



Season 5 Episode 4
Physicians with Disabilities – A Conversation with Dr. John Hall
Transcript

Host/Associate Producer: Dr. Candace Sprott

Guest: Dr. John Hall

Production Assistants: Dr. Erynn Beeson, Andrea Anampa-Guzmán

Learning Objectives:

1. Define the legal framework of disability as stipulated by the Americans with Disabilities Act (ADA).
2. Identify strategies for person-centered care for people with disabilities, understanding the significance of tailoring interactions with these patients based on individual preferences.
3. Examine the concept of intersectionality in healthcare, identifying how various aspects of identity, including disability, influence the patient-physician relationship and acknowledging the diverse ways individuals view their disabilities.

[00:00:00] Candace Sprott: Welcome back to The DEI Shift. My name is Dr. Candace Sprott. I am an Internal Medicine- and Pediatric-trained physician working with the Southern California Permanente Medical Group in San Diego, and I'm an associate producer of The DEI Shift. Today, we're going to be talking with Dr. John Hall, an episode that centers on physicians with disabilities. I'm going to pause and let him introduce himself. John, please.

[00:00:35] John Hall: Hi. Thank you for having me today. My name is Dr. John Hall. I practice in upstate New York in Buffalo, New York. And for those of you who are familiar with New York, that's in the Western most part of the state. Go Bills, by the way. So I practice medicine, both Internal Medicine, primary care. I also practice obstetric medicine, which is medical care of the medically complex pregnant patient. I work in a private office in Buffalo area called R&B Medical Group. And I'm also an associate professor of Medicine and clinical associate professor of

Obstetrics and Gynecology at the Jacobs School of Medicine and Biomedical Sciences in Buffalo.

[00:01:20] Candace Sprott: Wonderful. Thank you for sharing with the audience who you are. And just so the audience is aware, are you comfortable if we just use first names?

[00:01:26] John Hall: Sure, I'd be happy to do that.

[00:01:28] Candace Sprott: So the ADA defines disability as an individual who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment. John, you wrote an amazing narrative about the power of a stethoscope that shared a bit about your journey with cerebral palsy. Can you share with us what that definition means for your lived experience and a little bit about some of the language that will be useful when we refer to a physician with a disability?

[00:02:16] John Hall: I think, first off, the information that we have related to the Americans with Disabilities Act and what its impact on accessibility and inclusion for people with disabilities has been helpful beyond measure in our country. However, we need to remember that the kinds of things we are talking about are legal definitions of what a disability is and what the legal implications of those categorizations are. Because that often is related to how businesses, institutions comply with legal regulations. It has to do with what services a person with a disability may or may not be eligible for by meeting certain definitions. In turn, that isn't a very good, in my opinion, working definition of what having a disability is and living with a disability is about. Lived experience is quite important. If you're asking about how that relates to the article that you mentioned, "The Power of the Stethoscope," the essence of what I was trying to convey in that article is that physicians have a position of privilege. And we all know in one way or another that we've experienced that as a position of privilege as a physician, in particular related to disability, even me as an individual with my disability, I'm afforded privileges as a physician that other individuals that have disabilities may not. Some of the point of the article is that I personally have been viewed differently when people are unaware of what I do professionally. The essence of the power of the stethoscope is that it may remove a barrier that might be imposed by my disability in terms of someone's perceptions and view me as not a person with a disability but as a physician with a disability. Becoming a secondary thing.

[00:04:39] Candace Sprott: Thank you for sharing that. And I'd love to get back to that a little bit later in the conversation. You mentioned earlier that the idea definition is really more of a legal kind of binding, if you will, or legal terminology, and that's not something that you would use as a person who has a disability to convey. Kind of who you are, how to interact or how to speak to someone who has a disability. And you mentioned a little bit of this in your article about you had an example of a child asking their parent what was wrong with you. Can you share more about that?

[00:05:11] John Hall: The particular example that you're referring to is something that happens relatively often through the course of my life. And I've noticed that it also happens to others with disabilities. When I observe it's an outside person who's just walking around a store, looking at what's going on, that kind of thing. And what happens is that sometimes people have questions about what's going on and why I might walk the way I do, what happened, why has it been that way? How long has it been that way? And I think it's, as a person, I think the best way to handle that is straight ahead when a person has a question. The best thing to do is give a

straightforward answer that gives them the information that they're looking for. I'm in a position of privilege in the sense that from a medical standpoint, I know more than the average person about what the implications of a disability are, not just from my own lived experience, but also from a medical standpoint. And that perhaps puts me in a better position to answer some of the more technical aspects of things than other people may be able to do. I think it's part of my responsibility to educate people to the best of my ability about the things that they're asking for. So the example you're using is, a child may ask their parent what happened to him rather than trying to prevent the child from asking the question or try to prevent me from hearing the fact that they're talking about it, I think it's really important for me to say. Hey, give them a break. They just want to be a kid and they really want to know they're asking because they want to know what things are about and why things are the way they are and I think that we're all better off if we give people honest answers.

[00:07:06] Candace Sprott: So John, thank you for that. And I want to ask, does it feel weighty? To have that responsibility from what you said to educate when people ask you about your disability.

[00:07:18] John Hall: I think the answer to that question goes back to what I mentioned before about physicians having a position of privilege as a physician. I work not only as an educator for my patients but also for students and residents, and as a physician educator, it's really part of my duty and my responsibility to also educate people with regard to Being a physician with a disability and being able to answer questions and educate the public, even if they ask for information I think that it's a role and a responsibility that has over time it's a role and responsibility that over time has found its way to me rather than me looking for it, regardless of the way that I have arrived at this point. And I do think that. It's a responsibility that I take seriously, but also a responsibility that I take joyfully.

[00:08:28] Candace Sprott: I love that. And I want to pivot a little bit because you mentioned about the privilege of being a position affords you. And I suspect that was not always there. Specifically, I'm thinking about training. As a med student and a resident, what difficulties did you face in terms of being a trainee with a disability, a physical disability that was very visible to all at the time where accommodations may not have been readily available or even accepted? Can you talk a little bit about that?

[00:08:59] John Hall: Actually, you hit on a very interesting part of my career path that I don't necessarily talk about unless people know about it a little bit. My first interest in medicine actually was Obstetrics and Gynecology. And in fact, I started out in my training, I did some training as an OBGYN and I trained for a year actually as an OBGYN. It's a little bit of a convoluted path. I won't get into the whole thing, but I did train for a year as an OBGYN. And after that year, it became clear. To all of us, myself included, mentors, program directors, that because of my physical disability, it would be difficult for me to meet the rigors of a surgical specialty. Doing things during an intern year when my responsibilities were more limited, that was manageable. The question came up as I proceeded farther into that residency program: would I be able to do the things that needed to be done? Would I be able to meet the requirements that were necessary? Ultimately, we made a mutual decision it would be better for me to change my educational path and my training path and pivoted back to training in Internal Medicine and completed that training program. However, it afforded me the ability to actually pursue what I was most interested in about Obstetrics and Gynecology. I actually didn't have a lot of interest in doing complex gynecologic surgery. My interest within the field is actually medical complications of pregnancy and wanting to deal with those types of issues. With the

combination of my training and my own personal experiences of what I'm physically able and not able to do, I actually was able to connect with people locally who are experts in the field of obstetric medicine and moved my career in that direction. So although I am a practicing Internal Medicine specialist, and that's what I do most of my time with most of my time, I also practice obstetric medicine on a regular basis, which is actually the specific part of what I was most interested in Obstetrics and Gynecology.

[00:11:37] Candace Sprott: That's an amazing pivot. The fact that your interests. Combined in a way that, unfortunately, it sounds like systemic barriers prevented from doing a traditional path, you created an entirely new area that aligned with what you were interested in.

[00:11:54] John Hall: With all due respect, I wouldn't refer to it as something that's unfortunate. I think it was quite fortunate because it allowed me to understand that even though I had set forth a path that was the way I wanted my training to go, the way I wanted my professional life to go, the reality of what I was able to do and the reality of the gifts and talents that I was able to bring to the profession were not necessarily clear to me. From the outset, and only by living that experience was I able to understand the intersection of those things and move my career in a path that was more beneficial, not just to myself, but to the profession.

[00:12:41] Candace Sprott: I see. Thank you for that clarification. You're absolutely right. And I'd love to know more about how your lived experience informs your care of patients. Is that a different lens that you look through when you are managing complex patients who may have disabilities as well? How do you go about your day to day practice with that lens?

[00:13:04] John Hall: In my day to day practice, I try to be cognizant of disabilities that patients may have, whether those disabilities are visible or invisible. Physical disability is a little bit easier in the sense of, we think about mobility issues, right? But people have disabilities of all kinds. types. Some examples of things of invisible disabilities are people that are on the autism spectrum, that are highly functional, people who have hearing impairments, people who are dyslexic. All of those things are disabilities in one way or another, but may not be inherently obvious. So in terms of my day to day practice, I try to be mindful of that. When I know that someone has a disability, I only try to focus on the disability if that disability is actually relevant to the care issue at hand. If it's something that is not relevant to why I'm caring for the person at that time, I try to help to make the person feel comfortable with putting their disability in the background. Acknowledging that it exists, but knowing that it always doesn't have to be up front. And a good example is if I were seeing a patient for a visit who uses a wheelchair for mobility, like a power chair, I would say things to them. For example, before I got too close to them, I'd say, make sure you got your power chair turned off because I want to make sure I leave the visit with as many toes as I started with. And it's often, and they often are "Oh yeah, that's really important". And, when I'm a safe distance away, I give them a little break and say, "if you want to turn it back on, you can turn it back on now", that kind of thing. But knowing that I understand some of the things they're going through as a disabled person, and that it's okay to have that be part of our interaction, but also it's okay to let that move into the background if that's not the most important part of why they're here today.

[00:15:26] Candace Sprott: I think that makes so much sense, and what you're doing is the living embodiment of person-centered care. What we've been doing with this episode is person-centered language. So that's putting the person before either their disability, ethnicity, race, medical conditions, or assistive devices—the person, then the thing. And so the language

that we use is also important. The corollary, I think, is when I have patients with obesity who come into an office visit and have knee pain. What they share with me is that everyone focuses on their obesity first and doesn't address their knee pain. I love how you said putting the disability in the background if it's not part of the care you're delivering that day but acknowledging it because this is a part of who they are as a human. What I see that as is providing that human connection.

[00:16:20] John Hall: As a follow-up on that, I think it's important to understand who it is you're talking to and who it is you're dealing with as an individual. Because some people with disabilities view their disability as central to who they are and what they're about. Others view it the other way around, where they're a person that is or does X, Y, Z and happens to have a disability, independent of our interactions as a patient and physician.

[00:16:56] Candace Sprott: Ah, so you're saying that there are some individuals whose disability is a firm part of their identity and should be acknowledged, and there are some who aren't? Is that right?

[00:17:06] John Hall: If we want to look at it in a different arena of the spectrum of DEI, if you look at someone who is gay or lesbian, do they always want that to be out front? Do they always want someone to know? That's who I am. That's what I'm about. Sometimes yes, sometimes no. Some people, it's very important to say this is part of my identity. Some people, it's important to say I don't want to talk about that right now. I think as a person, apart from my role as a physician, I wait for people to let me know what they prefer, or I try to pick up clues as to what they might prefer and then test the waters. As a physician, it's a little bit different. Because I think the conversation can be freer in that respect because the patient's disability may be part of the medical issues they're there to deal with. And the door is open, so to speak, to ask those questions by the fact that they're in the office, right?

[00:18:20] Candace Sprott: I see. So the white coat, the stethoscope, as we talked about, the power gives us generally a shared—it may not be shared, but it gives us a tacit understanding that we're going to be asking about more personal and private areas of their life as their physician. Whereas in a non-medical setting, that tacit understanding is not there. And we really have to be more cognizant of our underlying relationship before we delve deeper.

[00:18:51] John Hall: In reference to the power of the stethoscope, one of the concluding statements that I made, I think, speaks well to this point. And I'll quote it if you would indulge me for that. Please. The power of the stethoscope is experienced in its ability to change perceptions. The perceived barriers created by physical disability dissolve, allowing the person to be seen and understood. And I think that's part of what we're allowed as physicians. In our position of privilege, we're allowed to enter that space where others may not be allowed to enter. There are things that happen in the exam room on that side of the door that don't happen on the opposite side of the door. And by the fact that the patient has allowed us, given us permission to enter into that space of their life, that gives me as a physician the opportunity to ask those questions that I may not ask otherwise. One example that I like to use that I say to patients, especially to people who are patients who know me in other aspects of my life other than directly the physician-patient relationship, is that the "me" that you know or see on one side of the exam room door is not necessarily the same "me" that you know or see on the other side of the exam room. When we were at the most recent American College of Physicians Board of Governors meeting, one of the things that we did during the course of that meeting was a panel on DEI. One of the issues that were brought up, or one of the topics that were brought up, was

intersectional identities. And I think that's what I'm getting at in terms of this, is the "me" on one side of the exam room door is not necessarily the same "me" on the other side of the exam room door. And we need to be cognizant of that because that plays into how we take care of patients and how my disability manifests itself, my lived experience as a disabled person manifests itself in different roles that I play.

[00:21:23] Candace Sprott: That's a, that really resonated with me as a female physician, a physician of color. What you said in terms of the intersectionality, truly, I think that people have expectations that they put on you. And you're right. If you see folks outside of the office who you happen to have seen as a patient, there are a lot of unspoken expectations there. And so what I think you're also speaking to is creating some boundaries around that intersectionality, that there are some things that you share with others due to maybe the nature of that physician-patient relationship to provide that trust. And outside of that, you may not share that or you may not go in that direction to keep that somewhat sacred to yourself, and I see you nodding.

[00:22:10] John Hall: Precisely, so sacred to myself but also sacred to the patient.

[00:22:16] Candace Sprott: Speak more about that. Sacred to the patient.

[00:22:17] John Hall: I think that when we are involved in a physician-patient relationship, and that patient has allowed us into their life to understand and experience things that they may not feel comfortable otherwise sharing with other people in other parts of their lives, I think that is what I feel my duty and responsibility of as a physician is for any patient. Regardless of those other extenuating circumstances of what each individual person's medical issues, disabilities, socioeconomic difficulties, whatever it may be, I think that treating all of that information and trust with respect is very important. Talking about patients with disabilities is just one aspect of a much greater piece of who we are as physicians.

[00:23:20] Candace Sprott: John, I want to revisit the ADA definition of disability once more and take the conversation in a different direction. As a reminder for our listeners, it's defined as an individual who has a physical or mental impairment that substantially limits one or more major life activities. a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment. Can you share with me and our listeners how or if that definition resonates with your lived experience?

[00:23:59] John Hall: Let me start by saying that as citizens of the United States, I think that we're very fortunate to have the series of protections and requirements that come along with the Americans with Disabilities Act. However, I do think that we need to remember that's a legal document with legal definitions. And the legalities of what is required under the Americans with Disabilities Act are different than potentially than the experiences and lived experiences of people with disabilities. The ADA accounts for things like universal access in public settings. It accounts for definitions that would potentially allow a person to be eligible for certain types of services. But that's different than what someone may experience in their daily life. A good example in my lived experience would be that one could have a very well-designed accessible parking space with curb cutouts for wheelchairs or other assistive devices, but once the person gets to the door of the building they're at, they may not be able to enter the building without assistance with opening the door. There may be a perfectly well-designed accessible bathroom for someone to use in a public building, but they may not be able to enter that restroom without assistance because of the way the doors are designed. Those are the kinds of things that I was

thinking about. So we do need to be grateful that we have those protections and definitions, but we also have to think about, I believe, the difference between accessibility and inclusivity.

[00:26:12] Candace Sprott: So that, to me, gets at the difference between the letter and the spirit, and it's probably institution or company-specific as to how they implement. They may be just trying to do what the law says, as you mentioned, having the supports, the losses that are needed versus really viewing it from the lens of a person with a disability and how they're going to interact with that environment. So in my mind, it speaks to having voices that are diverse and inclusive when we're creating policies or implementing policies or creating environments where our patients and ourselves interact with one another. And John, that brings me to one of my final thoughts that I want to discuss with you the importance of diversity, equity, inclusion on all levels. When we're thinking about the medical education space and the physical practice space. Can you speak to what you've seen in your career as to how that's been done?

[00:27:25] John Hall: Let me say that any effort that we make in furthering the idea of diversity, equity, and inclusion is a very positive step. There are very common ways that we are familiar with that our learning institutions and our practice sites incorporate that. But I think that as we focus on DEI efforts at all levels, expanding that classic definition of DEI, as it were, to include more even more diverse populations, such as people with disabilities. We've made that an even richer experience and we've made it an even better experience for ourselves, our trainees, our patients, and including people with disabilities, whether they be as we discussed visible or invisible can inform and enrich and advocate on an additional level.

[00:28:34] Candace Sprott: John, I want to thank you for the time that you spent with me today. I think the conversation was illuminating, rich, personal, and I know I learned a lot and I hope our listeners feel the same. And just the care that you put into sharing your story today and what we can do in the future was palpable and I'm grateful.

[00:28:58] John Hall: Thank you for giving me the opportunity to spend this time with you and share with you things that I, as a person and as a physician, value and see as important. It's truly my hope that our conversation today can move that needle just a little bit farther in terms of giving people a chance to say, as you said, what are the technicalities versus the spirit? Hopefully, our conversation today can move that needle a little bit farther to say, can we do better? Can we think more about what is the spirit of what we're trying to do and how can we make things more inclusive?

[00:29:43] Candace Sprott: Thanks again to Dr. John Hall for sharing his lived experience and views on physicians and patients with disabilities. Please check out his article *The Power of the Stethoscope* which will be linked in this episode's show notes. We have some additional resources there including a link to the docs with disabilities initiative whose founder, Dr. Lisa Meeks, will be featured in a forthcoming episode to explore more on this topic from a medical education perspective so be sure to tune in. If you loved this episode, tell us! You can find @thedeishift on X (formerly known as Twitter) and Instagram, or you can email us at thedeishift@gmail.com. Please email or tweet our team with your comments, feedback and questions, and we look forward to keeping the conversation going. Take care.

Disclaimer: The DEI Shift podcast and its guests provide general information and entertainment, but not medical advice. Before making any changes to your medical treatment or execution of your treatment plan, please consult with your doctor or personal medical team. Reference to

any specific product or entity does not constitute an endorsement or recommendation by The DEI Shift. The views expressed by guests are their own, and their appearance on the podcast does not imply an endorsement of them or any entity they represent. Views and opinions expressed by The DEI Shift team are those of each individual, and do not necessarily reflect the views or opinions of The DEI Shift team and its guests, employers, sponsors, or organizations we are affiliated with.

The DEI Shift podcast is proudly sponsored by the American College of Physicians Southern California Region III Chapter.

The DEI Shift theme music is by Chris Dingman. Learn more at www.chrisdingman.com.