the first provincial medical association that has developed any resource for accommodations of physicians with disabilities. And there's a, there is now an online resource by the OMA, identifying the, the law and recommendations for hospital institutions and raising awareness for physicians themselves who live and work with disabilities. So, I just wanted to highlight some of the progress that's being made. Despite the heaviness of the conversation, we are making progress, and with your help, we can hopefully share some of these resources and policies across the country and all work towards structural anti ableism.

[Applause]

Lisa Meeks

Great. So, I'm going to move off this stage for a second so I can share some resources with you and then we'll start our Q and A. So, through advocacy and through policy development is how you are enacting anti ableism. And I do think it takes collective leadership and collective work. So, while you may feel like you can't do something alone, the idea of many people across the provinces doing something right, collecting, coming together towards a shared goal, that makes a lot of sense, and it works really well.

So, I just want to give you a few resources before we go to the Q and A. One is the book written by our learners, *Am I ableist?* And here you have your QR code. The second is an article that was written by Michael addressing ableism and physician wellbeing in *JAMA*-and again, a QR code for that. There are a few more articles that I like to recommend in this space. If you want to know more, we ha we just scratched the surface today. But the capability imperative, this idea of theorizing ableism and medical education Neera Jain, who by the way, wrote it when she was a postdoc in Canada; Canada. You got it going on. I mean, this work is, is fantastic and I highly recommend this as well. Another Dr. Neera Jain article about unlearning ableism. This is a really accessible article. It would be great for your faculty development meetings, something of that nature.

And then another one by Megan Brown and Gabrielle Finn in clinical teacher called characterizing Ableism to promote inclusivity within clinical teaching. And so, for those of you who want to think about ableism in the context of your teaching, this is a great one as well. And then RJ adapted, RJ is is making videos of how he does things to directly combat the assumption that it can't be done. So, follow RJ along with the other billion people who are following him right now. He's also an avid surfer, so you can see his surf pictures. And then here's the resource drive and we'll add things, you're welcome to add things to it, um, academic in nature. And we'll just build a shared community as we start to, if there's something that you know of a resource that should be in there, we'd love to see it.

You can follow our organization on any of those social media platforms. So, Pam, you want to assist with the Q and A? And so again, if you have a question that you don't want to ask yourself, you want it to be anonymous, write it out, hand it to Pam and she will help.

Pam Liao

Any takers for the first question in the room or comments?

Audience Member

Hi, I wanted to start by saying thank you for allowing me to see things that I hadn't seen before. And so one of those things was thinking about our reappointment processes every year that we have in our department. And one of the questions that you have to answer is, "do you have a condition either medical, you know, physical or mental health that might prevent you from carrying out your kind of responsibilities?" And so, I'm struck by the fact that, you know, that puts the ownership on the individual. And so, you know, if the answer is yes, it isn't necessarily because of that individual's disability or condition, it's because this of the structural ableism that they are operating in. And so, I guess I just question is that question, is that a, is that a, is that a legal question? Is that a question that can be asked in a medical reappointment form and, you know, in a way that actually truly represents the answer that they're looking for?

Michael Quon

I'm not by no means a legal expert, but from what I understand, that the regulatory bodies have a duty to the patient, so they are more stringent on their language in that to sort of quote unquote protect the patient population. But I don't believe there's legal protection to sort of ask questions in that way. And I know Erene Stergiopolous, as Lisa referred to her earlier, she is a researcher in Toronto, and she audited all like the regulatory bodies across Canada. And as you may or may not be surprised, a lot of the provinces have more stigmatized language such as things like, "do you live

with an impairment, or have you ever lived with an impairment that may impair your practice?" And so, these, these questions people tend to not be honest and answer no. And that creates more hiding and affects the overall culture of inclusion and working safely with accommodations in an accessible workplace.

Audience Member (Dolores McKean)

Hi, my name is Dolores McKean. I'm the Dean of medicine at Memorial University. I don't really have a question. I just have a comment to say thank you so very much for sharing your lived experiences. Thank you to our learners up there who are helping us in the Canadian medical education context, become better and be more inclusive and be more thoughtful. And Lisa, if you really wanted to leave the US you might have friends in low places who could offer you a job here **<laugh>. [applause]**

Lisa Meeks

Before you ask your question, I just want to point out, some of you may go, who's Pam and why is she running the mic? Pam Liao, actually, a zillion years ago, Pam and I were on the phone together. I was in Fellowship, I was driving home, and we were having this conversation and I remember saying, if we could just get people to know that there's not one or two doctors, there's like thousands of doctors with disabilities. And she was like, "yeah, we have to come up with something like a campaign." And I was like, what if we just said "docs with disabilities? And we like did pictures of people with quotes from them." And that is how Docs with disabilities started a zillion years ago was a Canadian and an American who were on the phone and we just said, let's just get some stories out there. And so, we did that first hashtag project together and then it wasn't enough, so we moved to the podcast, but to have Pam here is kind of this treat because we haven't gotten to see each other. And so, I just wanted to acknowledge the Canadian influence on the Docs with Disabilities podcast.

[applause]

Audience Member (Sheila)

Hi everyone, my name's Sheila. I'm an endocrinologist in Toronto and with TMU, I'm the, the pre clerkship curriculum director. Well, I mainly just wanted to say thank you. I came I guess to learn some ideas as a medical educator, but I came out with a lot of other ideas as well as like a person, a family member. My mom had a stroke this year and she's using a wheelchair, so I'm starting to know about accessible transit and, you know, 10 hours for physio appointment and all these kind of things. But I just wanted to share an idea that I had, as a physician. So, I work at an osteoporosis clinic, and we don't have an accessible scale. We don't, we have people lie down for their bone density, but we don't check their height. So, we don't know if the height has decreased. We don't have an evidence-based way of doing a physical exam in somebody with osteoporosis who, is, for example, using a wheelchair. And, you know, people using wheelchairs do less weight-bearing activities, so probably are higher risk of osteoporosis. And I think there probably are major gaps in terms of having screening for bone densities, having treatment. And in terms of physical activity, I have some patients who have like SMA, osteogenesis imperfecta who've had a fracture and they're using a wheelchair. And I try and come up with them with some ideas for exercise. But this has just inspired me to think about some different ways in my practice that I can make some changes, for my own

practice and at the institutional level, to make things more accessible. So, I just want to say thank you so much and I hope a lot of other people here got some ideas to improve things too. So, thank you.

Audience Member (Keely)

Hello. My name's Keely and I'm a first-year medical student, and, I also have a primary immune deficiency, so can definitely appreciate having some barriers with accessibility. I've also done some research in disability and medicine and have to say I'm a big fan, Dr. Meeks <laugh> but my question kind of revolves around this topic that Dr. Quon brought up, or the concept I should say, of undue hardship. And something that I've always kind of grappled with is what exactly constitutes the point at which you reach this level of undue hardship? Like when you're asking for accommodations or, like when we're working within this system that has so many preset ableist constraints, how do we kind of argue that no, this isn't undue hardship. Like this is, as Dr. Quon said, like my human right.

Lynn Ashdown

I can try and take that. That's the, the catch 22 is that often using undue hardship, um, if one side wants to argue with undue hardship, and then the other side says that it's not, it goes to the courts, unfortunately, that's the, the reality of having such a vague term is up to interpretation but getting to the courts is in an inaccessible in and of itself. Or, you know, if you have a learner that, a learner that you're trying to advocate for something and then they have to take it to the courts, well, that's three years that they're waiting to continue their education. That's lost income, I mean, so, so many things. So, no answer to that because it, it often comes down to the courts, unfortunately.

Pam Liao

Could I chime in? So maybe just for context, I'm very connected and attached to this group also Lisa Meeks fan and among other things, I'm most recently the disability health lead at Toronto Metropolitan University. I see all of you here represent, so Canada's newest medical school, and we're working towards building an accessible school from the ground up. Sadly though, so much of this, and I'm standing in front of another powerhouse right here, is that there have been cases of learners in our country, in our profession who've had to go to the courts because there hasn't been another option. And so sadly, it's, I think because of that, because I'd look to the states and all the work Lisa was doing and say like, "why can't Canada, like, where are we at?" Because they were so much further ahead. And I think it's some of that pioneering work, sadly, through the courts that's really started this movement and maybe is now going to be moving kind of past the US, we'll see, but so, so important. And sadly, that's how it's played out.

Audience Member (Bishan)

Hi, my name is Bishan. I am a physiatrist from Montreal, so I'm going to answer to my endocrinologist friend to remind people that physiatrists exists—PMR exists. So, you are welcome to have your resident come for an elective, or even better, you can have one of us come to you for one of your division meetings and show you how to do a physical exam in a wheelchair. So that's something you can do.

But I have a question for the panel. So obviously busy being physiatrist we deal with disability and ableism all day, and only very recently have I started looking at my own ableism because you think you would think that treating patients with spinal cord injury, that you're not ableist, but you are.

And I'm looking at and hearing your stories about, especially what happens in the acute hospital. I hear it all the time from my patients, like, "oh my God, I don't want to go to the acute hospital. "Do I really have to go for this test, blah, blah, blah, or can I go to X hospital?" They know how to take care of spinal cord injured patients. So obviously I have no control over what happens elsewhere, but I'm very concerned of how, and this is a very niche question, and you may or may not answer, but how we are perpetuating ableism within our own rehab institutions. I wondered if you had comments about that.

RJ Roggeveen

I really like this question. It's very, there's a lot of levels to it. But one of the things that I've actually had a lot of recent discussions about have been physicians, their attitudes around mobility aids, and how that can really impact a patient's like quality of life. If you have access to the mobility aid that you need you can preserve function in your body. But the way that a physician comes at that conversation as they might be the first person to have that discussion with the patient can derail someone for years, if they're going to accept using something that's going to support their wellbeing because I often hear the terms 'use it or lose it', and I think that that makes sense in many ways, but we shouldn't be doing, use it till you lose it. Where are we harming our bodies to the point of having no choice on being ambulatory, and then saying, okay, you're disabled enough.

Because a lot of patients will come into the space who are in that, that zone and say, "well, yeah, I have this disability, but I'm not disabled enough." And I think questioning that narrative and how we perpetuate it with patients is just something that comes to mind in a way to process that.

Lynn Ashdown

And I'll add to that. It was interesting because I had an interesting experience because I had a spinal cord injury and a moderate traumatic brain injury at the same time. So, I really straddled kind of both worlds. And, you know, initially with my moderate traumatic brain injury, I had a hard time understanding. I had a hard time putting just a couple of words together. And it was interesting that the doctor would come and see me for maybe two minutes, give me this like super quick, sort of, okay, we're doing this, this, this, this. And then he would be gone and, and it's like, okay, well you work with brain injury patients every single day. I… I had no time to, to kind of, to process anything, didn't remember what was said. And actually, interestingly, when I was in this location, um, there's an accessible bathroom, but that doesn't have the button to get into the bathroom, and this is at like a rehabilitation facility. And I remember saying to the OT I said, "you know, there's no button here." And she's like, "oh yeah, it's been like that since it was built in 1980." And it's like, okay, this, if this is the standard at a rehabilitation facility, then we still have a little bit of ways to go.

Pam Liao (Written question from audience member)

How do you suggest starting to advocate for changes at your medical school with regards to physical accessibility of learning spaces?

RJ Roggeveen

This is something that I'm very actively involved in with my school is advocating for the physical spaces. And I think the first thing is noticing it and calling it out. I'm not saying like call people out for the decisions made but calling out the inaccessible spaces. We cannot do anything until we recognize that it exists and we're putting it in like, not just in our minds. And I think they're, because I, I think that medical schools, at least in my experience at mine wants Dal wants to do their best. They do. They have, they have told me, and they've shown me that they want to make these changes. They do not know how. And part of that is also bringing in ideally, professionals to make those decisions, who we have OTs who just do accessibility-analyzing. So, ideally bringing in professionals in that space if you notice a problem and knowing that there is one. and then being willing to also notice that there is going to be financial elements to putting inaccessibility, but it's not just for one person. It's for the benefit of your whole student body and then the patients that they're going to serve. And so those would be my initial ways is notice it, call it out, make a plan, and, um, work within work, work with the team, but don't be quiet about it.

Lisa Meeks

I'm going to add one thing to that, and that is write it out. Don't just say it out. You-want to have some history of communicating that as well.

Audience Member

Thanks so much, for everyone for the panel. My, my question is mainly kind of regarding, and, and this is a point that I think was included in the *Am I ableist* resource book about kind of intersectionality and, and disability particularly regarding kind of race and, and BIPOC and new immigrants. and we talked a lot about advocacy today on, on this panel. And, and even here at ICAM, one of our keynotes was about patient advocacy overall. And so, this is kind of a, a recurring, theme that, that that's we've seen over this weekend.

But my question is mainly when, when we think about advocacy as a whole, that there's, there's a need for not only knowledge, but encouragement and capacity in order to pursue these initiatives and advocacy as a whole and, and how these might be more adverse within populations that are, that are unfamiliar with the, the scale and scope of say, human rights laws and, and things of that sort. And particularly in communities that might have trauma and, you know, mistrust in the medical system as a whole. And, and as we're looking at our reviewing our disability guidelines and things of that scope, how might we encourage and, and inform patients particularly from these marginalized backgrounds about ways to advocate for themselves and, and see that as a whole.

Lisa Meeks

I love just what the way that you're thinking and I really appreciate it. The diversity community has taken care of the disability folks for so long. It's time, especially in the climate that we're in and the United States to take care of one another. I think that until we look at oppression as oppression,

across all groups, and no one thrives when anyone is marginalized and held back, that we won't have complete success. So, when people ask me to do anti ableism work, which I am doing, I always say, I'm happy to do that, but it's going to be in an anti-oppressive lens. I won't do anti ableist work without recognizing that there are a lot of groups that are marginalized. They are all part of the disability community. So, I can't talk about disability without talking about race or sexual identity or, socioeconomic difference. I just can't. And our team has committed to this. About 18 months ago we said we're not going to do any research that isn't intersectional in nature, and we have a ton of work coming out, so I think you'll be pleased with that.

But as far as with patients, I think meeting them where they're at, what's the most salient barrier that you're facing? It could depend it for that person. The disability could be the least issue for them in that moment. That may be their race and maybe their gender, it may be their sexual orientation, but kind of meeting them with "what is the biggest threat to you at this moment?" And then once we have that threat addressed how do we broaden this to look at all of your identities and make it so that you can feel safe in this space? I know we have one question that has been patiently waiting over there, and we are at, we are at time, so we'll, we'll end with your question.

Audience Member (Maria Goodridge)

I'm Maria Goodridge from Memorial and thank you very much for the wonderful enlightening talk. It's been fantastic. My question is, and it's probably not something you can answer in one minute, <laugh>, but the question is, I lead clinical skills at Memorial and, are there any resources available to help us come up with accommodations for students when they're doing physical examination skills, who had, for students who have physical disabilities, and have any of you had any experience where if a doctor who's disabled cannot do a particular maneuver, a particular skill, that they have somebody with them who will do the skill and describe it to the physician?

Lisa Meeks

So yes, and I can actually send you case studies on those and articles on adopting and adapting OSCE's, things of that nature. And on intermediaries, which is what we refer to when we're talking about someone who, at the direction of the learner, performs a particular skill or moves a patient in a particular way without doing something that would be required for meeting competency of the degree program or the training program.

Lynn Ashdown

Over the last few years, the Canadian Association of Physicians with Disabilities, for many years we've been developing a Pan-Canadian curriculum. And some of it includes how to do modified or adapted physical exam for, people with disabilities. There's sort of been a delay in getting the, the modules to fruition. And so, we're, actually just looking at other resources right now to be able to, the modules are done. So, if anyone knows anyone that wants to fund feel free to approach us. But, um, it's pending.

Lisa Meeks

And I'll just end by saying thank you so much for, for showing up to have this conversation. Please take stickers books, spread the word, spread the book, and I am with you, Michael and Lynn. I can't,

these learners just blow my mind. I've had the pleasure of meeting with them several times over the last six months and they're a joy.

And to ICAM and to everyone who runs this organization, just thank you so much for inviting us back and for all of the great work that all of the Canadian researchers are doing and educators are doing in this space to make healthcare and healthcare education more accessible. So, thank you so much and thank you to our panel.

[Applause]

Outro:
We extend our heartfelt gratitude to the Association of Faculties of Medicine of Canada (AFMC) for inviting us to host a live DWDI panel at the International Congress on Academic Medicine (ICAM). We also wish to thank our wonderful panelists and the incredible audience for their warm welcome, interest and engagement during the panel! This podcast is a production of the DocsWithDisabilities Initiative. The opinions expressed on this podcast do not necessarily reflect those of the hosts, their respective institutions, or their funders. This podcast is released under a Creative Commons Attribution Non-Commercial, Non-Derivative License. This episode was produced by me, Lisa Meeks.

Resources:

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Podcast episodes

Michael Quon

https://www.docswithdisabilities.org/docswithpodcast/episode/24e3bf62/episode-55-dr-michael-quon

Lynn Ashdown

https://www.docswithdisabilities.org/docswithpodcast/episode/2db0245f/episode-54-dr-lynn-ashdown

Social Media:

RJ Instagram @RJ_adapted

Resource Drive: https://bit.ly/FacingAbelism

DocsWithDisabilities Initiative:

Website: www.docswithdisabilities.org
YouTube: **@docswithdisabilitiesinitiative**
Twitter (X): **@DocsWith**
Instagram: **@docswithdisabilities**

Canadian Association of Physicians with Disabilities

https://www.capd.ca

Physician Health Inclusion community of Practice:
https://mscnorth.thinkific.com/products/communities/PHI