TDS S2E5 Transcript

[00:00:00] **Jaeel:** Welcome to The DEI shift a podcast, focusing on shifting the way we think and talk about diversity, equity and inclusion in the medical field. My name is Pooja and I am a med peds resident, physician.

Takimoto: And I'm Sarah Takimoto, an internal medicine resident in Southern California. We'll be your co-hosts for this episode.

Jaeel: Before we jump in and meet our guests. We wanted to start off with a brief background and intro about today's episode.

Takimoto: We, as providers are often referred to as heroes, we respond to codes and emergencies work long hours and put the needs of others before our own. In this episode, we want to challenge the narrative of the invincible doctor, a narrative that we believe does a disservice to our profession and our patients.

It creates the idea that doctors are superhuman, that they can't struggle with physical limitations, suffer from mental illness or set boundaries to protect their personal health from their work. Thanks to pioneering doctors like Dr. Meeks, an expert in disabilities and medical education and co-creator of the social media campaign, #docswithdisabilities, physicians are speaking up. They're defying the superhuman doctor stereotype and breaking down barriers to medical education for learners with disabilities.

Jaeel: Today, we'll hear the lived experiences of doctors going through the medical training system with a chronic diagnosis to understand how far we've come and how much further we need to build a stronger system of support for all of our students and trainees.

Later on in this episode, our guests will be sharing stories from their medical training experiences. We'll be discussing disability and chronic illnesses, both physical and mental. This piece discusses suicide and suicidal ideation. If you or someone you know is suicidal, please contact your physician, go to your local, ER, or call the suicide prevention hotline in your county for the United States. The numbers are as follows: the national suicide prevention lifeline in 800-273-TALK or 8255, or message the crisis text line at 741741.

Takimoto: We wanted to focus this discussion on the experience of the trainee. Pooja and I are grateful for two of our colleagues from medical school who have graciously agreed to be our guests on today's episode. We are excited to welcome Dr. Justin Bullock, a second year internal medicine resident from the Bay area and Dr. Mansi Sheth, a fourth year anesthesia resident from Ann Arbor to The DEI Shift podcast. Thank you both for joining us.

Bullock: Thank you very much for having us. I'm really excited.

Sheth: Absolutely happy to be here

Jaeel: Before we dive in. We'd love to get to know you a little better. So it's time for a step in their shoes segment, where each of our guests shares an element of their background or

culture. That's been important in their life. And we as listeners flex our muscles in their realms of cultural competency and humility.

Bullock: I'm happy to go first. The, uh, one of the really defining things for my life actually is, um, my experience as an athlete. Um, so I ran track in high school and college continued to race now, and it's actually something that really, um, is very important to my well-being, but also is just something that is huge for my self-identity. You know, the running community is a very strong one. I identify very strongly as a runner. And that's where I made all of my friends. And interestingly, when I started med school, it was the first time I wasn't a sports team. And so it was sort of a culture shock for me, because I wasn't sure how normal people made friends when they weren't doing sports.

Jaeel: That's awesome. Um, what was your race or what was your event?

Bullock: I was mostly a miler, so I did 800 meter, the 1K, mile, 3K and occasionally I ran cross country, but I wasn't very good at cross country.

Jaeel: Nice. Yeah, I did a track and cross country, um, in high school. I didn't get to do it very much in college, but I totally agree that the running community is truly really special. And I think one of my favorite parts of doing it in high school was to be able to kind of run off campus and go anywhere with my team and kind of be able to hang out too. Mansi, do you want to go next?

Sheth: Uh, sure. So I figured I would just, since it's the new year, I would just tell you guys my new year's resolution. I have a two-part new year's resolution: one was that I was going to complain less because I love to, I don't love to complain. I'm just saying that I love I do. I do. And I just, you know, it's always been a way of bonding for me, especially bonding with co-residents as I'm sure you guys will sympathize, but, um, I've been working about having a positive attitude. So I'm going to complain less. [00:05:00] That's a serious one. The less serious one is I'm trying to, um, have my chocolate intake because I think 50% of my caloric intake is from chocolate and ice cream. So I'm working on having chocolate only for one meal a day. And so, um, as you can see, I'm very food and dessert centric, which does tie in a little bit to what I'll talk about later. But, um, just being able to eat as much chocolate as I want has been really great for me mentally, but less great for me physically. So that's the goal for me.

Takimoto: Thank you for sharing. What is your chocolatier choice?

Sheth: I love Cadbury. Um, I love Lindor, but I like milk chocolate more than dark chocolate.

Bullock: That means this is also a financial goal. If you're eating less chocolate.

Sheth: Yes, that's a good point.

Takimoto: Unlike our other The DEI Shift episodes, we wanted our guests to have the opportunity to share their story uninterrupted. In this next segment, we turn it over to our guests and hear about their experiences in medical training.

Bullock: So my story centers on my mental health, specifically around the fact that I had bipolar disorder and my mental health experience really began in high school. But I think at that time, I didn't really have the words, um, or really understand what was happening to recognize that I was depressed. And then when I went to undergrad, I really just had a period of really a year and a half where I was like quite profoundly depressed. And I started to see a therapist and, you know, they sort of recommended them start taking meds. And at that point I really was not, um, very excited about that idea to me. Medication felt like giving up and I sort of continued to do worse and worse. And there was a period where, um, I actually, my overall GPA took a huge hit as a junior. It dropped by 0.4.

I kind of thought that that meant that I wouldn't be able to go to medical school. And basically that, and many other things kind of led me to eventually start taking medication and, um, actually got better, you know, over a few months and ended undergrad actually pretty well. Um, so when I came to medical school at this point, I recognize now that I'd had two pretty big depression events and I thought it was probably likely that it would happen again.

And so I tried really hard to, to get set up with a therapist and a psychiatrist when I came, um, to San Francisco, because it's where I was for medical school. And it started med school started off really great. But, uh, January of my first year, I basically had a running injury and slowly started to get depressed and kind of entered the, what ended up being the worst depression in my life and was very, very, very profoundly depressed and very, very suicidal.

And, and ultimately in, um, October of my second year of medical school, I attempted suicide. Um, I ended up in the ICU and I didn't have a diagnosis of bipolar until around this time. And sort of before, um, the suicide attempt had happened there, I had really like stopped sleeping. I was the doctor. I was sort of in like a mixed state when I would get angry, I would go for an angry 22-mile run.

And so anyways, I had this diagnosis of bipolar disorder, but I actually felt like my medical school was very supportive of me. Fortunately, my therapist was like affiliated with my institution and, and, and I feel like I was given sort of the appropriate amount of time to heal and was not sort of, um, but also was not forced to leave for a year. Um, because I was someone who medical school was actually very healing and, and, and, and important in my well-being. Like med school was never the thing that actually stressed me out. So I sort of, um, through the rest of medical school actually did okay. And then residency, I kind of thought that kind of understood that this is, I sort of have cyclical mood episodes and, you know, everyone talks about how hard intern year was going to be.

So I tried to be very transparent with my residency program and I told them that I was bipolar. I had formal accommodations to go to therapy and my psychiatry appointments and, and again had a pretty bad, um, depression episode my first year. And had another suicide attempt. And interestingly, this time was much harder to come back specifically because of the way that my institution treated me.

And I actually stayed at the same place for medical school and residency. So I kind of expected them to like, handle this well, because I'm someone who I don't really show in my,

my work, you know, I never had any issues with professionalism and my performance. I had a psychiatric issue and I was cleared to return to work, but it turns out that was not the case.

I had to go through a pretty extensive process, called fitness for duty, which basically was for me, very traumatic. I was like, they made me do multiple drug tests. I had to have this extensive psychiatric evaluations, like personality tests. Um, all for them to [00:10:00] tell me that I was bipolar, which I already knew.

And so that's kind of where I am now. I'm back feeling fine in respect to my mental health, but I was quite profoundly disappointed at my experience the second time, because there was really this, all this stigma, because, because I'm bipolar, everyone said that I have a condition which potentially could impair my cognition, but there is no evidence of my cognition ever being impaired. And I think the institution does recognize that there are huge areas of improvement. And I care a lot about de-stigmatizing mental illness, because I recognize in my life that I both have a mental illness and I think I'm like not bad at what I do.

Fortunately, I've actually found that because I'm very vocal about my mental illness. In some ways it's actually a little bit protective. Because there's never any surprises because I've always been very transparent. Yeah. I feel very free to stand up for things when things don't feel right. But I also don't think that people should have to share their stories in order to be treated like human.

Sheth: Uh, for me, you know, I was my illness is that have ulcerative colitis. Um, I really wasn't diagnosed actually until med school. So I actually went through the process of essentially, um, manifesting my symptoms and then eventually getting treatment throughout med school and then, uh, persisting that treatment throughout residency.

So I started kind of having symptoms like towards the middle of my first year of, um, medical school. And it was just kind of a bunch of bloody bowel movements, loose bowel movements, things like that. I think one of the hardest parts for me initially was just like, it's super embarrassing. Uh, I feel like ulcerative colitis is not, um, there's no such thing as a glamorous disease by any means, but it's definitely not a disease that I felt comfortable talking about.

You're constantly like having diarrhea. It's not a nice thing to kind of confide in people about. And then the other thing is that I feel like you have to go to the bathroom right away. That idea of not having control anymore was a huge negative part of the whole thing. And a huge negative part of my quality of life was this idea that I was just like chained to a bathroom almost. I wouldn't do anything. I wouldn't go out with friends or anything because I would be like, well, what if walking down the street and I have to go to the bathroom? And then the other big part of it was also just like, I didn't quite know. You know, I'd always been very fortunate to be extremely healthy my whole life.

Like I never really had any issues and you know, I want to do well in med school. I want to become a doctor. I want to do all these things. And now all of a sudden you're, that's the least of your concerns. So I was not able to concentrate because I didn't want to go to class because I was worried I would have to go to the bathroom. I think a big learning part for me

was that, you know, treatment is a gradual process and treatment for a chronic illness is a gradual process. So, you know, sometimes, and especially in med school, you think like, Oh, you get diagnosed. Here's the treatment. You get better. Move on. And that's not necessarily what happened. Different treatments, um, don't work for you. It takes a long time to adjust medications. And not just that, the physical time it takes just to go from diagnosis to treatment is long, you know, for somebody who's healthy, it's like what's a couple of weeks. What's a month, you know, between your colonoscopy and starting your medication. It feels like forever.

I started on some medications, which was fine, but those medications are also not super glamorous. So it's like kind of hard to talk about. Had to pretty much do like enemas every night, which like is not great for your social life. You know, my symptoms got better a little bit gradually, but still it wasn't like what my quality of life used to be. Um, and, and that was something that I also learned as well, is that, you know, you, you get into this state where you're willing to accept a quality of life. That's a little lower only because it's better than what it was when you were at your sickest. So you feel a little bit better.

So you you're like, okay, I'm fine. I'm fine. I just don't want anything to get worse. But the reality is then you look back on your life like a couple of years ago, and you're not doing the stuff that you used to do. You're still super limited. I had to keep going back to my doctor, being like, look, I don't think this is working. I understand that we didn't want to do some medications that are really strong. And I think part of that was also my family. They were a little bit afraid. They're like, Oh, we don't want you to be on immunosuppressants. We don't want you to, you know, um, be on these medications that are big guns because they understood that they have a lot of side effects.

And it took a long time for me to finally accept that my disease is probably severe enough that I need to be on immunosuppressants in order to have the quality of life that I used to have. Part of it was also just like the, or the unknown. Like, I didn't know if these medications would work for me. So I'd always be worried that like, what if I moved on to the next step and that didn't work as well.

During [USMLE] step 2, I did like a big steroid burst, which was like, great, I guess, some ways, cause I would like not be able to sleep. Uh, no, sorry. During step one. Um, I would not be able to sleep, but um, you know, that kind of really helped calm down my disease. And then I started on, um, some of them use [00:15:00] immunosuppressants, which fortunately have really worked well for me almost essentially close to what I was before I was diagnosed. Fortunately, I feel like throughout residency I've been able to do, um, essentially what any other resident would do. And for me that was really important. You know, I was really afraid of the different call schedules and being on 24-hour call and things like that only because, um, all the things you have in residency, like stress and poor diet, um, you know, a lot of caffeine, those are all things that trigger ulcerative colitis.

So I, I was worried that, you know, maybe my body wouldn't be able to handle it, but I've been very fortunate, um, to be on constant medication that has worked really well for me, has not limited me, has allowed me to do everything that I need to do in residency. For me, and I think kind of Justin alluded to this, some people, it's important for them to talk about

their disease and I very much applaud that. They feel like they want to be private about it. And I feel like I've been fortunate enough that I've been able to be private about it because of the medication regimen that I've been on. Obviously when COVID came, you know, they talk about, you know, are you immunosuppressed? Should we be, you know, should I be taking care of COVID patients? So that was a conversation that I thought about. And initially, um, kind of talked to my, uh, GI doctor about, but ultimately I decided that I think, um, I'm just going to continue taking care of all patients, just like the rest of my co-residents. And then that's where I am.

Bullock: Thank you for sharing your story. As you were talking, I hear so many parallels, even though our stories are completely different, they're actually quite similar versus starting off before we even began us just talking about the things that we do, like, you know, me talking about running and you talking about chocolate. They tell a lot about our stories without really sort of overtly telling our stories. And then kind of your experience of like whether or not to start immunosuppression and your family having like, thoughts about that. And also this idea that your disease can flare over time. And that's not necessarily a feature-- that doesn't mean that you haven't been taking your medications. It just like sometimes your disease flares and the various ways that residency can impact that. I'm really grateful for everything that you said and really appreciate it. And it's very interesting for me to hear too.

Sheth: Yeah, I totally agree. And I think it's really interesting how I think it just shows how connected also mental well-being and physical well-being really are because when one of them suffers, inevitably the other one tends to suffer.

Jaeel: Yeah, I completely agree. I mean, I think, um, the stuff Justin that you highlighted, um, I had also written down in terms of the parallels in both of your stories. I appreciate that you both kind of talked about how this is like a constantly evolving, constantly re-evaluating process.

Um, and things might look different from, um, you know, one month to another, depending on how, um, the you know medical school or residency demands are different versus the medication trials that you're working on or different treatment is that kind of gradual process.

Sheth: Justin, there was a moment when you were talking about your experience and undergrad, and you saying that GPA drop, I can't be a doctor

Bullock: You know, it's, it's crazy because, so my GPA like got obliterated and I actually was thinking about withdrawing from MIT. And I actually went to go tell my track coach. And I told him because I was going to be a captain in the spring. And I, and obviously that's kind of a big deal if I wasn't going to be there. When I went to talk to him, you know, he's a very pragmatic person. And I was like, I'm, you know, I said, like, I was like, I'm depressed. And he's like, Um, what did the doctor tell you to take medications? And I was like, yes. And he's like, have you taken medication? I was like, no, he was like, why not? Um, and he was the first person in my life who was just like, like, this is an easy problem for you to fix, you know, the medication always works for everyone, but like, there's an obvious solution. And like, you should use this solution. My family was very afraid of me taking medication. They didn't

want me to like, want it to mess with my head. And he was the first person who I really looked up to who was like, Dude, like there is something that you could do, like, just do that.

Jaeel: I mean, just hearing that, and then the comparison that you were making between the experience in medical school and the experience in residency, I think right now, we're not at a place where we have unified standardized structures in place. And so much is dependent on the individuals that you kind of run to mentors, advisors, and the people that are surrounding you in the kind of the tone they set, the amount of, um, kind of support they give and the kind of the freedom that they give you to set that balance between having time to heal, but not being taken or forced to take more time off than you want to.

Bullock: Yeah. I really think that, you know, we are talk about this default to leave of absence. Um, this is something with, um, Dr. Lisa Meeks, who used to be at UCSF is now in Michigan. Um, you know, we talk about it all the time . She always says how it infuriates her because it assumes, you know, when people say, Oh, leave and get better, it assumes that you have somewhere to go where you can get better, that you, that you have some way to pay for your life, you know? And, and, um, you know, and, and that you have a sort of safe, welcoming home to go to. And that's just not true for everyone.

Jaeel: So specifically, I wanted to ask both of you about, um, the process of kind of discussing your diagnoses with, um, [00:20:00] either your, um, medical school, school leadership or mentors. Um, and then, um, how you had that conversation or thought about having that conversation, um, when applying to residency.

Sheth: Um, so in terms of medical school, um, I think, you know, honestly, the first people I really told were my friends. Um, I didn't really tell anybody from, um, the overall medical school leadership, um, about, uh, getting diagnosed, you know, I think, uh, the first couple of years of medical school, you're kind of like semi in lecture, somewhat online. So I was fortunate in that way. Cause there was like a little bit of flexibility. Um, I think my disease was one of control during my like, uh, clinical rotations that I just kind of, I didn't say anything. And if I had a problem, then I would usually like tell one of my friends, or I would just tell like my direct mentor, like the person I was like the attending or the chief resident or something that I was working under. um, if I had any issues.

Jaeel: And how did that conversation go? Like what, I guess, how, um, how much did you feel comfortable telling them and, um, kind of, where did you draw that line?

Sheth: Um, I think I would only really mention it. I mean, some of it is that I'm like very stubborn. And hard-headed, and I like, almost felt like, and I don't think this is necessarily the correct thing to do, but I think I almost would like, it would, it would take a lot for me to mention anything.

Like, I really wouldn't. I actually don't to be honest, like, I don't actually think I ever mentioned to anyone other than my friends during medical school and even telling my friends was like a big deal to me. Um, uh, during residency, like it's the same thing. Like I never, I didn't tell my program director. I didn't tell anybody really, um, until COVID happened. And then I felt like, you know, I should share this with them. Um, and I think for

me, I ultimately have to say, I think I'm fortunate enough that my symptoms were controlled, that I could be private about it. I mean, like one thing I did want to mention, I think I'm kind of bouncing off actually, a point that Justin made earlier was this difference between residency and medical school and how, like you can have one experience in medical component, completely different experience in residency. And I think, um, the big difference that I felt was like, you know, in medical school, you're treated as like a learner and that all the experiences are for your education, right? So a lot of accommodations are made rightfully for you to have that learning experience. And unfortunately, I think the reality is then you get to residency and it can be a little bit of a rude awakening in the sense that now you're really balancing education and service. And then that service part of it um, sometimes rears its ugly head. And you kind of, I think that's the part, um, that kept me a little bit on the quieter side, um, was this idea that, and I don't think necessarily that's the right thing to do. I'm just saying it's this idea that all of a sudden, like, you know, you're not fulfilling your service part of the residency um, which I, you know, I'm not a big fan of, of that. I think the balance should always be in, in, um, skew of the education standpoint, because we're still, you know, very much in training. But, um, unfortunately I think the reality of the service kind of tends to prevail sometimes depending on the situation.

Takimoto: I really like how you brought up, how sometimes it's hard to speak up because there's this idea in residency of education, that we are still learners, even though we're no longer students. And the idea of service that as a resident, you have a job to do. And I want to take a moment to share with our listeners about the Americans with Disabilities Act, or the ADA, which was a law passed in1990. It's the law that holds medical schools and residency programs to a certain standard in terms of accepting and including learners with a. Under the ADA, the official terminology is that "employers may not discriminate against a qualified individual with a disability and must provide a reasonable accommodation to enable that individual to perform the essential functions of his or her position, so long as those accommodations don't create an undue hardship for the employer."

Bullock: This idea that for some reason, when we become doctors that like ADA does not exist is something that makes me very angry. And it's definitely, it is, it is something that we are sort of bred to believe that, that, you know, that patient care comes at the cost of everything. And the thing that I always think about with myself is I'm like, I mean, if I'm not taking care of myself, then I literally like. First I'm going to be dead, but I also can't take care of patients. Um, and that's sort of what I, that's how I like internally justify it, but I, I completely agree. And there's this pressure to like, not ask for help, to not ever leave, you know, that you have to be here for everything. And a lot of it's because you don't want to push work onto your co-residents, who are all like barely surviving as is.

Jaeel: Yeah, I think kind of going back to, um, what we can do as a [00:25:00] system to make sure that we safeguard against that. I mean, have other options for backup where it isn't put that much pressure on your co-residents or on the attendings or fellows or whatever, to have to step in and help out when, when one person who, you know, it's, it's a normal human thing to be able to, to need to kind of step out and do whatever you need to do. Um, and so the fact that we don't have, um, like a structure in place to, to cover that I think is, um, kind of wild and something that we can definitely work to change.

Takimoto: The jeopardy system does sometimes prevent residents from speaking up because you feel like you're inconveniencing a colleague. If you're someone who needs accommodations, whether that's time to go to appointments, limited overnight call, you are protected under the Accreditation Council for Graduate Medical Education. The ACGME has two specific requirements for all residency programs. And that's: 1) that they have to follow federal law and 2 that they have to provide accommodations for residents with disability, consistent with their institutional policies. As much as we can continue talking about that and normalizing that, uh, and taking away the guilt that sometimes residents and physicians and medical students feel when they ask for those accommodations is really important.

Sheth: Um, I just want to also bring up something that I think maybe might be a little bit, um, specific to anesthesia, but maybe you guys will appreciate, you cannot leave the OR once you're in there without another provider. So that's like another thing that's been like a big stress, like, you know, like your other residents in theory, like obviously you can't just leave a patient's room, but in theory, if you needed to go to the bathroom or, you know, do something like that, like you could just leave and go. But when I'm in an OR, I can't do that. So I think that was like one additional level of, um, Uh, kind of like stress that has for that. And that's where I lean on my co-residents and that's mostly when I would, if I were having issues, I would talk to my attending and been like, Hey, today's not a good day for me. Like, I might like, page you like, can you please come in here so I can, you know, go to the bathroom or something?

Takimoto: Did you ever think, Hey, I can't do this because of my disease. I can't be in an OR. Or when you're thinking about what jobs you take after residency, do you lean towards a position with under the field of anesthesia that isn't necessarily the anesthesiologist that is doing anesthesia in the operating rooms?

Sheth: I think that may have been something that I, I considered, if my, if I hadn't been able to be on the medications that I am on now, I think right now, I would say at least I lead like a fairly normal life. And that I think more, most importantly, and this is a question they always ask on the questionnaires when you go to the GI office is that they'll be like, is your UC like, um, changing your decisions of what you want to do in your life? And if your answer is no, then they consider that disease as well-controlled. Unfortunately, my answer since like about fourth year of medical school has been no . I have the fortunate that I don't have to make my life decisions based on, you know, what I can and cannot do, but that's obviously not something that is available to everybody.

Takimoto: And Justin, when you were deciding to go into internal medicine, um, did your, uh, mental health diagnoses ever affect what specialty you wanted to pursue?

Bullock: I think early on in medical school, I thought I wanted to be a surgeon who obviously have notoriously. Challenging, um, work schedules with a lot of night shifts and a lot of sleep irregularity. And my therapist was like very, very, very, very not in support of that. Um, and, but fortunately I basically sort of, I liked internal medicine more for independent reasons. And so I think it just happened to be a fortunate, like shift. Uh, definitely was something that, you know, and I would say, I mean, it impacts the fellowships that I would think about doing, you know, if I want to do a fellowship at all. And for me, like, yeah, I, I wouldn't do something

like cardiology or GI or Pulmonary/Critical Care because it just has a lot of like sleep irregularity. It's actually really fascinating. Now that I'm being more thoughtful about my sleep. Um, I'm able to see the ways in which irregular sleep impacts me. And I think it impacts all humans, quite frankly.

Jaeel: Oh, absolutely.

Takimoto: I agree with that.

Jaeel: I wanted to transition um, to talk about how having these diagnoses has really impacted the experience you have with patients. And if it's changed the way that you provide care, you provide any counseling or anything to your patients. What are some of the insights that you have to patients that, um, folks without your diseases don't?

Bullock: I can start.

Sheth: Yeah, go ahead. Because you spend more time with patients who are awake than I do.

Bullock: I think one of the biggest things that I've learned is [00:30:00] I've actually dealt with a lot of providers who, um, I think they know me best, and those are people who don't know my medical history and who aren't my actual, like long-term care providers. And seeing the ways that people sort of judge me because of my mental illness. Um, and I think that that actually applies to many, many, many, many medical conditions.

I'll say is like, I know my body best. Um, and you know, and as doctors we're like, yeah. And as doctors, we're like, we know, like, I know, you know, I'm the expert in multiple sclerosis. I therefore know like, you know what to do for your body. And they're saying that I know medicine more than you. What they're saying is like, I know myself and the way that I respond to certain things. Um, and so for instance, for me, an example of that would be like, what would be like what people saying like, Oh, you shouldn't work because work is stressful. And I'm like, well, work is stressful for a lot of people, but work is something that actually gets me up in the morning. And instead of me being at home, being suicidal thinking about wanting to kill myself, I get to come in and try to like help people. And that actually is helpful for me. Um, you know, and that's something that like it's, so basically I think it's really humility.

So, so now basically when someone will say something like, I know my body best, what I hear from that is like, Um, I'm saying something that is important to me and important to my body and I am the expert in my body. So please listen to me. Um, and yeah, yeah, I actually has really changed the way that I've interacted with patients and I've actually found that it has now allowed me to like better align with my patients very frequently.

Jaeel: Yeah, I think you like that kind of alludes to that, um, aspect of like what motivates you to, um, continue getting care? Like what is, I guess more like back to Mansi's point, like the major kind of quality of life, things that are important to you and give you joy and give your life meaning and keep you going. Um, and I don't think we ask that enough, um, of our patients. Um, and I think, you know, Having that experience, um, and kind of knowing what

motivated you to continue, you know, doing medicine, which gives you joy, um, is, is really, uh, kind of an important insight to have.

Bullock: Yeah. Yeah. And really it's this, um, and to say it a different way, it's really, for me really is this moving from a place of, "I'm the doctor. I know more than you" to, "I'm your partner. How can I help you accomplish your goals?"

Sheth: I totally agree. And I think part of it is also just kind of, like you said, um, you need to remove stress from your life. You need to remove this from your life. You need to get X hours of sleep. You need to not drink caffeine. And then just like how the patient says to you is like, well, I can't do those things. Like this is an intact, like, critical part of my life, you know, and understanding that, I think that was big for me is, you know, realizing that there are things that people can not compromise on because it is the essence of their life or what they're doing.

You know, it's like asking a resident, you know, like , "You should get more sleep." I'm like, "Okay. But like, I can't." So that has really helped me, you know, I mean, obviously I don't deal with as much continuity of care as you guys do. [I deal with] much more like shorter interactions, um, in anesthesia. But I think, um, I've had a much greater appreciation of just trying to listen to what my patients tell me. And then also just improve the small quality stuff. I mean, we're always trying, but like things like postop nausea, vomiting, things like pain control is just, you know, when a patient tells you that, like, I really hate to be nauseous then, you know, I try to make a really conscientious effort to be extra aggressive about that. Whereas another patient you can tell is like much more uncomfortable with the pain aspect post-surgically so, I mean, you know, you obviously try to get rid of all of it, but the reality is like you can't and sometimes you have to compromise. Just try to figure out what matters more to that specific patient I think, um, um, having a little bit of that experience has helped me too. To have my doctor listen to me and be like, "These are the things that are important to me," and she's being like, "Okay, then let's work around that."

Takimoto: Thank you. The idea of really just listening to your patients is so simple yet so powerful. I wanted to ask what motivated you to share your story today with us.

Bullock: One of the things that is profoundly important to me: as I've shared on various like stages, every single time, I have multiple, multiple, multiple people who come up to me. And I'm not exaggerating when I say this, like who come up to me and share their own experiences of both like mental illness, physical illness, like so many people with various disabilities, um, who, for whatever reason, aren't vocal about it. And for me, that actually gives me strength to sort of keep going [00:35:00] because, um, one, for me, it says that people appreciate, like, hearing my voice, because again, like I'm sort of already out there. So like, what does it mean if I'm like out there a little bit more, you know, it's kind of like, I'm like, well, I'm standing here now. I might as well do this. Um, and, and, and, and then sort of in some ways, take the burden away from other people from having to, but also just to like say that we are here and numbers in huge numbers and there, like, there are tons of studies and statistics that specifically mental health, you know, it's like one in, uh, I think it's. I think there's a study that's like 40% of interns at some point during intern year meet criteria for depression by like PHQ-9 criteria. Um, that's ridiculous. That's a huge number. So much of

medicine we're seen as like, you know, I think we are definitely part of the problem as well, but we view ourselves as like these heroes and these like superhumans, who can do everything and you can save lives, who like bring people back from the dead, who keep people alive when they're like blood pressure is like, I dunno, whatever 70/40 and like in the operating room. If you do all these really cool things, um, but that, but that doesn't mean that we're not human.

Sheth: And I do have to say, I feel like, you know, I think, um, uh, Justin, you've been super courageous, like talking about everything and you know, like you said, you're already out there right? So I feel like that actually has been something that I've personally learned is like, I feel like, um, I think I've already, you know, um, I don't tend to talk about my ulcerative colitis, but, um, seeing that, you know, you're talking about your, um, um, illness, you know, hearing other people talk about their illnesses. It makes me suddenly be like, why, you know, like there's not a stigma. Like I should say something too. Maybe there'll be other people who are willing to talk about it. So I feel like it takes a lot of strength to be the first, um, people to do it, or at least in the first wave to do it so that people like me can follow behind in the second wave

Takimoto: As a first year medical student coming in, being lucky enough to hear Justin's story, you sort of exemplified what it meant to be a physician. Uh, for me, even as, as a younger medical student, it was this idea that you're coming in and you have so much imposter syndrome and there's already so much stress and pressure feeling the need to, to perform and do well. And yes, you've just got into medical school or you just got into residency, and now you need to prove that you are meant to be here and to have people ahead of you and around you being able to share vulnerabilities in a way that says, "Hey, I'm doing it. I'm succeeding. I'm an excellent medical student, resident and physician. And I deal with mental health issues. And I deal with sometimes a loss of control of my body, but that doesn't make me any less of a great physician" is so powerful because it sets expectations. And it also prepared me for when you experienced those lows or those moments when you're out of control and knowing that 1) I can speak up and 2) I'm not alone. And it doesn't mean that I can't be a doctor and it doesn't mean I'm not good enough.

Bullock: Preach.

Jaeel: I know, that was so well said. I definitely connect with that.

Sheth: Absolutely.

Bullock: Yeah. And the one thing I will say, I should've said this earlier, but to Mansi, you know, I think it's so powerful for me to hear you talk as someone who doesn't share their story often. For you to share it with us, I just think that's so cool. And I'm actually super, super, super, super grateful for that. I feel like that should be acknowledged because it's amazing and it takes a lot of strength and it's very scary.

Sheth: Thank you. All credit goes to Pooja.

Jaeel: No, I mean thank you for saying yes. Um, I didn't want to pressure you or anything, but, um, I'm so glad you shared because it's so important for people to hear. Um, just like

Sarah was saying, I think it, um, inspires folks. Uh, so you can feel you can be human and be in this field.

Takimoto: Definitely. So we wanted to end today's episode by asking Justin and Mansi if you could speak to learners out there with disabilities who are interested in entering the field of medicine or who are currently trainees in medicine, what advice would you give?

Sheth: Um, I guess the one thing I would say is just, you know, don't let it define you. Having an illness is an important part of you and it may, uh, take up, uh, some certain part of your life, but at the end of the day, you know, don't let it control all of it.

Bullock: I love that. I think mine would be learning to put yourself first. I am someone who was like, I love work. I'm a workaholic. I can like hammer myself super, super, super far. And sometimes I just take it too far. And part of my like growth with my bipolar disorder is learning to like respect boundaries for myself, you know? And like I have to sleep seven hours and like, you know, being very, very, very disciplined and um, sometimes doing less work actually takes more [00:40:00] discipline. And for me, that's definitely the case.

Jaeel: All right. Uh, well, thank you, Justin and Mansi for sharing your stories with such honesty and vulnerability. Um, our goal of The DEI Shift is to create a safe space to discuss difficult topics in the hopes that it'll support and build up our listeners who may be going through similar situations and, um, really inspire them, um, to, you know, feel welcome, included, and connected. Um, and so thank you so much for doing it.

Sheth: Thank you guys.

Bullock: This was awesome.

Takimoto: Thank you. Thank you both again. Um, and for our listeners also remember to go to our website www.thedeishift.com for the episode, transcript, show notes, and additional resources. And you can follow us on Instagram and Twitter @TheDEIShift. Thank you for tuning in and we hope you join us next time.

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