Docs with Disabilities: Rethinking Inclusion in Medical Education – with Dr. Lisa Meeks

---

Keith Casebonne (00:00):

What happens when medical school is built around an "ideal" body and brain? Who gets pushed out, and what does that cost patients? Today, we're taking this beneath the surface and into what works on Disability Deep Dive.

(00:40):

Hello listeners. We're really glad you're here. I'm Keith.

Jodi Beckstine (00:43):

And I'm Jodi. Welcome back to Disability Deep Dive.

Keith Casebonne (00:46):

Today's episode is Docs With Disabilities, Rethinking Inclusion in Medical Education, and we're joined by Dr. Lisa Meeks of the Docs With Disabilities Initiative. You'll hear how the initiative began and what it does, the barriers learners face in training, and the practical steps schools and hospitals can take now.

Jodi Beckstine (01:05):

We also get into why this matters for patients, and what accountability looks like across admissions, classrooms and clinics.

Keith Casebonne (01:12):

Yeah, and after the interview, stick around for our Deep Cut. This week's Deep Cut is the TV series The Pitt. Told through the day-to-day of a modern Pittsburgh hospital, the Pitt raises the exact questions we will explore today, who gets heard, who gets sidelined, and how training culture shapes care.

Jodi Beckstine (01:30):

So let's get into it.

(01:37):

Hello and welcome to Disability Deep Dive, Dr. Meeks. Let's start at the beginning. Can you introduce yourself and tell us about the Docs With Disabilities Initiative, how it started and what its mission is?

Dr. Lisa Meeks (01:49):

Sure. So my name is Lisa Meeks. I'm a professor of medical education at the University of Illinois College of Medicine in Chicago, Illinois, and I still retain an appointment at the University of Michigan in their Department of Family Medicine. But mostly, and why we're here today, I'm the founder of the Docs With Disabilities Initiative, and currently, I co-direct that initiative alongside Dr. Justin Bullock.

(02:18):

It's And the Docs With Disabilities Initiative is interesting because it began really as this very, very small grassroots effort to tell stories. I remember thinking so clearly that what I knew to be true, it felt like the world didn't know about, and so I just kept thinking about ways that we could tell stories about disability that didn't have to lean into a deficit model or an overly inspirational model, which is what I saw when I read about the one or two physicians with disabilities. So I wanted to change that and position disability really as this normal, valuable part of someone's identity that would lend its experience and expertise to medicine and health professions broadly in a really lovely way. So that's really how it started.

(03:21):

And at the same time that it started, I had gone to the University of Michigan and started my academic career. Now, just for contextualization, I'm, this is my third career, a little bit older. I was in private practice doing diagnostics for children and adolescents, and so I would see and evaluate those children for ADHD, learning disabilities, autism spectrum disorders, things of that nature. And on the heels of that, I was also teaching at the same time, I wound up going and working in a counseling center in higher education, and that's where I really started to see the inequity.

(04:03):

Because in my private practice, I had the luxury of saying, "Yes, we see something here, so statistically, there's this difference." But I got to really lean into the strengths-based model and say, "Your child has so many wonderful abilities, let's discuss how we maximize these." Where in the higher education setting, I was serving first as a counselor, and then very quickly on the heels of that, became a disability resource professional, because I knew the psychometrics and because I had written letters on the other side for a combination. And I saw a lot more limitation once I was seeing it from the perspective of the school, the way that faculty were interpreting even the letters that went out to say, "John has an accommodation," and the way that they would really see that as an affront or a challenge to their course and the integrity of their course.

Keith Casebonne (05:01):

Wow.

Dr. Lisa Meeks (05:01):

So I had those two careers prior, about a decade in each, and then, all of a sudden, became a researcher at the invitation of the University of Michigan, which I could never be more grateful for the opportunity that I was given, because it allowed me and the individuals that I work with to ask bigger questions and to make more impact. So that's a little context. At the same time, I was building my academic career for the first time and doing research and publishing research papers, and I thought, gosh, telling stories, AKA the podcast, and doing research, AKA publication, it's too disconnected. And then, I would build these little educational models, because I knew people needed the information, and my children are grown, I was willing to do this work, labor of love type of work. If you're in disability work at all, you know the labor of love at work.

Keith Casebonne (06:02):

Sure.

Dr. Lisa Meeks (06:02):

And I just thought there's no cohesion, we need something that brings all of this together so that collectively, it can start to impact and actually move the needle. This one-off here, one-off there is helpful, but not as helpful as I felt like it could be if it were brought together and formalized, hence the Docs With Disabilities Initiative. And so, our mission remains fairly simple. I always say I unapologetically want to increase the number of disabled people in healthcare professions, but it really is to drive change in perception, in policies, in the way people practice disability inclusion in their healthcare program, and we do this by that synergy of the high-quality research, the storytelling. And then, one thing we've been able to add, once we got off the ground, so to say, was these strategic partnerships with core organizations, so people like the AAMC, for example, or the AACM, so the medicine and the nursing associations that provide a home for all those nursing schools and medical schools.

Jodi Beckstine (07:17):

Wow.

Keith Casebonne (07:19):

That's incredible. There's so much behind that. So you mentioned research, and we know you've obviously done a lot of research in this space. Can you tell us a little more about what inspired you personally to focus your work and advocacy on disability inclusion in medical education?

Dr. Lisa Meeks (07:36):

Well, I think that's a two-part question really if you break it down, it's what inspired you to focus on disability, and then what inspired you to focus on disability in medical education, because the disability part actually and obviously came first. So for me, it's a mix, it's a mixture of having had that experience in private practice and seeing the ways in which parents would deflate if they received a diagnosis about their child or the way that the whole system was set up. You needed this diagnosis to access resources, but then the minute you did that, you were placing your child essentially in a structure that now viewed them very differently, and perhaps, not always, but perhaps would cap what the expectations were of that child's achievement, and that always really bothered me.

(08:36):

I hadn't really dug too much into why disability just never seemed to be this huge thing for me, until recently, I was writing an essay on it, and it really goes back to the way that I was raised. My grandmother, I was born on the south side of Chicago and raised in a fairly poor household so we struggled a bit, and I spent a lot of time living in and out with my grandparents, and my grandparents were amazing people. My grandfather was a mechanic and worked on buses for the school system, but my grandmother was an aide on those buses. So if you think back, I don't know how it works today, but there used to be different buses for disabled children and she served as an aide. My grandparents were the best people in the world, and they would very quickly be adopted into families, and vice versa, my grandparents would adopt families and children into our family.

(09:41):

So for me, being around individuals that were wheelchair users or that were scooter or walker users or that were deaf, this was not abnormal to me ever, it was just part of the human experience. And in my house, we didn't pity people and we didn't make them superheroes either because of their disability, it was if something was inaccessible, you figured it out. My dad was a bit of a carpenter and he would make ramps so that people could get into our house. I think growing up and having that model of behavior of really valuing people for all of who they are, their full identity, was something that was just ingrained in me so early on.

(10:36):

And then, my dad became disabled earlier in my teenage years, and I bore witness to the change in the way society perceived him. My father was a dashingly good-looking man and very gregarious and very big personality, and was a fireman and had an accident, fell off of a roof-

Keith Casebonne (11:00):

Oh goodness.

Dr. Lisa Meeks (11:00):

... and very quickly went downhill, wound up having, after one of his surgeries, had a stroke and became a wheelchair user. And the way that he was treated, not only by the healthcare system, but by society, was shocking to me, to be honest. And so, there were all of those things that personally informed my desire to change healthcare for the better and to also change the perspectives of individuals with disabilities.

(11:30):

But I think the medical education part came from my desire to be a physician early on. I was diagnosed with cancer at 20 and actually had to take a leave of absence out of school and then was unable to move forward and complete medicine, but I always volunteered in community-free clinics. Having been a patient in those clinics, I felt that this was my way to give back. And so, I was constantly surrounded by medicine and spoke that language. And so, when I was at this institution where I was seeing faculty really push back if they received a letter or question, like I said, the ability of people to be in their courses, that was very difficult for me personally. But also, I felt that I knew better, I knew what disabled people could do, I knew the behind the scenes perspective of ability, and felt very strongly that individuals with disabilities could make a big difference in healthcare by challenging and combating those stereotypes.

(12:42):

So my first interaction with a health professions program was nursing, and it was not positive, it was extraordinarily challenging, and I thought, no one's doing this work. We had done a lot of work with the law and with practice for K-12, we had done a lot of work with undergraduate education, but no one had tackled this put-up-on-a-pedestal healthcare profession space, and I thought, I speak the language, I know the way that healthcare providers talk. I've never been afraid, so I wasn't afraid. I think sometimes we can be intimidated by titles, right?

Jodi Beckstine (13:28):

Yeah.

Keith Casebonne (13:28):

Sure.

Dr. Lisa Meeks (13:30):

And because we make such a big deal out of individuals that are physicians or that are nurses and give them so much power, it is difficult for the average disability resource professional or advocate to hold their space and their knowledge with someone of that stature. But again, being raised by the individuals I was raised by, I was taught no one is better because of a degree, my grandparents didn't finish high school, and so I just didn't have that fear.

(14:06):

And I think it was that combination of not fearing it, having a little bit of that language, seeing a space that had been untapped and knowing what the possibilities were for disabled people, one, to go into a career where one of two things was happening, either they had poor care and they wanted to change that for others that came after them, or they'd been the recipient of excellent care that had changed the trajectory of their life, maybe their functioning or the way they viewed themselves, and they wanted to equally give back.

(14:38):

So I think it was just this very unique space and time and set of qualities and life experiences on my part that all came together to lead me to the work I'm doing, none of it was planned. Oh my gosh, if I followed through with my career plan, I can't even imagine where I would be right now. I always say I'm so grateful to the people that were part of the process for the jobs that I did not receive, so grateful to those people, because I love where I am and I am so blessed to be able to do the work that I do. And it's meaningful to me, but when I hear the stories of people who are now successfully navigating medicine, nursing, OT, PT, dentistry, and the fact that they feel like they now have a community, it just fills my bucket in such a big way.

Jodi Beckstine (15:36):

That's phenomenal.

Keith Casebonne (15:37):

Thanks for sharing that story. That's just such a beautiful story, just start to finish. You're right, all the pieces just fell into place. I think it's amazing.

Jodi Beckstine (15:45):

It's fantastic. So what do you think are some of the biggest barriers that students and professionals with disabilities face in medical training today?

Dr. Lisa Meeks (15:56):

That's a great question, and of course, it's multifactorial, but I would say the biggest is they're not doing what we are doing here today. The three of us are connecting, we're having a conversation, we're getting to a shared understanding of this construct. And the people involved in the system, the institution or institutional representative, which is often a disability resource professional, and the faculty that teach the courses, the clinical faculty that are precepting on the words, are not having those important conversations that they need to be having.

(16:35):

So there's a lot of assumptions on the part of the faculty, and those assumptions aren't being challenged, and there's also a lot of assumptions on the part of the DRP about what the faculty would say if they entered this conversation, or a lack of trust or a fear, as I had talked about earlier, because oh my gosh, I can't talk to a dean of a XYZ or a clerkship director for this program. That person is viewed as being so smart and so above all the knowledge that someone else would have. And so, I think sometimes people get a little in their head and are afraid to have those conversations.

(17:16):

You know what's so interesting? I'm doing a study right now with clerkship directors from a very prestigious medical school, and their study was on clerkship directors, so the faculty members, and the findings are that faculty members want to have these conversations, they're eagerly awaiting these conversations, they don't feel like they're being made part of the equation. And then, of course, there's always the learner, the student that is getting varied levels of engagement from either the institution or the faculty, and everybody's scared. I keep coming back to that, everybody's scared. But faculty know that there's a legal implication for what happens, so they're worried on just that level, I don't want to get sued, I don't want to do anything wrong.

(18:08):

I believe most faculty are also very kind people who really want to help people. Most people don't go into medicine for the prestige or the money, that's not there anymore, look at our healthcare system. Most people go into medicine really, and when I say medicine, I mean broadly, this could be any specialty, really want to help people, and they feel that way about their students too. And so, they really want to help, but they don't know what to do. And then, you have disability resource professionals who are struggling to just see the students because their caseloads are so high or they don't have the knowledge of medicine or nursing or PT that they need to make good decisions.

(18:55):

And I know it sounds simple and it sounds a little Pollyanna-ish, but I do feel like if you could get all parties at the table and have a conversation, there would be such a renewed level of understanding that we could get past the hesitation and do some real good. I think that when we operate with this disconnect, students are the ones that have the biggest loss, but we also aren't able to move forward and be innovative and have it be fun. Oh my gosh, my job is so fun. I get to think about how to innovate every day and how to build solutions so that people can have more access, and not just the disabled learner, but if I do something for a disabled learner, 99% of the time, it's going to help someone else. So we're talking really about improving education, optimizing education, improving the healthcare workforce, there's just no bad for me.

(20:01):

But some other things that are known barriers, technical standards, although I think we're really in a good place, I know most of the medical schools are starting to change these, and a new paper just came out in Academic Medicine that highlights some of the remaining deficits. And so, I think that... Sometimes, when papers come out, they're a little bit of a fire lit under programs to address something when it shows that there's so many barriers. So technical standards, and I just really think ableism in general, so the generalization about disabled people, the assumptions, the stereotypes, that really still remains the biggest issue, and part of that could be broken down with addressing that first issue, the communication.

Jodi Beckstine (20:57):

Yeah.

Keith Casebonne (20:57):

Yeah, absolutely. This has been a theme in some past episodes too, but the idea that most people don't want to be ableist, they just don't know, they don't have the information. So that communication is critical, I think, and we see that theme over and over again with different guests in different worlds, different jobs, different et cetera, and what it comes down to is people just don't know, and if they knew, they would do better.

Jodi Beckstine (21:24):

Yeah.

Keith Casebonne (21:25):

Well, you mentioned solutions and how that's so exciting, that you get to find solutions, so let's talk a little bit about solutions. So how can medical schools and residency programs better support learners with disabilities, what are the solutions?

Dr. Lisa Meeks (21:38):

Yeah, that's a great question. So I don't have all the answers, but I have a few. I like to give low-hanging fruit answers, because some answers are more complex. For this audience, I would say, listen, the learners are afraid. They know that ableism exists, that it's very deeply ingrained in healthcare professions writ large, and they are looking for signals. They're looking for signals that let them know that you are safe and that it's okay to disclose, similar to what we see with the LGBTQI population and wearing your rainbow pin on your lapel or having a sign in your office that says, "This is a safe space," or for whichever population you are trying to connect with.

(22:37):

And so, the students are coming in and they're fearful. Signal to them, if you are an institution or you're a program or you're a faculty member that believes in disability inclusion and that wants to serve as an institutional agent or an advocate, or you want to make sure that people know that your medical school or nursing school is inclusive, signal that publicly. You can do that by saying, "Disability is a part of diversity." I know that especially in Florida, diversity is under attack, if you want to instead signal just by saying, "We aim to create a disability-inclusive environment," anything that you can do to let people know, we know that disabled people are going to be here... And they'll be there no matter what you say, you could be the most inaccessible environment in the world, disabled people are still going to be there, because at one in four, this is a huge population. It's just, are they going to tell you that they're disabled and ask for the resources need?

(23:46):

So signaling is really important, having transparent policies, help people find the information they need quickly and efficiently. I should not have to go dumpster diving in your website and go through 25 keywords to find the information I need. And what I say to programs is go into incognito mode, go to your website and find information as if you were a disabled student, see how easy it is or how hard it is. Look at the words you use to describe the services you have. Would you, if you were a disabled learner, want to engage your program?

(24:28):

So let's say you signal that you're inclusive, you have policies and procedures up, and you have a process for requesting and it's all transparent, but your language starts with, "The Americans with Disabilities Act requires," blah, blah, blah, blah. Think about the message that's being sent with the words you are using, so I think that is the first one. The second one is faculty need to be educated, and they don't need to be educated in ADA 101, they don't need to know how wide a doorway needs to be, they need to have their assumptions directly challenged with a counter-narrative that shows disabled people thriving, and that needs to lead the conversation, because until that happens, they're going to be defensive and they're going to want to talk about, well, what is a unreasonable accommodation, or what about patient safety?

(25:30):

I can show you the regs that tell you how to make a decision about patient safety, but let's talk about the possibility of disabled people being in your program first and get you to not be as reactive as we're talking about that, by showing you that it's not only possible, but that people thrive, and that they contribute to patient care, to innovation, to all of these things in a way that is so meaningful so that when we start having our conversations about patient safety... And by the way, people with disabilities are far more diligent about patient safety, it is really interesting. We have fail-safes in place in any profession that involves patient care to minimize the risk of a medical error. Medical errors happen to everyone in every scenario, but to minimize it...

(26:35):

And what I have seen with disabled learners and disabled providers is that they create an even bigger fail-safe for themselves, knowing what their strengths are, knowing areas that they need to be cognizant of, they are being hyper-vigilant, and that maybe hubris, the competence without humility that we might see in some people, I don't see that in disabled providers. I see interactions with patients that are full of humility and grace and a lot more active listening, and so I don't worry about those things. But before you can get to all those discussions, I think we need to directly combat people's assumptions about disability. So I think that would be my second thing that I would say, and those are two of the most important things, to be honest with you.

Jodi Beckstine (27:43):

Yeah.

Keith Casebonne (27:43):

Wow.

Dr. Lisa Meeks (27:44):

The rest of the stuff is so much easier to figure out than you think it is. The things that people worry themselves about are the things that would take me five minutes to solve. And in fact, the majority of the time, when I get a phone call, I already know the answer, because it's been done in two or three other institutions. What I focus on before I give that answer is, let's think about the assumptions that are in the question you're asking, or let me tell you about how this can be successful. So I get you to come down off of that almost angst, this anxiety-driven concern about people with disabilities.

(28:26):

And I understand, society constantly reinforces a negative stereotype of disability, so I don't think... Back to what you were saying earlier, I think it's understandable why ableism would be a thread throughout. I never blame people for ableism, up until the point where it's been defined, they understand it, and they've had several opportunities to check their ableism as they're operating. I always try to meet people where they're at and say, "I know you don't understand what's happening." And quite frankly, for most people, they didn't have my upbringing, they had an upbringing-

Keith Casebonne (29:09):

No, that's true.

Dr. Lisa Meeks (29:09):

... with the parents in the grocery store, where the first time they saw a disabled person, the mother said what?

Keith Casebonne (29:16):

Don't stare.

Jodi Beckstine (29:17):

[inaudible 00:29:17] yeah.

Dr. Lisa Meeks (29:18):

Don't stare, don't do that. And so, what did we learn from a young, young age? There's something wrong there, it's bad, I'm not supposed to be engaging with it. So I understand, I get that. That was not my experience and I feel so blessed to have not had that experience, but that is the normative experience. And then, we get bombarded by... Oh my gosh, if you're in healthcare professions, you get bombarded by your textbooks that situate disability as a deficit, you watch movies where people with disabilities are either these superheroes or they're these fragile beings. So society is constantly feeding us this narrative.

Jodi Beckstine (30:05):

You had mentioned patient care, why do you think it's critical for patients to see themselves reflected in their healthcare provider?

Dr. Lisa Meeks (30:14):

That's a great question. I think because representation matters, but in healthcare, it can be almost transformative. If you are someone... And I go back to thinking about how my dad was treated by the healthcare system, he was dismissed a lot, there were limitations put on him, and he actually carried... And I wish I had talked to him more before he passed away about this, because I think it could have been really insightful for my work. But I got the sense that he carried a lot of shame about his disability and felt like he was a bother if he were to go to these appointments or if he had to go, which he often had to go to the emergency room.

(31:00):

And I think that when you know that somebody's been through something and they understand you, there's this hope, this connection, this trust, I think that connection is really powerful. And we see that in studies that look at race and gender and other dimensions of diversity, how having that connection can improve communication, reduce feelings of isolation, improve outcomes, usually because someone has listened more or because someone is following the recommendations, because again, it's a trusted source. So I think being cared for by somebody that understands disability is powerful in that way.

(31:47):

But also, it shifts the dynamic. We talked about how the DRPs view people that are physicians or nurses or healthcare providers in this elevated class and they're afraid to talk to them or afraid to challenge them. But when you share an identity with someone, when you share an experience with somebody, it can also shift the power differential in ways that are really important, because if I trust you and, and, this is not or, I'm not afraid of you, I know that you've had this experience and I feel like we're in some ways equal, I know that you know that my experience and what I'm going to report to you as a disabled person is the most valuable data you're going to get today, because you, as a disabled person, know that you are the expert in your disability. So you see how that shifts the dynamic, and I think that changes the way healthcare is received.

(32:50):

One of the fears of faculty is, well, the patients won't like it. I think complete opposite.

Keith Casebonne (32:58):

For sure.

Dr. Lisa Meeks (32:58):

The patients will like it, they will feel even better.

Keith Casebonne (33:05):

They'll embrace it.

Jodi Beckstine (33:06):

Yes.

Dr. Lisa Meeks (33:07):

Yeah.

Keith Casebonne (33:08):

Yeah, I think it's human nature to just feel more comfortable with someone that you feel is like you, similar to you, it's such a simple thing. Yeah, that's amazing.

Dr. Lisa Meeks (33:21):

You know what's interesting? As an aside, I was diagnosed with a disability at 41 and it was a horrible experience, it was a very degrading experience, there was a lot of gaslighting, which you hear people talk about gaslighting and I thought, oh, it can't be that bad. It is that bad, it really is. And I'm an educated woman in health professions with all the privilege that one could possibly have, and was part of the healthcare system at a healthcare institution, and I was treated like... Well, I was treated very poorly and I was questioned and I wasn't listened to, and it took a year and a half to get to a diagnosis that I think could have come a lot sooner and had a lot less implications and destruction on my body had I been listened to and believed.

(34:22):

It's problematic for women anyway around that age who are often not listened to, women in general are not listened to, other minoritized populations are not listened to by healthcare providers. But it really, when I had that experience, I had already been working for 20 years and I thought, oh, I'm tripling down. I thought it, I hypothesized it, my work was focused on it. I had not planned to get sick, there was no indication, when I started this work, that I would ever be disabled. And I was shocked, I got very ill very quickly, and it was shocking, and the way that I went through the healthcare system was shocking. And I thought, now, this is it, this has got to be what we work on.

Jodi Beckstine (35:14):

Yeah, that's powerful.

Keith Casebonne (35:15):

Yeah, it is. I'm sorry that happened. Wow. On the flip side of that, are there any success stories, signs of progress and the like that you've seen in recent years that give you hope?

Dr. Lisa Meeks (35:26):

Yes. Actually, it's funny, because in preparation for this, I was going over the questions again, and all weekend, this weekend, I've been home and been producing podcast episodes, and they're podcast episodes that are focused on a disability resource hub that is being launched next week through the ACGME, and the podcast episodes are program directors from residency programs and their disabled residents in a joint interview.

Jodi Beckstine (35:58):

Oh, wow.

Keith Casebonne (35:59):

Nice.

Dr. Lisa Meeks (35:59):

And all weekend, I couldn't help but think, oh my gosh, this is going to be so impactful, because getting back to the very first thing we started talking about, the power of storytelling to change perceptions. And as I listened to these amazing leaders in medicine talking about how much they've learned, how they would take this learner back in a heartbeat and they would take 10 more like them, I thought, this is really going to help change the game, it's going to spark some interesting conversations.

(36:36):

And those are the moments, like I said, in addition to learners... I have learners that will private message me on Twitter or Instagram and say, "I never thought I could be a doctor. I just got my acceptance letter. Four years ago, when I started listening to the Docs With Disabilities podcast, I would never have thought this was possible," and people that would've never gone into the profession. And then, of course, I have a research lab, and I have about 12 disabled learners and faculty in the lab, and seeing their success, it's my success.

Keith Casebonne (37:16):

Sure, sure.

Dr. Lisa Meeks (37:18):

It's my success in that I am cheerleading for them, I am so excited for them. So I feel like just anytime they do anything, whether I had anything to do with it or not, that the system has changed enough that they can do this, and I get to celebrate with them. I'm so proud of our research lab and our learners and so proud of the faculty who have done so much work in this space. So I think every day, there's something I can find every single day to put...

Even if it's just a drop, it goes from ounces and liters to a drop, but every day, there's something that's going in my bucket and keeping me motivated to do the work.

Keith Casebonne (38:05):

Nice.

Jodi Beckstine (38:06):

That's wonderful. So what can our listeners, whether they're in healthcare or not, what can they do to push for more inclusive practices in medicine?

Dr. Lisa Meeks (38:17):

Start by look up the term ableism. What does it look like [inaudible 00:38:24] manifest. Challenge your own ableism. Going to a course, completing a certificate program on anti-ableism, it's a step, but honestly, it's like anything else that comes or is derived from our own thoughts, we have to challenge it, it's not something that can constantly be challenged by other people. So think about your language, think about your assumptions, think about your everyday practices. I would be interested to say, when you see disabled people on the street, in the airport, in a restaurant, what is your reaction? What is your body language? What do you do? Are you still that kid in the grocery store that's looking the other way? Are you telling your children not to look the other way?

(39:11):

The second thing, support organizations that do the work. Money is being stripped away from anyone who's trying to do any diversity work right now, so support those people. If you can't support them financially, support them emotionally, send them a letter. I cannot tell you, every once in a while, I'll get a letter through our organization from a learner or a faculty, and it makes my day. Send a letter, tell people the impact you've had on their lives, share stories, amplify the stories of disabled people and give them credit for it.

(39:51):

If you are in healthcare, if you are an advocate or in a position to have an impact on institutional policies that promote disability inclusion, start sharing information. Everything on our website is free, everything that I create is free, all of my articles are open access.

Keith Casebonne (40:09):

Excellent.

Dr. Lisa Meeks (40:09):

Share them, just share one, share a podcast episode.

(40:14):

And I think the most important thing is when disabled people are speaking with you, listen, listen to them. Don't placate people, don't give the whole canned speech about what you can do and can't do. Sit and listen to the person in front of you and what they're telling you. So often, the change that is needed doesn't cost hundreds of thousands of dollars, it's attitudinal change, it's climate change, it's culture change. Sitting and listening to someone's story is the first step in creating a culture where people feel safe.

(40:56):

And I think disability inclusion, I'm doing the work in the healthcare space, but ableism is a societal problem.

Jodi Beckstine (41:03):

Yeah.

Keith Casebonne (41:04):

Oh, indeed.

Dr. Lisa Meeks (41:04):

So it is going to take everybody, it's going to take everybody thinking about why they think certain things about people, because there's a lot of cognition going on. But it's the same for any minoritized or marginalized population and our belief system about them, why do we think that, and what can we do to challenge ourselves about that?

Keith Casebonne (41:29):

Brilliant. Before we wrap up, a fun question we like to ask at the end of each interview, is there a book, a film, a TV show, piece of music, any media, that you would say reflects your work, or even just has been on your mind lately?

Dr. Lisa Meeks (41:49):

This is such a great question that it's such a fun question, but I always get so much anxiety from the fun questions, because I'm like, oh, am I read enough? Am I worldly enough?

What do I do? What do I say? So this question actually had me thinking. A lot of Buddhist philosophy has really shaped the way I think about things.

Keith Casebonne (42:11):

Oh, that's awesome.

Dr. Lisa Meeks (42:12):

But honestly, what I came back to was the song This Is Me from The Greatest Showman, and thinking about one of the lyrics, one of the lines in there, that I think captures this feeling that most of the learners that we have would want to have as they're going into a healthcare profession program, which is, "I'm not scared to be seen and I make no apologies." And while not every learner is there, just like I meet faculty where they're at, I meet learners where they're at, not everyone's ready to disclose, not everyone has been brought up with a sense of disability pride, but my hope for everyone is that they can be in a place where they're not scared to be seen and where they don't feel like they have to apologize.

Keith Casebonne (43:11):

Nice.

Jodi Beckstine (43:12):

Yes.

Keith Casebonne (43:13):

That's a great answer.

Jodi Beckstine (43:14):

Yes, good answer, you did great.

Keith Casebonne (43:18):

Well, this has been an eye-opening interview and such a pleasant conversation. Thanks so much for being our guest today, Dr. Meeks. We really appreciate your time and everything that you've worked for in this regard. Yeah, thank you so much.

Dr. Lisa Meeks (43:32):

It was wonderful, thank you.

Jodi Beckstine (43:47):

Before we get started, a quick heads-up. The Pitt is a medical drama for mature audiences. It includes emergency care scenes, injury and trauma, flashing lights and alarms, and storylines involving mental health and sensory overload. If you choose to watch, please use your discretion and do what feels safe for you.

Keith Casebonne (44:05):

This week's Deep Cut takes us to The Pitt, a series set in a modern Pittsburgh teaching hospital. We're zooming in on Dr. Melissa King, known as Mel on the show, a second-year resident who many viewers read as neurodivergent.

Jodi Beckstine (44:19):

The show never names a diagnosis, but Mel uses strategies that people with autism or ADHD might recognize, and her perspective shapes how she cares for patients. It connects directly to our conversation with Dr. Lisa Meeks, and how we train and support future physicians.

Keith Casebonne (44:35):

So what stood out to you about how Mel manages sensory overload on shift, like adjusting lights, stepping outside, or using lyrics to self-soothe?

Jodi Beckstine (44:47):

I think we see her right away showing her limits and how she does something about it, that they jump right in with that. She lowers the lights, like you said, she steps outside, she recites lyrics, and those simple acts become the tools that she uses to help regulate and steady herself in this chaotic environment that she's found herself in. And I like how they treat it as these are just facts for her, these are just steps that she takes, it's not overly dramatic, we don't necessarily zone in on it, it's just there and part of who she is.

Keith Casebonne (45:25):

Yeah, no, for sure.

Jodi Beckstine (45:27):

So going with that, there's a scene where Mel connects with a patient that has autism after another doctor seems to have missed the key cues on that. What did you notice about her communication choices and pacing in that scene?

Keith Casebonne (45:42):

Yeah, I thought that was really interesting. That whole episode had, I guess, a few scenes, honestly, with that, and it was really great to see how... So first, she's not the initial doctor that meets with the patient. The doctor that first sees this patient with autism, he's one of the attendings, so of course that means he's got a lot more experience and should be the... I don't want to say the better doctor, the one that's just a little more experienced with dealing with a variety of patients, that sort of thing. But he has a lot of trouble communicating with this patient, and the patient's getting restless and angry, not being able to... I don't think the patient feels really heard.

(46:19):

And Mel steps in because she notices that there's something about the patient that she recognizes, and the way she communicates is completely different, she calms him down, the patient, calms him down, and just uses an entirely different tone, a different pace, kind of a reset, really. And the patient then does a much better job of being able to communicate what he needs and they build a rapport quickly. And just seeing that difference in how this, quote, "less-experienced" doctor comes in and changes everything, just changes everything, it's really incredible.

Jodi Beckstine (47:01):

Yeah, the whole temperature of the room just completely drops where it's escalating, and she's able to just bring it down to a low simmer again and start fresh.

Keith Casebonne (47:09):

Yeah, yeah, for sure. So interestingly, the show keeps her diagnosis off-screen, it's never mentioned. So what are the upsides and downsides of a character being coded as neurodivergent without actually saying it?

Jodi Beckstine (47:25):

I was thinking about this when we first discussed covering the show on the podcast. Keeping the diagnosis off-screen is a mixed bag for me. It, on one hand, invites people to notice what she does well and how she works and her diagnosis isn't a label. But for me, there's a trade-off, because if you're not naming it, there is the possibility that some viewers can miss what's going on and miss the context clues and miss why support matters. And also, in turn, then I feel like the show can lose out on a chance to model this good language and behavior and disability rights that happen in the workplace. So I go back and forth on my opinion on whether it's good or not. And hopefully, in future seasons, they'll start talking about it, because the fans of the show have been talking about it off-screen, maybe they'll take that into account.

Keith Casebonne (48:19):

Yeah, yeah, it'll be interesting to see what they do with that. And I tend to agree with that, your way of looking at that, yeah, it's a mixed bag, for sure.

Jodi Beckstine (48:29):

Well, we also learned that her sister, Becca, is a person with autism and in a care facility. How do you think that family context informs Mel's bedside manner and her advocacy in the emergency room?

Keith Casebonne (48:44):

Yeah, I think that context is incredibly important. It's how she knows what to do in that situation that we talked about earlier with the patient with autism, it's how she recognizes the patterns and knows that you need to do the sensory reset. I think one of the first things she does when she goes in the room is she dims the lights a little bit. So it's those little touches that you may not think about as something that can help that she's obviously seen a number of times maybe, just knowing her sister and the things that work with her and help her stay calm and focused, she's able to then translate into working with others. And so, I think that context is really huge.

(49:28):

And I think it might even additionally hint, going back to the previous question and answer we were talking about, I think that might actually be a hint toward the fact that Mel also is neurodivergent, like, hey, my sister is autistic. That doesn't, of course, mean automatically that any other family member is or isn't. But I think that's set up as a way to make you say, well, that's interesting, because I felt like Mel is showing interesting signs of being a little like that. And so, I think that maybe makes you think about, is Mel also autistic or have ADHD, or what's going on there? So I think the whole dynamic is important to the show and Mel's character development.

Jodi Beckstine (50:14):

Yeah, her actions are almost like muscle memory for her. She keeps the doctor portion going forward with the diagnosing what's going on as she's slowly doing these other things to change the environment, and it just comes naturally, it appears, to her.

Keith Casebonne (50:33):

Yep, yeah, I agree. So where do you think The Pitt gets representation right with Mel, and where would you like to see more depth?

Jodi Beckstine (50:43):

Well, we've talked about showing how she deals with patients, showing how she regulates herself, building that trust with the patient, noticing details that others miss, and making sure she sets boundaries for herself. What I'd like to see is a little bit more acknowledgement of those supports that she has in the dialogue, maybe showing how the team backs her up or doesn't back her up, I think it's important to show both sides, and maybe give a little bit of background on how the program is set up to either help her or hinder her realistically. In future seasons, I'd love to know more about her relationship with her sister, did that cause her to go into the medical field? And just other personal details. I know they like to stay within the hospital so far, there's only one season, I don't know if they ever go out of the hospital. But just trying to bring as much of her family experiences into what makes her, I think, would be important.

Keith Casebonne (51:46):

Yeah, that makes a lot of sense, for sure.

Jodi Beckstine (51:49):

So if the writers choose in the next seasons to explicitly name her diagnosis, what would you like to see handled carefully so that it supports the character, as well as supporting the audience?

Keith Casebonne (52:02):

That's a really good question, because there's a lot of ways it can go wrong and maybe only a few where it comes out looking good. So I think one of the first things you want to do, I think, is avoid the whole savant trap and show that she's a team player, she's not into doing things solo and showing off, I don't know, just being separated from the group, which I think in the first season, she is, she's definitely a team player.

Jodi Beckstine (52:27):

Definitely.

Keith Casebonne (52:27):

That's all handled great. But you want to also make sure that Mel stays as a whole person and it doesn't become a focus that, oh, this is the disabled character, I don't want to see that happen. And again, like you mentioned, we don't go too much outside of the hospital, but making sure that you can see that growth and that she has a life aside of her job.

(52:46):

Oh, and another thing too I would mention is that we don't want this to become some ridiculous thing where a doctor gets mad at her, or I say a doctor, it could be any fellow staff person, gets mad or accuses her of something or... I don't know. I just think there's so many trite ways of doing it that I get a little nervous, and maybe in the end, it's best that they still never say it. I don't know. Like I said, it's a mixed bag.

Jodi Beckstine (53:13):

Absolutely.

Keith Casebonne (53:15):

We have to wait and see what happens. But if they do it, I just hope they do it well and just... I don't know, just not make it as trite as sometimes other things show up, and then, again, lose that focus on who she is as a person.

Jodi Beckstine (53:28):

Their best bet is to talk to some people who have these diagnoses and find out how they would deal with it. Hopefully, that's what they do.

Keith Casebonne (53:37):

Absolutely, absolutely. Well, and I think it's important to note that the actress that plays Mel has ADHD, and so is herself neurodivergent, and I think that helps. And hopefully, maybe when it comes to that development of the character, you mentioned talking to other people, I hope they also work with her herself and maybe get some insight on what makes sense and what doesn't.

Jodi Beckstine (54:00):

Absolutely. The Pitt gives us a useful lens, a resident using practical supports and delivering strong care, it's a reminder that access isn't extra, it's part of safe, effective medicine.

Keith Casebonne (54:12):

If you watch, notice where Mel adjusts the environment, sets boundaries, and builds trust with patients others struggle to reach, then ask, what would it take for every training program to make those supports standard?

Jodi Beckstine (54:27):

And that's this week's Deep Cut. Thanks for going deeper with us.

(54:36):

That's it for this episode of Disability Deep Dive. A huge thank you to Dr. Lisa Meeks for joining us and helping us unpack how medical education can better support learners and clinicians with disabilities.

Keith Casebonne (54:48):

Dr. Meeks brought clarity and concrete ideas to a topic that's often complex and overlooked. She reminded us how important it is to keep the voices of people with disabilities at the center when we talk about training and care.

Jodi Beckstine (55:01):

If you enjoyed this conversation, make sure to subscribe, leave us a review, and share it with someone who will benefit from hearing it.

Keith Casebonne (55:08):

You can learn more about the Docs With Disabilities Initiative at www.docswithdisabilities.org. So this is our last episode for a little while, this is Disability Deep Dive.

Jodi Beckstine (55:19):

That's right. But we'll be back on November 6th, and we have a few surprises we think you'll be excited about, so stay tuned. Thanks for listening.

Announcer (55:27):

Disability Deep Dive is produced by Jodi Beckstine, Keith Casebonne and Disability Rights Florida, Florida's protection and advocacy agency. You can learn more about the services we provide, explore a vast array of resources on a variety of disability-related topics, and complete an online intake at disabilityrightsflorida.org. Any comments about the podcast can be sent to podcast@disabilityrightsflorida.org. Thank you for listening to Disability Deep Dive.